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**INTRODUCTION**

Our residency is a nationally accredited, three-year program, which meets all training requirements of the American Board of Dermatology. As of January 1, 2007, thirteen permanent full-time training positions have been approved by the ACGME. Prior to entry into our program, each trainee must have creditably completed at least one postgraduate year within an ACGME-approved program. Most of our residents have had one prior year in internal medicine, although additional years of training, or training in another approved field, such as pediatrics, have also occasionally been taken.

As our overall goal, it is our intent that every graduate of our residency program will have acquired outstanding clinical skills, encompassing all major areas within the field of dermatology. In so doing, our graduates will then be able to successfully pursue any of several career paths, including clinical practice or academic medicine. To accomplish this goal, each resident will be taught clinical dermatology through the evaluation and management of a large patient population, which is seen within a variety of outpatient and inpatient clinical settings, under the close supervision of our clinical teaching faculty, both in Chapel Hill and at affiliated hospitals and departmental clinics elsewhere.

This traditional approach to clinical training will be complemented by a series of weekly didactic lectures and conferences, the contents of which comprise a curriculum which is intended to meet all recommended areas of study, as prescribed by the American Board of Dermatology. Training will be further supported and enhanced by the presence within our department of a number of federally-funded research laboratories, clinical investigative programs, and active dermatopathology and immunodermatology service laboratories, each of which can provide additional educational experiences to our trainees.

The success of our residency training program over many decades is reflected in (i) the level of performance of our graduates on the certification examination of the American Board of Dermatology; (ii) the ability of our trainees to obtain fellowships (i.e., in dermatological surgery; dermatopathology; pediatric dermatology; other) or research postdoctoral positions within other nationally acclaimed institutions, and (iii) the number of our graduates who have gone on to develop their own academic careers in clinical or investigative dermatology.

As of July 1, 2002, we implemented the new rules and regulations of the ACGME in three areas of our residency program: Educational program, Evaluation of residents, and Program evaluation as briefly outlined below:

I. **Educational Program**
As approved by the ACGME in September 1999, the residency program must require its residents to obtain competencies in the six areas below to the level expected of a new practitioner. Toward this end, programs must define the specific knowledge, skills, and attitudes required and provide educational experiences as needed in order for their residents to demonstrate: (Refer to Appendix A for a copy of our Core Competency Curriculum.)
**Patient Care** that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health;

**Medical Knowledge** about established and evolving biomedical, clinical, and cognate (e.g. epidemiological and social-behavioral) sciences and the application of this knowledge to patient care;

**Practice-Based Learning and Improvement** that involves investigation and evaluation of their own patient care, appraisal and assimilation of scientific evidence, and improvements in patient care;

**Interpersonal and Communication Skills** that result in effective information exchange and teaming with patients, their families, and other health professionals;

**Professionalism**, as manifested through a commitment to carry out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population; and

**Systems-Based Practice**, as manifested by actions that demonstrate an awareness of and responsiveness to the larger context and system of health care and the ability to effectively call on system resources to provide care that is of optimal value.

### II. Evaluation of Residents

The residency program must demonstrate that it has an effective plan for assessing resident performance throughout the program and for utilizing assessment results to improve resident performance. This plan should include:

- use of dependable measures to assess residents' competence in patient care, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice;

- mechanisms for providing regular and timely performance feedback to residents, and

- a process involving use of assessment results to achieve progressive improvements in residents' competence and performance.

Programs that do not have a set of measures in place must develop a plan for improving their evaluations and must demonstrate progress in implementing the plan. (Refer to Appendix B for a copy of our evaluation forms.)

### III. Program Evaluation

- The residency program should use resident performance and outcome assessment results in their evaluation of the educational effectiveness of the residency program.

- The residency program should have in place a process for using resident and performance assessment results together with other program evaluation results to improve the residency program.
HISTORY OF THE DEPARTMENT

The Department of Dermatology at The University of North Carolina at Chapel Hill School of Medicine [UNC School of Medicine, (http://www.med.unc.edu/derm)] had its beginning as a Division of Internal Medicine in September, 1952. The Division of Dermatology faculty initially consisted of Dr. Joseph M. Hitch, a practicing dermatologist in Raleigh as Chief of the Division, and Dr. George W. Crane, Jr., a practicing dermatologist in Durham. Soon thereafter, Dr. Herbert Z. Lund, a pathologist at Moses Cone Hospital in Greensboro, joined the part-time clinical faculty as its teaching dermatopathologist. In 1957, the first full-time faculty member, Dr. Richard L. Dobson, was added. These faculty members established a research program and an accredited residency training program in dermatology.

In February, 1962, Dr. Clayton E. Wheeler, Jr. became Chief of the Division and Professor of Dermatologic Medicine. The residency training program was reaccredited. An NIH training grant and two research grants were approved; these served to initiate and/or expand the research, teaching, and patient care activities of the Division. On July 1, 1972 the Division became a full-fledged Department of Dermatology in the UNC School of Medicine and Dr. Wheeler became its Chair in October, 1972. Outlying clinics were started in 1969, and AHEC clinics were added in 1974. A dermatology inpatient service was established in 1976. A program in Mohs surgery was established in 1980. On September 30, 1987, Dr. Wheeler retired from the chairmanship after 25 years as Chief or Chair of Dermatology, but he stayed on as Professor Emeritus. On October 1, 1987, Dr. Robert A. Briggaman became Chair of the department. Dr. Briggaman retired from the chairmanship in 1999, but he will remain as professor. His successor, Dr. Luis A. Diaz, was named the Professor and Chairman of the department on January 1, 2000. Dr. Diaz is an internationally recognized clinician investigator in the area of cutaneous autoimmunity. He was the Professor and Chairman of the Department of Dermatology at the Medical College of Wisconsin for 10 years previous to his arrival in Chapel Hill. Dr. Diaz’s career spans over 25 years from his dermatological training at SUNY at Buffalo under Dr. Richard L. Dobson and the Mayo Clinic under Robert E. Jordan. He moved through the academic ranks at the University of Michigan and Johns Hopkins University School of Medicine. Dr. Diaz’s research has pioneered the area of immunopathology of pemphigus and pemphigoid.

From 1992-June 2009, the dermatology clinics were housed in about 4,900 square feet of space located at the UNC Ambulatory Care Center (ACC). Since July 2009, the core dermatology clinics are housed on the fourth floor at Southern Village, building 410. The administrative offices, dermatopathology and research laboratories are located in the Mary Ellen Jones Building. The dermatology outpatient service has shown steady growth since 1952, but records of the number of patient visits are available only from 1965. Patient visits at UNC Hospitals have ranged from 5,500 in 1965 to 16,500 in 1998-1999. Patients seen in the outlying clinics have ranged from 1,700 in 1970 to 7,600 in 1998-1999. Over the last several years, the total number of patients seen by UNC Dermatology is consistently over 20,000 annually.

Basic research in the department has been active since 1957, largely funded by NIH research and training grants, but also by private foundations, especially the Dermatology Foundation, the Army, and pharmaceutical companies. The Department of Dermatology at UNC ranked number 12 among US programs receiving NIH grants in 2000. Research fellowships have been available
since 1962, largely through NIH training grants and most years, one or two fellowships have been awarded. Resident and fellow trainees have been high caliber, productive people. Of the many residents who have completed training, four have become chairs of departments of dermatology, another was acting chair, and more than 20 others have held full-time academic positions at one place or other for varying lengths of time. Many of the research fellows have obtained academic posts in the United States, Japan and Europe. Prior and current faculty at UNC have held important positions in all of the regional, state and national dermatological societies. Over the years, publications by the departmental faculty, residents, and fellows have made major contributions to the field of dermatology.
**Overall UNC Dermatology Goals and Objectives 2015-2016**

**Patient Care**
Residents must be able to provide patient care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health.

Residents:

(1) will demonstrate knowledge and competence in four broad categories: medical dermatology, procedural dermatology, dermatopathology and pediatric dermatology.
(2) will demonstrate knowledge and competence in:
   a. immunobullous diseases
   b. contact dermatitis
   c. connective tissue diseases
   d. infectious diseases
   e. medically complicated patients displaying dermatologic manifestations of systemic disease or therapy.
(3) will demonstrate knowledge and competence in techniques supporting diagnoses in the general field of medical dermatology
   a. patch testing
   b. KOH examination
(4) will demonstrate knowledge and competence in
   a. Photomedicine
   b. Phototherapy
   c. topical/systemic pharmacotherapy.
(5) will demonstrate knowledge and competence in a wide array of surgical techniques and maintain accurate case logs through the ACGME online Case Log System
   a. residents should achieve competency in
      i. biopsy techniques
      ii. destruction of benign and malignant tumors
      iii. use of lasers for the treatment of superficial vascular tumors
      iv. excision of benign and malignant tumors with simple, intermediate and complex repair techniques including flaps and grafts.
   b. residents will demonstrate knowledge through significant exposure to other procedures either through direct observation or as an assistant in:
      i. Mohs micrographic surgery and reconstruction of defects
      ii. application of a wide range of lasers and other energy sources
      iii. sclerotherapy
      iv. botulinum toxin injection
      v. soft tissue augmentation
      vi. chemical peels.
   c. residents will demonstrate knowledge through education relating to certain cosmetic techniques in:
      i. liposuction
      ii. scar revision
      iii. dermabrasion.
(6) will gain experience in the diagnosis and management of the wide range of skin diseases seen in infants and children through supervised experience in consultative inpatient neonatal and pediatric dermatology.

(7) will demonstrate knowledge and competence in pediatric:
   a. atopic dermatitis
   b. psoriasis
   c. blistering disorders
   d. infectious diseases
   e. patients with cutaneous manifestations of multisystem diseases.

(8) will demonstrate knowledge and competence in pediatric diagnostic and therapeutic techniques
   a. skin biopsy
   b. excision
   c. patch testing
   d. intrallesional injections
   e. phototherapy.

(9) will demonstrate knowledge and competence in the diagnosis and age-appropriate management of
   a. birthmarks
   b. genodermatoses
   c. cutaneous signs of child abuse.

(10) will understand how research is applied to patient care.

**Medical Knowledge**
Residents must demonstrate knowledge of established and evolving biomedical, clinical, epidemiological and social-behavioral sciences, as well as the application of this knowledge to patient care.

Residents:
(1) will complement and, when possible, precede or parallel the clinical activities;
(2) will participate in a structured study of the basic sciences (Lecture Series);
(3) will participate in various combinations of lectures, conferences, seminars, demonstrations, individual or group study of:
   a. color transparencies or images,
   b. histologic slides,
   c. clinical rounds,
   d. chart and record reviews (Quality Assurance Meeting),
   e. journal reviews, and
   f. local, regional, and/or national meetings.
(4) will examine routinely stained histologic sections from the full spectrum of dermatologic diseases through:
   a. participation in an active faculty-run sign-out setting.
   b. dermatopathology conferences and study sets,
   c. lectures and participation in interpretation of direct immunofluorescence specimens,
   d. lectures regarding appropriate use and interpretation of immunohistochemistry (special stains, including immunoperoxidase) and electron microscopy.
(5) will understand the basic principles of research, including how research is conducted, evaluated;
(6) will participate in scholarly activity including but not limited to case reports, chapter writings, case presentations at local/national meetings;
(7) will participate in clinical conferences and didactic lectures related to patient care, consultations, inpatient rounds, dermatologic surgery, dermatopathology, and other dermatology-related subspecialty rotations, and
(8) will maintain accurate case logs through the ACGME online Case Log System.

**Practice-based Learning and Improvement**
Residents must demonstrate the ability to investigate and evaluate their care of patients, to appraise and assimilate scientific evidence, and to continuously improve patient care based on constant self-evaluation and life-long learning.

Residents are expected to develop skills and habits to be able to meet the following goals:
(1) identify strengths, deficiencies, and limits in one’s knowledge and expertise;
(2) set learning and improvement goals;
(3) identify and perform appropriate learning activities;
(4) systematically analyze practice using quality improvement methods, and implement changes with the goal of practice improvement;
(5) incorporate formative evaluation feedback into daily practice;
(6) locate, appraise, and assimilate evidence from scientific studies related to their patients’ health problems;
(7) use information technology to optimize learning;
(8) participate in the education of patients, families, students, residents and other health professionals;
(9) teach dermatology to other residents, medical students, nurses, and/or allied health personnel, and
(10) maintain accurate case logs through the ACGME online Case Log System.

**Interpersonal and Communication Skills**
Residents must demonstrate interpersonal and communication skills that result in the effective exchange of information and collaboration with patients, their families, and health professionals.

Residents are expected to:
(1) communicate effectively with patients, families, and the public, as appropriate, across a broad range of socioeconomic and cultural backgrounds;
(2) communicate effectively with physicians, other health professionals, and health related agencies;
(3) work effectively as a member or leader of a health care team or other professional group;
(4) act in a consultative role to other physicians and health professionals;
(5) maintain comprehensive, timely, and legible medical records;
(6) teach dermatology to other residents, medical students, nurses, and/or allied health personnel, and
(7) will understand how research is explained to patients.
Professionalism
Residents must demonstrate a commitment to carrying out professional responsibilities and an adherence to ethical principles.

Residents are expected to demonstrate:
(1) compassion, integrity, and respect for others;
(2) responsiveness to patient needs that supersedes self-interest;
(3) respect for patient privacy and autonomy;
(4) accountability to patients, society and the profession, and
(5) sensitivity and responsiveness to a diverse patient population, including but not limited to, diversity in gender, age, culture, race, religion, disabilities, and sexual orientation.

Systems-based Practice
Residents must demonstrate an awareness of and responsiveness to the larger context and system of health care, as well as the ability to call effectively on other resources in the system to provide optimal health care.

Residents are expected to:
(1) work effectively in various health care delivery settings and systems relevant to their clinical specialty;
(2) coordinate patient care within the health care system relevant to their clinical specialty;
(3) incorporate considerations of cost awareness and risk-benefit analysis in patient and/or population-based care as appropriate;
(4) advocate for quality patient care and optimal patient care systems;
(5) work in interprofessional teams to enhance patient safety and improve patient care quality;
(6) participate in identifying system errors and implementing potential systems solutions;
(7) be given selected administrative responsibility commensurate with their interests, abilities, and qualifications;
(8) will understand how research is evaluated, explained to patients, and applied to patient care, and
(9) will become acquainted with administrative aspects of the specialty.
GOALS AND OBJECTIVES 2015-2016 PER LEVEL OF TRAINING

Dermatology Year 1

Patient Care
1. Obtain pertinent history and perform a complete dermatologic examination.
2. Perform routine diagnostic laboratory tests to include:
   a. KOH examination
   b. Viral culture
   c. Fungal culture
   d. Bacterial culture
   e. Ectoparasitic scraping
3. Perform basic surgical techniques to include:
   a. Punch biopsy
   b. Simple excision with two-layered closure
   c. Simple excision with one-layered closure
   d. Shave biopsy
   e. Perform cryosurgery
   f. Perform electrosurgery
   g. Scissor excision
   h. Perform electrodessication and curettage
4. Know the basics of how to perform local anesthesia
5. Provide counseling on skin care and protection
6. Perform basic skin photography

Medical Knowledge
1. Recognize primary and secondary lesions and group skin diseases in diagnostic categories
2. Recognize common skin diseases, such as:
   a. Inflammatory diseases
   b. Infectious diseases
   c. Cutaneous malignancies
   d. Papulosquamous diseases
   e. Connective tissue diseases
   f. Vesiculo-Bullous diseases
   g. Diseases of the hair and nails
   h. Diseases of mucosa
   i. Pigmented lesions
   j. Common skin diseases in children
3. Learn basic therapeutic options for common dermatologic processes
4. Should know the basic histological diagnoses
5. Become familiar with topical medications to include:
   a. Topical steroids
   b. Tars
   c. Retinoids
   d. Antifungals
e. Antibiotics
f. Antiacne medications
g. Keratolytics
6. Know the various types of local anesthetics

Professionalism
1. Maintain a surgical log and portfolio
2. Be on time for clinical assignments (ready to see patients at 8am and 1pm) and educational activities
3. Attend minimum 90% educational conferences
4. Be an active participant in educational activities
5. Wear professional attire during clinical activities

Systems-Based Practice
1. Maintain a surgical log and portfolio
2. Work effectively with healthcare system
3. Learn method to refer to dermatology surgeons and institutional consults

Communication
1. Provide counseling on skin care and protection
2. Work within a team of nurses, students and physicians
3. Score minimum of 10 on speaker score

Problem-Based Learning and Improvement
1. Fully research and present interesting case at all UNC-Duke conferences
2. Self-assess strengths and weaknesses at 6 month and annual reviews
3. Create individual learning plan to address weaknesses or deficiencies at end-of-year evaluation

Dermatology Year 2

Patient Care
1. Obtain pertinent history and perform a complete dermatologic examination
2. Perform routine diagnostic laboratory tests to include:
   a. KOH examination
   b. Viral culture
   c. Fungal culture
   d. Bacterial culture
   e. Ectoparasitic scraping
3. Perform basic surgical techniques to include:
   a. Punch biopsy
   b. Simple excision with two-layered closure
   c. Simple excision with one-layered closure
   d. Shave biopsy
   e. Perform cryosurgery
f. Perform electrosurgery
g. Scissor excision
h. Perform electrodessication and curettage
4. Know the basics of how to perform local anesthesia
5. Provide counseling on skin care and protection
6. Perform basic skin photography
7. Become increasingly capable of using and understanding systemic therapy to include:
   a. Antineoplastic Therapy
   b. Retinoids
c. Phototherapy
d. Biologic therapy
8. Know the principles of and be able to perform phototherapy
9. Know the principles of and be able to perform ulcer care
10. Be increasingly familiar with sexually transmitted diseases and be able to provide counseling to patients with these disease processes
11. Become familiar with chronic wounds, their evaluation, care, and types of dressings
12. Know the principles of and be able to perform laser therapy
13. Perform simple flaps with indirect supervision
14. Perform nail avulsions
15. Know the principles of and be able to perform ulcer care
16. Be increasingly familiar with sexually transmitted diseases and be able to provide counseling to patients with these disease processes
17. Become familiar with chronic wounds, their evaluation, care, and types of dressings
18. Know the principles of and be able to perform laser therapy
19. Perform simple flaps with indirect supervision
20. Perform nail avulsions
21. Know the art and science of consultative dermatology on all types of patients
22. Manage inpatients in the care of the dermatologic patient

Medical Knowledge
1. Recognize primary and secondary lesions and group skin diseases in diagnostic categories
2. Recognize common skin diseases, such as:
   a. Inflammatory diseases
   b. Infectious diseases
c. Cutaneous malignancies
d. Papulosquamous diseases
e. Connective tissue diseases
f. Vesiculo-Bullous diseases
g. Diseases of hair and nails
h. Diseases of mucosa
i. Pigmented lesions
j. Common skin diseases in children
3. Learn basic therapeutic options for common dermatologic processes
4. Should know the basic histological diagnoses
5. Become familiar with topical medications to include:
   a. Topical steroids
   b. Tars
c. Retinoids
d. Antifungals
e. Antibiotics
f. Antiacne medications
g. Keratolytics
6. Know the various types of local anesthetics
7. Recognize the cutaneous manifestations of systemic disease
8. Become increasingly capable of using and understanding systemic therapy to include:
   a. Antineoplastic Therapy
   b. Retinoids
   c. Phototherapy
   d. Biologic therapy
9. Know the principles of and be able to order phototherapy
10. Know the principles of and be able to perform ulcer care
11. Know the principles of radiation therapy
12. Know the principles of radiation therapy
13. Know the principles of patch testing
14. Become familiar with chronic wounds, their evaluation, care, and types of dressings
15. Know the principles of and be able to perform laser therapy
16. Know the principles of an excision by the Mohs’ technique
17. Expand diagnostic capabilities in histopathology
18. Know the principles of research methodology, and participate (if interested) in a research project, clinical, or basic science activity
19. Know the art and science of consultative dermatology on all types of patients
20. Be familiar with the current literature of dermatology, to include *Journal of American Academy of Dermatology* and *JAMA Dermatology*
21. Manage inpatients in the care of the dermatologic patient
22. Recognize immunofluorescent patterns on histology, and be familiar with immunoperoxidase diagnostics
23. Be increasingly familiar with cosmetic procedures performed in the outpatient dermatology settings (Botox injections, chemical peels, sclerotherapy, soft tissue augmentation)
24. Submit a case to AAD Annual Conference for presentation

**Professionalism**

1. Be on time for clinical assignments (ready to see patients at 8am and 1pm) and educational activities
2. Attend minimum 90% educational conferences
3. Be an active participant in educational activities
4. Wear professional attire during clinical activities
5. Know the art and science of consultative dermatology on all types of patients
6. Manage inpatients in the care of the dermatologic patient

**Systems-Based Practice**

1. Maintain a surgical log and portfolio
2. Work effectively with healthcare system
3. Learn method to refer to dermatology surgeons and institutional consults
4. Know the art and science of consultative dermatology on all types of patients
5. Manage inpatients in the care of the dermatologic patient
Communication
1. Provide counseling of skin care and protection
2. Work within a team of nurses, students and physicians
3. Score minimum of 11 of speaker score
4. Know the art and science of consultative dermatology on all types of patients
5. Manage inpatients in the care of the dermatologic patient

Problem-Based Learning and Improvement
1. Fully research and present interesting case at half of UNC-Duke conferences
2. Self-asses strengths and weaknesses and 6 month and annual reviews
3. Create individual learning plan to address weaknesses or deficiencies at end-of-year evaluation
4. Know the art and science of consultative dermatology on all types of patients
5. Manage inpatients in the care of the dermatologic patient
6. Submit a case to AAD Annual Conference for presentation

Dermatology Year 3

Patient Care
1. Obtain pertinent history and perform a complete dermatologic examination
2. Perform routine diagnostic laboratory tests to include:
   a. KOH examination
   b. Viral culture
   c. Fungal culture
   d. Bacterial culture
   e. Ectoparasitic scraping
3. Perform basic surgical techniques to include:
   a. Punch biopsy
   b. Simple excision with two-layered closure
   c. Simple excision with one-layered closure
   d. Shave biopsy
   e. Perform cryosurgery
   f. Perform electrosurgery
   g. Scissor excision
   h. Perform electrodessication and curettage
4. Know the basics of how to perform local anesthesia
5. Provide counseling of skin care and protection
6. Perform basic skin photography
7. Become increasingly capable of using and understanding systemic therapy to include:
   a. Antineoplastic Therapy
   b. Retinoids
   c. Phototherapy
   d. Biologic therapy
8. Know the principles of and be able to order/adjust phototherapy
9. Know the principles of and be able to perform ulcer care
10. Be increasingly familiar with sexually transmitted diseases and be able to provide counseling to patients with these disease processes
11. Become familiar with chronic wounds, their evaluation, care, and types of dressings
12. Know the principles of and be able to perform laser therapy
13. Perform simple flaps with supervision
14. Perform nail avulsions
15. Know the art and science of consultative dermatology on all types of patients
16. Manage inpatients in the care of the dermatologic patient
17. Will be able to demonstrate knowledge in advanced differential diagnosis and patient therapeutic/patient care
18. Will be able to manage blistering diseases
19. Will be familiar with advanced therapeutics: radiation therapy, systemic therapy for psoriasis, and antineoplastic therapy
20. Will demonstrate clinical knowledge of complex cutaneous disease processes
21. Will be able to manage chronic ulcers
22. Will be able to perform and interpret patch testing
23. Should be able to dose and administer phototherapy
24. Will become familiar in diagnosing genodermatoses
25. Will be able to demonstrate proficiency in laser therapy
26. Will perform more complicated flaps and grafts
27. Will become proficient in nail surgery
28. Will gain experience in administrative aspects of coordinating and conducting consultation service
29. Will demonstrate ability to instruct peers and interact with other physicians on problems relative to dermatology
30. Will be able to teach the principles of all program objectives to those residents of lower rank and students
31. Will demonstrate overall independent responsibility for directing service and patient care decisions

Medical Knowledge
1. Recognize primary and secondary lesions and group skin diseases in diagnostic categories
2. Recognize common skin diseases, such as:
   a. Inflammatory diseases
   b. Infectious diseases
   c. Cutaneous malignancies
   d. Papulosquamous diseases
   e. Connective tissue diseases
   f. Vesiculo-Bullous diseases
   g. Diseases of hair and nails
   h. Pigmented lesions
   i. Common skin diseases in children
3. Learn basic therapeutic options for common dermatologic processes
4. Should know the basic histological diagnoses
5. Become familiar with topical medications to include:
a. Topical steroids  
b. Tars  
c. Retinoids  
d. Antifungals  
e. Antibiotics  
f. Antiacne medications  
g. Keratolytics  

6. Know the various types of local anesthetics  
7. Recognize the cutaneous manifestations of systemic disease  
8. Become increasingly capable of using and understanding systemic therapy to include:  
   a. Antieoplastic Therapy  
   b. Retinoids  
   c. Phototherapy  
   d. Biologic therapy  

9. Know the principles of and be able to perform phototherapy  
10. Know the principles of and be able to perform ulcer care  
11. Know the principles of radiation therapy  
12. Know the principles of patch testing  
13. Be increasingly familiar with sexually transmitted diseases and be able to provide counseling to patients with these disease processes  
14. Become familiar with chronic wounds, their evaluation, care, and types of dressings  
15. Know the principles of and be able to perform laser therapy  
16. Know the principles of an excision by the Mohs’ technique  
17. Expand diagnostic capabilities in histopathology  
18. Know the principles of research methodology, and participate (if interested) in a research project, clinical, or basic science  
19. Know the art and science of consultative dermatology on all types of patients  
20. Be familiar with the current literature of dermatology, to include Journal of American Academy of Dermatology and JAMA Dermatology  
21. Manage inpatients in the care of the dermatologic patient  
22. Recognize immunofluorescent patterns on histology, and be familiar with immunoperoxide diagnostics  
23. Be increasingly familiar with cosmetic procedures performed in the outpatient dermatology setting (Botox injections, chemical peels, sclerotherapy, soft tissue augmentation)  
24. Submit a case to AAD Annual Conference for presentation  
25. Will be able to demonstrate knowledge in advanced differential diagnosis and patient therapeutic/patient care  
26. Will be familiar with advanced therapeutics: radiation therapy, systemic therapy for psoriasis, and antineoplastic therapy  
27. Will demonstrate clinical knowledge of complex cutaneous disease processes  
28. Will demonstrate competence in diagnosing and treating dermatologic pediatric diseases  
29. Should be able to dose and administer phototherapy  
30. Will become familiar in diagnosing genedermatoses  
31. Will be familiar with dermabrasion through lectures or didactic activities  
32. Will be familiar with tissue augmentation
33. Will be familiar with hair transplant through didactic activities
34. Should be familiar with the economics and ethics of dermatology
35. Should be able to clinically interpret the dermatologic literature
36. Should attend and submit for presentation at one national meeting (AAD)
37. Will gain experience in administrative aspects of coordinating and conducting consultation service
38. Will demonstrate ability to instruct peers and interact with other physicians on problems relative to dermatology
39. Will be able to teach the principles of all program objectives to those residents of lower rank and students
40. Will demonstrate overall independent responsibility for directing service and patient care decisions
41. Will demonstrate ability to correlate clinical and pathologic findings

**Professionalism**
1. Be on time for clinical assignments (ready to see patients at 8am and 1pm) and educational activities
2. Attend minimum 90% educational conferences
3. Be an active participant in educational activities
4. Wear professional attire during clinical activities
5. Know the art and science of consultative dermatology on all types of patients
6. Manage inpatients in the care of dermatologic patient
7. Will gain experience in administrative aspects of coordinating and conducting consultation service
8. Will demonstrate ability to instruct peers and interact with other physicians on problems relative to dermatology
9. Will be able to teach the principles of all program objectives to those residents of lower rank and students
10. Will demonstrate overall independent responsibility for directing service and patient care decisions

**Systems-Based Practice**
1. Maintain a surgical log and portfolio
2. Work effectively with healthcare system
3. Learn method to refer to dermatology surgeons and institutional consults
4. Know the art and science of consultative dermatology on all types of patients
5. Manage inpatients in the care of the dermatologic patient
6. Should be familiar with the economics and ethics of dermatology
7. Will gain experience in administrative aspects of coordinating and conducting consultation service
8. Will demonstrate ability to instruct peers and interact with other physicians on problems relative to dermatology
9. Will be able to teach the principles of all program objectives to those residents of lower rank and students
10. Will demonstrate overall independent responsibility for directing service and patient care decisions
**Communication**

1. Provide counseling on skin care and protection
2. Work within a team of nurses, students and physicians
3. Score minimum of 12 on speaker score
4. Know the art and science of consultative dermatology on all types of patients
5. Manage inpatients in the care of the dermatologic patient
6. Will gain experience in administrative aspects of coordinating and conducting consultation service
7. Will demonstrate ability to instruct peers and interact with other physicians on problems relative to dermatology
8. Will be able to teach the principles of all program objectives to those residents of lower rank and students
9. Will demonstrate overall independent responsibility for directing service and patient care decisions

**Problem-Based Learning and Improvement**

1. Incorporate information learned from UNC-Duke conferences into patient care
2. Self-assess strengths and weaknesses at 6 month and annual reviews
3. Create individual learning plan to address weaknesses or deficiencies at end-of-year evaluation
4. Know the art and science of consultative dermatology on all types of patients
5. Manage inpatients in the care of the dermatologic patient
6. Submit a case to AAD Annual Conference for presentation
7. Should attend and submit for presentation at one national meeting (AAD)
8. Will gain experience in administrative aspects of coordinating and conducting consultation service
9. Will demonstrate ability to instruct peers and interact with other physicians on problems relative to dermatology
10. Will be able to teach the principles of all program objectives to those residents of lower rank and students
11. Will demonstrate overall independent responsibility for directing service and patient care decisions
**Specific Rotations 2014-2015**

The UNC Dermatology Training Program stresses areas of training as core rotations for our residents during the three years. Additionally, rotations on highly specialized areas are offered within our own campus or as electives in other universities. The special rotations are:

- General Dermatology
- Pediatric Dermatology
- Dermatopathology
- Dermatological Surgery
- Pigmented Lesion/Melanoma Clinic
- Immunodermatology
- Cosmetic Dermatology (Jackson Clinic, Aesthetic Solutions, Laser Clinics)
- Piedmont Health Services
- Contact Dermatitis
- Consult Service
- Resident Continuity Clinics
- High Risk Skin Cancer Clinics
General Dermatology

Goals:
1. Develop basic clinical and procedural skills in the evaluation and treatment of dermatology conditions.
2. To equip the trainee with the basic dermatologic surgery skills needed for a modern dermatology practice.
3. Develop expertise in the diagnosis, treatment, and management of patients with pigmented lesions and skin cancers.
4. Demonstrate ability to apply fundamental knowledge of immunodermatology in the clinical setting.

Objectives:

Dermatology Year 1

Patient Care
1. Obtain pertinent history and perform a complete dermatologic examination.
2. Perform routine diagnostic laboratory tests to include:
   a. KOH examination
   b. Tzanck smear
   c. Viral culture
   d. Fungal culture
   e. Bacterial culture
   f. Ectoparasitic scraping.
3. Perform basic surgical techniques to include:
   a. Punch biopsy
   b. Simple excision with two-layered closure
   c. Simple excision with one-layered closure
   d. Shave biopsy
   e. Perform cryosurgery
   f. Perform electrosurgery
   g. Scissor excision
   h. Perform electrodessication and curettage.
4. Know the basics of how to perform local anesthesia.
5. Provide counseling on skin care and protection.

Medical Knowledge
1. Recognize primary and secondary lesions and group skin diseases in diagnostic categories.
2. Recognize common skin diseases, such as:
   a. Inflammatory diseases
   b. Infectious disease
   c. Cutaneous malignancies
   d. Papulosquamous diseases
   e. Connective tissue diseases
   f. Vesiculo-Bullous diseases
   g. Diseases of hair and nails
h. Diseases of mucosa
i. Pigmented lesions

3. Learn basic therapeutic options for common dermatologic processes.
4. Should know the basic histological diagnoses.
5. Become familiar with topical medications to include:
   a. Topical steroids
   b. Tars
   c. Retinoids
   d. Antifungals
   e. Antibiotics
   f. Antiacne medications
   g. Keratolytics.
6. Know the various types of local anesthetics.

**Professionalism**
1. Maintain a surgical and laboratory log for patient care follow up.
2. Enter procedures into ACGME Case Log.
3. Be on time for clinical assignments (ready to see patients at 8 am).
4. Be a team player in a busy clinical setting.
5. Wear professional attire during clinical activities.

**Systems-Based Practice**
1. Maintain a surgical log and portfolio.
2. Work effectively with healthcare system.
3. Learn method to refer to dermatology surgeons.

**Communication**
1. Provide counseling on skin care and protection.
2. Work within a team of nurses, students, and physicians.

**Problem-Based Learning and Improvement**
1. Self-assess strengths and weaknesses at 6 month and annual reviews.
2. Create individual learning plan to address weaknesses or deficiencies at end-of-year evaluation.

**Dermatology Year 2**

**Patient Care**
1. Obtain pertinent history and perform a complete dermatologic examination.
2. Perform routine diagnostic laboratory tests to include:
   a. KOH examination
   b. Tzanck smear
   c. Viral culture
   d. Fungal culture
   e. Bacterial culture
   f. Ectoparasitic scraping.
3. Perform basic surgical techniques to include:
   a. Punch biopsy
   b. Simple excision with two-layered closure
   c. Simple excision with one-layered closure
   d. Shave biopsy
   e. Perform cryosurgery
   f. Perform electrosurgery
   g. Scissor excision
   h. Perform electrodessication and curettage.
4. Know the basics of how to perform local anesthesia.
5. Provide counseling on skin care and protection.
6. Become increasingly capable of using and understanding systemic therapy to include:
   a. Antineoplastic Therapy
   b. Retinoids
   c. Phototherapy
   d. Biologic therapy.
7. Know the principles of and be able to perform ulcer care.
8. Be increasingly familiar with sexually transmitted diseases and be able to provide counseling to patients with these disease processes.
9. Become familiar with chronic wounds, their evaluation, care, and types of dressings.
10. Perform simple flaps with indirect supervision.
11. Perform nail avulsions.
12. Know the art and science of consultative dermatology on all types of patients.

**Medical Knowledge**
1. Recognize primary and secondary lesions and group skin diseases in diagnostic categories.
2. Recognize common skin diseases, such as:
   a. Inflammatory diseases
   b. Infectious disease
   c. Cutaneous malignancies
   d. Papulosquamous diseases
   e. Connective tissue diseases
   f. Vesiculo-Bullous diseases
   g. Diseases of hair and nails
   h. Diseases of mucosa
   i. Pigmented lesions
3. Learn basic therapeutic options for common dermatologic processes.
4. Become familiar with topical medications to include:
   a. Topical steroids
   b. Tars
   c. Retinoids
   d. Antifungals
   e. Antibiotics
   f. Antiacne medications
g. Keratolytics.
5. Know the various types of local anesthetics.
6. Recognize the cutaneous manifestations of systemic disease.
7. Become increasingly capable of using and understanding systemic therapy to include:
   a. Antineoplastic Therapy
   b. Retinoids
   c. Phototherapy
   d. Biologic therapy.
8. Know the principles of and be able to perform ulcer care.
9. Know the principles of patch testing.
10. Be increasingly familiar with sexually transmitted diseases and be able to provide counseling to patients with these disease processes.
11. Become familiar with chronic wounds, their evaluation, care, and types of dressings.
12. Know the art and science of consultative dermatology on all types of patients.

Professionalism
1. Maintain a surgical and laboratory log for patient care follow up.
2. Enter procedures into ACGME Case Log.
3. Be on time for clinical assignments (ready to see patients at 8 am).
4. Be a team player in a busy clinical setting.
5. Wear professional attire during clinical activities.
6. Ask the Attending for assistance in times of need.

Systems-Based Practice
1. Maintain a surgical log and portfolio.
2. Learn method to refer to dermatology surgeons.
3. Know the art and science of consultative dermatology on all types of patients.

Communication
1. Provide counseling on skin care and protection.
2. Work within a team of nurses and physicians.
3. Know the art and science of consultative dermatology on all types of patients.

Problem-Based Learning and Improvement
1. Self-assess strengths and weaknesses at 6 month and annual reviews.
2. Create individual learning plan to address weaknesses or deficiencies at end-of-year evaluation.
3. Know the art and science of consultative dermatology on all types of patients.

Dermatology Year 3
Patient Care
1. Obtain pertinent history and perform a complete dermatologic examination.
2. Perform routine diagnostic laboratory tests to include:
   a. KOH examination
   b. Tzanck smear
   c. Viral culture
d. Fungal culture
e. Bacterial culture
f. Ectoparasitic scraping.
3. Perform basic surgical techniques to include:
   a. Punch biopsy
   b. Simple excision with two-layered closure
c. Simple excision with one-layered closure
d. Shave biopsy
e. Perform cryosurgery
f. Perform electrosurgery
g. Scissor excision
h. Perform electrodessication and curettage.
4. Know the basics of how to perform local anesthesia.
5. Provide counseling on skin care and protection.
6. Become increasingly capable of using and understanding systemic therapy to include:
   a. Antineoplastic Therapy
   b. Retinoids
c. Phototherapy
d. Biologic therapy.
7. Know the principles of and be able to perform ulcer care.
8. Be increasingly familiar with sexually transmitted diseases and be able to provide counseling to patients with these disease processes.
9. Become familiar with chronic wounds, their evaluation, care, and types of dressings.
10. Perform simple flaps with supervision.
11. Perform nail avulsions.
12. Know the art and science of consultative dermatology on all types of patients.
13. Will be able to demonstrate knowledge in advanced differential diagnosis and patient therapeutic/patient care.
14. Will be able to manage blistering diseases.
15. Will be familiar with advanced therapeutics: radiation therapy, systemic therapy for psoriasis, and antineoplastic therapy.
16. Will demonstrate clinical knowledge of complex cutaneous disease processes.
17. Will be able to manage chronic ulcers.
18. Will be able to perform and interpret patch testing.
19. Will become familiar in diagnosing genodermatoses.
20. Will perform more complicated flaps and grafts.
21. Will become proficient in nail surgery.
22. Will demonstrate ability to instruct peers and interact with other physicians on problems relative to dermatology.
23. Will be able to teach the principles of all program objectives to those residents of lower rank.
24. Will demonstrate overall independent responsibility for directing service and patient care decisions.
Medical Knowledge
1. Recognize primary and secondary lesions and group skin diseases in diagnostic categories.
2. Recognize common skin diseases, such as:
   a. Inflammatory diseases
   b. Infectious disease
   c. Cutaneous malignancies
   d. Papulosquamous diseases
   e. Connective tissue diseases
   f. Vesiculo-Bullous diseases
   g. Diseases of hair and nails
   h. Diseases of mucosa
   i. Pigmented lesions
   j. Skin diseases in children.
3. Learn basic therapeutic options for common dermatologic processes.
4. Should know the basic histological diagnoses.
5. Become familiar with topical medications to include:
   a. Topical steroids
   b. Tars
   c. Retinoids
   d. Antifungals
   e. Antibiotics
   f. Antiacne medications
   g. Keratolytics.
6. Know the various types of local anesthetics.
7. Recognize the cutaneous manifestations of systemic disease.
8. Become increasingly capable of using and understanding systemic therapy to include:
   a. Antineoplastic Therapy
   b. Retinoids
   c. Phototherapy
   d. Biologic therapy.
9. Know the principles of and be able to perform ulcer care.
10. Know the principles of radiation therapy.
11. Know the principles of patch testing.
12. Be increasingly familiar with sexually transmitted diseases and be able to provide counseling to patients with these disease processes.
13. Become familiar with chronic wounds, their evaluation, care, and types of dressings.
14. Know the principles of an excision by the Mohs’ technique.
15. Know the art and science of consultative dermatology on all types of patients.
16. Will be able to demonstrate knowledge in advanced differential diagnosis and patient therapeutic/patient care.
17. Will be familiar with advanced therapeutics: radiation therapy, systemic therapy for psoriasis, and antineoplastic therapy.
18. Will demonstrate clinical knowledge of complex cutaneous disease processes.
19. Will become familiar in diagnosing genodermatoses.
20. Should be familiar with the economics and ethics of dermatology.
21. Will demonstrate ability to instruct peers and interact with other physicians on problems relative to dermatology.
22. Will be able to teach the principles of all program objectives to those residents of lower rank.
23. Will demonstrate overall independent responsibility for directing service and patient care decisions.
24. Will demonstrate ability to correlate clinical and pathologic findings.

**Professionalism**
1. Maintain a surgical and laboratory log for patient care follow up.
2. Enter procedures into ACGME Case Log.
3. Be on time for clinical assignments (ready to see patients at 8 am).
4. Be a team player in a busy clinical setting.
5. Wear professional attire during clinical activities.
6. Ask the Attending for assistance in times of need.
7. Know the art and science of consultative dermatology on all types of patients.
8. Will demonstrate ability to instruct peers and interact with other physicians on problems relative to dermatology.
9. Will be able to teach the principles of all program objectives to those residents of lower rank and students.
10. Will demonstrate overall independent responsibility for directing service and patient care decisions.

**Systems-Based Practice**
1. Maintain a surgical log and portfolio.
2. Learn method to refer to dermatology surgeons.
3. Know the art and science of consultative dermatology on all types of patients.
4. Should be familiar with the economics and ethics of dermatology.
5. Will demonstrate ability to instruct peers and interact with other physicians on problems relative to dermatology.
6. Will be able to teach the principles of all program objectives to those residents of lower rank and students.
7. Will demonstrate overall independent responsibility for directing service and patient care decisions.

**Communication**
1. Provide counseling on skin care and protection.
2. Work within a team of nurses and physicians.
3. Know the art and science of consultative dermatology on all types of patients.
4. Will demonstrate ability to instruct peers and interact with other physicians on problems relative to dermatology.
5. Will be able to teach the principles of all program objectives to those residents of lower rank and students.
6. Will demonstrate overall independent responsibility for directing service and patient care decisions.
**Problem-Based Learning and Improvement**

1. Self-assess strengths and weaknesses at 6 month and annual reviews.
2. Create individual learning plan to address weaknesses or deficiencies at end-of-year evaluation.
3. Know the art and science of consultative dermatology on all types of patients.
4. Incorporate information learned from UNC/Duke conferences into patient care.
5. Will demonstrate ability to instruct peers and interact with other physicians on problems relative to dermatology.
6. Will be able to teach the principles of all program objectives to those residents of lower rank and students.
7. Will demonstrate overall independent responsibility for directing service and patient care decisions.

**Pediatric Dermatology**

**Goals:**

1. Develop basic clinical and procedural skills in the evaluation and treatment of pediatric dermatology conditions.
2. Learn tertiary outpatient management for children with skin disorders.

**Objectives:**

**Dermatology Year 1**

**Patient Care and Medical Knowledge**

- Evaluate and treat common pediatric dermatology conditions including warts, acne, molluscum, atopic dermatitis, and tinea capitis.
- Learn to correctly classify pediatric vascular lesions as vascular tumors or vascular malformations.
- Perform with supervision potassium hydroxide preparations, Tzanck smears, skin biopsies, and fungal cultures on children.
- Develop awareness of cutaneous markers of underlying syndromes including: neurofibromatosis, tuberous sclerosis, McCune-Albright, incontinentia pigmenti, etc.
- Recognition, management, and differential diagnosis of common pediatric skin conditions including atopic dermatitis, psoriasis, acne, diaper dermatitis, newborn rashes, viral exanthems, molluscum contagiosum, and warts as well as other bacteria/viral infections.
- Gain familiarity with examination of infants and young children including making children at ease with physicians, lap examination, and speaking with children and parents about pediatric skin disease.
- Recognition and management of common “birthmarks” in pediatric dermatology such as port wine stains, salmon patches, uncomplicated hemangiomas of infancy, nevus sebaceous, segmental pigmentary disorder, and congenital melanocytic nevi.
- Gain familiarity with administration and dosing of basic pediatric dermatology therapeutics, including topical steroids/immunomodulatory agents (such as
Protopic® and Elidel®), topical retinoids, systemic antibiotics, and systemic antihistamines, as well as developmental aspects of pharmacology such as when children are old enough to swallow pills and apply medications on their own.

- Comfort with cryotherapy and skin biopsy technique in infants and children; observe and when possible assist in laser dermatologic procedures.
- Understand methods of anesthesia, analgesia, distraction techniques, and methods of restraint for procedures in pediatric dermatology.
- Participate in the preoperative assessment and preparation of children and their families for laser surgery, including the importance of detailing pain management and obtaining informed consent.
- Learn postoperative management of pediatric patients including techniques in child-friendly wound care and control of postoperative pain.
- Learn the indications and use of the pulsed dye laser, and other lasers in the treatment of vascular and other skin lesions in children.
- Learn the evaluation and formulation of therapeutic strategies for pediatric patients referred for dermatologic surgery.
- Participate in the preoperative assessment of patients, in the education and preparation of families for surgery, and in the postoperative management of surgical patients.
- Residents will develop skills in pediatric diagnostic and therapeutic procedures in the clinic setting including, but not limited to:
  - Skin biopsy techniques
  - Potassium hydroxide examinations
  - Tzanck examinations
  - Mineral oil examinations
  - Hair mounts
  - Fungal cultures
  - Cryotherapy
  - Laser therapy
  - Development of a therapeutic plan for children with both acute and chronic skin diseases

**Communication**

- Discuss the natural history of hemangiomas and congenital melanocytoic nevi with families.
- Familiarity with examination of infants and young children including making children at ease with physicians, lap examination, and speaking with children and parents about pediatric skin disease.
- Educating parents in the management of dermatologic problems.
- Communication with children and parents.

**Professionalism**

- Appropriately dress for patient care
- Appropriately interact with patients and parents
• Appropriately interact with visiting residents

**Problem-Based Learning and Improvement**

• Review assigned reading related to common pediatric conditions
• Apply information learned from UNC/Duke conference or independent reading to patient care

**Systems-Based Practice**

• Work with referring pediatricians and family doctors in regards to patient care
• Utilize systems of care in departmental and office administration, including:
  o Necessary authorizations
  o Facilitation and coordination of patient care
  o Understanding the impact of skin disease on the psychological well-being of the child and family

**Dermatology Year 2**

**Patient Care and Medical Knowledge**

• Evaluate and treat common pediatric dermatology conditions including warts, acne, molluscum, atopic dermatitis, and tinea capitis.
• Correctly classify pediatric vascular lesions as vascular tumors or vascular malformations.
• Independently perform potassium hydroxide preparations, Tzanck smears, skin biopsies, and fungal cultures on children.
• Develop awareness of cutaneous markers of underlying syndromes including: neurofibromatosis, tuberous sclerosis, McCune-Albright, incontinentia pigmenti, etc.
• Recognition, management, and differential diagnosis of common pediatric skin conditions including atopic dermatitis, psoriasis, acne, diaper dermatitis, newborn rashes, viral exanthems, molluscum contagiosum, and warts as well as other bacteria/viral infections.
• Familiarity with examination of infants and young children including making children at ease with physicians, lap-examination, and speaking with children and parents about pediatric skin disease.
• Recognition and management of common “birthmarks” in pediatric dermatology such as port wine stains, salmon patches, uncomplicated hemangiomas of infancy, nevus sebaceous, segmental pigmentary disorder, and congenital melanocytic nevi.
• Familiarity with administration and dosing of basic pediatric dermatology therapeutics, including topical steroids/immunomodulatory agents (such as Protopic® and Elidel®), topical retinoids, systemic antibiotics, and systemic antihistamines, as well as developmental aspects of pharmacology such as when children are old enough to swallow pills and apply medications on their own.
• Comfort with cryotherapy and skin biopsy technique in infants and children; observe and when possible assist in laser dermatologic procedures.
• Understand methods of anesthesia, analgesia, distraction techniques, and methods of restraint for procedures in pediatric dermatology.
• Participate in the preoperative assessment and preparation of children and their families for laser surgery, including the importance of detailing pain management and obtaining informed consent.
• Learn postoperative management of pediatric patients including techniques in child-friendly wound care and control of post-operative pain.
• Learn the indications and use of the pulsed dye laser, and other lasers in the treatment of vascular and other skin lesions in children.
• Learn the evaluation and formulation of therapeutic strategies for pediatric patients referred for dermatologic surgery.
• Participate in the preoperative assessment of patients, in the education and preparation of families for surgery, and in the post-operative management of surgical patients.
• Residents will develop skills in pediatric diagnostic and therapeutic procedures in the clinic setting including, but not limited to:
  o Skin biopsy techniques
  o Potassium hydroxide examinations
  o Tzanck examinations
  o Mineral oil examinations
  o Hair mounts
  o Fungal cultures
  o Cryotherapy
  o Laser therapy
  o Development of a therapeutic plan for children with both acute and chronic skin diseases

Communication
• Discuss the natural history of hemangiomas and congenital melanocytic nevi with families.
• Familiarity with examination of infants and young children including making children at ease with physicians, lap-examination, and speaking with children and parents about pediatric skin disease.
• Educating parents in the management of dermatologic problems
• Communication with children and parents

Professionalism
• Appropriately dress for patient care
• Appropriately interact with patients and parents
• Appropriately interact with visiting residents
**Problem-Based Learning and Improvement**

- Review assigned reading related to common pediatric conditions
- Apply information learned from UNC/Duke conference or independent reading to patient care

**Systems-Based Practice**

- Work with referring pediatricians and family doctors in regards to patient care
- Utilize systems of care in departmental and office administration, including:
  - Necessary authorizations
  - Facilitation and coordination of patient care
  - Understanding the impact of skin disease on the psychological well-being of the child and family

**Dermatology Year 3**

**Patient Care and Medical Knowledge**

- Evaluate and treat common pediatric dermatology conditions including warts, acne, molluscum, atopic dermatitis, and tinea capitis.
- Correctly classify pediatric vascular lesions as vascular tumors or vascular malformations.
- Independently perform potassium hydroxide preparations, Tzanck smears, skin biopsies, and fungal cultures on children.
- Develop awareness of cutaneous markers of underlying syndromes including: neurofibromatosis, tuberous sclerosis, McCune-Albright, incontinentia pigmenti, etc.
- Recognition, management, and differential diagnosis of common pediatric skin conditions including atopic dermatitis, psoriasis, acne, diaper dermatitis, newborn rashes, viral exanthems, molluscum contagiosum, and warts as well as other bacteria/viral infections.
- Familiarity with examination of infants and young children including making children at ease with physicians, lap-examination, and speaking with children and parents about pediatric skin disease.
- Recognition and management of common “birthmarks” in pediatric dermatology such as port wine stains, salmon patches, uncomplicated hemangiomas of infancy, nevus sebaceous, segmental pigmentary disorder, and congenital melanocytic nevi.
- Familiarity with administration and dosing of basic pediatric dermatology therapeutics, including topical steroids/immunomodulatory agents (such as Protopic® and Elidel®), topical retinoids, systemic antibiotics, and systemic antihistamines, as well as developmental aspects of pharmacology such as when children are old enough to swallow pills and apply medications on their own.
- Comfort with cryotherapy and skin biopsy technique in infants and children; observe and when possible assist in laser dermatologic procedures.
• Understand methods of anesthesia, analgesia, distraction techniques, and methods of restraint for procedures in pediatric dermatology.

• Participate in the preoperative assessment and preparation of children and their families for laser surgery, including the importance of detailing pain management and obtaining informed consent.

• Learn postoperative management of pediatric patients including techniques in child-friendly wound care and control of post-operative pain.

• Learn the indications and use of the pulsed dye laser, and other lasers in the treatment of vascular and other skin lesions in children.

• Learn the evaluation and formulation of therapeutic strategies for pediatric patients referred for dermatologic surgery.

• Participate in the preoperative assessment of patients, in the education and preparation of families for surgery, and in the post-operative management of surgical patients.

• Residents will develop skills in pediatric diagnostic and therapeutic procedures in the clinic setting including, but not limited to:
  o Skin biopsy techniques
  o Potassium hydroxide examinations
  o Tzanck examinations
  o Mineral oil examinations
  o Hair mounts
  o Fungal cultures
  o Cryotherapy
  o Laser therapy
  o Development of a therapeutic plan for children with both acute and chronic skin diseases

**Communication**

• Discuss the natural history of hemangiomas and congenital melanocytic nevi with families.

• Familiarity with examination of infants and young children including making children at ease with physicians, lap-examination, and speaking with children and parents about pediatric skin disease.

• Educating parents in the management of dermatologic problems

• Communication with children and parents

**Professionalism**

• Appropriately dress for patient care

• Appropriately interact with patients and parents

• Appropriately interact with visiting residents

**Problem-Based Learning and Improvement**

• Review assigned reading related to common pediatric conditions
• Apply information learned from UNC/Duke conference or independent reading to patient care

**Systems-Based Practice**
- Work with referring pediatricians and family doctors in regards to patient care
- Utilize systems of care in departmental and office administration, including:
  - Necessary authorizations
  - Facilitation and coordination of patient care
  - Understanding the impact of skin disease on the psychological well-being of the child and family

**Dermatopathology**
*Goals: To learn the basics of dermatopathology and be able to recognize the common findings at the microscope.*

**Objectives:**

**Dermatology Year 1**
*Medical Knowledge*
- Evaluate tissue at the microscope.
- Recognize the normal anatomy of the skin by site, tissue, and adnexa.
- Provide a basic differential diagnosis.
- Recognize the histochemistry and immunodiagnostics of dermatopathology, tissue markers, and basic electromicroscopy.
- Appreciate the clinicopathologic relations of clinical and histological features.
- Learn how to biopsy a lesion to obtain optimal results.

**Patient Care**
- Apply pathological findings to patient care.

**Communication**
- Discuss cases with pathologist in an effective manner.

**Systems-Based Practice**
- Learn to apply pathological results to the patient clinical scenario.

**Problem-Based Learning and Improvement**
- Receive feedback and critically evaluate biopsy technique.

**Dermatology Years 2 and 3**
*Medical Knowledge*
- Evaluate and teach from tissue at the microscope.
• Be knowledgeable of the normal anatomy of the skin by site, tissue, and adnexa.
• Provide a comprehensive differential diagnosis.
• Understand the histochemistry and immunodiagnostics of dermatopathology, tissue markers, and basic electronmicroscopy.
• Understand the clinicopathologic relations. Be able to see the clinical and predict the histological features.
• Know how to biopsy a lesion to obtain optimal results:
  o Select the proper lesion or lesional area
  o Obtain the specimen with the proper depth
  o Identify technical problems during tissue processing

**Patient Care**
• Apply pathological findings to patient care.

**Communication**
• Discuss cases with pathologist in an effective manner.

**Systems-Based Practice**
• Apply pathological results to the patient clinical scenario.

**Problem-Based Learning and Improvement**
• Receive feedback and critically evaluate biopsy technique.

**Dermatologic Surgery**
**Overall Resident Training Goal:** To equip the trainee with the skills needed to understand management of benign and malignant skin lesions as well as provide outstanding general dermatologic surgical care. To understand and know how to apply techniques used in aesthetic facial rejuvenation.
• PGY-2 (Year 1) Goals: Learn the techniques involved in biopsy and the subsequent surgical treatment of benign and malignant skin lesions. Introduction to facial rejuvenation techniques.
• PGY-3 (Year 2) Goals: Refinement of basic surgical skills with the goal of developing mastery in the excision of benign and malignant lesions as well as primary repair. Gain experience using fillers and neuromodulators.
• PGY-4 (Year 3) Goals: Demonstrate mastery of surgical skills such that total independence is achieved. Develop competence in facial rejuvenation techniques.

**Objectives:**

**Dermatology Year 1 (PGY-2)**
**Patient Care and Medical Knowledge**
• Learn basic anatomy of the skin with an emphasis on structures of the head and neck.
• Learn the principles of wound healing.
• Gain experience with all biopsy types in all anatomic locations.
• Develop understanding of the appropriate management of benign and malignant skin lesions.
• Gain experience with elliptical excisions and layered closures in non-facial areas.
• Become familiar with Mohs surgery and the indications for its appropriate utilization.
• Gain Exposure to flaps and grafts associated with post-Mohs reconstruction.
• Develop an understanding of the multiple lasers applicable to dermatologic care.
• Begin to develop an understanding of the varied approaches to facial rejuvenation including fillers and BOTOX®.

**Professionalism**
• Interact with patients, staff and colleagues in a professional manner.

**Communication**
• Educate patients and family members on expectations of procedures.
• Obtain informed consent.
• Discuss wound care.

**Systems-Based Practice**
• Appreciate importance of accurate and timely referral to surgery.
• Learn the economics of surgical approaches.

**Problem-Based Learning and Improvement**
• Receive criticism and feedback on surgical technique.
• Assess outcomes of surgeries.

**Dermatology Year 2 (PGY-3)**

**Patient Care and Medical Knowledge**
• Refine the understanding of anatomy with a greater emphasis on the potential skin changes associated with aging as well as aesthetic consequences of skin-cancer treatment.
• Gain confidence in selecting the appropriate treatment for benign and malignant skin lesions.
• Participate in a variety of complex closures (local flaps, full and split thickness skin grafts, interpolation flaps).
• Gain direct experience using lasers in dermatology.
• Observe Mohs surgery and assist in the subsequent repairs, gaining experience with repairs of head and neck defects.
• Learn to perform cosmetic dermatologic procedures.
• Learn techniques for nail biopsy and surgery.

**Professionalism**
• Interact with patients, staff and colleagues in a professional manner.

**Communication**
• Educate patients and family members on expectations of procedures.
• Obtain informed consent.
• Discuss wound care.
• Deliver pathology results of procedure effectively to patient/family.

**Systems-Based Practice**
• Perform accurate and timely referral to surgery
• Know the economics of surgical approaches

**Problem-Based Learning and Improvement**
• Perform self-criticism on surgical technique
• Assess outcomes of surgeries

**Dermatology Year 3 (PGY-4)**

**Patient Care and Medical Knowledge**
• Understand anatomy of the skin fully, including the head and neck region, with awareness of surgical danger zones, as well as anatomy as it pertains to the utilization of fillers and BOTOX® for facial rejuvenation.
• Be able to independently select appropriate treatment for benign and malignant skin lesions.
• Be able to independently perform standard excision and complex repairs with mastery of suturing techniques in all anatomic locations.
• Be comfortable performing skin grafts.
• Develop confidence with the independent selection of appropriate lasers as well as their use.
• Develop confidence with the correct selection of patients for aesthetic procedures and the utilization of neuromodulators and fillers in facial rejuvenation.

**Professionalism**
• Interact with patients, staff and colleagues in a professional manner.

**Communication**
• Educate patients and family members on expectations of procedures.
• Obtain informed consent.
• Discuss wound care.
• Deliver pathology results of procedure effectively to patient/family.

**Systems-Based Practice**
• Perform accurate and timely referral to surgery.
• Know the economics of surgical approaches.

**Problem-Based Learning and Improvement**
• Perform self-criticism on surgical technique.
• Assess outcomes of surgeries.
Pigmented Lesion/Melanoma Clinic
Goals: Develop expertise in the diagnosis, treatment, and management of patients with pigmented lesions.

Objectives:

Dermatology Year 1
Patient Care and Medical Knowledge
- Evaluate and treat pigmented lesions such as common acquired nevi, congenital nevi, dysplastic nevi, Spitz nevi, blue nevi, and melanoma.
- Accurately diagnose pigmented lesions.
- Learn how to evaluate pigmented lesions using state-of-the art methods of diagnosis, including digital imaging and dermoscopy.
- Learn about the controversies in the diagnosis of Spitz nevi and dysplastic nevi.
- Learn the appropriate biopsy methods for pigmented lesions. Perform biopsies of pigmented lesions.
- Learn how to appropriately stage melanoma patients.
- Learn about the availability of Sentinel Lymph Node biopsy.
- Learn the appropriate surgical treatments for patients with melanoma.
- Learn about treatments available to patients with melanoma.
- Learn the appropriate follow-up care for patients with dysplastic nevi and melanoma.

Systems Based Practice
- Learn how to manage patients with complex pigmented lesions.

Professionalism
- Interact with patients in a professional manner.

Practice-Based Learning and Improvement
- Self-critique interactions with patients for personal improvement.

Communication
- Learn to deliver bad news to patients and families.

Dermatology Years 2 and 3
Patient Care and Medical Knowledge
- Evaluate and treat pigmented lesions such as common acquired nevi, congenital nevi, dysplastic nevi, Spitz nevi, blue nevi, and melanoma.
- Accurately diagnose pigmented lesions.
- Learn the appropriate biopsy methods for pigmented lesions. Perform biopsies of pigmented lesions.
- Learn how to appropriately stage melanoma patients.
- Learn about the availability of Sentinel Lymph Node biopsy.
- Learn the appropriate surgical treatments for patients with melanoma.
- Learn about treatments available to patients with melanoma.
• Learn the appropriate follow-up care for patients with dyplastic nevi and melanoma.

**Systems Based Practice**
• Learn how to manage patients with complex pigmented lesions.

**Professionalism**
• Interact with patients in a professional manner.

**Practice-Based Learning and Improvement**
• Self-critique interactions with patients for personal improvement.

**Communication**
• Learn to deliver bad news to patients and families.

**Immunodermatology**
**Goals:** Demonstrate ability to apply fundamental knowledge of phototherapy and immunodermatology in the clinical setting.

**Objectives:**

**Dermatology Year 1**
**Patient Care and Medical Knowledge**
• Utilize systemic therapies in appropriate patients and conditions.
• Monitor response to phototherapy and appropriately adjust therapy.
• Develop awareness of particular systemic medications.
• Effectively handle potential adverse events related to systemic therapy.
• Demonstrate knowledge of immunofluorescent findings in the evaluation of patients with pemphigus, pemphigoid, cicatricial pemphigoid, dermatitis herpetiformis, linear IgA bullous dermatosis, and lupus erythematosus.

**Systems-Based Practice**
• Learn how to manage patients with immunobullous dermatoses.

**Professionalism**
• Interact with patients in a professional manner.

**Practice-Based Learning and Improvement**
• Self-critique interactions with patients for personal improvement.

**Communication**
• Educate patients and families on the nature of their immunobullous disorder.
Dermatology Years 2 and 3

Patient Care and Medical Knowledge
- Utilize systemic therapies in appropriate patients and conditions.
- Monitor response to phototherapy and appropriately adjust therapy.
- Develop awareness of particular systemic medications.
- Effectively handle potential adverse events related to systemic therapy.
- Demonstrate knowledge of immunofluorescent findings in the evaluation of patients with pemphigus, pemphigoid, cicatricial pemphigoid, dermatitis herpetiformis, linear IgA bullous dermatosis, and lupus erythematosus.

Systems-Based Practice
- Learn how to manage patients with immunobullous dermatoses.

Professionalism
- Interact with patients in a professional manner.

Practice-Based Learning and Improvement
- Self-critique interactions with patients for personal improvement.

Communication
- Educate patients and families on the nature of their immunobullous disorder.

Cosmetic Dermatology
Goals: Develop expertise in the patient selection, mechanisms of action and techniques in improving the cosmetic appearance of patients.

Objectives:

Dermatology Year 1
Patient Care and Medical Knowledge
- Learn about advances in dermatology concerning the biochemical basis for the aging face.
- Appropriate patient selection, mechanisms of action, risks/benefits and technique for the use of Botox, chemical peels, laser resurfacing and collagen injections/filler substances for rhytids.
- Appropriate patient selection, mechanisms of action, risks/benefits and technique for microdermabrasion.
- Appropriate patient selection, mechanisms of action, risks/benefits and technique for sclerotherapy with/without Doppler ultrasound for varicose veins.
- Appropriate patient selection, mechanisms of action, risks/benefits and technique for lasers for the treatment of vascular anomalies, pigmentary changes and tattoos.
- Appropriate patient selection, mechanisms of action, risks/benefits and technique for the use of Botox for axillary, palmar, and plantar hyperhidrosis.
- Develop knowledge of tumescent liposuction, collagen augmentation, laser resurfacing, and use of botulinum toxin through observation, participation, and/or performance.

**Systems-Based Practice**
- Learn how to manage patients with complex medical problems.

**Professionalism**
- Interact with patients in a professional manner.

**Practice-Based Learning and Improvement**
- Self-critique interactions with patients for personal improvement.

**Communication**
- Learn to deliver accurate expectations to patients and families.

**Dermatology Years 2 and 3**

**Patient Care and Medical Knowledge**
- Learn about advances in dermatology concerning the biochemical basis for the aging face.
- Appropriate patient selection, mechanisms of action, risks/benefits and technique for the use of Botox, chemical peels, laser resurfacing and collagen injections/filler substances for rhytids.
- Appropriate patient selection, mechanisms of action, risks/benefits and technique for microdermabrasion.
- Appropriate patient selection, mechanisms of action, risks/benefits and technique for sclerotherapy with/without Doppler ultrasound for varicose veins.
- Appropriate patient selection, mechanisms of action, risks/benefits and technique for lasers for the treatment of vascular anomalies, pigmentary changes and tattoos.
- Appropriate patient selection, mechanisms of action, risks/benefits and technique for the use of Botox for axillary, palmar, and plantar hyperhidrosis.
- Develop knowledge of tumescent liposuction, collagen augmentation, laser resurfacing, and use of botulinum toxin through observation, participation, and/or performance.

**Systems-Based Practice**
- Learn how to manage patients with complex medical problems.

**Professionalism**
- Interact with patients in a professional manner.

**Practice-Based Learning and Improvement**
- Self-critique interactions with patients for personal improvement.
Communication

- Learn to deliver accurate expectations to patients and families.

Piedmont Health Services Clinic

Goals:
1. Develop advanced clinical and procedural skills in the evaluation and treatment of dermatology conditions.
2. Develop expertise in the diagnosis, treatment, and management of patients with inflammatory conditions, pigmented lesions and skin cancers.
3. Demonstrate ability to apply fundamental knowledge of biologics and other systemic treatments.

Objectives:

Dermatology Year 1

Patient Care
1. Obtain pertinent history and perform a complete dermatologic examination.
2. Perform routine diagnostic laboratory tests to include:
   a. KOH examination
   b. Viral culture
   c. Fungal culture
   d. Bacterial culture
   e. Ectoparasitic scraping.
3. Perform basic surgical techniques to include:
   a. Punch biopsy
   b. Shave biopsy
   c. Perform cryosurgery
   d. Scissor excision
   e. Perform electrodessication and curettage.
4. Know the basics of how to perform local anesthesia.
5. Provide counseling on skin care and protection.

Medical Knowledge
1. Recognize primary and secondary lesions and group skin diseases in diagnostic categories.
2. Recognize common skin diseases, such as:
   a. Inflammatory diseases
   b. Infectious disease
   c. Cutaneous malignancies
   d. Papulosquamous diseases
   e. Connective tissue diseases
   f. Vesiculo-Bullous diseases
   g. Diseases of hair and nails
   h. Diseases of mucosa
   i. Pigmented lesions.
3. Learn basic therapeutic options for common dermatologic processes.
4. Become familiar with topical medications to include:
   a. Topical steroids
   b. Tars
   c. Retinoids
   d. Antifungals
   e. Antibiotics
   f. Antiacne medications
   g. Keratolytics.
5. Know the various types of local anesthetics.

**Professionalism**
1. Maintain a surgical and laboratory log for patient care follow up.
2. Enter procedures into ACGME Case Log.
3. Be on time for clinical assignments (ready to see patients at 1pm).
4. Be a team player in a busy clinical setting.
5. Wear professional attire during clinical activities.
6. Ask the Attending for assistance in times of need.

**Systems-Based Practice**
1. Maintain a surgical log and portfolio.
2. Work effectively within the healthcare system.
3. Learn method to refer to dermatology surgeons and other institutional consultants.

**Communication**
1. Provide counseling on skin care and protection.
2. Work within a team of nurses and physicians.
3. Provide concise yet thorough patient presentations to attending physicians.

**Practice-Based Learning and Improvement**
1. Self-assess strengths and weakness at 6 month and annual reviews.
2. Create individual learning plan to address weaknesses or deficiencies at end-of-year evaluation.

**Dermatology Year 2**

**Patient Care**
1. Obtain pertinent history and perform a complete dermatologic examination.
2. Perform routine diagnostic laboratory tests to include:
   a. KOH examination
   b. Viral culture
   c. Fungal culture
   d. Bacterial culture
   e. Ectoparasitic scraping.
3. Perform basic surgical techniques to include:
   a. Punch biopsy
   b. Shave biopsy
c. Perform cryosurgery
d. Scissor excision
e. Perform electrodessication and curettage.
4. Know the basics of how to perform local anesthesia.
5. Provide counseling on skin care and protection.
6. Become increasingly capable of using and understanding systemic therapy to include:
   a. Antineoplastic Therapy
   b. Retinoids
   c. Biologic therapy
7. Know the principles of and be able to perform ulcer care.
8. Be increasingly familiar with sexually transmitted diseases and be able to provide counseling to patients with these disease processes.
9. Become familiar with chronic wounds, their evaluation, care, and types of dressings.
10. Know the art and science of consultative dermatology on all types of patients.

**Medical Knowledge**
1. Recognize primary and secondary lesions and group skin diseases in diagnostic categories.
2. Recognize common skin diseases, such as:
   a. Inflammatory diseases
   b. Infectious disease
   c. Cutaneous malignancies
   d. Papulosquamous diseases
   e. Connective tissue diseases
   f. Vesiculo-Bullous diseases
   g. Diseases of hair and nails
   h. Diseases of mucosa
   i. Pigmented lesions.
3. Learn basic therapeutic options for common dermatologic processes.
4. Become familiar with topical medications to include:
   a. Topical steroids
   b. Tars
   c. Retinoids
   d. Antifungals
   e. Antibiotics
   f. Antiacne medications
   g. Keratolytics.
5. Know the various types of local anesthetics.
6. Recognize the cutaneous manifestations of systemic disease.
7. Become increasingly capable of using and understanding systemic therapy to include:
   a. Antineoplastic Therapy
   b. Retinoids
   c. Biologic therapy.
8. Know the principles of and be able to perform ulcer care.
9. Be increasingly familiar with sexually transmitted diseases and be able to provide counseling to patients with these disease processes.
10. Become familiar with chronic wounds, their evaluation, care, and types of dressings.
11. Know the art and sciences of consultative dermatology on all types of patients.

**Professionalism**
1. Maintain a surgical and laboratory log for patient care follow up.
2. Enter procedures into ACGME Case Log.
3. Be on time for clinical assignments (ready to see patients at 1pm).
4. Be a team player in a busy clinical setting.
5. Wear professional attire during clinical activities.
6. Ask the Attending for assistance in times of need.

**Systems-Based Practice**
1. Maintain a surgical log and portfolio.
2. Work effectively within the healthcare system.
3. Learn method to refer to dermatology surgeons and other institutional consultants.
4. Know the art and science of consultative dermatology on all types of patients.

**Communication**
1. Provide counseling on skin care and protection.
2. Work within a team of nurses and physicians.
3. Know the art and science of consultative dermatology on all types of patients.

**Practice-Based Learning and Improvement**
1. Self-assess strengths and weakness at 6 month and annual reviews.
2. Create individual learning plan to address weaknesses or deficiencies at end-of-year evaluation.
3. Know the art and science of consultative dermatology on all types of patients.

**Dermatology Year 3**

**Patient Care**
1. Obtain pertinent history and perform a complete dermatologic examination.
2. Perform routine diagnostic laboratory tests to include:
   a. KOH examination
   b. Viral culture
   c. Fungal culture
   d. Bacterial culture
   e. Ectoparasitic scraping.
3. Perform basic surgical techniques to include:
   a. Punch biopsy
   b. Shave biopsy
   c. Perform cryosurgery
   d. Scissor excision
   e. Perform electrodesication and curettage.
4. Know the basics of how to perform local anesthesia.
5. Provide counseling on skin care and protection.
6. Become increasingly capable of using and understanding systemic therapy to include:
a. Antineoplastic Therapy  
b. Retinoids  
c. Biologic therapy.  

7. Know the principles of and be able to perform ulcer care.  
8. Be increasingly familiar with sexually transmitted diseases and be able to provide counseling to patients with these disease processes.  
9. Become familiar with chronic wounds, their evaluation, care, and types of dressings.  
10. Know the art and science of consultative dermatology on all types of patients.  
11. Will be able to demonstrate knowledge in advanced differential diagnosis and patient therapeutic/patient care.  
12. Will be able to manage blistering diseases.  
14. Will demonstrate clinical knowledge of complex cutaneous disease processes.  
15. Will be able to manage chronic ulcers.  
16. Will demonstrate ability to instruct peers and interact with other physicians on problems relative to dermatology.  
17. Will be able to teach the principles of all program objectives to those residents of lower rank.  
18. Will demonstrate overall independent responsibility for directing service and patient care decisions.  

**Medical Knowledge**  
1. Recognize primary and secondary lesions and group skin diseases in diagnostic categories.  
2. Recognize common skin diseases, such as:  
   a. Inflammatory diseases  
   b. Infectious disease  
   c. Cutaneous malignancies  
   d. Papulosquamous diseases  
   e. Connective tissue diseases  
   f. Vesiculo-Bullous diseases  
   g. Diseases of hair and nails  
   h. Diseases of mucosa  
   i. Pigmented lesions.  
3. Learn basic therapeutic options for common dermatologic processes.  
4. Become familiar with topical medications to include:  
   a. Topical steroids  
   b. Tars  
   c. Retinoids  
   d. Antifungals  
   e. Antibiotics  
   f. Antiacne medications  
   g. Keratolytics.  
5. Know the various types of local anesthetics.  
6. Recognize the cutaneous manifestations of systemic disease.
7. Become increasingly capable of using and understanding systemic therapy to include:
   a. Antineoplastic Therapy
   b. Retinoids
   c. Biologic therapy.
8. Know the principles of and be able to perform ulcer care.
9. Know the principles of radiation therapy.
10. Be increasingly familiar with sexually transmitted diseases and be able to provide counseling to patients with these disease processes.
11. Become familiar with chronic wounds, their evaluation, care, and types of dressings.
12. Know the art and science of consultative dermatology on all types of patients.
13. Will be able to demonstrate knowledge in advanced differential diagnosis and patient therapeutic/patient care.
15. Will demonstrate clinical knowledge of complex cutaneous disease processes.
16. Should be familiar with the economics and ethics of dermatology.
17. Will demonstrate ability to instruct peers and interact with other physicians on problems relative to dermatology.
18. Will be able to teach the principles of all program objectives to those residents of lower rank.
19. Will demonstrate overall independent responsibility for directing service and patient care decisions.
20. Will demonstrate ability to correlate clinical and pathologic findings.

**Professionalism**

1. Maintain a surgical and laboratory log for patient care follow up.
2. Enter procedures into ACGME Case Log.
3. Be on time for clinical assignments (ready to see patients at 1pm).
4. Be a team player in a busy clinical setting.
5. Wear professional attire during clinical activities.
6. Ask the Attending for assistance in times of need.
7. Know the art and science of consultative dermatology on all types of patients.
8. Will demonstrate ability to instruct peers and interact with other physicians on problems relative to dermatology.
9. Will be able to teach the principles of all program objectives to those residents of lower rank.
10. Will demonstrate overall independent responsibility for directing service and patient care decisions.

**Systems-Based Practice**

1. Maintain a surgical log and portfolio.
2. Work effectively within the healthcare system.
3. Learn method to refer to dermatology surgeons and other institutional consultants.
4. Know the art and science of consultative dermatology on all types of patients.
5. Should be familiar with the economics and ethics of dermatology.
6. Will demonstrate ability to instruct peers and interact with other physicians on problems relative to dermatology.
7. Will be able to teach the principles of all program objectives to those residents of lower rank.
8. Will demonstrate overall independent responsibility for directing service and patient care decisions.

**Communication**
1. Provide counseling on skin care and protection.
2. Work within a team of nurses and physicians.
3. Know the art and science of consultative dermatology on all types of patients.
4. Will demonstrate ability to instruct peers and interact with other physicians on problems relative to dermatology.
5. Will be able to teach the principles of all program objectives to those residents of lower rank.
6. Will demonstrate overall independent responsibility for directing service and patient care decisions.

**Practice-Based Learning and Improvement**
1. Self-assess strengths and weakness at 6 month and annual reviews.
2. Create individual learning plan to address weaknesses or deficiencies at end-of-year evaluation.
3. Know the art and science of consultative dermatology on all types of patients.
4. Incorporate information learned from UNC/Duke conferences into patient care.
5. Will demonstrate ability to instruct peers and interact with other physicians on problems relative to dermatology.
6. Will be able to teach the principles of all program objectives to those residents of lower rank.
7. Will demonstrate overall independent responsibility for directing service and patient care decisions.

**Contact Dermatitis Clinic**
**Goals:** Develop basic clinical and procedural skills in the evaluation and treatment of contact dermatitis in a specialty clinic setting.

**Objectives:**

**Dermatology Year 1**

**Patient Care and Medical Knowledge**
- List the most common plants to cause irritant contact dermatitis, allergic contact dermatitis and phytophotodermatitis.
- Describe the clinical and immunonologic differences between irritant and allergic contact dermatitis.
- Understand the procedure of patch testing placement.
- Know how to read patch testing.
• Identify the most common allergens causing eyelid dermatitis, facial dermatitis, lip dermatitis and hand and foot dermatitis.
• Evaluate the patient and discuss with Dr. L-S.
• Observe the nurse when he/she applies the patch tests.
• Read at least one of the follow-up visits.
• Learn how to use the CAMP link on the American Contact Dermatitis Society site to create handouts for the patients.

Systems-Based Practice
• Learn how to manage patients with complex eczematous disorders.

Professionalism
• Interact with patients in a professional manner.

Practice-Based Learning and Improvement
• Self-critique interactions with patients for personal improvement.

Communication
• Educate patients and families regarding the use of patch testing.

Dermatology Years 2 and 3
Patient Care and Medical Knowledge
• List the most common plants to cause irritant contact dermatitis, allergic contact dermatitis and phytophotodermatitis.
• Describe the clinical and immunonologic differences between irritant and allergic contact dermatitis.
• Understand the procedure of patch testing placement.
• Know how to read patch testing.
• Identify the most common allergens causing eyelid dermatitis, facial dermatitis, lip dermatitis and hand and foot dermatitis.
• Evaluate the patient and discuss with Dr. L-S.
• Observe the nurse when he/she applies the patch tests.
• Read at least one of the follow-up visits.
• Learn how to use the CAMP link on the American Contact Dermatitis Society site to create handouts for the patients.
• Be able to select appropriate patch tests.
• Demonstrate satisfactory knowledge of the patch test series of allergens available.
• Be able to distinguish between irritant and allergic reactions.
• Understand the concept of the relevance of patch test reactions for the patient and communicating that information to them.
• Distinguish various patterns of dermatitis (especially of the hands).
• Basic knowledge of the immunology of contact reactions.
• Interpret hazard data sheets.
• Have an understanding of writing reports for occupational dermatology patients.
**Systems-Based Practice**
- Learn how to manage patients with complex eczematous disorders.

**Professionalism**
- Interact with patients in a professional manner.

**Practice-Based Learning and Improvement**
- Self-critique interactions with patients for personal improvement.
- Interpret hazard data sheets.
- Have an understanding of writing reports for occupational dermatology patients.

**Communication**
- Educate patients and families regarding the use of patch testing.
- Interpret hazard data sheets.
- Have an understanding of writing reports for occupational dermatology patients.
Lectures:
- Contact Dermatitis
- Pathophysiology
- Rubber
- Acrylates
- Plants
- Fragrances
- Hand dermatitis
- Cases

Rotation:
- True test allergens, interpretation of results
- Read book
- Knowledge of NA-65
- Observe nurse placing allergens
- Knowledge of CAMP link for handouts

Understand the different patterns of hand dermatitis, understand latex allergy, observe nurse while preparing trays, place tests in some patients with assistance from nurse, prepare CAMP handout and be able to discuss it with a patient. Pass a quiz at the end of rotation.

Pathophysiology
- General knowledge about TRUE test and other trays,
- Understand when to refer a patient, clinical manifestations of ACD,
- Observe nurse placing allergens, interpretation of tests.
Consult Service

Goals:
1. Develop advanced clinical and procedural skills in the evaluation and treatment of dermatology conditions.
2. Develop expertise in the diagnosis, treatment, and management of patients with pigmented lesions and skin cancers.
3. Demonstrate ability to apply fundamental knowledge of biologics and other systemic treatments.
4. Effectively work within the healthcare system to educate other physicians as co-treating inpatients.

Objectives:

Dermatology Year 1

This is not a PGY-2 experience.

Dermatology Year 2

Patient Care
1. Obtain pertinent history and perform a complete dermatologic examination.
2. Perform routine diagnostic laboratory tests to include:
   a. KOH examination
   b. Viral culture
   c. Fungal culture
   d. Bacterial culture
   e. Ectoparasitic scraping.
3. Perform basic surgical techniques to include:
   a. Punch biopsy
   b. Shave biopsy
   c. Know the basics of how to perform local anesthesia.
4. Provide counseling on skin care and protection.
5. Become increasingly capable of using and understanding systemic therapy to include:
   a. Antineoplastic Therapy
   b. Retinoids
   c. Biologic therapy.
6. Know the principles of and be able to perform ulcer care.
7. Be increasingly familiar with sexually transmitted diseases and be able to provide counseling to patients with these disease processes.
8. Become familiar with chronic wounds, their evaluation, care, and types of dressings.
9. Know the art and science of consultative dermatology on all types of patients.

Medical Knowledge
1. Recognize primary and secondary lesions and group skin diseases in diagnostic categories.
2. Recognize common skin diseases, such as:
   a. Inflammatory diseases
b. Infectious disease
c. Cutaneous malignancies
d. Papulosquamous diseases
e. Connective tissue diseases
f. Vesiculo-Bullous diseases
g. Diseases of hair and nails
h. Diseases of mucosa
i. Pigmented lesions

3. Learn basic therapeutic options for common dermatologic processes.
4. Become familiar with topical medications to include:
   a. Topical steroids
   b. Tars
   c. Retinoids
   d. Antifungals
   e. Antibiotics
   f. Antibiotics
   g. Keratolytics.

5. Know the various types of local anesthetics.
6. Recognize the cutaneous manifestations of systemic disease.
7. Become increasingly capable of using and understanding systemic therapy to include:
   a. Antineoplastic Therapy
   b. Retinoids
   c. Biologic therapy.
8. Know the principles of and be able to perform ulcer care.
9. Know the techniques of patch testing.
10. Be increasingly familiar with sexually transmitted diseases and be able to provide counseling to patients with these disease processes.
11. Become familiar with chronic wounds, their evaluation, care, and types of dressings.
12. Know the art and science of consultative dermatology on all types of patients.

**Professionalism**
1. Maintain a surgical and laboratory log for patient care follow up.
2. Work effectively with other non-dermatology physicians.
3. Supervise a fourth-year medical student.
4. Wear professional attire during clinical activities.
5. Ask the Attending for assistance in times of need.

**Systems-Based Practice**
1. Work effectively with the healthcare system.
2. Learn systems and methods to effectively interact with other institutional consultants.
3. Know the art and science of consultative dermatology on all types of patients.

**Communication**
1. Provide counseling on skin care and protection.
2. Work within a team of nurses and physicians.
3. Know the art and science of consultative dermatology on all types of patients.
Problem-Based Learning and Improvement
1. Self-assess strengths and weaknesses at 6 month and annual reviews.
2. Create individual learning plan to address weaknesses or deficiencies at end-of-year evaluation.
3. Know the art and science of consultative dermatology on all types of patients.

Dermatology Year 3

Patient Care
1. Obtain pertinent history and perform a complete dermatologic examination.
2. Perform routine diagnostic laboratory tests to include:
   a. KOH examination
   b. Viral culture
   c. Fungal culture
   d. Bacterial culture
   e. Ectoparasitic scraping.
3. Perform basic surgical techniques to include:
   a. Punch biopsy
   b. Shave biopsy
   c. Know the basics of how to perform local anesthesia.
4. Provide counseling on skin care and protection.
5. Become increasingly capable of using and understanding systemic therapy to include:
   a. Antineoplastic Therapy
   b. Retinoids
   c. Biologic therapy.
6. Know the principles of and be able to perform ulcer care.
7. Be increasingly familiar with sexually transmitted diseases and be able to provide counseling to patients with these disease processes.
8. Become familiar with chronic wounds, their evaluation, care, and types of dressings.
9. Know the art and science of consultative dermatology on all types of patients.
10. Will be able to demonstrate knowledge in advanced differential diagnosis and patient therapeutic/patient care.
11. Will be able to manage blistering diseases.
12. Will be familiar with advanced therapeutics: radiation therapy, systemic therapy for psoriasis, and antineoplastic therapy.
13. Will demonstrate clinical knowledge of complex cutaneous disease processes.
14. Will be able to manage chronic ulcers.
15. Will demonstrate ability to instruct peers and interact with other physicians on problems relative to dermatology.
16. Will demonstrate overall independent responsibility for directing service and patient care decisions.

Medical Knowledge
1. Recognize primary and secondary lesions and group skin diseases in diagnostic categories.
2. Recognize common skin diseases, such as:
   a. Inflammatory diseases
   b. Infectious disease
   c. Cutaneous malignancies
   d. Papulosquamous diseases
   e. Connective tissue diseases
   f. Vesiculo-Bullous diseases
   g. Diseases of hair and nails
   h. Diseases of mucosa
   i. Pigmented lesions

3. Learn basic therapeutic options for common dermatologic processes.

4. Become familiar with topical medications to include:
   a. Topical steroids
   b. Tars
   c. Retinoids
   d. Antifungals
   e. Antibiotics
   f. Antiacne medications
   g. Keratolytics.

5. Know the various types of local anesthetics.

6. Recognize the cutaneous manifestations of systemic disease.

7. Become increasingly capable of using and understanding systemic therapy to include:
   a. Antineoplastic Therapy
   b. Retinoids
   c. Biologic therapy.

8. Know the principles of and be able to perform ulcer care.

9. Be increasingly familiar with sexually transmitted diseases and be able to provide counseling to patients with these disease processes.

10. Become familiar with chronic wounds, their evaluation, care, and types of dressings.

11. Know the art and science of consultative dermatology on all types of patients.

12. Will be able to demonstrate knowledge in advanced differential diagnosis and patient therapeutic/patient care.


14. Should be familiar with the economics and ethics of dermatology.

15. Will demonstrate ability to instruct peers and interact with other physicians on problems relative to dermatology.

16. Will demonstrate overall independent responsibility for directing service and patient care decisions.

17. Will demonstrate ability to correlate clinical and pathologic findings.

**Professionalism**

1. Maintain a patient list and laboratory log for patient care follow up.

2. Work effectively with other non-dermatology physicians.

3. Supervise a fourth-year medical student.

4. Wear professional attire during clinical activities.
5. Ask the Attending for assistance in times of need.
6. Know the art and science of consultative dermatology on all types of patients.
7. Will demonstrate ability to instruct peers and interact with other physicians on problems relative to dermatology.
8. Will demonstrate overall independent responsibility for directing service and patient care decisions.

**Systems-Based Practice**
1. Work effectively with the healthcare system.
2. Learn systems and methods to effectively interact with other institutional consultants.
3. Know the art and science of consultative dermatology on all types of patients.
4. Should be familiar with the economics and ethics of dermatology.
5. Will demonstrate ability to instruct peers and interact with other physicians on problems relative to dermatology.
6. Will demonstrate overall independent responsibility for directing service and patient care decisions.

**Communication**
1. Provide counseling on skin care and protection.
2. Work within patients’ team of nurses and physicians.
3. Know the art and science of consultative dermatology on all types of patients.
4. Will demonstrate ability to instruct peers and interact with other physicians on problems relative to dermatology.
5. Will demonstrate overall independent responsibility for directing service and patient care decisions.

**Problem-Based Learning and Improvement**
1. Self-assess strengths and weaknesses at 6 month and annual reviews.
2. Create individual learning plan to address weaknesses or deficiencies at end-of-year evaluation.
3. Know the art and science of consultative dermatology on all types of patients.
4. Incorporate information learned from UNC/Duke conferences into patient care.
5. Will demonstrate ability to instruct peers and interact with other physicians on problems relative to dermatology.
6. Will demonstrate overall independent responsibility for directing service and patient care decisions.

**Resident Continuity Clinics**
**Goals:**
1. Develop therapeutic relationships with continuity patients while performing basic clinical and procedural skills in the evaluation and treatment of dermatology conditions.

**Objectives:**

Dermatology Year 1

This is not a PGY-2 experience.

Dermatology Year 2

Patient Care
1. Obtain pertinent history and perform a complete dermatologic examination
2. Perform routine diagnostic laboratory tests to include:
   a. KOH examination
   b. Viral culture
   c. Fungal culture
   d. Bacterial culture
   e. Ectoparasitic scraping
3. Perform basic surgical techniques to include:
   a. Punch biopsy
   b. Shave biopsy
   c. Perform cryosurgery
   d. Perform electrosurgery
   e. Scissor excision
   f. Perform electrodessication and curettage
4. Perform local anesthesia
5. Provide counseling on skin care and protection
6. Become increasingly capable of using and understanding systemic therapy to include:
   a. Antineoplastic Therapy
   b. Retinoids
   c. Phototherapy
   d. Biologic therapy
7. Know the principles of and be able to perform ulcer care
8. Be increasingly familiar with sexually transmitted diseases and be able to provide counseling to patients with these disease processes
9. Become familiar with chronic wounds, their evaluation, care, and types of dressings
10. Know the art and science of consultative dermatology on all types of patients

Medical Knowledge
1. Recognize primary and secondary lesions and group skin diseases in diagnostic categories
2. Recognize common skin diseases, such as:
   a. Inflammatory diseases
   b. Infectious diseases
   c. Cutaneous malignancies
   d. Papulosquamous diseases
   e. Connective tissue diseases
   f. Vesiculo-Bullous diseases
   g. Diseases of hair and nails
h. Diseases of mucosa
i. Pigmented lesions
j. Common skin diseases in children
3. Learn basic therapeutic options for common dermatologic processes
4. Become familiar with topical medications to include:
   a. Topical steroids
   b. Tars
   c. Retinoids
   d. Antifungals
   e. Antibiotics
   f. Anti-acne medications
   g. Keratolytics
5. Know the various types of local anesthetics
6. Recognize the cutaneous manifestations of systemic disease
7. Become increasingly capable of using and understanding systemic therapy to include:
   a. Antineoplastic Therapy
   b. Retinoids
   c. Phototherapy
   d. Biologic therapy
8. Become increasingly capable of using and understanding systemic therapy to include:
   a. Antineoplastic Therapy
   b. Retinoids
   c. Phototherapy
   d. Biologic therapy
9. Know the principles of and be able to perform ulcer care
10. Know the principles of and appropriately refer to patch testing
11. Be increasingly familiar with sexually transmitted diseases and be able to provide counseling to patients with these disease processes
12. Become familiar with chronic wounds, their evaluation, care, and types of dressings
13. Know the art and science of consultative dermatology on all types of patients

**Professionalism**
1. Be on time for clinical assignments
2. Be a team player in a busy clinical setting
3. Wear professional attire during clinical activities
4. Ask the Attending for assistance in times of need
5. Establish appropriate therapeutic relationships with your continuity patients

**Systems-Based Practice**
1. Learn method to refer to dermatology surgeons and non-dermatology specialty care physicians
2. Know the art and science of consultative dermatology on all types of patients

**Communication**
1. Provide counseling on skin care and protection
2. Work within a team of nurses and physicians
3. Know the art and science of consultative dermatology on all types of patients

**Problem-Based Learning and Improvement**
1. Self-assess strengths and weaknesses at 6 month and annual reviews
2. Create individual learning plan to address weaknesses or deficiencies at end-of-year evaluation
3. Know the art and science of consultative dermatology on all types of patients

**Dermatology Year 3**

**Patient Care**
1. Obtain pertinent history and perform a complete dermatologic examination
2. Perform routine diagnostic laboratory tests to include:
   a. KOH examination
   b. Viral culture
   c. Fungal culture
   d. Bacterial culture
   e. Ectoparasitic scraping
3. Perform basic surgical techniques to include:
   a. Punch biopsy
   b. Shave biopsy
   c. Perform cryosurgery
   d. Perform electrosurgery
   e. Scissor excision
   f. Perform electrodessication and curettage
4. Know the basics of how to perform local anesthesia
5. Provide counseling on skin care and protection
6. Become increasingly capable of using and understanding systemic therapy to include:
   a. Antineoplastic Therapy
   b. Retinoids
   c. Phototherapy
   d. Biologic therapy
7. Know the principles of and be able to perform ulcer care
8. Be increasingly familiar with sexually transmitted diseases and be able to provide counseling to patients with these disease processes
9. Become familiar with chronic wounds, their evaluation, care, and types of dressings
10. Know the art and science of consultative dermatology on all types of patients
11. Will be able to demonstrate knowledge in advanced differential diagnosis and patient therapeutic/patient care
12. Will be able to manage blistering diseases
13. Will be familiar with advanced therapeutics: radiation therapy, systemic therapy for psoriasis, and antineoplastic therapy
14. Will demonstrate clinical knowledge of complex cutaneous disease processes
15. Will be able to manage chronic ulcers
16. Will become familiar in diagnosing genodermatoses
17. Will demonstrate ability to instruct peers and interact with other physicians on problems relative to dermatology
18. Will demonstrate overall independent responsibility for directing service and patient care decisions

**Medical Knowledge**

1. Recognize primary and secondary lesions and group skin diseases in diagnostic categories
2. Recognize common skin diseases, such as:
   a. Inflammatory diseases
   b. Infectious diseases
   c. Cutaneous malignancies
   d. Papulosquamous diseases
   e. Connective tissue diseases
   f. Vesiculo-Bullous diseases
   g. Diseases of hair and nails
   h. Diseases of mucosa
   i. Pigmented lesions
   j. Skin conditions in children
3. Learn basic therapeutic options for common dermatologic processes
4. Become familiar with topical medications to include:
   a. Topical steroids
   b. Tars
   c. Retinoids
   d. Antifungals
   e. Antibiotics
   f. Antiacne medications
   g. Keratolytics
5. Know the various types of local anesthetics
6. Recognize the cutaneous manifestations of systemic disease
7. Become increasingly capable of using and understanding systemic therapy to include:
   a. Antineoplastic Therapy
   b. Retinoids
   c. Phototherapy
   d. Biologic therapy
8. Know the principles of and be able to perform ulcer care
9. Know the principles of radiation therapy
10. Be increasingly familiar with sexually transmitted diseases and be able to provide counseling to patients with these disease processes
11. Become familiar with chronic wounds, their evaluation, care, and types of dressings
12. Know the art and science of consultative dermatology on all types of patients
13. Will be able to demonstrate knowledge in advanced differential diagnosis and patient therapeutic/patient care
14. Will be familiar with advanced therapeutics: radiation therapy, systemic therapy for psoriasis, and antineoplastic therapy
15. Will demonstrate clinical knowledge of complex cutaneous diseases processes
16. Will become familiar in diagnosing genodermatoses
17. Should be familiar with the economics and ethics of dermatology
18. Will demonstrate ability to instruct peers and interact with other physicians on problems relative to dermatology
19. Will demonstrate overall independent responsibility for directing service and patient care decisions
20. Will demonstrate ability to correlate clinical and patholgicial findings

Professionalism
1. Be on time for clinical assignments.
2. Be a team player in a busy clinical setting
3. Wear professional attire during clinical activities
4. Ask the Attending for assistance in times of need
5. Know the art and science of consultative dermatology on all types of patients
6. Will demonstrate ability to instruct peers and interact with other physicians on problems relative to dermatology
7. Establish appropriate therapeutic relationships with continuity patients
8. Will demonstrate overall independent responsibility for directing service and patient care decisions

Systems-Based Practice
1. Know method to refer to dermatology surgeons and non-dermatology specialty physicians
2. Know the art and science of consultative dermatology on all types of patients
3. Should be familiar with the economics and ethics of dermatology
4. Will demonstrate ability to instruct peers and interact with other physicians on problems relative to dermatology
5. Will demonstrate overall independent responsibility for directing service and patient care decisions

Communication
1. Provide counseling on skin care and protection
2. Work within a team of nurses and physicians
3. Know the art and science of consultative dermatology on all types of patients
4. Will demonstrate ability to instruct peers and interact with other physicians on problems relative to dermatology
5. Will demonstrate overall independent responsibility for directing service and patient care decisions

Problem-Based Learning and Improvement
1. Know the art and science of consultative dermatology on all types of patients
2. Incorporate information learned from UNC-Duke conferences into patient care
3. Will demonstrate ability to instruct peers and interact with other physicians on problems relative to dermatology
4. Will demonstrate overall independent responsibility for directing service and patient care decisions
5. Appropriately investigate clinical questions/decisions as related to personal continuity care patients

**High Risk Skin Cancer Clinic**

**Goals:**
1. Understand mechanisms of carcinogenesis of non-melanoma skin cancers in both immunocompetent and immunosuppressed patients.
2. Understand features of these skin cancers that make them amenable to non-surgical treatments.
3. Develop comfort with using both standard and augmented photodynamic therapy.
4. Develop comfort using various home and in-office field treatment procedures (PDT, chemical peels).
5. Develop comfort using both fractionated and ablative CO2 laser as adjunct and definitive treatments for skin cancer including vermilionectomy.
6. Understand characteristics of immunosuppressant medications and their respective risks regarding NMSC development.

**Objectives:**

**Dermatology Years 1-3**

**Patient Care**
1. Obtain pertinent history and perform a complete dermatologic examination including lymph node examination in high risk individuals
2. Perform basic surgical techniques to include:
   a. Shave biopsy
   b. Punch biopsy
   c. 2-layered closure
3. Know the basics of how to perform local anesthesia including nerve blocks
   a. Trigeminal (V1, V2 and V3 blocks)
4. Provide counseling on skin care and protection
5. Ablative CO2 laser
   a. Learn how to use the ablative setting on the laser to treat NMSC
   b. Learn how to use the ablative setting on the alser to treat NMSC on the lip and actinic cheilitis (vermilionectomy)
6. Intraleisional 5-fluorouracil (5-FU)
   a. Learn how to select patient subsets who would benefit from intraleisional therapy to skin cancers and other squamoproliferative lesions like warts
   b. Learn how to monitor for toxicity and determine appropriate dose and dose intervals for each patient
7. Jessner-35% TCA Peel
   a. Learn proper application technique and methods to inactivate the acid

**Medical Knowledge**
1. Recognize primary and secondary lesions and group skin diseases in diagnostic categories
2. Recognize common skin cancers such as:
   a. Basal cell carcinoma
   b. Squamous cell carcinoma and Bowen’s disease
   c. Merkel Cell Carcinoma
   d. Melanoma and Melanoma in Situ
3. Understand principle of using systemic therapies to help augment field treatment or reduce skin cancer burden
   a. Methotrexate to augment PDT
   b. Acitretin as a chemopreventative agent – understand mechanism of action and side effects of this medication in both immunocompetent and immunosuppressed patients
4. Understand various immunosuppressant medications used in solid organ transplant medications and their respective risks to the development of NMSC
   a. Cyclosporine A
   b. Imuran
   c. Cellcept
   d. Prograf
   e. Leflunomide
   f. Sirolimus
5. Other systemic medications that confer increased risk of both melanoma and NMSC
   a. TNF-alpha inhibitors
   b. Voriconazole
6. Standard Photodynamic Therapy:
   a. Understand the various sensitizers used (20% aminolevulinic acid solution – levulan and 16.8% methyl amino levulinic acid cream)
   b. Understand the purpose of choosing blue light, red light or pulsed dye laser
7. Augmented Photodynamic Therapy:
   a. Understand rationale for using fractionated CO2 laser to enhance PDT
   b. Understand rationale for using CO2 laser as a drug delivery tool for other agents (efudex, aldara, picato and even other topicals like antifungals)
8. Jessner-35% TCA Peel
   a. Understand mechanism by which this peel helps treat field damage in particular on the arms and legs

**Professionalim**
1. Maintain a surgical and laboratory log for patient care follow up
2. Enter procedures into ACGME Case Log
3. Be on time for clinical assignments (ready to see patients at 9am)
4. Be a team player in a busy clinical settings
5. Wear professional attire during clinical activities

**Systems-Based Practice**
1. Maintain a surgical log and portfolio
2. Learn method to refer to dermatology surgeons
**Communication**
1. Provide counseling on skin care and protection
2. Work within a team of nurses and physicians

**Problem-Based Learning and Improvement**
1. Self-assess strengths and weaknesses at 6 month and annual reviews
2. Create individual learning plan to address weaknesses or deficiencies at end-of-year evaluation
**FACULTY EXPECTATIONS**

As a faculty, we expect our residents to make their dermatology education one of their highest priorities during the three years in which they train with us in Chapel Hill. Residency training is not a mere rite of passage or worse, a 40-hour per week job. It is instead the first phase of a life-long program of disciplined self-education.

In order to effectively practice dermatology, each physician must develop very specialized visual skills, aptly referred by some as the "dermatologic eye." Therefore, the most important training that each resident receives will be acquired by seeing and treating large numbers of patients, each of whom presents with a unique presentation of a dermatologic condition. As faculty, we are committed to working closely with you, in supervised clinical settings, to help each of you develop these critical clinical skills. As a correlate, you will be given increasing responsibility in the management of our patients, commensurate with your level of clinical experience, and training.

Dermatology, however, cannot be adequately mastered just by repeated hands-on exposures to patients. It will additionally require considerable outside reading, not only of the many major current textbooks in the field, but also of the primary (journals) literature, of specialized monographs, and of more historical texts. This, by necessity, will require a commitment to study during evening hours and on weekends, much like medical school.

With increasing time in our residency, we expect our trainees to develop progressive sophistication in their diagnostic and therapeutic skills, to include basic and more advanced surgical techniques, as well as in-depth knowledge of all areas, which encompass the certification examination of the American Board of Dermatology. These include, but are not limited to:

(i) the anatomy, histopathology, immunopathology and immunology, embryology, metabolism, photobiology, aging, of normal skin;

(ii) the pathophysiology of diseases of the skin;

(iii) the pharmacologic or surgical basis for specific therapies of skin diseases, and

(iv) pertinent aspects of mycology, tropical medicine, radiotherapy, cancer biology, and clinical epidemiology.

Residents play an essential role in patient care within our department. As a correlate, our large patient population relies heavily upon our residents, just as they do all other physicians who participate in their overall care. We therefore expect our residents to take this responsibility seriously, and in every encounter with our patients to treat our patients with the same level of concern, respect, compassion, and maturity as they hopefully will with every patient whom they treat within their own private practices in future years.
RESIDENT EXPECTATIONS

Clinical teaching and education are two-way streets. Faculty certainly can learn as much from their encounters with our residents and patients as our residents can from each faculty member.

Our residents should expect to be treated by each faculty member with courtesy, consideration, collegiality, and respect, and to have every clinical encounter be treated as a teaching opportunity by its faculty. Residents can also reasonably expect that each of our faculty members will actively participate in the many didactic teaching sessions and conferences of our department, and, by their actions, professional accomplishments, and interactions with others, to serve appropriately as role models.

Residents: At present, we are approved for 13 residents in our training program. Assignments vary by training year, although each resident participates in our outpatient clinics during all three years of the residency. Specific assignments may vary from one year to another, based on current clinical needs and the number of residents available to participate. In general,

- Residents do not begin to participate in the inpatient consultation service until their second year of dermatology training.
- The clinics at the Piedmont Health Services, Hillsborough and Raleigh may be attended by all trainees, starting with their first year.
- Electives are reserved for our second and third year (senior) residents. Second year residents can use 1 week of the total 4 week allotment.

Departmental Reimbursements

At the beginning of your first year, the department will provide you with 2 white lab coats. These will be ordered during your orientation, from the Health Affairs Bookstore. At the beginning of your second and third years, the department will provide you with 1 additional white coat. Ask the Residency Coordinator for an account number to charge them directly to the department.

The department will reimburse you for the full cost of renewing your NC Medical Resident Training License. Please give receipts to Cherie.

Chief Resident: The Chief Resident is selected by the Departmental Chair and Program Director after consultation with the faculty. Appointment is based upon his/her performance as a resident and the demonstration of leadership and administrative skills.

The Chief Resident(s) serve(s) several major roles simultaneously:

1. As a senior resident he/she participates in the same clinical and other educational activities, and at the same level, as any other resident within our program. That is, the Chief Resident participates in outpatient clinics and in conferences, just as does every other resident within our program. Similarly, he/she takes evening and weekend call, at the same frequency as all other residents.
2. The Chief Resident performs a number of critical administrative functions, to include the establishment and maintenance of schedules (i) for the assignment of residents to the clinics and consultation service; (ii) for resident vacations, and (iii) for resident, faculty, and outside speaker participation in our departmental conferences.

3. The Chief Resident serves as the senior representative of the residents to the Program Director and the Chair. As such, he/she is the first individual to whom other residents are to go if questions or problems arise regarding their day-to-day activities.

4. As a senior resident, the Chief Resident will also occasionally participate in the education of residents in other departments on our campus, who are preparing for their own board examinations, via scheduled lectures or other types of presentations.

In order to facilitate a smooth transition in scheduling at the beginning of each academic year, the Chief Residency will be a one-year position, beginning April 1st of his/her second year of dermatology residency.

Program Director: The Program Director is responsible for the overall design and functioning of the residency program. He/She acts under the mandate of the Department Chair and serves as the final conduit between the residents and the faculty. He/She administers the yearly in-training examination by the American Board of Dermatology and generates yearly progress reports on each resident to the Board. He/She is the department’s formal contact with the ACGME. He/She ensures that all policies and regulations of the University, of UNC Hospitals, and of its Office of Graduate Medical Education are met by the department and its residents. The Program Director is in charge of the residency selection process, working with a subcommittee of faculty members. He/She further oversees all didactic teaching sessions and assists the Chief Resident and Chair in the selection of outside speakers. He/She establishes a mentorship program for career counseling for each resident, as well as written certification of completed training upon graduation from the program. Most importantly, he/she intervenes if problems arise among the residents which cannot be resolved by the Chief Resident.

Residents are strongly encouraged to speak with the Program Director at any time regarding specific questions, concerns, or problems which can impact either the resident or the program itself. If possible, however, any issues that involve day-to-day interactions among residents (to include scheduling) or clinic matters should first be broached with the Chief Resident. Any problems which cannot be handled at the level of the Program Director, will then be deferred to the Departmental Chair.
**RESIDENTS' RESPONSIBILITIES**

**Clinics**

Residents are assigned to each of our local and outlying clinic facilities on a multiple-week block basis. There are no resident clinical activities scheduled during educational sessions. While clinics are occasionally cancelled, residents may be scheduled to clinical activities on all non-educational half days. Residents are not guaranteed to have protected time off during the work week. Individual faculty members may have different ways in which they wish residents to participate in patient care. As such, residents should consult with each individual attending.

In order to provide optimal care, as well as show maximal courtesy and respect to our patients in the most professional manner, it is important that each resident be ready to begin each clinic on time.

In general, within our standard teaching clinic, each patient is first interviewed and examined by a resident, prior to presentation to the attending. All necessary procedures are then performed and prescriptions prepared by the resident, unless otherwise specified by the attending.

Of most importance, each resident is ultimately responsible for following up on the biopsies and other laboratory studies which have been performed on every patient, and for informing the attending (and subsequently the patients) of these findings. This includes biopsies and laboratory studies performed at each of our outlying clinics. As a correlate, each resident should notify the attending of the results of these findings as soon as they become available, and then inform and explain to each patient what these findings mean and what further studies (if any) should be done.

During the last few weeks of each academic year, there is a potential risk that studies initiated by a soon-to-graduate third year resident may not be available for review and follow-up until after July 1st. Each graduating resident must formally arrange for another resident to follow-up on these patients, to guarantee that quality of care is maintained during this yearly transition period. Phone calls to the referring physicians may be appropriate, especially for some of the patients who are referred to us from within the UNC Hospitals system, to facilitate communication within our institution.

As many of the residents may be either scheduled away or on vacation/elective from the dermatology clinic, each resident should identify one fellow resident (“buddy”) with whom to cover clinical and elective mailbox messages. This is an extremely important issue regarding continual effective care to our patients.

Each resident will furthermore generate formal clinical notes on all patients not requiring, per federal regulations, notes prepared by the attendings, unless an attending chooses instead to create each note. As a correlate, it is important that each note be corrected, as necessary, by each resident as soon as possible, so that a final record can be made available to the referring physician and other health care professionals who may be participating in the care of that patient.
Unexpected coverage needs may arise at any time, due to personal illnesses, family medical leave, etc., of other fellow residents. As such, it may become necessary to recruit other residents to fill clinic openings on very short notice. To meet these unpredictable needs, the following rules must be adhered to by each resident in our program:

1. During each weekday, each resident must be immediately reachable via beeper from 8:00 a.m. to 5:00 p.m. unless they are on elective or vacation.

2. In addition, each resident who is not otherwise assigned to a clinic on a given morning or afternoon is also expected to be available, should unexpected coverage be required. That is, each resident who is unassigned to a clinic on a given half-day must still be available to be at the clinic within no more than 15 minutes after receipt of a page from the Chief Resident, Clinic Director, or Program Director, to assign him/her to such a duty.

Any release from this responsibility must be approved on a case-by-case basis by the Program Director, and will be based on the overall number of residents who are still available for coverage.

**Inpatient Consultations**

It is critical that we be able to meet the dermatologic needs of our colleagues from other departments within the medical school in a professional and timely manner. Each consultation must be completed as fully and as expeditiously as possible. That is, the consult resident should attempt to see and evaluate each consultation personally, and as soon as possible, rather than merely trying to serve as a triage officer for our outpatient clinic. If the consultation is regarding an outpatient clinic and the requesting service/clinic feels transfer of the patient is safe and justified, the consult resident can refer the patient to the dermatology clinic. Even if you feel that the consult is inappropriate, unnecessary, or excessive, you are expected to provide consultations for any service/team/attending upon request.

In general, every non-Emergency Room consult must be seen on the same day of the request. Emergency Room consultations are indeed that, and must be seen as quickly as possible by the resident. A decision can then be made as to the need for the on-call attending to physically staff that consultation, after the resident has spoken to the on-call attending, based on the resident's findings and the specific needs of or requests by the patient and ER staff.

Evening and weekend coverage schedules will similarly be assigned by the Chief Resident. In order to provide optimal care (which includes the best possible continuity of care) for our patients, it will be unacceptable to have multiple residents cross-covering one another within any single day (i.e., on a weekend). Any changes in coverage for our consultation service must be reported not only to the attending, who is on service but also to the page operators at UNC Hospitals.
Miscellaneous

Each resident is expected to perform all duties in a highly professional manner. This includes being punctual and properly attired for each of our clinics. White lab coats are provided to each resident, and should be worn within the hospital during any anticipated inpatient contacts. Although white lab coats are optimal, other equally professional attire may be acceptable within our department's outpatient facilities, unless otherwise noted by the attendings of individual clinics.

For security reasons and entry into the selected hospital wards, each resident should always wear his or her UNC Hospitals Identification Badge while in any of our clinics or in the hospital.

Pagers are provided to each resident. During the work week, each resident must be available via pager, even if he or she is not assigned to a clinic during a particular half-day. It is unacceptable for any resident to have another resident carry his/her beeper, or to leave it unattended in the clinic or office areas.
CONFERENCES

Departmental

Residents are expected to attend and participate in all of the scheduled conferences and teaching sessions and activities of the department. As part of their training, each resident will prepare formal presentations to the department yearly, consistent with the goals of the curriculum for our residency training program.

Similarly, each resident will also participate in all journal clubs and all other announced conferences.

Our department meets with the residents and faculty of Duke on a nearly every two week basis during nine months of each academic year (September through June). Half of these patient-focused UNC/Duke conferences are held at UNC. First and second year residents are expected to give formal presentations at the UNC meetings, with the advice and assistance of the faculty member who has participated with the resident in the evaluation and care of each patient. Details of the format for these presentations are available from the Chief Resident and Program Director.

The Hideaway/Consultant’s Conference occurs almost weekly. In this conference, interesting patients with attendant teaching value are present for evaluation. Residents and faculty members are responsible for referring challenging and/or interesting patients to this conference. It is important to gather and review all referring physicians’ notes prior to the conference. For all patients with prior biopsies, please inform our dermatopathologist of the patient a week before the patient attends this conference. Rotating faculty preceptors run the conference including oral examination of the residents’ knowledge base, evaluation strategy, and treatment plans. The faculty will evaluate residents on their performance and provide feedback in regards to patient care, medical knowledge, practice-based learning and improvement, and systems-based practice.

Didactic lectures are scheduled weekly. A Chief Resident is responsible for establishing the year’s schedule with the Program Director’s guidance to cover a wide range of topics related to dermatology. Lecturers include UNC departmental faculty, UNC Hospitals faculty, UNC dermatology residents, and local and national dermatologists.

Dermatopathology is taught throughout the year with unknown cases, weekly formal reviews based upon chapters of a pathology textbook, and monthly mock board examinations.

Journal Clubs are held on a regular basis with a faculty preceptor.

Kodachromes are reviewed on a weekly basis with a faculty preceptor. Unknown cases are projected. Residents are asked to provide differential diagnoses and potential evaluation strategies.
National and Local Conferences

We well appreciate that our residents may benefit from the opportunity to learn from faculty members of other universities, via attendance of approved educational meetings and forums.

At the present time, all residents in U.S. dermatology training programs have some expenses (hotel and travel) paid to attend the annual meeting of the American Academy of Dermatology by an educational grant. Depending upon the fiscal state of the department, residents are provided a stipend to apply to additional costs of registration. The second-year class is responsible to cover the consult service during the meeting. Arrangements are negotiated among this class to decide upon logistics of consult coverage and meeting attendance.

All of our first and second-year residents are encouraged to attend the annual Southeastern Consortium on Dermatology, a regionally based clinical meeting, which is focused on graduate and postgraduate education. Depending upon the fiscal state of the department, residents are provided a stipend to apply to the costs of travel, accommodations, and registration. Third-year residents provide coverage of call activities. If third-year residents attend this meeting, they do so without financial support of the department.

If clinic coverage scheduling is adequate, it may be possible to permit residents to attend other meetings within the continental United States, based on individual career needs or interests. If departmental funding allows, it may be also possible to reimburse or provide some stipend to apply to expenses if a presentation by the resident is involved. This will be applied on a case-by-case scenario.

The ability to give cogent presentations is an equally important skill, which we wish to see each of our residents develop before he or she graduates from our program. The two-day Gross and Microscopic Symposium at the annual meeting of the American Academy of Dermatology is an outstanding format. Each of our returning dermatology residents will be expected to submit an appropriate clinical vignette in this or comparable AAD symposium. Our faculty will assist each resident in identifying appropriate cases for presentation. Applications for submission will be due in late spring or early summer of the year preceding the next AAD meeting, so each resident needs to be looking for possible cases for presentation.

We would be delighted to have our residents give presentations at other regional or national meetings, in addition to the AAD annual meeting, if departmental resources allow. Interested residents should discuss this with the Program Director and/or Chair.
CLINIC AND INPATIENT SERVICE SCHEDULES

The Chief Resident is responsible for all assignments of the residents to the clinics and to the consultation/ward service. Clinic rotations will be assigned in units of multiple weeks, to simplify scheduling and balance assignments.

It is the intent that over the course of each year of residency, each member of a class will have had approximately equal amounts of time within each clinic setting. The only major exception will be if significant program changes occur which alter the current composition of our clinics (for example, in where and how often we will be providing services within outlying facilities). Similarly, some residents may not be able to have exactly the same clinic assignments as others if, for example, they choose to participate in some electives (i.e., within foreign institutions; to participate in research electives).

It cannot be overstressed that every attempt will be made by the Chief Resident and the Program Director to ensure that each resident graduates from our program having had, over the three year training period, the same clinical educational opportunities of their fellow classmates. Micromanaging ("bean counting") by individual residents is strongly discouraged, since it impacts negatively on what is hoped to be a department-wide collegial environment, as well as on the day-to-day interrelationships among its fellow trainees.
ELECTIVES AND INTERVIEW TIME

Resident elective time is 4-5 weeks of the third year of residency training. As the clinical and staffing needs of the department must not be compromised, the length of elective time is always subject to change. In addition, each resident is permitted to use 5 work days during their training for interview purposes.

Electives are commonly taken at Greensboro Pathology and Aesthetic Solutions, although they also may be taken at other institutions, with the prior approval of the Program Director and the cooperating institution. All electives require an elective approval form submitted to the Program Director.

While the specific length of each elective may vary, based on the type of elective being proposed, it is hoped that each resident will use this time to augment their residency training and/or potentially develop a specific area of interest and expertise, through the intensive study of some field within our specialty.

If residents take 4 weeks of elective outside of the North American continent, they will accrue one additional week of elective.

Because some fellowships (Mohs, procedural, pediatric) match toward the end of the second year, second year residents can use 1 week of their senior elective.

In order to attempt to ensure that each resident can take elective time during his/her senior year, no more than one dermatology resident may take his/her elective during the same time period. Despite this, however, please note that this our targeted goal, and that the exact length of each elective period will ultimately remain dependent on the availability of sufficient numbers of residents to provide adequate coverage for our department's many clinical activities. At present, this should be possible, based on the number of residents who are currently enrolled within our training program. The Chief Resident will be instrumental in helping to keep this a reality, by carefully scheduling vacations and specific clinical assignments during particularly busy portions of the academic year. Electives should be discussed with the Program Director as early as possible, both for approval and to facilitate scheduling by the Chief Resident.

Third-year residents are encouraged to participate in a longstanding exchange program, which was established by Dr. Diaz with the Department of Dermatology at the University of Sao Paulo in Brazil. This elective is up to 4 weeks in length. Interested residents are encouraged to obtain details from Dr. Diaz about this unique educational opportunity.

The International Residency Exchange Program University of North Carolina – University of Sao Paulo, Brazil

The Faculty of Medicine at the University of Sao Paulo opened in 1912 and the Department of Dermatology began its academic activities in 1916. Renowned members of the university have made important contributions in clinical and basic research, among them Professor A. Carini (Pneumocystis Carini), Professor A. Bovera, Professor S. Taylor-Darling, Professor Lambert and
Professor Lambert-Mayer. Four outstanding individuals have headed the department: Professor A. Lindenberg (1912-1929), Professor J. Aguiar-Pupo (1930-1960) and Professor S.A.P. Sampaio (1961-1989) and Professor Evandro A. Rivitti, (1990 - To date).

The Department of Dermatology at the University of Sao Paulo is the largest dermatology-training program in Brazil and Latin America. The missions of the department are teaching, patient care, and research. There are 25 faculty members, 24 dermatology residents, and seven post-doctoral fellows. Many of the faculty members are former trainees of dermatological programs in the United States and Europe. There is a strong emphasis in the postdoctoral program to train future academicians. The department is divided in active divisions, i.e., clinical dermatology, pediatric dermatology, dermatological and cancer surgery, cryotherapy, dermatopathology, tropical medicine and immunodermatology. An expert faculty member heads each unit.

The Dermatology Outpatient Service at the Hospital das Clinicas (http://www.hcnet.usp.br/) attends more than 300 patients per day. The census of patients seen in the dermatology clinic service from 1987 through 1990 is as follows: 48,302 (1987); 46,962 (1988); 59,648 (1989); and 73,298 (1990). The department maintains an active inpatient service of approximately 30 patients providing specialized therapy for such diseases as leprosy, leishmaniasis, lupus, endemic pemphigus (fogo selvagem), chromoblastomycosis, blastomycosis, and lymphomas.

Sao Paulo is one of the largest cities in the world with a population that approximates 18 million and the University Hospital is the premier referral center for the city of Sao Paulo.

History of Dermatology Residency Exchange Program: The faculty of the Department of Dermatology of the University of Sao Paulo has maintained, for several years, a close association with Dr. Luis A. Diaz’s research team on Fogo Selvagem. It began when Dr. Diaz was a faculty member at the University of Michigan (1976-1982) and continued when he joined the Dermatology Department at Johns Hopkins University (1982-1998). The aims of these interactions were focused on research and training opportunities for junior faculty members of both departments. As a result of these efforts, both departments have benefited from grants and subcontracts from the National Institutes of Health (NIH) to support research in Fogo Selvagem. Faculty members from the University of Sao Paulo and US universities benefited from these interactions as well.

The International Residency Exchange Program for dermatology residents officially began at the Medical College of Wisconsin in 1992 when Dr. Diaz was serving his tenure as Professor and Chairman of the Dermatology Department at that institution (1989-1999). This program moved to The University of North Carolina in Chapel Hill in 2000 when Dr. Diaz was appointed as Professor and Chairman of the Dermatology Department.

The close and productive interactions between academic departments of two major universities will continue to benefit both programs. The exchange program stands as an example of a multinational effort for the advancement of dermatology education in two countries. From Brazil we offered training opportunities in the USA to Dr. Ciro Martins, Dr. Justin Roscoe, Dr. Giles Landman, Dr. V. Aoki, Dr. H. Friedman, Dr. R. Rocha, and Dr. G. Hans. Dr. Martins is an
Assistant Professor of Dermatology at Johns Hopkins University; Dr. Roscoe is a board-certified dermatologist in Maryland, and the rest of visiting scientists are dedicated to academic careers in Brazil. Several investigators from the U.S.A. have also enjoyed these interactions, including Dr. G. Anhalt (Johns Hopkins University), Dr. T. Russell, Dr. Fairley, Dr. Neuburg, B. Drolet (faculty members of the Medical College of Wisconsin), and Dr. J.R. Stanley (Professor & Chair Dermatology, University of Pennsylvania).

The Resident Exchange Program: Senior residents from both departments are allowed to spend 1 month in the exchange facility, i.e., Sao Paulo or Chapel Hill. The exchange program is not mandatory. Upon arrival the dermatology resident is incorporated into the respective residency program. This program provides the opportunity for residents from each program to visit the other institution and to participate fully in the various aspects of the teaching program of each department. The residents from both institutions are able to learn and appreciate a culture of each country and most important to learn aspects of dermatology in areas difficult to reproduce in their own institutions. For example, the teaching of tropical dermatology is unique in Sao Paulo and it is unmatched in any other U.S.A. Dermatology Program. The exchange program is voluntary for our residents.

The Department of Dermatology of the University of Sao Paulo provides free housing for our residents during their stay in Brazil. The apartment in Sao Paulo is furnished and within walking distance of the University Hospital. The UNC Department of Dermatology also provides free housing to Brazilian dermatology residents. This facility is also furnished and is located on a free bus line convenient to UNC Hospitals and the UNC Dermatology clinic at Southern Village.

U.S.A. dermatology residents have benefited from the exposure to the practice of dermatology in a country outside the U.S.A. The Brazilians are generous and gracious hosts and our residents have found this rotation to be a real highlight in their educational experience. Many have remarked that the experience gained during this rotation was a real benefit in taking their exams for the American Board of Dermatology. There have been more than 25 U.S. residents (Medical College of Wisconsin, University of Rochester, Duke University, Stanford University, and UNC) that have visited the Sao Paulo program and a similar number of Brazilian residents that have come to our U.S.A. institutions.

This program won an award for Excellence in Education from the American Academy of Dermatology in 1993. The award consisted of a trophy and a $4,000 check, which was divided equally between the two institutions.

Educational Objectives for UNC Dermatology Residents:
- Learning experience in tropical dermatology. Our residents will be seeing patients suffering from all forms of leprosy, leishmaniasis, superficial and deep fungal infections, and endemic pemphigus foliaceus.
- Learning features of skin diseases that are unique to Brazil. Similar diseases are seen in the U.S.A., but in their milder forms because patients seek medical attention sooner than their Brazilian counterparts. Severe forms of psoriasis, lupus, pemphigus vulgaris, lymphomas, etc. are commonly housed in the inpatient service of the University Hospital in Sao Paulo.
• Learning and understanding the health systems applied to patient care in Brazil.
• Learning the culture of another country.

**Educational Objectives for USP Dermatology Residents:**
• Learning and comparing clinical dermatology as is practiced in the U.S.A. with Brazil.
• Increasing their English proficiency.
• Comparing the Health Care Systems, Brazilian, and U.S.A.
• Learning the USA culture.

**Other Aspects of the Exchange Program.** Dermatology residents participating in the exchange program will be working as “Observers” when visiting each training facility. They will not be involved in direct patient care. Health related risks for visitors to Sao Paulo are the same as those found in any large city around the world. Vaccination against tropical diseases is not required, only if planning to visit the Amazon regions. The language spoken in Brazil is Portuguese. The majority of dermatology residents and faculty from the Department of Dermatology of the University of Sao Paulo communicate well in English. Dermatology residents from Brazil are encouraged to obtain health insurance before coming to the U.S.A. UNC residents must complete the required Health Insurance forms before traveling to Brazil.
ELECTIVES APPROVAL FORM .................................................................

The Program Director, Elective Committee, and the Director of the elective experience at the sponsoring institution must approve third-year electives. Please complete this form, sign it and submit to the Program Director for approval. After approval, have the sponsoring institution sign it and give the original to the Residency Coordinator, who will need it for GME paperwork.

**ELECTIVE DATES:** _______________________________________________

**ELECTIVE LOCATION:** ___________________________________________

**DIRECTOR/CONTACT PERSON OF ELECTIVE:** ______________________

**EDUCATION GOALS OF ELECTIVE:**

______________________________________________________________

______________________________________________________________

______________________________________________________________

______________________________________________________________

______________________________________________________________

______________________________________________________________

Resident Signature

Date

Approved by committee:

☐ Yes

☐ No

Director of Elective

Date

Program Director

Date
RESEARCH OPPORTUNITIES

We agree with the American Board of Dermatology and Dermatology RRC that exposure to research (basic or clinical) is a worthwhile component of the training of every dermatologist, even if an academic career is not being ultimately sought. We therefore encourage each trainee to consider supplementing his or her own training with exposure to some form of research, if time and interest permit. It is important to emphasize, however, that this is not a requirement of our residency program, since our primary focus is to provide comprehensive clinical training for each of our residents. Any research pursued part-time by a resident must not, however, interfere with the scheduled clinical activities or educational programs of our department.

Less formal research opportunities (to include possible participation in ongoing clinical trials) may be possible within our department to any resident, who wishes to participate in a particular ongoing project while still participating fully in all of his/her scheduled clinical activities. Residents interested in pursuing such research should discuss such options with the Program Director and other members of our faculty.
EVALUATIONS

Resident Evaluation of Faculty, Program, and Rotations

The faculty of the Department of Dermatology realizes the importance of regular evaluation of the program. On a yearly basis, residents are asked to complete evaluations of the program’s faculty members and subspecialty rotations. Residents also evaluate satellite clinics. This is accomplished through anonymous evaluations filled out online via E*Value. The Coordinator prints the E*Value reports and forwards to the Program Director. Faculty members receive feedback through the Chair individually.

A Program Evaluation Committee (PEC) comprised of the Program Director, two faculty members, Chief Resident(s), Past Chief Resident(s), and one representative from the first year residents meets on an annual basis to address the overall educational objectives of the program with feedback from program/rotation evaluations and resident performances on the ABD In-Training examination.

Program Evaluation of Residents

Each resident will be evaluated individually, consistent with the requirements of the University's Office of Graduate Medical Education, the Accreditation Council of Graduate Medical Education, and the American Board of Dermatology.

Each resident will meet with the Program Director twice yearly to discuss his or her progress, and to hear of any recommendations from the Clinical Competency Committee (CCC), which are focused on improving performance within our many clinical and teaching settings. Written summaries of all evaluations are always available and on file for review.

The American Board of Dermatology Evaluation

The American Board of Dermatology evaluation is performed yearly in the spring. Each attending physician completes an evaluation of every resident. The final report is a summary of all the evaluations. This evaluation tool addresses all required competencies including patient care, medical knowledge, interpersonal and communication skills, professionalism, practice-based learning and improvement, and systems-based practice.

In-Training Examinations

An in-training examination (mock boards) is administered yearly in the Spring to all dermatology residents according to the guidelines set by the American Board of Dermatology. This examination measures resident competencies in medical knowledge, practice-based learning and improvement, and systems-based practice. Results of these examinations will also be used by the department as one formal marker of the progress of each trainee and, when necessary, to direct further study during one or more electives during the senior year of training, if a resident has performed poorly in any portion of the examination.
360 Degree Milestones Evaluation Tool

Each resident will be evaluated twice per year via a 360 degree milestones evaluation tool. This tool assesses resident competencies in patient care, interpersonal and communication skills, professionalism, practice-based learning and improvement, and systems-based practice. Evaluators will include faculty, fellow residents, administrative personnel, nursing staff, clinic staff, resident self, and patients. These evaluations will be performed in November/December and May/June via E*Value.

Portfolios

Residents have been asked to maintain portfolios, which will be reviewed on a yearly basis. With portfolios, residents can document their progress in medical knowledge, practice-based learning and improvement, and systems-based practice. Each portfolio entry should have a brief reflective statement demonstrating the educational value of the activity.

Procedure Log

All residents are required to maintain a record of their procedures performed in the clinical setting using the ACGME web-based procedure log. At the end of each year, each resident should update their procedure log for a final report.

Speaker Score

Residents are evaluated by meeting attendees in which they present talks. End of the year reports provide feedback regarding their teaching abilities and areas of needed improvement.

Conference Attendance

Attendance at all educational activities is measured.

Clinical Skills Evaluation (Sept.)

Faculty evaluate residents in the Fall for competency with clinical encounters, medical records, and systems-based practice.

Personal Feedback Card (Spring)

In the Spring of each year, residents select 1 faculty member to provide direct personal feedback with 1 item for improvement.
**PUBLICATIONS DURING RESIDENCY**

The optimal way in which a resident can become most knowledgeable about a specific disease or a clinical presentation is to perform an in-depth study of the literature on that topic and then synthesize that information into a report, which eventually can be submitted for publication in a peer-reviewed journal.

Each resident should also realize that significant contributions to our field are not solely dependent on the publication of cutting-edge bench or clinical research. Indeed, much can be learned from a well-written and exhaustively researched case report or case series.

We would therefore encourage each resident to look for opportunities to publish novel clinical observations, and to develop these ideas with the assistance and encouragement of one or more members of our faculty.

**Teaching During Residency**

There are many opportunities to develop effective teaching skills during residency training. Effective teaching is a very important aspect to master as it is a key to success in the residents’ future (interactions with patient, referring physicians, office staff, etc.). In addition to daily interactions with patients and fellow residents, rotating medical students often shadow residents during clinics and consults. Teaching is both an honor and responsibility, which must be accepted with professionalism.
POLICIES AND PROCEDURES

DEPARTMENT OF DERMATOLOGY

Faculty
Luis A. Diaz, MD, The C.E. Wheeler Jr. Distinguished Professor & Chair
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Craig N. Burkhart, MD
Donna Culton, MD, PhD
Amy W. Fox, MD
Lowell A. Goldsmith, MD, MPH, Emeritus
Brooke A. Jackson, MD
Punnet Jolly, MD, PhD
Ning Li, PhD
Zhi Liu, PhD
Aida Lugo-Somolinos, MD
Patricia M. Mauro, MD
Diana McShane, MD
Bradley Merritt, MD
Dean S. Morrell, MD
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Dermatology at Hillsborough
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Dermatology at Rex
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DEPARTMENT OF DERMATOLOGY

POLICY AND PROCEDURE
UNIVERSITY OF NORTH CAROLINA HOSPITALS
GRADUATE MEDICAL EDUCATION
POLICY ON DUTY HOURS FOR ALL ACGME SPECIALTY & SUBSPECIALTY TRAINING PROGRAMS

A) Background
UNC Hospitals Policy on Duty Hours must be consistent with the ACGME Common Program Requirements and Specialty Specific Resident Duty Hour Requirements. Although the responsibilities for patient care are not necessarily over a specific time, duty hours must be regulated in order to promote excellent patient care and safety, resident education and physician well being. The Program’s Duty Hour Policy must be in compliance with the relevant Program requirements and UNC Hospitals Policy on Duty Hours.

B) Maximum Duty Period Length and Mandatory Time Free of Duty
1. UNC Hospitals Policy on Duty Hours and the ACGME requirements take precedence over all other policy statements and apply to all sites to which residents are assigned.
2. Duty hours must be limited to 80 hours per week, averaged over a 4-week period, inclusive of all in-house call activities and all moonlighting and special duty projects.
Duty hours are defined as all clinical and academic activities related to the residency program, i.e., patient care (both inpatient and outpatient), administrative duties related to patient care, the provision for transfer of patient care, time spent in-house during call activities, and scheduled academic activities such as conferences. Duty hours DO NOT include reading and preparation time spent away from the duty site.

3. Residents must be scheduled for 1 day free of duty every week when averaged over 4 weeks. At home call cannot be assigned on these free days.

4. PGY1 and intermediate level residents should have 10 hours off between scheduled duty periods. Per the ACGME, “should” is a term used to designate requirements so important that their absence must be justified and a program or institution may be cited for failing to comply with a requirement that includes the term “should.” There are however, appropriate educational justifications, and inevitable, unpredictable circumstances which result in a respite of less than 10 hours. In these instances, residents must have a minimum of 8 hours free of duty before the next scheduled duty period. Per the ACGME, “must” is a term used to identify a requirement which is mandatory or done without fail, and therefore constitutes an absolute requirement.
   - All residents who have duty hour reports indicating a respite period of between 8 and 10 hours will be required to document the activities that prohibited 10 hours of respite. They will be asked to provide written educational justification or explain in writing the unpredictable circumstance that resulted in the reporting of between 8 and 10 hours respite between scheduled duty periods.
   - All reports of less than 8 hour respite periods will be treated as an absolute violation of the duty hour regulations.

5. Duty periods of PGY1 residents must not exceed 16 hours in duration. Duty periods of PGY2 residents and above may be scheduled to a maximum of 24 hours of continuous duty in the hospital. After 16 hours of continuous duty, residents are encouraged to engage in strategic napping, especially when the 16 hour mark occurs between 10:00 p.m. and 8:00 a.m.
   - After 24 hours of continuous duty, the resident may remain on-site for transitions of care and/or to attend an educational conference when that transition is completed, but this period of time must be no longer than an additional four hours. No new patients may be assigned or additional clinical duties assigned (including continuity clinics) during those additional four hours.
   - After 24 hours of in-house duty, residents must have 14 hours free of duty before the next scheduled duty period.

6. Individual exceptions to maximum duty hour periods. In unusual circumstances, a resident may remain beyond their scheduled period of duty to continue to provide care to a single patient with the following additional policies:
   - The extension of duty hour period must be initiated voluntarily by the resident – never assigned, or suggested, by the faculty member or senior resident.
   - PGY1 residents are not permitted to remain beyond their scheduled duty hour period.
   - Possible justifications for this extension of the duty hour period include those established by each program’s respective RRC.
   - The resident will complete such reporting processes as established by the program to record the extended duty hour period.
   - The program director will review each submission of additional service.
7. Residents in the final years of education [as defined by the Review Committee] must be prepared to enter the unsupervised practice of medicine and care for patients over irregular or extended periods. This preparation must occur within the context of the 80 hour, maximum duty period length, and one-day-off-in-seven standards. While it is desirable that residents in their final years of education have eight hours free of duty between scheduled duty periods, there may be circumstances [as defined by the Review Committee] when these residents must stay on duty to care for their patients or return to the hospital with fewer than eight hours free of duty. Such instances must be reported to, and monitored by, the Program Director.

C) **On-call Activities**

PGY2 residents and above must be scheduled for in-house call no more frequently than every 3rd night when averaged over a four week period, unless there are different provisions specified by the program’s respective RRC.

D) **At-Home Call (pager call is defined as call taken from outside the assigned Institution)**

1. Time spent in the hospital by residents on at-home call must count towards the 80-hour maximum weekly hour limit. The frequency of at-home call is not subject to the every-third-night limitation, but must satisfy the requirement for one-day-in-seven free of duty, when averaged over four weeks.

2. At-home call must not be so frequent or taxing as to preclude rest or reasonable personal time for each resident.

3. Residents are permitted to return to the hospital while on at-home call to care for new or established patients. Each episode of this type of care, while it must be included in the 80-hour weekly maximum, will not initiate a new “off-duty period.”

E) **In-House Night Float**

Residents must not be scheduled for more than six consecutive nights of night float, unless there are other provisions specified by the program’s respective RRC.

F) **Oversight**

1. Each program must have written policies and procedures consistent with the Institutional and Program Requirements for resident duty hours and the working environment. These policies must be distributed to residents and faculty. Monitoring of duty hours is required with frequency sufficient to ensure an appropriate balance between education and service.

Each program must monitor duty hours within the education committee by regularly reviewing the duty hours within their program and at all Institutions at which the residents rotate. The GMEC Subcommittee on Duty Hours must receive semiannually a report regarding program residents’ compliance with duty hours. Each program must have an educational program to recognize the signs of fatigue for the residents and faculty.
2. Back-up support systems must be provided when patient care responsibilities are unusually difficult or prolonged or if unexpected circumstances create resident fatigue sufficient to jeopardize patient care.
   a. The program must adopt and apply policies to prevent and counteract the potential negative effects of fatigue and sleep deprivation.
   b. Residents must be provided with on-call rooms that permit rest and privacy when on duty in the hospital.
3. All duty hour concerns by residents should first be directed to the Program Director. Alternatively, the resident may go directly to the Office of Graduate Medical Education to request investigation.

G) Reporting and Compliance Requirements
1. All residents and subspecialty residents appointed through the Office of Graduate Medical Education are required to record all duty hours in E*Value in a timely manner.
2. Residents will receive reminders from E*Value to record their hours every seven (7) days.
3. Residents who have not recorded their hours for a period of eight (8) days will be contacted by their Program Director and will be expected to record their hours to the current date immediately.
4. When a resident reaches a threshold of fourteen (14) days delinquent, said resident’s information will be forwarded to their Program Director and Department Chair on the fifteenth (15th) day for action.
5. When a resident reaches a threshold of 21 days delinquent, the DIO will contact the Department Chair on the 22nd day.

H) Moonlighting
1. Education of a resident is a full-time academic pursuit. Moonlighting is to be discouraged. However, the time spent moonlighting must count toward the weekly 80-hour duty limit, averaged over a 4-week period.
2. If a Program allows moonlighting, the Program Director must ensure that moonlighting does not interfere with the ability of the resident to achieve the goals and objectives of the educational program, and the Program Director and resident must comply with UNC Hospitals Graduate Medical Education Policy on Moonlighting.
3. If a program allows moonlighting and a resident chooses to moonlight, it is the responsibility of that resident to assure that all moonlighting activity occurs within the duty hour restrictions, including total hours per week, days off per week, and a mandatory 10 hour respite between all moonlighting and duty periods (see the Moonlighting Policy for more details.)

I) Duty Hour Exception
1. An RRC may grant exceptions for up to 10% of the 80-hour limit, to individual programs based on a sound educational rationale. The GMEC must approve the proposal prior to the program requesting an exception on the RRC level.
2. The program must follow the attached procedure for requesting a 10% exception for the 80-hour limit.

**J. UNC Dermatology Specific Duty Hour Policy**

*Residents are required to enter work hours into E*Value system. Failure to do so in a timely manner results in an email reminder to complete. Delinquency greater than 7 days stimulates emails to the Program Director for immediate corrective action.*

*On a weekly basis, the Program Coordinator reviews duty hour reports to assess for violations and/or errors. In case of errors, residents are informed and the entry error is corrected. Violations are investigated by the Coordinator with a discussion with the resident. In case of true violations, incidents are reported to the Program Director for corrective action in schedules. On a monthly basis, the Program Director reviews and signs monthly duty hour reports.*
1. An ACGME-accredited training program may request an exception for up to 10% of the 80-hour duty limit averaged over a four-week period.

2. The request must be submitted to the GMEC Chair of the Subcommittee on Duty Hours. The GMEC Subcommittee on Duty Hours will make a recommendation to the GMEC.

3. In requesting an exception to the 80-hour duty limit, the Education Committee of the program must include the following:
   a. The program’s ACGME accreditation status;
   b. The educational rationale for the exception as it applies to a particular assignment, rotation(s), and level(s) of training; a blanket exception for the entire educational program should rarely be requested;
   c. Resident rotation(s) changes and call schedules must be provided;
   d. There must be attestation of continuous faculty supervision during the extended hours;
   e. Effect of extended hours on rotations outside of UNC Hospitals;
   f. Plans for monitoring the duty hours in total and in particular the hours above 80 hours; and
   g. The program’s moonlighting policy must be noted for the period in question.

4. If approved by the GMEC, the Program Director may send the request to the respective RRC. The DIO of UNC Hospitals must sign this letter. If the 10% increase is granted to the program, all residents must be notified in writing that the GMEC and ACGME have approved the increase in duty hours. The duration of the exception will be limited to no more than the date of the next program review.

5. The Education Committee of the program must assess and document semiannually the impact of the increase on the physical well being of the residents and whether the program’s educational goals have been enhanced by the increase in duty hours and that patient safety has not been compromised.

6. The program’s Education Committee’s semiannual report must be sent to the GMEC Chair of the Subcommittee on Duty Hours. These reports will be presented to the GMEC.
DEPARTMENT OF DERMATOLOGY

Faculty
Luis A. Diaz, MD, The C.E. Wheeler Jr. Distinguished Professor & Chair
Robert A. Briggsman, MD, Emeritus
Craig N. Burkhart, MD
Donna Culton, MD, PhD
Amy W. Fox, MD
Lowell A. Goldsmith, MD, MPH, Emeritus
Brooke A. Jackson, MD
Puneet Jolly, MD, PhD
Ning Li, PhD
Zhi Liu, PhD
Aida Lugo-Somolinos, MD
Patricia M. Mauro, MD
Diana McShane, MD
Bradley Merritt, MD
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Policy Name | Professional Business Attire
---|---
Policy Number | HR 0312
Date This Version Effective | February 2014
Responsible for Content | Human Resources Division

I. Description
This policy is about how employees must present themselves while at work and is often referred to as the dress code.

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HR 0312 | Page 1 of 4
II. Rationale
Neatness and cleanliness are evidence of concern for our patients, their families, the public, and each other. Personal neatness and appropriate attire provide an atmosphere of professionalism and inspires confidence in our ability to deliver services. This policy supports and promotes work place safety, creates a standard for professional appearance and fosters a positive working environment. The policy applies to all employees including contract employees, residents, volunteers, students, Medical Staff of UNC Hospitals, and School of Medicine, and research personnel utilizing UNC Health Care facilities.

Employees arriving at work and clocking in must present themselves in accordance with the Professional Business Attire Policy. Department policies may specify additional requirements as appropriate for employee and patient safety.

III. Policy
A. Identification
All employees, staff members, volunteers, and visitors, while on UNC Health Care premises, shall be required to wear appropriate identification as defined in the Identification and Access Control Card Policy in UNC Health Care Policy Manual. An employee’s name and picture be visible at all times.

B. Uniforms
Department managers may require staff to wear uniforms as appropriate for the department, position, or work duties. Employees for whom uniforms are required for the job must wear the appropriate uniform. Uniform short pants and uniform hats may be appropriate if part of a department’s overall approved uniform. Alternations to the uniform or alternatives to uniforms are allowed only if prior approval has been obtained from a Department Head and if the intent of this policy, as stated above, is not violated.

C. Scrub Suits
A scrub suit is defined as a hospital provided, hospital laundered top and bottom apparel that is worn in specific departments of the hospital as prescribed by Infection Control. It is to be worn as a set of jade green shirt and pant as specified by the specific departmental policy. Scrub suits, masks, shoe covers, and gloves should be worn only in areas designated by relevant departmental policies and only by those designated to wear them as part of their personal protective equipment. These items are not to be removed from the hospital.

D. Non-Uniform Clothing
Clothing should fit properly, be clean, pressed, and in good condition.

The following is a list of attire that is inappropriate attire in the workplace at UNC Health Care:

1. Clothing that is non-professional in appearance, length, and fit of clothing, such as:
   - Backless dresses or tops
   - Skirts above the knee or have high slits
   - Pants shorter than mid-calf
   - Clothing that is excessively tight or revealing
2. Casual beach or athletic wear (such as sweat pants, stretch pants/warm up pants, and tights or leggings worn as pants
3. T-shirts with logos unless the logo identifies UNC Health Care or units within UNC Health Care
4. Shirts with revealing necklines, bare midriff tops, and clothing bearing any type of unauthorized message, including but not limited to offensive messages, or offensive images
5. Spaghetti strap blouses, unless worn with a jacket
6. Denim unless part of an approved uniform component
7. Shorts or skorts (or similar attire) unless a part of an approved uniform
8. Hats unless a part of an approved uniform

E. Safety
As required by the Occupational Safety and Health Act, UNC Health Care shall provide appropriate personal protective equipment for employees who perform hazardous work. The equipment will protect the face, eyes, head, and extremities. The Infection Control policies and the Employee Handbook must be used to guide departmental dress requirements where appropriate. Reference the UNC Health Care Infection Control Manual and the Employee Handbook for specific guidelines.

F. Protective Equipment
Protective equipment, shields, and respiratory devices shall be used whenever the employee has the potential of being exposed to a hazardous environment, chemical, radiation, or mechanical irritant capable of causing injury or impairment in the function of any part of the body through absorption, inhalation, or physical contact. The use of protective glasses and shoes is covered in the “Personal Protective Equipment Requirements Policy” in the UNC Health Care Safety Policy Manual.

G. Footwear
For safety reasons, all employees must wear shoes that are appropriate to their job. Shoes should be clean and in good repair.

OSHA Standard 1910.136(a) mandates that the employer shall ensure that each affected employee uses protective footwear when working in areas where there is a danger of foot injuries due to falling or rolling objects, or objects piercing the sole, and where the employee’s feet are exposed to electrical hazards. (OSHA standard 1910.1030(d) (3) (i) Closed-toed shoes are required in departments and areas in which the above hazards exist including all patient care areas. In addition OSHA requires that protective clothing/covering be worn that will prevent blood or other potentially infectious materials from reaching the skin.

The following are not appropriate footwear for the workplace at UNC Health Care:
1. Flip-flops
2. Slippers
3. Excessively high-heeled shoes

Employees serving in non-patient care areas may wear open-toed shoes, but are encouraged to wear close-toed shoes in accordance with the above provisions.

H. Grooming Standard
Cleanliness is an essential part of providing high-quality service to our customers. A neat, clean, business-like and professional appearance is a requirement for all jobs. In most instances, an employee may wear his or her hair the way he or she chooses while working, as long as it remains well trimmed, well groomed, and business-like in appearance.

I. Other Considerations
Supervisors will inform employees if business needs warrant additional requirements for the employee’s position.
Visible tattoos and excessive body piercing may offend some customers and co-workers while at the workplace. Therefore, these shall not be visible.

All jewelry and other accessories must comply with OSHA standards in the respective departments. These items present a safety hazard around certain equipment and generally can be disruptive to the work environment.

Chewing gum is not considered appropriate in the presence of patients, visitors, or guests. Chewing gum may be approved on a case-by-case basis for special circumstances such as participation in a Smoking Cessation Program.

The use of earphones, headphones, Walkman or ipods in public or patient care areas is not permitted, unless approved by management or required.

J. Hygiene Standards
Good personal hygiene is required. Other employees, as well as patients and guests, have a right to expect general cleanliness and good dental hygiene from the staff.

Employees shall not use body fragrances such as cologne, perfume, talc powder, and after-shave lotions. Smoke odors are prohibited.

Artificial nails may not be worn by staff involved with direct patient care.

Consideration must always be given to the adverse effect on patient care, on co-workers, and on visitors.

K. Special Occasion Exceptions
Costumes, holiday specific outfits or other special event outfits are acceptable for predetermined special occasions/holidays upon preapproval from department managers through their Division Vice President.

Other than the above exception, UNC Health Care does not have “casual” or “dress down” days.

L. Inappropriate Dress Penalty
Inappropriately dressed employees as referred to in the sections regarding identification, uniforms, and non-uniform clothing will be excused from work without pay, and must return to work as directed by their supervisor. Violations of the Professional Business Attire Policy will result in corrective action up to and including termination. Department managers are responsible for ensuring that every member of their department dresses in accordance with this policy, and the Residency Program Directors are likewise responsible for UNC Health Care’s residents’ compliance with this policy.

Violations of this policy may result in any of the following Performance related Corrective Actions depending on the severity of the violation:

- 1st Violation Verbal Warning
- 2nd Violation Written Warning
- 3rd Violation Final Written Warning or Suspension Without Pay
- 4th Violation Termination

IV. Related Policies
B. Personal Protective Equipment Policy in UNC Health Care Policy Manual

HR 0312
POLICY AND PROCEDURE
UNIVERSITY OF NORTH CAROLINA HOSPITALS
GRADUATE MEDICAL EDUCATION POLICY ON MOONLIGHTING

POLICY:
The Executive Committee of the Medical Staff has the responsibility for determining institutional policy regarding whether moonlighting by residents in training should be authorized. Unauthorized moonlighting is inconsistent with the educational objectives of the residency program requirements as specified by the UNC Hospitals Graduate Medical Education Office and the Accreditation Council on Graduate Medical Education (ACGME) and, therefore, is prohibited. Violation of this policy may result in dismissal.

“Moonlighting” is defined as extra work for extra pay, and includes non-medical/non-clinical positions. A non-clinical position is defined as a position in a healthcare-related field with no patient contact, either direct or indirect (such as chart review for research purposes) and with no medical decision-making that could impact patient care. A non-medical position would be one outside of healthcare that does not require medical training, such as working in a store or restaurant.
While performing clinical moonlighting services, residents must have a full, unrestricted license issued by the North Carolina Medical Board. All moonlighting hours must be documented in E*Value, including non-medical and non-clinical hours; failure to do so will result in suspension or revocation of moonlighting privileges. All residents must comply with the written policies regarding duty hours as per the training program, UNC Hospitals and ACGME.

Those resident trainees moonlighting at UNC Hospitals or a UNC Health Care System affiliated entity (except for Rex Healthcare and Chatham Hospital) are covered under the UNC Hospitals Liability Insurance Trust Fund Professional Liability program. No other moonlighting is covered under the UNC Hospitals Liability Insurance Trust Fund Professional Liability Insurance Program as the activity is outside the scope of UNC Health Care System employment. Trainees who are not moonlighting at UNC Hospitals or a UNC Health Care System affiliated entity are responsible for their own professional liability coverage (either independently or through the entity for which the trainee is moonlighting), DEA licensure, Medicare (or other governmental) provider number and billing training, and must meet any other requirements for clinical privileging at the employment site, including those trainees moonlighting at Rex Healthcare and Chatham Hospital.

Authorized moonlighting which does not interfere with the Residency Program requirements as specified by the ACGME is permitted under limited circumstances. The term for any authorized moonlighting shall not extend beyond the end of the academic year in which the moonlighting is approved. Residents who want to participate in moonlighting activities for longer than one academic year must apply for approval of such activities each academic year. For multiple reasons (including impact upon resident learning, call schedules, and duty hours), the Department of Dermatology at The University of North Carolina at Chapel Hill DOES NOT ENCOURAGE moonlighting activities. If a resident wishes to pursue moonlighting activities, they must do so in accordance with the policies of UNC Graduate Medical Education office. Prior to commencement of moonlighting, the Acknowledgement of Moonlighting Activities Form must be submitted to the Office of Graduate Medical Education.

I. All duly appointed residents to the Housestaff of UNC Hospitals shall perform their duties during such hours as the Departmental Duty Hour Policies specify. Duty hours, although subject to modification and variation depending on the clinical area to which the Housestaff member is assigned and/or exigent circumstances, shall be in accordance with State, Federal, Departmental or Institutional requirements.

II. Permission to engage in moonlighting in addition to, or outside of, the Residency Program’s requirements by a member of the Housestaff, must:
A. be granted in writing by the Residency Program’s Director and Chair of the Department;
B. be approved by the Graduate Medical Education Committee;
C. be consistent with ACGME and Program Requirements;
D. not impinge upon the performance of educational obligations of the resident; and
E. not require the resident to work more than the hours permitted by the Program, ACGME, State and Institution requirements.
It is the responsibility of the Program Director/Department Chair to monitor each resident who has been approved to moonlight for the effect of moonlighting on the resident’s residency training and with respect to compliance with this policy; any adverse effects on the resident or resident failure to comply with this policy may lead to withdrawal of permission to moonlight by the Program Director, Department Chair or the Graduate Medical Education Committee.

III. Residents must not be required to perform moonlighting.

IV. All residents engaged in clinical moonlighting in addition to, or outside of, the residency program requirements must be licensed for unsupervised medical practice in the state where the moonlighting occurs.

V. In evaluating proposed moonlighting, the Program Director and Department Chair must consider the following:

A. The capacity of the resident to fulfill his/her educational objectives and responsibility for patient care within his/her residency program;

B. The total number of hours worked, including moonlighting, must not exceed the 80-hour duty limits; and

C. The resident must have at least ten (10) hours respite time between the end of the moonlighting hours and the start of duty hours of his/her residency that involve patient care.

VI. A Department considering a resident’s request to moonlight must submit the resident’s “Request for Approval To Moonlight” Form and supporting documentation to the Office of Graduate Medical Education. The Office of Graduate Medical Education will review the paperwork for the following prior to GMEC consideration:

A. The name of the site and a particularized description of the moonlighting activity(ies), including the estimated number of hours to be worked;

B. The Program Director’s and Department Chair’s signatures approving the resident’s request to moonlight;

C. Documentation that the resident has a permanent medical license, not a training license, if required;

D. Documentation that adequate liability coverage is provided by the site, if required;

E. Whether the resident has the appropriate training skills to carry out the assigned duties;
F. The total hours worked, including moonlighting, do not exceed the 80-hour duty limits;

G. Document their DEA status and provide the DEA number to be used, if applicable, at any site external to UNC Hospitals;

H. Agreement by resident to provide documentation of all sites resident or subspecialty resident is moonlighting, including documentation by the site of the number of hours worked; and

I. For non-clinical/non-medical moonlighting, certification by the Program Director that the moonlighting activities were reviewed and fall under the category of non-clinical or non-medical moonlighting.

VII. The Graduate Medical Education Committee (GMEC) will act upon the request and make a recommendation to the Executive Committee of the Medical Staff.

VIII. Residents who perform moonlighting must record their moonlighting hours, in addition to their regular duty hours, in E*Value.

IX. Housestaff will be provided with a copy of this policy prior to their appointment.

X. This policy will appear in the Housestaff Manual.

XI. A Chair or Program Director may decide that moonlighting in his/her program only be allowed under a stricter policy than the one outlined herein; such a departmental policy should be provided to applicants for residency training and reaffirmed at the time of appointment and orientation to the department.

XII. A Chair or Program Director may decide that moonlighting is not allowed during residency training in his/her program; this policy should be provided to applicants for residency training and reaffirmed at the time of appointment and orientation to the department.

XIII. Residents who perform moonlighting must report to the GME Office, the UNC Hospitals’ Legal Department, and their program director any lawsuit filed against them concerning their moonlighting activities.

XIV. Residents who are on Family Medical Leave will not be approved for or permitted to moonlight and prior permission to moonlight will be suspended during any period of Family Medical Leave.

XV. PGY1 residents are prohibited from any moonlighting.

XVI. All moonlighting counts toward the 80-hour duty limits.
XVII. Moonlighting cannot be used to avoid compliance with the 80-hour duty limits.

XVIII. Moonlighting activities must not commence prior to approval by the GMEC. Moonlighting requests will not be approved retrospectively.

IX. DEA Registration Number

a. Under no circumstances are residents or subspecialty residents permitted to use the institutional DEA registration number for UNC Hospitals when moonlighting externally.

b. Residents and subspecialty residents may use the UNC institutional DEA registration number for UNC Hospitals, modified by an appropriate suffix, when moonlighting at UNC Hospitals and UNC Hospitals-affiliated facilities. Any questions about whether a particular facility qualifies as a UNC Hospitals-affiliated facility can be addressed through the moonlighting application and approval process.

c. When residents and subspecialty residents are moonlighting at another hospital (e.g., Carolina Medical Center, Central Regional, Chatham Hospital, Moses Cone, Rex Hospital, WakeMed), they should use the institutional DEA registration number of the applicable hospital, modified by an appropriate suffix. If the other hospital does not permit a moonlighting resident to use its institutional DEA registration number, the moonlighting resident will have to obtain his/her own DEA registration number, or the moonlighting request will be denied.
Resident Moonlighting Preparation Checklist
UNC Graduate Medical Education

Deadline for submitting is 2nd Wednesday of each month by 12:00 pm

**Moonlighting may NOT COMMENCE until formally approved by the UNC Graduate Medical Education Committee**

☐ Read and understand the entire UNC GME Moonlighting policy (available on SharePoint)

☐ Obtain full and unrestricted North Carolina Medical License

☐ Obtain an individual DEA number for moonlighting outside of UNC Healthcare facilities (unless you have written documentation that you may use an outside institution’s DEA number for clinical activities at that institution)

☐ Complete the written “Request for Approval to Moonlight” application form for EACH separate moonlighting activity:
  - All areas completed, initialed, and signed by resident
  - Signed by Program Director
  - Signed by Department Chair
  - Submit to GME office for processing and consideration by GMEC moonlighting subcommittee

☐ If previously approved for moonlighting, submit a new request for EACH approved moonlighting activity ANNUALLY (must renew at the beginning of each academic year before you can continue to moonlight)

☐ Record all moonlighting hours in E*value (moonlighting hours count toward duty hour limits)

☐ Never moonlight without formal GMEC approval
REQUEST FOR APPROVAL TO MOONLIGHT

► Moonlighting may NOT COMMENCE until formally approved by the UNC Graduate Medical Education Committee ◄

Deadline for submitting is 2nd Wednesday of each month by 12:00 pm

PLEASE TYPE OR PRINT (Incomplete or illegible forms will be returned to you)

<table>
<thead>
<tr>
<th>Resident Name:</th>
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<tr>
<td>PGY Level:</td>
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<tr>
<td>Program Name:</td>
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<td>Program Director:</td>
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<td>Chair of Department:</td>
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<tr>
<th>Detailed Description of Activity (must include a description of what your actual duties will be during a typical moonlighting shift)</th>
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<th>Site of Activity and Service</th>
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<th>Beginning/Ending Dates of Activity *</th>
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<th>Estimated Shifts/Month</th>
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List any other moonlighting activities/sites for which you have been approved this academic year

*Moonlighting requests will not be approved retrospectively. The end date for any moonlighting activities must not extend beyond the current academic year. Activities with open-ended dates, or end dates that extend beyond the current academic year, if approved, will only be approved through the end of the current academic year.

The Resident above must initial each of the following criteria for moonlighting and provide supporting documentation, where requested, prior to any moonlighting request being considered for approval:

- For clinical moonlighting, the resident named above has a permanent medical license and not a resident training license (MUST attach copy of permanent medical license).

- For external clinical moonlighting, the resident must obtain written permission from the site to use the site’s DEA number OR pay for his/her own DEA number prior to the start of any moonlighting duties. (MUST attach copy of written permission from site or personal DEA registration)

- The resident has a written agreement with site (MUST attach copy of moonlighting agreement with institution where moonlighting will occur).

- For clinical moonlighting, resident must obtain professional liability coverage (MUST attach certificate of insurance from institution where moonlighting will occur).
The resident has appropriate training skills to carry out assigned duties.

Total number of hours moonlighting in primary program and/or sponsoring institution and participating institution do NOT exceed 80 hours per week, averaged over a four-week period. Residents performing moonlighting must record all hours (regular and moonlighting hours) in E*Value. Failure to do so can result in termination of moonlighting privileges. Residents must also provide the GME Office with copies of pay stubs received for moonlighting activities to verify the hours entered into E*Value.

The resident has provided information for a contact at the site (including name, phone number, email, and US mailing address) who will be able to verify hours worked by the resident.

The resident agrees to immediately report to the GME Office and the UNC Hospitals Legal Department any lawsuit filed against him/her concerning his/her moonlighting activities.

The resident must reapply for approval to participate in the moonlighting activities described above if he/she desires to continue to participate in said activities during the next academic year.

The resident certifies that he/she is not on Family Medical Leave and understands that approval for all moonlighting is suspended during any periods of Family Medical Leave.

The performance of the resident must be monitored by the Program Director for the effect of moonlighting activities on the resident’s residency training, and any adverse effects may lead to withdrawal of permission by the Program Director.

TOTAL NUMBER OF HOURS MOONLIGHTING PER WEEK (ON AVERAGE), INCLUDING ALL MOONLIGHTING FOR WHICH YOU ARE APPROVED

TOTAL NUMBER OF REGULAR PROGRAM DUTY HOURS PER WEEK (ON AVERAGE)

The above-described “moonlighting” hours as defined in our program and/or participating institution have been included in the 80-hour/week limit for the resident.

For non-clinical/non-medical moonlighting:
I have reviewed the proposed moonlighting activities and certify that the activities fall under the category of non-clinical or non-medical (circle one) moonlighting as outlined in the Moonlighting Policy, for the following reasons:

Signature of Resident: ____________________________ Date: ____________
Signature of Program Director: ____________________________ Date: ____________
Signature of Department Chair: ____________________________ Date: ____________
Date Reviewed by GMEC: _______________ Action: ____________

I:GMED:Moonlighting Ad Hoc Committee:Moonlighting Request Form 12-19-12
MOONLIGHTING SERVICES AGREEMENT

THIS MOONLIGHTING SERVICES AGREEMENT (the “Agreement”), is entered into and is effective the ____ day of ________ 2014 (the “Effective Date”), by and between UNC Hospitals (hereinafter “Hospital”) and _______________________, M.D. (hereinafter the “Physician”).

WITNESSETH:

THAT WHEREAS, the Hospital serves patients in the Chapel Hill community and beyond, and offers a broad range of outpatient medical services;

WHEREAS, Hospital desires to contract with Physician to provide _________________[specify services to be provided] at _____________________[specific the location/Service where physician’s services will be provided].

WHEREAS, the Physician desires to provide the services listed above; and

WHEREAS, the Physician is qualified by training and experience to provide such clinical services, as more fully specified within the Agreement;

NOW THEREFORE, in consideration of the promises and covenants contained herein and intending to be legally bound hereby, Hospital and Physician agree as follows:

1. **Physician’s Responsibilities and Representations.**
   1.1. Physician shall provide ____________________________[specify services] at ____________________________ [specific location and Service] (hereinafter “Physician Services”). It is anticipated by the parties that Physician shall provide such Physician Services _______ hours per shift, for _______ shifts per month.
   1.2. Physician agrees to meet the credentialing requirements established for Hospital’s medical staff.
   1.3. Physician shall hereunder provide the full range of services for which he/she is authorized to perform as a physician and supervise the performance of services by such non-physician practitioners of Hospital as required by federal and state law and Hospital’s policies and procedures.
   1.4. Physician shall devote his/her best efforts to perform diligently the provision of services as directed by Hospital; notwithstanding the foregoing, in all instances, Physician shall retain the responsibility for exercising his/her independent medical judgment. Physician shall at all times perform his/her duties under this Agreement in accordance with such standards of professional ethics, Hospital policies, standards, and protocols, and all statutes, rules and regulations as may from time to time be applicable to Physician or to any professional services that he/she may render. Nothing in this Agreement shall be construed to modify the relationship between Physician and patients receiving professional services under this Agreement.
   1.5. Physician shall hold a currently valid and unlimited license to practice medicine unsupervised in the State of North Carolina and shall possess an unlimited controlled substance permit. Physician’s participation under this Agreement may be immediately
terminated in accordance with section 3 of this Agreement if said Physician ceases to be so qualified.

2. **Compensation.**

2.1. **Payment to Physician.** In return for Physician Services provided by Physician under this Agreement, Hospital shall pay to Physician compensation as set forth herein. Physician shall keep and furnish to Hospital, on a form substantially similar to Exhibit A, accurate records of all services furnished to Hospital under this Agreement, including a daily schedule.

2.2. **Fair Market Value.** Both parties acknowledge and agree that the compensation set forth in this Agreement represents the fair market value of the services to be provided under this Agreement. Further, this Agreement has been negotiated in an arm’s length transaction and has not been determined in a manner which takes into account the volume, value or business that may otherwise be generated between the parties.

2.3. **Space: Equipment.** Hospital shall make available for the use of Physician such space, equipment, and personnel in Hospital as are reasonably necessary to enable Physician to perform his/her duties pursuant to this Agreement. Physician agrees that such space, equipment, and personnel shall be used solely for the performance of services under this Agreement.

3. **Term and Termination.** The initial term of this Agreement shall be for a period of one (1) year from the Effective Date. If Physician does no work for Hospital pursuant to this Agreement for 180 days in a row during the term of the contract, the Agreement will be automatically terminated. If the Agreement is terminated during the initial term with or without cause, the parties will not enter into a new agreement during the first year of the original term of the Agreement.

3.1. "**No Cause Termination by Either Party.**" This Agreement may be terminated at any time, without cause and without penalty, by either party upon sixty (60) days prior written notice to the other party.

3.2. "**For Cause Termination by Hospital.**" This Agreement may be terminated immediately by Hospital upon the occurrence of any of the following events with respect to Physician:

3.2.1. The failure of Physician to provide the Physician Services required under this Agreement or to follow Hospital policies, rules and/or regulations.

3.2.2. Physician’s Indictment for or conviction (within the meaning set forth in 42 U.S.C.§ 1320a-7(i)) of any criminal offense.

3.3.3. Imposition of any sanctions, including exclusion, suspension or other limitation relating to the Physician’s participation in any United States Government or any state health care program, including but not limited to Medicare and Medicaid.

3.3.4 Indictment, arrest or conviction for a felony or for any criminal charge related to the Hospital of his/her profession.

3.3.5 Judgment against Physician which might materially impair his/her ability to carry out his/her responsibilities under this Agreement.

3.3.6. Suspension or revocation of Physician's license by the North Carolina Board of Medical Examiners or revocation of unlimited controlled substance permit,
regardless of the pendency of any appeal of such suspension, curtailment or revocation.

3.3.7. The loss, suspension or reduction of Medical Staff membership or clinical privileges.

3.3.8. Death of Physician.

3.3.9. Upon the determination by Hospital that Physician providing services thereunder has engaged in personal or professional misconduct, including but not limited to abuse of any legal or illegal substance, including drugs or alcohol, which impairs Physician’s ability to perform hereunder or breach by physician of medical ethics.

3.3. “For Cause Termination by Either Party.” This Agreement may be terminated upon thirty (30) days prior written notice by either party in the event of a material breach of the terms of this Agreement by the other party which is not corrected within ten (10) days following written notice thereof, except as to such breaches as may reasonably take longer than ten (10) days to correct, in which event either party shall have no more than thirty (30) days thereafter to cure such breach unless such time frame is extended by the non-breaching party.

4. Status of the Parties. The parties acknowledge and agree that the Physician Services contemplated by this Agreement are being carried out by moonlighting Hospital house staff residents. This is done in accordance with prior approval to moonlight by the Hospital’s Graduate Medical Education Committee (GMEC), with all interested parties being aware that all moonlighting hours worked count toward UNC house staff appointee duty hour limits, as defined by the GMEC. The foregoing notwithstanding, the relationship between Hospital and Physician for services provided pursuant to this Agreement shall be that of independent contractor.

5. Duty Hours. Pursuant to GMEC policy, Physician should have ten (10) hours free of duty, and must have at least eight (8) hours respite time between the end of the moonlighting hours and the start of duty hours of his/her residency. Moreover, Physician must have at least fourteen (14) hours free of duty after 24 hours of in-house duty. The terms of this Agreement shall not interfere with such requirements.

6. Professional Liability Insurance. Hospital shall be responsible for its negligence in accordance with and in amounts required by the North Carolina Tort Claims Act. Hospital shall also maintain professional liability self-insurance in accordance with N.C. Gen. Stat. Chapter 116, Article 26, including medical malpractice, covering Physician with a total limit of liability for all loss arising out of a single claim of $7 million, regardless of the number of Hospital insureds involved in any legal action arising from the alleged negligent acts and regardless of the number of persons bringing claims for the alleged negligent acts. Subject to the single claim limit of liability, Physician is subject to a sublimit of $3 million. The “each person” limit is a sublimit of and does not increase the single claim limit of liability set forth above, and is the most the Hospital will pay for damages against Physician arising out of a single claim.

7. No Requirement To Refer. Nothing in this Agreement, whether written or oral, nor any consideration in connection herewith, contemplates or requires the referral of any patient by Physician to Hospital or to any entity affiliated in any way with Hospital. This Agreement is not intended to influence the judgment of Physician providing services to Hospital in choosing the medical facility or facilities appropriate for the proper care and
treatment of his/her patients. No physicians shall receive any compensation or remuneration for referrals, if any, to the Hospital or any affiliate. Hospital and Physician hereby support a patient’s right to select the medical facility or facilities and provider(s) of his/her choice. In the event that Physician admits patients to Hospital, Physician shall not discriminate against patients on the basis of the patients’ ability to pay.

8. **Time Records.** Physician shall record his/her moonlighting hours, in addition to their regular duty hours, in E*Value.

9. **Medical Services To All Patients.** Physician shall provide medical services as defined herein to all patients in Hospital without regard to the type or amount of reimbursement available; the ability of the patients to pay for said medical services; or the medical condition of the patients, provided that Physician and Hospital have the capability to perform said services. Also, Physician shall not discriminate against patients on the basis of race, sex, color, religion, national origin, age, handicap, or veteran status.

10. **Severability.** In the event any provision of this Agreement is determined to be invalid or unenforceable, the remaining provisions shall nevertheless be binding upon the respective parties hereto with the same effect as though the invalid provision was deleted.

11. **Applicable Law and Venue.** This Agreement is being delivered and is intended to be performed in the State of North Carolina and shall be construed and enforceable in accordance with the laws of the State of North Carolina. The venue for any litigation between the parties hereto arising out of or resulting from this Agreement is Orange County, North Carolina, and the parties hereto irrevocably submit themselves to the jurisdiction of the General Court of Justice in Orange County, North Carolina, and waive any right that they have or may have to any other jurisdiction.

12. **Assignment Prohibited.** This Agreement shall not be assigned in whole or in part by either party hereto without the express written consent of the other party. Notwithstanding the preceding sentence, Hospital shall have the right to assign this Agreement to any affiliate of Hospital.

13. **Non-waiver.** No waiver of any term or condition of this Agreement by either party shall be deemed a continuing or further waiver of the same term or condition or a waiver of any other term or condition of this Agreement.

14. **Captions.** The captions contained herein are not a part of this Agreement. They are only for the convenience of Hospital and Physician and do not in any way modify, amplify, or give notice of any of the terms, covenants, or conditions of this Agreement.

15. **Counterparts.** This Agreement may be executed in any number of counterparts, each of which shall be deemed to be an original.

16. **Notice.** Any notice required or allowed to be given hereunder shall be deemed to have been given upon deposit in the United States mail, registered or certified, with return receipt requested and addressed to the party to this Agreement to whom notice is given.

17. **Restructuring.** It is the intention of the parties to comply with all applicable laws and regulations, including, but not limited to, the Internal Revenue Code of 1986, as amended, the Medicare and Medicaid Anti-Kickback statute, the “Stark II” anti-referral legislation, and any regulations promulgated thereunder. The parties acknowledge that legislation, regulations, an administrative ruling or other legally binding opinion may be adopted, amended, promulgated or issued which effectively renders all or a portion of this Agreement unlawful and could affect the tax-exempt status of Hospital or its affiliated Physician or institutions, or could impose liability or exclusion from
participation in the Medicare or Medicaid program. In such event, either party may by written notice propose the termination, restructuring or re-negotiation of this Agreement in order to effect compliance. If such notice is given and the parties are unable within thirty (30) days thereafter to reach an agreement with respect to the termination, restructuring or re-negotiation of this Agreement, either party may terminate this agreement by providing at least fifteen (15) days written notice to the other. In the event of a termination as provided herein, the parties shall have no further obligation to each other under this Agreement.

18. **Entire Agreement.** This Agreement (including any exhibits and schedules attached hereto) contains the entire agreement between the parties concerning the subject matter contained herein and there are not other terms, covenants, obligations, or representations, oral or written, of any kind whatsoever. Any modification, addition or alteration of this Agreement must be in writing and signed by both parties.

19. **Eligibility For Federal Programs/Indemnification.** To the knowledge of Physician, there is no action, suit, proceeding or investigation pending or threatened against Physician by government authority and he/she has not been excluded from a federal government health care program. Physician will notify Hospital immediately if any action, suit, proceeding, investigation or exclusion brought against Physician in the future. If Hospital is denied payment from any third party payor because of the existence of any such action, suit, proceeding or investigation, Physician will reimburse Hospital for the amount of such denied payments and for any related losses and expenses incurred by Hospital.

20. **Standards.** Physician shall comply with all applicable federal, state and local laws, ordinances, rules, regulations and standards.

21. **HIPAA Compliance.** Both parties will comply with all applicable portions of HIPAA on and after its effective date(s).

22. **Omnibus Reconciliation Act Of 1980.** Pursuant to Section 952 of the Omnibus Reconciliation Act of 1980 (P.L. 96-499), Physician agrees as follows:

22.1. Hospital and its auditors and accountants, and fiscal intermediaries, accountants and agents for the Medicare and Medicaid programs, and the Secretary of Health and Human Services and the Comptroller General shall be given access by the Physician to the following records for a period of four (4) years after the furnishing of services under this Agreement:

This Agreement, and all books, documents and records of Physician necessary to certify the nature and extent of the cost to Hospital of services furnished by Physician under this Agreement; and

Physician’s subcontractors with a related organization, as such term is defined with regard to and provided in 42 C.F.R. Section 405.427{b}, and each such subcontractor’s books, documents and records necessary to verify the nature and extent of the cost to Hospital and Physician of services rendered by each such subcontractor under its subcontract.

22.2. The foregoing rights of access shall be exercisable through a written request and thereupon Physician and subcontractors shall give access to the above contracts,
their books, documents and records from time to time during reasonable business hours.

22.3 In the event of any breach of this provision by Physician or by any subcontractor of Physician, Hospital shall have the right to terminate this Agreement if within thirty (30) days after notice from Hospital, the asserted breach shall not have been corrected.

22.4 In the event of an administrative determination or court ruling determining that the Omnibus Reconciliation Act of 1980 amending 1861(v)(1) of the Social Security Act is not applicable to this Agreement, then the provisions of this paragraph shall be null and void.

IN WITNESS WHEREOF, the parties hereto have caused this Agreement to be executed as by law provided, the day and year first above written.

Physician

__________________________________

Brian P. Goldstein, MD
Executive Vice President and
Chief Operating Officer

Date: ____________________________

Hospital

__________________________________

Date: ______________________________
Exhibit A

SAMPLE PHYSICIAN ACTIVITY SUMMARY

Name: ____________________________________________

Address: ____________________________________________  Month Ending: __________

City, State, Zip: ____________________________________________

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<tr>
<th>DESCRIPTION OF SERVICES</th>
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I hereby certify that, to the best of my knowledge, the information contained in this form is true, correct, and complete.

PHYSICIAN SIGNATURE       DATE

HOSPITAL DEPARTMENT ADMINISTRATOR SIGNATURE  DATE
The paid time off (“PTO”) policy for residents and subspecialty residents at the University of North Carolina Hospitals is a minimum of ten (10) Monday through Friday workdays annually. PTO includes all vacation, sick and personal leave. Scheduling of all PTO must be made with the approval of the Program Director (or Department Chair, if appropriate), who will take into consideration service responsibilities, call schedules, attendance at professional meetings and holiday schedules. Each program must have a written PTO policy.

Additional leave, if required, may be authorized by the Program Director (or Department Chair, if appropriate) in compliance with the Residency Review Committee (RRC) and Specialty Board requirements. Programs must have a written policy describing the effects that additional leave may have on program completion and any need for training extension as a result of the additional leave.

PTO will not carry over from one academic year to the next.
PTO will be prorated for all residents who are appointed for only partial terms, or whose appointments are extended for less than a one-year period of time.

Please refer to the Family Medical Leave and Serious Illness Leave policies for other authorized leave.

_The Department of Dermatology currently allows first-year residents 2 weeks of vacation. Second and third-year residents receive 3 weeks of vacation. Scheduling of vacations is accomplished by the Chief Resident. Because of departmental activities at satellite clinics, UNC clinics, and consult service, a limited number of residents are allowed to be on vacation and/or elective at a time._

Written and Approved by GMEAC: November 1998
Executive Committee Approval: December 14, 1998
Reviewed and approved by GMEAC: November 15, 2000
Reviewed and approved by GMEAC: December 19, 2001
Medical Staff Approval: February 4, 2002
Reviewed and approved by GMEC: September 21, 2005
Reviewed and approved by GMEC: November 15, 2006
Revised to reflect change in titles: March 28, 2007
Reviewed and approved by GMEC: December 17, 2008
Medical Staff Approval: January 12, 2009
Reviewed and Approved by GMEC: March 17, 2010
Reviewed and Approved by GMEC: April 20, 2011
Medical Staff Approval: May 9, 2011
GMEC Reviewed and Approved: October 19, 2011
MSEC Approval: December 12, 2011
GMEC Reviewed and Approved: October 17, 2012
MSEC Approval: November 12, 2012
GMEC Reviewed and Approved: July 17, 2013
The ACGME requires that the sponsoring institution provide written institutional policies on residents’ vacation and other leaves of absences (with or without pay) to include parental and sick leave and that these policies comply with applicable laws.

The Graduate Medical Education Committee has approved the Graduate Medical Education Policy on Paid Time Off and the Graduate Medical Education Policy on Resident and Subspecialty Resident Family Medical Leave. These policies are distributed annually to residents during the appointment/reappointment process.

Each program must provide its residents with the following:

1. A written policy in compliance with its Program Requirements concerning the effect of leaves of absence, for any reason, on satisfying the criteria for completion of the residency program, and
2. Information relating to access to eligibility for certification by the relevant certifying board.

When a resident requests leave under the Graduate Medical Education Policy on Resident and Subspecialty Resident Family Medical Leave, the UNC Hospitals Family Medical Leave Request Form must be completed and signed by the resident, the program director, and the OGME designee and must include the Certification of Health Care Provider.

When the resident requests a leave of absence for reasons not covered by the Graduate Medical Education Policy on Resident and Subspecialty Resident Family Medical Leave, the terms of the leave of absence – including the effect of the leave of absence on satisfying the criteria for completion of the residency program and eligibility for certification by the relevant certifying board – must be put in writing and signed by the program director and the resident. A copy of this agreement must be sent to the Office of Graduate Medical Education.

In the Department of Dermatology, leaves of absences greater than six weeks per academic year will require additional weeks of training (the difference between the time of the leave of absence and six weeks) added to the end of the traditional resident training schedule. This policy will be used by the Department of Dermatology unless otherwise directed by the Dermatology RRC or American Board of Dermatology.

Originating Unit: Graduate Medical Education Committee
Approved: January 16, 2002
Medical Staff Approval: February 4, 2002
GMEC Revised and Approved: February 20, 2008
Medical Staff Approval: March 10, 2008
GMEC Reviewed and Approved: November 18, 2009
GMEC Reviewed and Approved: March 16, 2011
Medical Staff Approval: April 11, 2011
GMEC Reviewed and Approved: October 19, 2011
MSEC Approval: December 12, 2011
POLICY AND PROCEDURE
RESIDENT AND SUBSPECIALTY RESIDENT
FAMILY MEDICAL LEAVE

All duly appointed residents within a UNC Hospitals' graduate medical education program who are scheduled to work at least 20 hours each week are eligible for Family Medical Leave for a total of 12 weeks during any 12 month period for one or more of the reasons listed below. A maximum of 30 Monday through Friday workdays of the 12 weeks may be paid leave; however, the resident must first exhaust any accumulated paid time off (“PTO”). The Residency Program Director must also approve the request that part of the leave be paid leave in accordance with the above terms.

If extended Family Medical Leave is taken, residency training may need to be extended, contingent upon specialty or subspecialty board requirements and RRC requirements. See also Leave of Absence Policy.

Except in case of emergency (defined below), prior to the beginning of the leave under this Policy all required documentation must be submitted in accordance with the Procedure outlined below, reviewed by the Program Director and delivered to the Office of Graduate Medical Education.
Relation of leave granted under this Policy to Family and Medical Leave Act (FMLA):
Residents who have been employed in an ACGME program for which UNC Hospitals is the
sponsoring institution for at least twelve months and who, during the previous twelve months,
have worked for at least 1040 hours are eligible, under the federal Family and Medical Leave
Act, for a total of twelve weeks of unpaid leave in a fifty-two week period for serious illness or
major disability, or for parental purposes. For these residents, the leave defined by this Policy
shall constitute the leave for which they are eligible under FMLA. In other words, if a resident
meet the service requirements described above, than any paid leave taken under this Policy for
serious illness, major disability, or parental purposes shall count towards the twelve weeks of
leave guaranteed under the federal Family and Medical Leave Act.

If a resident does not meet the service requirements described above, the resident shall still be
eligible for PTO, but such leave shall not count as leave under the federal Family and Medical
Leave Act.

A resident is prohibited from moonlighting while on Family Medical Leave.

Reasons for Leave
The following are all justifications for taking Family Medical Leave:
• For the birth of a child and to care for the child after birth, provided the leave is taken
within a 12 month period following birth;
• For the resident to care for a child placed with the resident for adoption or foster care,
provided the leave is taken within a 12 month period following adoption;
• For the resident to care for his or her child/spouse/domestic partner/parent when that
child/spouse/domestic partner/parent has a serious health condition;
• The resident has a serious health condition that makes him or her unable to perform the
essential functions of his or her position.

Note: Intermittent leave is not permitted for taking care of a child after birth or adoption,
unless the leave is for the purpose of caring for a child with a serious medical illness.

Definitions
Parent: A biological or adoptive parent or an individual who stood in loco parentis to a resident
when the resident was a child.

Child: A son or daughter who is under 18 years of age, or is 18 years of age or older and
incapable of self-care because of mental or physical disability, who is:
• a biological child;
• an adopted child;
• a foster child (a child for whom the resident performs the duties of a parent as if it were the
resident's child);
• a step-child (a child of the resident's spouse from a former marriage);
• a legal ward (a minor child placed by the court under the care of a guardian); or
• a child of a resident standing in loco parentis.
**Spouse:** A husband or wife.

**Domestic Partners:** Two individuals (regardless of gender) who have reached the age of maturity, who live together in the same residence in a long term relationship of indefinite duration with an exclusive mutual commitment, who are not married or related to the other by blood or marriage, and who are responsible for each other’s welfare and share financial obligations, as evidenced by the following types of documentation, at least two of which should be provided upon request: (a) joint mortgage or lease; (b) designation of domestic partner as beneficiary for life insurance; (c) designation in will of domestic partner as primary beneficiary upon death; (d) domestic partnership agreement; (e) powers of attorney for property and health care; and (f) joint ownership of a motor vehicle, joint checking account or joint credit account.

**Serious Health Condition:**
- An illness, injury, impairment or physical or mental condition that involves either inpatient care in a hospital, hospice or residential medical care facility, or that involves continuing treatment by a health care provider;
- Any period of incapacity requiring absence from work of more than three calendar days that also involves continuing treatment by a health care provider;
- Continuing treatment by a health care provider for conditions so serious that, if not treated, would likely result in absence of more than three calendar days (prenatal care is also included);
- The period of actual physical disability associated with childbirth is considered a serious health condition and may be taken as family/medical leave. Prenatal care is also included.

**Workweek:** The number of hours a resident is regularly scheduled to work each week.

**Reduced Work Schedule:** A work schedule involving fewer hours than a resident is normally scheduled to work.

**Intermittent Work Schedule:** A work schedule in which a resident works on an irregular basis and is taking leave in separate blocks of time rather than for one continuous period of time. This leave is usually scheduled to accommodate some form of regularly scheduled medical treatment.

**Other Provisions**
In the event of illness that extends beyond the 60-day waiting period required for short-term disability, the resident may choose to exhaust the balance of available leave or begin drawing short-term disability benefits.

Periods of paid leave and period of leave without pay (including leave without pay while drawing short-term disability or Worker’s Compensation benefits) count toward the 12 work weeks for which the resident is eligible.

The leaves described in this Policy shall not accumulate nor be carried forward from year to year, shall not be allowable as terminal leave when the resident leaves the Hospitals, and shall not be used to extend years of creditable state service for retirement benefit purposes. For each
resident for the purposes of calculating leave, a “year” begins on the date of employment and then on each subsequent anniversary of employment.

**Intermittent Leave**
When medically necessary, the resident may take leave intermittently or work on a reduced schedule in order to care for his or her child/spouse/domestic partner/parent who has a serious health condition, or because the resident has a serious health condition. There is no minimum limitation on the amount of leave taken intermittently.

Only the time actually taken as leave may be counted toward the 12 weeks of leave for which a resident is eligible under the FMLA when leave is taken intermittently or on a reduced work schedule. If leave is taken intermittently and/or on a reduced work schedule, the number of hours not worked will be summed, and the number of weeks of leave will be calculated using a minimum of 40 hours as a “full week.” In other words, each 40 hours “not worked” will be counted as a week of leave under this Policy. However, each Program has the discretion to consider a number greater than 40 hours as a “full week,” up to a maximum of 80 hours. What constitutes a “full week” may vary from rotation to rotation within a Program, and is subject to the decision of the Program Director. The Program Director will provide regular written documentation to the resident of the number of weeks of leave taken to date.

If a resident works a reduced or intermittent work schedule, the resident may be required to extend his or her residency in order to meet requirements for residency certification.

**Non-Discrimination**
The Hospitals and departments will not interfere, restrain, deny any right, discharge or in any other way discriminate against any resident because he or she does any of the following:
- Files any internal appeal, civil action, or institutes or causes to be instituted any civil proceeding under or related to this Policy;
- Gives, or is about to give, any information in connection with any inquiry or proceeding relating to any right provided by this Policy, or
- Testifies, or is about to testify, in any inquiry or proceeding relating to any right provided under this Policy.

**Enforcement**
A violation of or denial of leave requested under the Family and Medical Leave Act of 1993 is not a contested case and creates no right of grievance or appeal under the State Personnel Act. Violations can result in any or all of the following and are enforced by the U.S. Secretary of Labor:
- US Department of Labor investigations;
- Civil liability with the imposition of court costs and attorney's fees, and/or
- Administrative action by the US Department of Labor.

**Posting Requirements**
The Hospitals will post, in a conspicuous place, a notice explaining the FMLA provisions and providing information concerning the procedures for filing complaints and violations of the Act with the US Department of Labor, Wage and Hour Division. In addition, when a resident
provides notice of the need for FMLA leave, the Hospitals shall provide him or her with a notice
detailing his or her specific expectations and obligations and explaining the consequences of a
failure to meet these obligations.

**PROCEDURE**
The resident shall give notice to his or her Residency Program Director for leave requested under
this Policy. He or she must explain in writing the reasons for the needed leave so as to allow the
Hospitals to determine that the leave qualifies under this Policy.

**Birth or Adoption:** The resident shall give the Department **30 days notice** in writing of the
intent to take leave, subject to the actual date of the birth or adoption. If the date of the birth or
adoption requires leave to begin in less than 30 days, the resident shall provide as much notice as
is feasible.

**Planned Medical Treatment:** When leave is necessary in order for the resident to care for his
or her child/spouse/domestic partner/parent, or because the resident has a serious health
condition, the resident must give **30 days notice**, or as many days notice as is feasible, of the
intention to take leave.

**Medical Emergency:** In the case of a medical emergency requiring leave because of a resident's
own serious health condition, or need to care for a family member/domestic partner with a
serious health condition, advance notice is not required. The resident (or if incapacitated, his or
her representative) should communicate with the residency program as soon as is feasible.

**Certification**
A leave because of adoption or foster care must be supported by reasonable proof of adoption or
foster care.

A leave because of serious illness must be supported by a doctor's **certification**.

**Doctor's Certification**
A doctor's certification should include the following:
- The date on which the serious health condition began;
- The probable duration of the condition;
- The appropriate medical facts regarding the condition;
- A statement that the leave is needed to care for the child/spouse/domestic partner/parent, and
  an estimate of the time that is needed; or that the resident is unable to perform the functions
  of their position because of a serious medical condition, whichever applies; and
- Where certification is necessary for intermittent leave for planned medical treatment, the
dates on which the treatment is expected to be given and the duration of the treatment.

**Second Opinions**
Where the Hospitals have reasons to doubt the validity of a certification, it may require the
resident to get the opinion of a second doctor designated or approved by the Hospitals.
Where the second opinion differs from the opinion in the original certification, the Hospitals may require the resident to get the opinion of a third doctor chosen by the Hospitals and the resident.

The Hospitals may require that the resident get subsequent re-certifications on a reasonable basis. The second and third opinions, as well as the re-certifications, must be at the Hospitals' expense.

**Reinstatement**
The resident shall be reinstated to the same position held when the leave began or one of like pay grade, pay, benefits, and other conditions of employment.

The Hospitals may require that the resident report, at reasonable intervals, his or her status and intention to return to work. Certification that the resident is able to return to work will also be necessary when the leave is for the resident's personal illness.

**Failure to Return to Work**
If the resident will not return to work after the period of leave, the Hospitals should be notified in writing immediately. Failure to report at the expiration of the leave, unless an extension has been requested, may be considered a resignation.

**Health Benefits**
The Hospitals or Department (depending on salary funding source) shall maintain coverage for the resident under the residents’ group health plan for the duration of the leave at the level and under the conditions coverage would have been provided if the resident had continued employment.

Any share of health plan premiums which a resident had prior to leave must continue to be paid by the resident during the leave period. The obligation to maintain health insurance coverage stops if the resident's premium payment is more than 30 days late.

If the resident's failure to make the premium payments leads to a lapse in coverage, the department must restore the resident, upon return to work, to the health coverage equivalent to that he or she would have had if leave had not been taken or premium payments not missed, without any waiting period or preexisting conditions.

**Recovery of Premiums**
The Department may recover the premiums if the resident fails to return to work after the period of leave for which the resident is eligible has expired, for a reason other than the continuation, recurrence or onset of a serious health condition or other circumstances beyond the resident's control.

**Denial of Leave and Appeals**
If leave is denied by the program director, the resident may appeal this denial to the Designated Institutional Official (DIO) in writing. This appeal must be submitted within 10 days of the denial receipt by the resident. The decision of the DIO is final.
**FML Forms**
Any resident or subspecialty resident request for FML must complete the attached form. The form must be completed 30 days in advance of the leave, or as many days as is feasible, unless the leave is based on an emergency. The completed form *must* be provided to the GME Office.

GMEC Approved: April 19, 2006
MSEC Approved: May 8, 2006
GMEC Reviewed: November 15, 2006
GMEC Reviewed: December 17, 2008
MSEC Approved: January 12, 2009
GMEC Reviewed: March 17, 2010
GMEC Reviewed: April 20, 2011
MSEC Approved: May 9, 2011
GMEC Reviewed and Approved: October 19, 2011
MSEC Approval: December 12, 2011
GMEC Reviewed and Approved: July 17, 2013
POLICY AND PROCEDURE

RESIDENT AND SUBSPECIALTY RESIDENT
SERIOUS MEDICAL ILLNESS LEAVE

Leave may be granted for residents and subspecialty residents who have a serious medical illness but who do not qualify for family medical leave. Such leave can only be authorized by the Program Director (or Department Chair, if appropriate) in conjunction with the Executive Associate Dean for GME. Paid leave for serious medical illness will not exceed 30 Monday through Friday workdays a year, and requires exhaustion of all PTO time. Serious medical illness leave cannot exceed twelve weeks a year, including both paid and unpaid leave, and must be supported by a doctor’s certification.

A doctor’s certification should include the following:

- The date on which the serious medical illness began;
- The probable duration of the condition;
- The appropriate medical facts regarding the condition; and
- A statement that the resident is unable to perform the functions of his/her position because of a serious medical illness.
A resident is prohibited from moonlighting while out on serious medical illness leave.

NOTE: Residents who request extended leaves for any reason, including involuntary leaves of absence such as for serious medical illness, must be informed about the potential effect of such leave on satisfying the criteria for completion of the residency program, based on specialty or subspecialty board requirements and RRC requirements.
POLICY AND PROCEDURE
UNIVERSITY OF NORTH CAROLINA HOSPITALS
GRADUATE MEDICAL EDUCATION
POLICY ON REAPPOINTMENT, NON-REAPPOINTMENT AND DISMISSAL

I. Reappointment

The duration of the Appointment to Graduate Medical Education is for a period of twelve (12) months, unless on individual resident’s current resident year is extended by the Program Director due to periods of remediation, probation, or resident absence. Reappointment and/or promotion to the next level of training is at the discretion of the Hospitals and Program Director and is expressly contingent upon several factors, including, but not limited to, the following: satisfactory completion of all training components; the availability of a position; satisfactory performance evaluations; full compliance with the terms of the Agreement of Appointment; the continuation of the Hospitals’ and Program’s accreditation by the ACGME; the Hospitals’ financial ability, and furtherance of the Hospitals’ objectives.

A resident’s appointment is expressly conditioned upon satisfactory performance of all Program elements by the resident. If the actions, conduct, or performance, professional or otherwise, of the resident are deemed by the Hospitals, GMEC or Program Director to be inconsistent with the
terms of the Resident Appointment Agreement, the Hospitals’ standards of patient care, patient 
welfare, or the objectives of the Hospitals, or if such actions, conduct, or performance reflect 
adversely on the Program or Hospitals or disrupts operations at the Program or Hospitals, 
corrective action may be taken by the Hospitals and Program Director.

II. Handling of Academic and Performance Problems, Grievances, and Appeals

Program Directors should refer to the UNC Hospitals “Guidelines for Handling Academic and 
Performance Problems.” The Grievance Procedures Policy is given to residents and is located in 
the UNC Hospitals Graduate Medical Education Manual. This procedure must be followed and 
shared with the resident.

III. Notice of Non-Reappointment or Non-Promotion

In instances where a resident’s agreement will not be renewed, or when a resident will not be 
promoted to the next level of training, the Program Director must provide the resident with a 
written notice of intent no later than four months prior to the end of the resident’s current 
appointment. (The Hospitals is under no obligation, nor may it be held liable for breach of the 
Agreement if it fails to provide such advance notice). If the primary reason(s) for the non-
renewal occur(s) within the four months prior to the end of the agreement of appointment, 
programs must provide their residents with as much written notice of the intent not to renew as 
the circumstances will reasonably allow, prior to the end of the agreement or appointment.

A. Summary Suspensions

The Executive Committee of the Medical Staff, the Board of Medical Examiners, the 
Hospitals and the Program Director each shall have the authority to summarily suspend, 
without prior notice, all or any portion of the Resident’s appointment and/or privileges 
granted by the Hospitals whenever it is in good faith determined that the continued 
appointment of the resident places the safety or health of UNC Hospitals’ patients or 
personnel in jeopardy, or to prevent imminent or further disruption of Hospitals operations, 
or in the event of egregious behavior by a resident. All summary suspensions shall be 
reviewed in accordance with the provisions of the Grievance Procedures Policy.

B. Automatic Termination

a. For Lack of License. Notwithstanding any provision to the contrary, a resident’s 
appointment shall be terminated automatically and immediately upon the 
suspension, termination, or final rejection of the resident’s application for his/her 
professional license. In the event of such a suspension, termination, or final 
rejection, a resident is obligated to report that fact to the Program Director, 
Department Chair, and Office of Graduate Medical Education immediately. Upon 
obtaining the necessary licensure, the resident may reapply for appointment to 
Graduate Medical Education through the clinical department and with the
approval of the same individuals as if for initial appointment. Residents must be familiar with UNC Hospitals Policy of Medical License Requirements.

b. For Egregious Behavior. Notwithstanding any provision to the contrary, a resident’s appointment shall be terminated automatically and immediately whenever it is in good faith determined that the resident’s egregious behavior, in violation of ethical and criminal regulations or laws, has placed the safety or health of UNC Hospitals’ patients or personnel in jeopardy, or has or may imminently cause serious disruption of the Hospitals operations. Egregious behavior includes providing false information as part of the application or interview process.

In the event a resident’s agreement is terminated by the Hospitals, the resident shall only be entitled to appeal rights and procedures accorded to residents and subspecialty residents as set forth in the Graduate Medical Education Grievance Procedures Policy. A resident shall not be entitled to the hearing appellate rights granted to physician members of the Medical Staff as described in the Hospitals’ Medical Staff Bylaws.

(i) The resident may terminate his/her appointment at any time after notice to and discussion with the Program Director, unless waived by the Hospitals, on at least 30 days’ written notice to the Hospitals after that discussion.

(ii) If a resident’s appointment is terminated either voluntarily or involuntarily, the Program Director shall recommend to the Hospitals whether or not to extend credit to the resident for participation in the Program; the Program Director is not obliged to recommend that such credit be extended and the Hospitals is not obliged to extend any such credit.

Upon such termination of appointment, the resident shall:

(1) Receive his/her stipend up to the effective date of such termination.

(2) Return to the Hospitals all property owned by it by or before the close of business on the effective date of termination of the resident’s appointment and the appointment agreement.

IV. Non-Reappointment Based on Institutional Factors

When non-reappointment is based on reasons other than the resident’s performance, such as residency closure or specific RRC actions to reduce number of residents, such non-reappointments when made by the Hospitals, GMEC or Program Director shall be final and not subject to further appeal or review and shall not be grievable under the Hospitals’ grievance procedure.

V. Non-Reappointment Based on Resident Factors
When non-reappointment is based on the resident’s unsatisfactory performance or noncompliance with the terms of the appointment agreement, the appropriate remediation actions shall be invoked prior to any such determination being “final” and the program director will follow the recommendations of the ACGME, respective RRCs and UNC Hospitals recommended “Guidelines for Handling Academic and Performance Problems.”

VI. Reporting Obligations

The Hospitals will comply with the obligations imposed by state and federal law and regulations to report instances in which the resident is not reappointed or is terminated for reasons related to alleged mental or physical impairment, incompetence, malpractice or misconduct, or impairment of patient safety or welfare.
I. All residency programs, whether accredited or non-accredited (Programs) should select residents from a pool of applicants who meet the eligibility requirements established by the ACGME or the Commission on Dental Accreditation (CODA), as applicable to the program’s specialty. University of North Carolina Hospitals is a participating member of the organized matching programs such as the National Resident Matching Program, Dental National Matching Service, and other advanced residency matching programs. When selecting from among qualified applicants, it is strongly suggested that Programs participate in an organized matching program, where such is available. The Designated Institutional Official (DIO) shall serve as the institutional representative for the National Resident Matching Program.

II. Applicants must meet the following minimum requirements in order to be considered for a residency position:
a. Graduates of medical or dental schools in the United States and Canada accredited by the Liaison Committee on Medical Education (LCME) or CODA;

b. Graduates of colleges of osteopathic medicine in the United States accredited by the American Osteopathic Association (AOA);

c. Graduates of medical schools outside the United States and Canada who have either:
   (i) a current valid certificate from the Educational Commission for Foreign Medical Graduates or
   (ii) a full and unrestricted license to practice medicine in North Carolina;

d. Graduates of medical schools outside the United States and have completed a Fifth Pathway program provided by an LCME-accredited medical school;

e. Graduates of dental schools outside the United States and meet the requirements to obtain a North Carolina Intern Permit from the North Carolina State Board of Dental Examiners; and

III. Visas that permit Graduate Medical Education training must be valid as outlined in the current Graduate Medical Education Directory. The University of North Carolina Hospitals sponsors J-1 visas as part of this process.

IV. Eligible applicants will be considered on the basis of residency program-related criteria such as their preparedness, ability, aptitude, academic credentials, communication skills, and personal qualities such as motivation and integrity.

a. UNC Hospitals will not discriminate with regard to sex, race, age, religion, color, national origin, disability, veteran status, sexual orientation, or any other applicable legally protected status.

b. Each program must have a written policy for resident selection and recruitment.

c. UNC Hospitals is committed to creating and sustaining an environment that values a variety of perspectives and experiences. As such, each UNC Hospitals residency program is encouraged to formally incorporate specific selection strategies into their policy for resident selection and recruitment enhances the recruitment of residents who represent diversity in the dimensions of race, ethnicity, gender, and geographic origin.

In the Department of Dermatology, all applications are considered and reviewed by the Program Director. The pool of applicants is narrowed to 60-80 applications based upon credentials (medical school performance and board scores), publications,
research activities, letters of recommendation, and extracurricular activities. The 60-
80 remaining applications are then independently ranked by the Chair and other
faculty members. Interviews are offered to the resulting top 20-30 applicants.

The interview process includes an evening dinner with all residents, dinner with all
residents, tour of facilities, and interviews with 8-9 faculty members, and residents.
Interviewing members have equal input into the final scoring and ranking of
applicants.

V. Each Program should consider the following in their selection process:

a. Each Program must have a selection committee that will review the applications
of the program’s resident candidates, both those applying for entry level positions
and candidates under consideration as transfers to fill advanced-level resident
vacancies within the program. Selection committee members should include the
Chair, Program Director, Assistant Program Director(s) and/or residents at
various levels of training;

b. For Programs participating in an organized matching program, the DIO, or his/her
designee(s) from the Office of Graduate Medical Education (OGME), shall
review the application of any candidate who is applying as a new resident outside
of the match process, or any candidate who is applying to fill a subsequent
vacancy in a Program, regardless of whether the Program participates in an
approved match process. The OCGME must approve all such candidates before
any offer is made;

c. Programs participating in the Electronic Residency Application Service (ERAS)
may accept application materials as provided through ERAS, for the match only;

d. Interviews should be extended to the best-qualified candidates. Qualities of
professionalism and character should be considered. The DIO, may, in his/her
sole discretion, interview and/or appoint his/her designee(s) from the OGME to
interview, any candidate who is applying to a Program outside of an organized
matching process, or any candidate who is applying to fill a subsequent vacancy
in a Program, regardless of whether the Program participates in an approved
match process;

e. The selection process should be broad-based to include participation by faculty,
residents and tour of facilities; and

f. Residency Programs must not enroll non-eligible physicians, as the enrollment of
non-eligible residents may be cause for withdrawal of accreditation of the
involved Program.

VI. Each program must include the following for applicants invited for interviews:
a. Candidates for interviews must receive oral and written information related to clinical rotations; didactic program; procedures for evaluating residents and programs; requirements for duty hours and call schedule; policies regarding vacation, sickness, family leave act, disability and medical/dental coverage; financial support; hospitalization; resident disability insurance, and health insurance for residents and their families. Call rooms, meals, and laundry services or their equivalents need to be included in the information package.

b. After the resident has been selected and matched, the resident folder must retain all letters of recommendation and references.

VII. All selected applicants will be required to submit the following:

a. UNC Hospitals Application for Appointment to Graduate Medical Education;

b. Three letters of reference:

(i) One letter of reference should be mailed from the Dean or designee at the School of Medicine/Dentistry from which the applicant graduated, certifying the degree awarded and the date awarded or anticipated date;

(ii) One letter of reference must be mailed from the Chair or designee in the chosen specialty at the Medical/Dental School from which the applicant graduated; and

(iii) A third letter of reference must be mailed from someone who has knowledge of the applicant’s experience, ability, educational accomplishments and character.

c. In the case of applicants applying for positions beyond the first year, the three letters of recommendation should include one from the program director of the residency program in which the applicant has most recently served and two from members of the medical or dental staff of the hospital affiliated with the sponsoring institution of that residency program (see also VIII, Verification of Previous GME Training);

d. An official Medical/Dental School transcript, from the Registrar of the School of Medicine/Dentistry subsequent to graduation. A photocopy is not acceptable;

e. Signed Authorization for Release of Information (included with the application);

f. Pre-employment drug screening;

g. Signed background check verification;
h. Current curriculum vitae that includes date or anticipated date of medical/dental school graduation and name of UNC Hospitals residency program the applicant hopes to enter; and

i. Any resident who has a disability (according to the Americans with Disabilities Act) and/or special restrictions on his/her medical license must report this information and requests for accommodations to the Program Director and the OGME no later than the first day his/her residency program begins.

VIII. Verification of Previous GME Training

To determine the appropriate level of education for a resident who is transferring from another residency program, the Program Director must receive written or electronic verification of the previous educational experience and summative competency-based performance evaluations of the transferring resident prior to acceptance into the program.

IX. Appointment

UNC Hospitals and the program directors shall assure that residents are given a Graduate Medical Education Appointment Agreement provided by the GME office, which outlines the terms and conditions of their appointment to a program. UNC Hospitals shall monitor programs with regard to implementation of terms and conditions of appointment by program directors. UNC Hospitals and program directors must ensure that residents are informed of and adhere to established educational and clinical practices, policies, and procedures in all sites to which residents are assigned following their appointment to a program.

Written and Approved by GMEAC: November 1998
Executive Committee Approval: December 14, 1998
Reviewed and Approved by GMEAC: November 15, 2000
Revised and Approved by GMEAC: December 19, 2001
Medical Staff Approval: February 4, 2002
Reviewed and Approved by GMEC: November 19, 2003
Reviewed and Approved by GMEC: September 20, 2006
Revised and Approved by GMEC: October 17, 2007
Revised and Approved by GMEC: December 17, 2008
Approved by MSEC: January 12, 2009
Reviewed and Approved by GMEC: March 17, 2010
Approved by MSEC: April 12, 2010
GMEC Revised and Approved: October 19, 2011
MSEC Approval: December 12, 2011
A residency program is a structured educational activity, comprising a series of learning experiences in Graduate Medical Education (GME) designed to conform to the program requirements of a particular specialty or subspecialty. A physician must possess the ability, knowledge and skill to function in a variety of clinical situations and to render a broad spectrum of patient care. All residents must meet the essential clinical as well as academic requirements of the post-graduate medical education program, which include, but are not limited to:

- the intellectual, behavioral, social capacity to observe and communicate;
- sufficient motor and sensory abilities to perform physical examinations and basic laboratory and diagnostic procedures;
- emotional stability to exercise good judgment and work effectively in stressful situations; and
- intellectual ability to synthesize data and solve problems.
POLICY:

UNC Health Care is committed to considering requests for reasonable accommodations made by residents with known disabilities who can meet the clinical and academic requirements of their residency program as set forth by its respective ACGME or ADA Residency Review Committee.

DEFINITIONS:

Disability: For the purpose of considering an accommodation, according to the Americans with Disabilities Act of 1990, the term “disability” means, with respect to an individual, a person with a physical or mental impairment that substantially limits one or more of the major life activities.

Making Life Activities: Functions such as caring for one’s self, performing manual tasks, walking, seeing, hearing, eating, sleeping, standing, sitting, reaching, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking, communicating, interacting with others, working, and receiving education or vocational training, and the operation of major bodily functions, including functions of the immune system, special sense organs and skin, normal cell growth, digestive, genitourinary, bowel, bladder, neurological, brain, respiratory, circulatory, cardiovascular, endocrine, hemic, lymphatic, musculoskeletal, and reproductive functions.

Reasonable Accommodation: Modifications or adjustments to the work environment, or to the manner or circumstances under which the position held or desired is customarily performed, that enables qualified individuals with disabilities to perform the essential functions of that position. Accommodation options may include job restructuring; part-time or modified work schedules; modification of training materials or policies; elimination of non-essential job functions; modification of current equipment; acquisition of adaptive software or assistive technology and equipment; talking calculators; and/or telephones compatible with hearing aids.

An accommodation is NOT considered reasonable if it imposes an undue hardship, alters the fundamental nature or requirements of the residency program, or poses a direct threat to the health or safety of others. Examples of proposed accommodations that may impose an undue burden include, but are not limited to: extensions of time to complete a residency training program that have an adverse effect on the accreditation of the residency program; or job restructuring that compromises duty hours for other residents or have a negative effect on the training of other residents in the program.

PROCEDURE:

Request for Accommodation - Residents with disabilities are responsible for requesting reasonable accommodations and providing medical documentation appropriate to verify the existence of the disability and to identify and assess potential reasonable accommodations. Requests should be directed to the Office of Graduate Medical Education, residency program director, and Designated Institutional Official (DIO). The Office of Graduate Medical Education, residency program director and DIO will review the request. If it is determined that additional medical information is needed, the resident will be provided with any
forms/questionnaires necessary for his/her health care provider to complete. The ADA Officer will evaluate information to determine eligibility within the guidelines of ADA.

The Office of Graduate Medical Education, residency program director and DIO will then coordinate with the resident to determine whether the requested accommodation would be effective, reasonable, and enable the resident to perform the essential functions of the position and achieve the essential educational goals and program objectives, or make a good faith effort to negotiate another accommodation. Each accommodation request will be handled on a case-by-case basis, including new requests from residents who are currently receiving accommodation. The process of evaluating accommodation requests is highly interactive, and requires a case-by-case review. Participants in the process may include, but are not limited to, the following:

- the resident and his or her medical provider
- Office of Graduate Medical Education, department chair/residency program director
- supervising faculty members
- Designated Institutional Official
- accrediting body for specialty/subspecialty area

A request for accommodation may be made any time during residency training. In order for the resident to receive maximum benefit from his/her residency training time, requests for accommodation should be made as early in the training process as possible.

**Confidentiality of Records** - All medical-related information must be kept confidential and maintained separately from other resident records. However, supervisors and managers may be advised of information necessary to make the determinations they are required to make in connection with a request for an accommodation. First aid and safety personnel may be informed, when appropriate, if the disability might require emergency treatment or if any specific procedures are needed in the case of fire or other evacuations. Government officials investigating compliance with the ADA may also be provided relevant information as requested. Medical information may also be provided, as needed for workers’ compensation purposes (for example, to process a claim), and for certain insurance purposes.

**Resident Responsibilities** - A resident requesting reasonable accommodation is responsible for:

1. Requesting the accommodation. The request must be made well in advance of the need, so that it can be evaluated or alternative accommodation considered. The request must be detailed enough to ensure that, if granted, the accommodation can be effectively implemented.

2. Identifying the nature of the condition which gives rise to the request.

3. Providing adequate medical documentation. Upon request from the Office of Graduate Medical Education, the resident must provide timely and adequate written documentation from an appropriate health care provider(s) which substantiates the presence of an impairment that entitles the resident to state or federal disability coverage and supports
the need for a requested accommodation. Each accommodation request may require additional documentation, and some covered disabilities require intermittent re-testing. The resident is responsible for complying in a timely manner with any request for documentation or information from the Office of Graduate Medical Education.

4. Fulfilling his/her responsibilities in conjunction with an agreed upon accommodation.

5. Maintaining regular contact with the Office of Graduate Medical Education and DIO. The resident should contact the Office of Graduate Medical Education and DIO at least once during each rotation which requires an accommodation to provide feedback about the effectiveness of the accommodation and discuss program needs.

Reviewed and Approved by GMEC: 12/19/07
Reviewed and Approved by GMEC: 12/17/08
Approved by MSEC: 1/12/09
Reviewed and Approved by GMEC: 3/17/10
Reviewed and Approved by GMEC: 3/16/11
Approved by MSEC: 4/11/11
GMEC Reviewed and Approved: 10/19/11
MSEC Approval: 12/12/11
GMEC Review and Approved: 6/18/14
MSEC Approval: 7/14/14
Interactions between faculty and residents/subspecialty residents in graduate medical education training programs sponsored by the University of North Carolina Hospitals are guided by mutual trust, confidence, and professional ethics. Because professional relationships between faculty and residents/subspecialty residents have a power differential that must exist for appropriate training to occur, personal relationships that may develop between faculty and trainees carry risks of conflict of interest, breach of trust, abuse of power and breach of professional ethics. In particular, sexual or amorous relationships between medical supervisors and their medical trainees raise concerns: 1) because of inherent inequalities in the status and power that medical supervisors wield in relation to medical trainees; and 2) because other healthcare team members may perceive such relationships as providing a trainee with preferential treatment from the faculty member or the faculty member’s colleagues, both of which may adversely affect patient care, as well as UNC Hospitals’ ability to provide appropriate medical training, in general. Accordingly, amorous relationships between a medical trainee and an attending or other
supervisor, even when consensual, are not acceptable regardless of the degree of supervision in any given situation.

POLICY:

It is the policy of UNC Hospitals that faculty members shall not engage in consensual relationships with trainees whenever the faculty member has a professional “position of authority” with respect to the trainee in matters involving evaluation of trainee performance as part of the graduate medical education program. Should a consensual relationship develop, or appear likely to develop, while the faculty member is in a position of authority, the faculty member and/or the trainee must terminate the position of authority.

This policy will also apply to relationships between residents/subspecialty residents and students during student rotations/experiences in which the performance of the student as part of their approved curriculum is being evaluated.

Definitions

1. Faculty, for purposes of this policy only, consists of full or part-time faculty and all other personnel who evaluate residents/subspecialty resident performance.

2. Residents/subspecialty residents are all full or part-time residents/subspecialty residents assigned to UNC Hospitals.

3. Medical student refers to any student enrolled in a course approved by the UNC School of Medicine.

4. Trainee refers individually or collectively to residents, subspecialty residents, medical students or other students participating in clinical education rotations at UNC Hospitals.

5. A consensual relationship exists when, without the benefit of marriage, two persons are consenting partners (a) have a sexual union or (b) engage in a romantic partnering or courtship that may or may not have been consummated sexually.

6. Position of authority includes situations in which a faculty member or other supervisor is responsible for supervision and/or evaluation of the performance of a resident/subspecialty resident or, when a resident/subspecialty resident is responsible for supervision and/or evaluation of the performance of a student. Instruction that does not have a supervision and/or evaluation component is not included.

Procedures
When a consensual relationship, as defined above, exists or develops, a position of authority with respect to the trainee must be avoided or terminated. Avoidance of termination includes, but is not limited to: removing any supervisory, teaching, evaluating, advising, coaching, or counseling responsibilities between the person in the position of authority and the trainee; or transfer of the trainee to another rotation. The supervisory role should be eliminated if the parties involved wish to pursue their relationship. Faculty members, residents, subspecialty residents, students or other trainees must notify the UNC Hospitals Office of Graduate Medical Education and their supervisor (e.g., department chair, program director or other responsible administrative official most directly involved in the training program, excluding the person alleged to have violated this Policy) of any prohibited relationship in which they are involved; and have a duty to cooperate in making acceptable alternative arrangements. The alternative arrangements should avoid negative consequences for the trainee. If acceptable alternative arrangements are not feasible, the relationship cannot continue.

Non-Compliance with Policy

Because of the sensitive nature of such relationships, every reasonable effort should be made to resolve alleged Policy violations on an informal basis if possible. Any credible allegation of a faculty member’s failure to avoid or terminate a position of authority while in a consensual relationship obligates the department chair, program director or other responsible administrative official most directly involved in the training program, excluding the person alleged to have violated this Policy, to conduct a prompt and thorough inquiry to determine whether the allegation is true. The University of North Carolina at Chapel Hill’s policy on Improper Relationships between Students and Employees shall govern any inquiries and violations of this policy that involve faculty or staff of the University. When the result of such an inquiry is that a violation of this Policy exists, and the supervisor refuses to terminate the position of authority or, alternatively, the involved persons refuse to terminate the relationship, the department chair, program director, or other responsible administrative official most directly involved in the training program, excluding the person alleged to have violated this Policy, shall terminate the position of authority and may impose sanctions against the parties involved. Any remedial action taken by the administrative officials shall depend on the totality of the circumstances.

Sanctions

Persons in violation of this policy shall be subject to appropriate sanctions. Efforts should be made to provide constructive education for concerned parties and to take corrective action rather than punitive action if a Policy violation is found; an acknowledgment of the violation and a commitment not to violate the Policy in the future, along with a warning or other appropriate action directed toward the faculty or staff member, may be sufficient resolution. In cases where further action is deemed appropriate, sanctions may range from a letter of reprimand to dismissal, all in accordance with applicable Hospital and/or University procedures.

Complaints found to be knowingly false or made in willful disregard of the truth shall subject the complainant to the same sanctions.
Faculty Rights

Nothing herein shall abridge the rights of faculty as outlined in applicable University policies on academic freedom, employment, or tenure.

Amorous Relationships Outside the Official Supervisory or Evaluative Context

Even when a faculty member has no professional responsibility for a trainee, the faculty member should be sensitive to the perceptions of other healthcare team members that a trainee who has a consensual relationship with a faculty member may receive preferential treatment from the faculty member or the faculty member’s colleagues. In particular, when the individual and the trainee are in the same academic unit, or in units that are allied, relationships that the involved parties view as consensual may be disruptive to unit activities and appear to others to be exploitative. Further, in these and other situations, the faculty or staff member may face serious conflicts of interest. In any such situation, therefore, persons in position of authority should be most careful to remove themselves from involvement with any decisions that may reward or penalize trainees. Individuals in positions of authority must also be aware that romantic or amorous relationships with trainees that may begin as consensual are fraught with danger for exploitation and pose a legal risk to both the individual and the institution.

Appropriate Relationships

Friendships or mentoring relationships between faculty or staff employees and students are not proscribed, nor is it the intent of the Hospital that such non-amorous relationships be discouraged or limited in any way.

GMEC Approved: 3-21-07
MSEC Approved: 4-9-07
GMEC Reviewed and Approved: 12/17/08
MSEC Approved: 1/12/09
GMEC Reviewed and Approved: 3/17/10
GMEC Reviewed and Approved: 10/19/11
MSEC Approved: 12/12/11
UNC Hospitals is committed to the health and well-being of our resident physicians, and all residents are encouraged to seek assistance promptly for any concerns. There are multiple avenues for assistance available including program directors, department chairs, mentors, and the Office of Graduate Medical Education. If requested, the Office of Graduate Medical Education can provide referral services to multiple resources. However, in recognition of the need for resident physicians to have a completely confidential means of seeking assistance without the knowledge of their program of the Office of Graduate Medical Education, this policy describes the mechanism for a resident physician or their spouse/significant other to access support services in a completely confidential manner.

The UNC Healthcare System has an Employee Assistance Program (EAP) to handle any concerns confidentially. The EAP can be reached at (919) 929-2362. A link to the EAP policy with contact information is available at the following web address: http://www.unchealthcare.org/site/humanresources/benefits/other/eap
The North Carolina Physicians Health Program (NCPHP) can be reached at (919) 870-4380. The NCPHP handles any medical, psychiatric, substance abuse or behavioral concerns that impact a physician’s ability to practice medicine. Treatment programs and monitoring programs are conducted under the direction of the NCPHP medical director, allowing physicians to get the evaluation and help they need in a protected, confidential manner that allows them to keep practicing without sanctions from the North Carolina Medical Board as long as the physician adheres to the terms of their NCPHP contract. Additional information is available at the NCPHP website: http://www.ncphp.org/

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UNC Hospitals is the sponsoring institution for ACGME-accredited residency training programs, American Dental Association training programs and other training programs appointed through the Office of Graduate Medical Education. The ACGME requires that faculty in each program must evaluate resident performance in a timely manner during each rotation or similar educational assignment, and document this evaluation at completion of the assignment. Each program must:

- provide objective assessments of competence in patient care, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice;
- use multiple evaluators (e.g., faculty, peers, patients, self, and other professional staff);
- document progressive resident performance improvement appropriate to educational level; and
- provide each resident with documented semiannual evaluation of performance with feedback.
Individual residency programs may have additional types of evaluations required by the respective RRC.

The evaluations of resident performance must be accessible for review by the resident, in accordance with institutional policy.

Each program must have a Clinical Competency Committee (CCC) as specifically defined by the ACGME, and the CCC is required to use the program’s existing evaluation tools to determine an individual resident’s progress toward meeting specialty-specific Milestones. The determination of Milestones achievement for each individual resident must occur twice yearly, with mandatory reporting to the ACGME in the November-December timeframe and again in the May-June timeframe. Progress toward Milestones targets will be used by the CCC and the program director to make decisions about resident progress including promotion, remediation, or dismissal. Ultimately, Milestones achievement will be used to determine successful program completion.

The program director must provide a summative evaluation for each resident upon completion of the program. This evaluation must become part of the resident’s permanent record maintained by the institution, and must be accessible for review by the resident in accordance with institutional policy. This evaluation must

- document the resident’s performance during the final period of education, and
- verify that the resident has demonstrated sufficient competence to enter practice without direct supervision.

All ACGME training programs, American Dental Association training programs and other training programs appointed through the Office of Graduate Medical Education are must use E*Value for the following evaluations, at a minimum:

1. faculty evaluations of residents after rotations;
2. resident evaluations of faculty at least annually; and
3. resident evaluations of rotations.

Other evaluative tools may be used as appropriate in addition to and to supplement E*Value.
POLICY AND PROCEDURE
UNIVERSITY OF NORTH CAROLINA HOSPITALS
GRADUATE MEDICAL EDUCATION
GRIEVANCE PROCEDURES POLICY

The ACGME requires that the sponsoring institution provide residents with fair, reasonable, and readily available written institutional policies and procedures for grievance and due process. These policies and procedures must minimize conflict of interest by adjudicating parties in addressing:

(1) Academic or other disciplinary actions taken against residents that could result in dismissal, non-renewal of a resident’s agreement, non-promotion of a resident to the next level of training, or other actions that could significantly threaten a resident’s intended career development; and

(2) Adjudication of resident complaints and grievances related to the work environment or issues related to the program or faculty.

Before bringing a grievance regarding either a disciplinary action or a complaint related to the work environment, a resident should first discuss the matter with the Residency Program Director in his/her training program (unless the grievance is based on an action or inaction of the
Residency Program Director) and/or the Designated Institutional Official (DIO) in the Graduate Medical Education Office.

**Academic or Other Disciplinary Actions:**

**Step I. Discussions Between Resident, Chief Operating Officer of UNC Hospitals and Chief Medical Officer**

A resident who faces academic or other disciplinary actions that could result in dismissal, non-renewal of the resident’s agreement, non-promotion to the next level of training, or other actions that could significantly threaten the resident’s intended career development has fifteen (15) days after receiving written notice of such action to appeal the decision by presenting a written statement of his/her grievance to the Chief Operating Officer of UNC Hospitals (COO) and Chief Medical Officer (CMO). The appeal shall be addressed to the COO. The COO and CMO shall meet with the resident within fourteen (14) days after receipt of the resident’s request and shall render a decision within seven (7) days after all necessary discussions are held. If the COO and CMO are unable to agree, the matter may be appealed to Step II within seven (7) days after the resident is notified in writing by the COO that s/he and the CMO cannot reach agreement.

**Step II. Appeal Committee**

If the Step I decision is not satisfactory to the resident, the resident may request consideration of the matter by an ad hoc hearing committee. The request must be presented to the President of UNC Hospitals within seven (7) days after receipt of the Step I decision. An ad hoc hearing committee shall be appointed by the Chair, Executive Committee of the Medical Staff upon recommendation of the COO of UNC Hospitals and CMO. Such committee shall have five (5) members, one of whom shall be designated to serve as Chair. A resident from the Housestaff Executive Council shall be one of the five (5) members.

A hearing shall be held not less than fourteen (14) days nor more than twenty-eight (28) days from the date of the resident’s request for a hearing. The President of UNC Hospitals shall notify the resident of the time, place and date of such hearing at least seven (7) days in advance of such hearing date. An accurate record of the hearing shall be kept. The resident shall have the right to call, examine and cross-examine witnesses and to representation by counsel. The hearing need not be conducted strictly according to the rules of law relating to the examination of witnesses or presentation of evidence.

Within seven (7) days after final adjournment of the hearing the ad hoc committee shall make a written report and recommendation, and shall forward its report and recommendation together with the hearing record and all other documentation to the President of UNC Hospitals. The President of UNC Hospitals shall render a written decision to the resident within seven (7) days after receipt of the ad hoc committee’s report and recommendation.
Complaints and Grievances Related to the Work Environment:

Step I. Discussions Between Resident, Chief Operating Officer and Chief of Staff of UNC Hospitals
A resident who wishes to file a complaint or grievance related to the work environment has fifteen (15) days after the incident that is the subject of the complaint or grievance occurs to provide written notice of such incident to the COO and CMO of UNC Hospitals. The request shall be addressed to the COO. The COO and CMO of UNC Hospitals shall meet with the resident within fourteen (14) days after receipt of the resident’s request and shall render a decision within seven (7) days after all necessary discussions are held. If the COO and CMO are unable to agree, the matter may be appealed to Step II within seven (7) days after the resident is notified in writing by the COO that s/he and the CMO cannot reach agreement.

Step II. Appeal
If the Step I decision is not satisfactory to the resident, the resident may request consideration of the matter by the President of UNC Hospitals. The request must be presented to the President of UNC Hospitals within seven (7) days after receipt of the Step I decision. The President of UNC Hospitals shall meet with the resident within fourteen (14) days after receipt of the resident’s appeal and shall render a decision within seven (7) days after all necessary discussions are held. The President’s decision is a final decision.

RESPONSIBLE UNIT
Director’s Office/Graduate Med. Ed. Comm.  5/92
GMEC Reviewed and revised as necessary:  5/94
3/95
1/98
9/00
11/03
10/06
3/08
11/09
11/10
3/11

GMEC Reviewed and Approved:  10/11
MSEC Approved:  12/11
GMEC Approved:  5/14
MSEC Approval:  6/14
POLICY AND PROCEDURE
UNIVERSITY OF NORTH CAROLINA HOSPITALS
GRADUATE MEDICAL EDUCATION POLICY ON HANDLING ACADEMIC AND PERFORMANCE PROBLEMS

When confronted with a resident who requires counseling and guidance in regard to an academic or performance problem, each Program may customize the following as determined by their Education Committee; however, all aspects of the Policy must be met:

1. The Program Director will:
   a. accurately, timely, and sufficiently document the nature and occurrence of the problem(s) by means of evaluations, personal interviews and letters received concerning performance or resident complaints, and
   b. discuss the issues and potential resolutions with the Designated Institutional Official, Office of Graduate Medical Education.

2. The Program Director will identify the source of the problems by utilizing:
   a. academic data, professional evaluations or performance relative to existing standards and requirements;
b. disciplinary violations of institution/departmental rules and policies regarding academic and/or professional conduct, and
c. discussions with the Designated Institutional Official, Office of Graduate Medical Education.

3. The Program Director will ensure fair and equitable treatment by:
   a. reviewing the entire record of performance;
   b. getting many points of input to avoid arbitrary and capricious actions;
   c. maintaining factual documentation and accurate information;
   d. receiving recommendations from the Program’s Clinical Competency Committee; and
   e. meeting with the Designated Institutional Official, Office of Graduate Medical Education.

4. The Program Director will:
   a. document, by letter and after consulting with Designated Institutional Official, Office of Graduate Medical Education, sufficient notification to the resident of the problem, plans for remediation and the consequences, if the problem is not resolved, and
   b. provide documentation for an appointment with the North Carolina Physicians Health Program for the resident, if recommended by the Designated Institutional Official, Office of Graduate Medical Education, which will be coordinated by the Office of Graduate Medical Education, and
   c. send a copy of the letter to the Designated Institutional Official, Office of Graduate Medical Education.

5. The Program Director will outline a timetable to the resident, in the educational enhancement plan letter, within which improvement must be made, during which time the resident is closely observed and scrutinized under the remediation plan, with a follow up review date.

6. The Program Director will:
   a. provide an opportunity for the resident to respond after initial contact, and
   b. recommend that the resident meet with Designated Institutional Official, Office of Graduate Medical Education, and
   c. recommend, if a formal evaluation by the North Carolina Physician’s Health Program is not required, that the resident seek any additional professional assistance that might be helpful to him/her through the Employee Assistance Program, his/her own personal healthcare professionals, or through resources that many be available through contacting the Office of Graduate Medical Education.

7. An educational enhancement plan, by definition, is not a disciplinary action, but, rather, offers a resident an opportunity for structured improvement that will prevent the need for disciplinary action. As such, being placed on an educational enhancement plan does not need to be reported to the North Carolina Medical Board, nor does it need to be reported
on future credentialing requests made to the institution and/or the program. Unsuccessful improvement, however, will require further action as delineated below.

8. The Program Director will, if educational enhancement fails, establish a probationary period for the resident, after consulting with the Designated Institutional Official, Office of Graduate Medical Education, during which time the resident is closely observed and scrutinized using a probationary plan and follow up review date. The resident will be notified by letter of probation of the probationary period and expectations during this period, as well as the consequences if the problem(s) is not resolved. The Designated Institutional Official and Office of Graduate Medical Education must receive signed copies of the probationary letter.

9. The Program Director will collect information during the probationary period, review and discuss the information with the Office of Graduate Medical Education, and conduct a follow up review with the resident on the established date.

10. The Office of Graduate Medical Education must report periods of probation to the North Carolina Medical Board, and requests for future credentialing and/or training verification must include the fact that the resident was placed on probationary status during training.

11. At the end of the probationary period, the Program Director will make one of the following decisions:
   a. accept resolution of the problem(s),
   b. continue the probationary period,
   c. dismiss the trainee for failure to meet the academic or performance standards, or
   d. provide notice of non-reappointment.

Each department must personalize the above and must adhere to the UNC Hospitals Reappointment, Non-Reappointment and Dismissal Policy. All residents must receive copies of the Grievance Procedures Policy and Reappointment, Non-Reappointment and Dismissal Policy during orientation; any resident placed on probation, dismissed for failure to meet academic or performance standards, or provided notice of non-reappointment must receive copies of the Grievance Procedures Policy and Reappointment, Non-Reappointment and Dismissal Policy at the time the disciplinary action is taken.

Originating Unit: Graduate Medical Education Advisory Committee
Approval: December 19, 2001
Medical Staff Approval: February 4, 2002
Revised and Approved: November 19, 2003
Reviewed and Approved: December 17, 2008
Medical Staff Approved: January 12, 2009
Reviewed and Approved: October 21, 2009
Medical Staff Approved: November 9, 2009
Reviewed and Approved: March 16, 2011
Medical Staff Approval: April 11, 2011
GMEC Reviewed and Approved: October 19, 2011
MSEC Approval: December 12, 2011
GMEC Reviewed and Approved: November 20, 2013
MSEC Approval: December 9, 2013
A. POLICY

The Graduate Medical Education Committee will ensure that sponsored residency programs provide appropriate supervision for residents in accordance with the ACGME Institutional and Common Program Requirements.

B. PROCEDURE

1. Each sponsored residency program will develop a policy and procedure on resident supervision which specifies that residents are provided with progressively increasing responsibility for patient care according to their level of education, ability, and experience. These policies must specify the extent to which residents may undertake patient care without direct supervision:
1) **Direct Supervision** – the supervising physician is physically present with the resident and patient.

2) **Indirect Supervision:**

   a. **With direct supervision immediately available** – the supervising physician is physically within the hospital or other site of patient care, and is immediately available to provide direct supervision.

   b. **With direct supervision available** – the supervising physician is not physically present within the hospital or other side of patient care, but is immediately available by means of telephone and/or electronic modalities, and is available to provide direct supervision.

3) **Oversight** – the supervision physician is available to provide review of procedures/encounters with feedback provided after care is delivered.

   PGY1 residents should be supervised either directly or indirectly with direct supervision immediately available (see also #5, below)

2. The program director and faculty members must evaluate and determine the level of responsibility for each resident in the provision of patient care with/without supervision, and in assuming a supervisory role, based on specific programmatic criteria.

3. Each sponsored program is to establish schedules which assign qualified faculty physicians, residents or fellows to supervise, at all times, and in all settings, in which residents provide any type of patient care. The type of supervision to be provided is delineated in the residency program curriculum’s rotation description.

4. The program must list guidelines for circumstances and events in which residents must communicate with appropriate supervising faculty members. Each program will reference the applicable ACGME RRC’s Specialty-Specific Program Requirements and RRC FAQs to identify, and incorporate as appropriate, specific circumstances in which the resident – regardless of level of training – should communicate with their supervising faculty attending physician, if such circumstances have been identified by the RRC. Programs are encouraged to add to the RRC’s list of mandated communication events as appropriate.

5. PGY1 residents should be supervised directly until the resident has demonstrated sufficient competence to progress to being supervised indirectly with direct supervision available. Each program will define and list (with guidance from the applicable ACGME RRC’s Specialty-Specific Program Requirements and RRC FAQs) specific examples of procedures or other patient care activities for which a minimum number of directly supervised activities must be performed successfully as the basis for granting indirect supervision status to a PGY1.
6. Faculty supervision assignments should be of sufficient duration to assess the knowledge and skills of each resident and delegate to him/her the appropriate level of patient care authority and responsibility.

7. Each sponsored program will provide the Graduate Medical Education with a copy of its policy on resident supervision as part of the annual program evaluation reporting.

C. UNC DERMATOLOGY SPECIFIC SUPERVISION AND PROGRESSIVE RESPONSIBILITY POLICY

1. Out-patient Clinics

Supervision is exercised through a variety of methods. Clinical activities at Southern Village, Raleigh, Hillsborough, and Piedmont Health Services have direct supervision and require the physical presence of the supervising faculty member. Patients are initially seen and examined by residents who then present to the attending. The resident and attending team then interacts with the patient together and directly. For some aspects of patient care (selected biopsy procedures, skin testing activities, etc), the supervising physician may be a more advanced resident.

2. In-Patient Activities

All in-patient clinical activities by residents are supervised by direct supervision provided by the consult attending. Selected procedures (KOH prep, Tzancks, skin biopsies, etc) may be performed by the resident with indirect supervision with direct supervision immediately available.

3. Progressive Authority and Independence

The privilege of progressive authority and responsibility, conditional independence, and a supervisory role in patient care delegated to each resident is assigned by the program director and faculty members. The program director evaluates each resident’s abilities based on specific criteria to include procedural logs and performance evaluations. New residents complete procedural cards and are signed off on supervised procedures by faculty members. Residents cannot perform such procedures without direct supervision until specific criteria met.

Faculty members functioning as supervising physicians delegate portions of care to residents, based on the needs of the patient and the skills of the residents. Residents are scheduled in all clinics throughout training such that faculty members are able to effectively evaluate individual resident abilities and resulting required supervision in a progressive manner.

4. Residents Supervising Residents

Senior residents serve in a supervisory role of junior residents during the first month of training of new residents. A formal shadowing schedule is made to allow new residents to learn from senior residents.
5. **Reasons For Immediate Communication To Faculty**

Residents must communicate with appropriate supervising faculty members when significant skin cancers (all melanomas; squamous cell carcinomas in immunocompromised) or critical laboratory results are received on their patients.

**D. TRANITIONS OF CARE**

1. **Consult patients**
   a. “Active” consult patients are recent dermatology consults which requires daily follow up for laboratory results, biopsy results, unclear diagnosis, evolution of skin disease, and/or implementation of recommended treatment. A daily note is not always required.
   
   b. “Inactive” consult patients are patients in which our medical expertise is no longer needed. The patient’s condition is stable, resolved, and/or well-defined. The on-call faculty member will declare when a patient is “inactive.” On the day that a patient becomes inactive, a note will be entered into the patient’s medical record providing declaration of sign off, recommendations for treatment, follow up, calling if the patient’s condition changes and pager number for further questions. Inactive patients do not need to be followed, but could be kept on the consult list until discharge (in case we are reconsulted). The consult resident should enter (“inactive” in the comments section of the consult list. Signing off makes it clear to the primary team that we will no longer be following the patient and that we should be contacted if any new issues arise. Inactive consults can be become active if requested by the hospital team.

2. **Residents**
   a. Programs must design clinical assignments to minimize the number of transitions in patient care.
      
      i. Scheduling of the on-call resident will be broken into weekday (M-F) resident and weekend (Sat-Sun) resident. Transitions of care will occur Friday at 5pm and Monday 745am at the SV clinic.
   
   b. Sponsoring institutions and programs must ensure and monitor effective, structured hand-over processes to facilitate both continuity of care and patient safety. Programs must ensure that residents are competent in communicating with team members in the hand-over process.
      
      i. A faculty member will observe the Friday transition. Random checks by faculty will occur throughout the year.
c. The sponsoring institution must ensure the availability of schedules that inform all members of the health care team of attending physicians and residents currently responsible for each patient’s care.

i. The Dermatology on-call team is posted on the hospital directory and accessible via HER and the Hospital Operator.

3. Faculty

a. Faculty consult schedules are built on a 10-30 day schedule. Transitions of care from off-going to in-coming faculty member will occur via personal communication (face to face or telephone).

GMEC Reviewed and Approved: 10/19/11
MSEC Approval: 12/12/11
POLICY AND PROCEDURE
UNIVERSITY OF NORTH CAROLINA HOSPITALS
GRADUATE MEDICAL EDUCATION
POLICY ON RESIDENCY CLOSURE/REDUCTION

Program Closure and/or Reduction in Size

In the event that an ACGME-accredited residency program, or the UNC Hospitals itself, is closed or reduced in size:

- UNC Hospitals will inform the GMEC, the DIO, and the residents as soon as possible when it intends to reduce the size or close one or more programs, or when UNC Hospitals intend to close;
- UNC Hospitals will allow residents already in the program(s) to complete their education or assist the residents in enrolling in an ACGME-accredited program(s) in which they can continue their education; and
- Fiscal resources permitting, UNC Hospitals will pay stipends and benefits through the conclusion of the term of the appointment agreement, or until such time as the resident secures a position in another residency program prior to the final date of the appointment agreement.
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<td>April 3, 2000</td>
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<td>December 19, 2001</td>
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POLICY AND PROCEDURE
UNIVERSITY OF NORTH CAROLINA HOSPITALS
GRADUATE MEDICAL EDUCATION
RESTRICTIVE COVENANT POLICY

It is the policy of UNC Hospitals that NO residents of ACGME accredited residency programs are required to sign a Restrictive Covenant.

Approved by Legal Office, UNC Hospitals: 7/18/02
Reviewed and Approved by GMEC: 3/17/10
Reviewed and Approved by GMEC: 3/16/11
Approved by MSEC: 4/11/11
GMEC Reviewed and Approved: 10/19/11
MSEC Approval: 12/12/11
Effective January 1, 2004, University of North Carolina Hospitals will accept resident physicians who have been issued a J-1 Visa and who hold a current ECFMG Certificate. H1-B visas are not sponsored at the University of North Carolina Hospitals.
POLICY AND PROCEDURE

UNIVERSITY OF NORTH CAROLINA HOSPITALS
GRADUATE MEDICAL EDUCATION
POLICY FOR NOTIFICATION AND ADMINISTRATIVE PROBATION
PROCEDURES FOR INCOMPLETE MEDICAL RECORDS

POLICY SUMMARY FOR COMPLETION OF MEDICAL RECORDS:

In accordance with the Bylaws, Rules and Regulations of the Medical Staff of the University of North Carolina Hospitals, all medical records are to be complete within twenty-eight (28) days of discharge from the hospital. Medical records that are not completed within 28 days are considered delinquent. The specific items that make up a complete record are found in the Policies and Procedures Governing Medical Records for physicians. These include signature requirements, dictation requirements and content requirements.
PROCEDURES FOR NOTIFYING MEDICAL STAFF OF CHART DEFICIENCIES:

1. **Weekly 28-Day Incomplete Records Report:**

   A. Each Wednesday the Chart Status Report, Executive Summary, Problem List, and Descending Deficiency List are created to notify the clinical departments of physicians with twenty-one (21) day old incomplete records.

   B. The reports are then distributed on Thursday morning to each Department Chair, Vice-Chair, Division Chief, Program Director, Clinical Documentation Committee member or designee as applicable.

2. **Weekly Notification Letters:**

   A. Notification letters (example 1) are printed every Thursday evening for each physician with incomplete medical records.

   B. These notifications Letters are distributed to the physicians' mailboxes on Friday morning.

**ADMINISTRATIVE PROBATION PROCESS:**

When a physician receives a pending administrative probation, the physician is notified via letter from the Director of Medical Information Management with copies to the Department Chair in the case of Medical Staff. For residents, additional copies will go to the Department Chair, the Residency Program Director and the Office of Graduate Medical Education. When the physician receives a final administrative probation, the physician is notified via a letter from the Chief of Staff and Executive Vice-President of the Hospitals with copies distributed as indicated above for Medical Staff and residents, respectively.

1. **Pending Administrative Probation:**

   Each Wednesday a list of physicians eligible for Administrative Probation is created. The following criteria must be met to be eligible for Administrative Probation:

   A. Incomplete medical records must be twenty-eight (28) days or older post discharge.

   B. These incomplete medical records must have been available in the Physicians Workroom (if applicable) or on the physician’s WebCIS activity list for the week immediately prior to when the pending probation list was created.

   C. Reasons for further consideration by Medical Information Management Administration to delay the probation process by one week includes:

   - physicians who are sick or on vacation. **NOTE:** a physician or designee must
notify Medical Information Management personnel as to this status.
- physicians who consistently keep their medical records up to date.
- physicians having only one incomplete medical record due to documentation or dictation requirements.
- physicians who need to sign two or less charts.

D. Those physicians selected on Wednesday are notified of "Pending Probation" on the following Monday. Notification letters are hand delivered on Monday to the Department Chair, and in addition, for residents, to the Residency Program Director and the Office of Graduate Medical Education. The letters are signed by the Director of Medical Information Management, (example 2).

2. Final Administrative Probation:

A. Those physicians who were notified and fail to complete all delinquencies prior to the next Wednesday morning (9 days later) are placed on Final Administrative Probation.

B. Final Administrative Probation letters are signed by the Chief Operating Officer and the Chief of Staff and are delivered to the following (Example 3)

- Physician
- Department Chairman
- Residency Program Director for Residents
- Office of Graduate Medical Education for Residents
- Systems Manager, Medical Information Management

C. The listing of physicians placed on Final Administrative Probation is delivered to the following (Example 4):

- Senior VP & C.F.O.
- Director of Medical Information Management
- Systems Manager, Medical Information Management

3. Referral to the Medical Staff Credentials Committee (Faculty Only):

A. All instances of final administrative probation along with the number of delinquent charts and the days on probation will be reported by the Clinical Documentation Committee to Medical Staff Credentials Committee and to the Department Chair.

B. When a threshold of 3 final administrative probations and 20 charts is reached during a rolling two year period OR when any probation lasts longer than 60 days, a medical staff member will be notified at least 2 weeks in advance that he/she are being put on the agenda for discussion and possible action at the next MSEC meeting (faculty). Prior to the meeting, the medical staff member will have the
opportunity to demonstrate to the MIM Department that the identified chart delinquencies are not accurate or complete the delinquent charts.

C. The biennial reappointment decision for medical staff will take into account the number and length of final administrative probations and the number of delinquent charts.

4. Referral to the Graduate Medical Education Committee (Residents Only):

A. All instances of final administrative probation along with the number of delinquent charts and the days on probation will be reported by the Clinical Documentation Committee to the Office of Graduate Medical Education (GME) to be placed in the resident’s personnel file in the Office of GME and in their Department’s program file for consideration during reappointment.

B. When a threshold of 3 final administrative probations and 20 charts is reached during a rolling two year period OR when any probation lasts longer than 60 days, a resident will be notified at least 2 weeks in advance that he/she are being put on the agenda for discussion and possible action at the next Graduate Medical Education Committee. Prior to the meeting, the resident will have the opportunity to demonstrate to the MIM Department that the identified chart delinquencies are not accurate or complete the delinquent charts.

C. The reappointment decision and evaluation of general competencies for residents every year will take into account the number and length of final administrative probations and the number of delinquent charts.

5. Review by the Clinical Documentation Committee:

A report of physicians placed on Administrative Probations will be reviewed by the Clinical Documentation Committee annually. Follow-up action will be determined by the committee on a case-by-case basis.

Approved by Executive Committee: 12/6/95
Approved by Graduate Medical Education Committee: 2/20/08
Revised: 2/08

“administrative probation policy”
POLICY AND PROCEDURE
UNIVERSITY OF NORTH CAROLINA HOSPITALS
GRADUATE MEDICAL EDUCATION
POLICY ON INSTITUTIONAL DISASTER PLAN

PURPOSE: To establish the procedures to be followed to provide administrative support for the GME programs and residents subsequent to an event or series of events that cause significant interruption in the provision of patient care, as mandated by ACGME’s Policies and Procedures.

SCOPE: This policy applies to all UNC Hospitals ACGME-accredited residency programs, associated faculty, residents, and staff.

DEFINITIONS:
Disaster:
An event of set of calamitous events bringing damage, loss, or destruction causing significant alteration to the residency/fellowship experience at one or more of UNC Hospitals’ residency and subspecialty residency programs.

Extreme Emergent Situation:
A local event (such as a hospital-declared disaster for an epidemic) that affects resident education or the work environment but does not rise to the level of an ACGME-declared disaster as defined in the ACGME Policies and Procedures.
POLICIES APPLICABLE TO A DISASTER

ACGME Declaration of a Disaster:
When warranted, the ACGME Chief Executive Officer, in consultation with the ACGME Executive Committee and the Chair of the Institutional Review Committee, will make a declaration of a disaster. A notice of such will be posted on the ACGME website with information relating to ACGME response to the disaster.

After declaration of a disaster, triggering implementation of this Disaster Policy:

I. The Designated Institutional Official (DIO), or designee, is responsible for maintaining communications between the various Program Directors, the Director of Graduate Medical Education, the Office of Graduate Medical Education (OGME), and appropriate university and/or hospital officials to assess the impact of the disaster on the ability of any and all areas of GME to continue to provide adequate educational experiences for all residents. If it is determined that a program or the institution cannot provide at least an adequate experience for all residents because of the disaster, the DIO and Program Directors will proceed to:

II.  
   a. Arrange temporary transfers to other programs/institutions until such time as the residency/fellowship program can provide an adequate educational experience for each of its residents/fellows, or

   b. Assist the residents in permanent transfers to other ACGME-accredited programs/institutions in which they can continue their education.

III. Program Directors are to use a previously developed contact list of potential sites for resident placement. The Program Director and DIO are jointly responsible for maintaining ongoing communication with the GMEC throughout the placement process. If more than one program/institution is available for temporary or permanent transfer of a particular resident, the preferences of each resident must be considered. Programs must make the “keep/transfer” decision expeditiously so as to maximize the likelihood that each resident/fellow will complete the year in a timely fashion.

IV. The Director of Graduate Medical Education (DGME), working with IT within UNC Hospitals, will make every attempt to prevent data loss by developing offsite back-ups using remote facilities. The DGME will also work with IT to complete transition to electronic data capture and storage in a timely fashion for data not currently stored in electronic form.

V. The Chief Medical Officer will monitor and maintain communication between the DIO, the Program Directors, the DGME, and the GMEC. In the event the DIO is unavailable or incapacitated, the Chief Medical Officer will appoint the interim DIO.
VI. The OGME will be responsible for maintaining current contact information for all residents, the PDs, and members of the OGME and the GMEC. The GMEC will function as a clearing house to maintain communication within the system and aid in recovery planning for colleagues in other programs, if possible.

VII. The President of UNC Hospitals will appoint an interim Chief Medical Officer, if necessary, and an interim DIO if both parties are unavailable or incapacitated.

VII. The DIO or designee will contact the ACGME Institutional Review Committee Executive Director within ten days after declaration of the disaster to discuss the due date for submission of plans for program reconfigurations and resident transfers to the ACGME. The DIO will provide initial and ongoing communication to university/hospital officials and all affected Program Directors. As soon as arrangements for temporary or permanent transfers have been confirmed, but no less than 10 days after declaration of the disaster, the Program Director or designee will notify each resident of those arrangements.

IX. Each Program Director and/or the DIO will determine/confirm the location of all residents, determine the means for ongoing communication with each, and notify emergency contacts of any resident who is injured or cannot be located.

X. The DIO will access information on the ACGME website to provide Program Directors with assistance in communicating and documenting resident transfers, program reconfigurations, and changing participating sites.

**COMMUNICATION WITH ACGME**

I. On its website, the ACGME will provide phone numbers and email addresses for emergency contact and other communication with the ACGME from disaster-affected institutions and programs. The DIO shall ensure that each Program Director and resident is provided with information annually about this emergency communication availability.

II. In General:
   a. The DIO will call or email the Institutional Review Committee Executive Director with information and/or requests for information.

   b. Program Directors will call or email the appropriate Review Committee Executive Director with information and/or requests for information.

   c. Residents will call or email the appropriate Review Committee Executive Director with information and/or requests for information, if they are unable to reach their Program Director or DIO.
POLICIES APPLICABLE TO EXTREME EMERGENT SITUATIONS

DECLARATION OF AN EXTREME EMERGENT SITUATION:
Declaration of an extreme situation may be initiated by a Program Director or by the DIO. Declaration of a qualifying local disaster is made by the DIO, in collaboration with the hospital CEO, the COO, the Chief Medical Officer, affected Program Directors, and Department Chairs. When possible, an emergency meeting of the GMEC – conducted in person, through conference call, or through web-conferencing – shall be convened for discussion and decision-making as appropriate.

PROCEDURE:
After declaration of an extreme emergent situation:

I. The Program Director of each affected residency/fellowship program shall meet with the DIO and other university/hospital officials, as appropriate, to determine the clinical duties, schedules, and alternate coverage arrangements for each residency program sponsored by the Institution. ACGME’s guidelines for development of those plans should be implemented, including:

a. Residents and fellows must be expected to perform according to the professional expectations of them as physicians, taking into account their degree of competence, level of training, and context of the specific situation. Residents who are fully licensed in this state may be able to provide patient care independent of supervision in the event of an extreme emergent situation, as further defined by the applicable medical staff by-laws.

b. Residents are also trainees/students. Residents/fellows should not fist-line responders without consideration of their level of training and competence, state licensing requirements, the scope of their individual license, if any, and/or beyond the limits of self-confidence in their own abilities.

II. Program Directors will remain in contact with the DIO about implementation of the plans to address the situation, and additional resources as needed.

III. The DIO will call the ACGME IRC Executive Director if (and only if) the extreme emergent situation causes serious, extended disruption that might affect the Institution’s/Program’s ability to remain in substantial compliance with ACGME requirements. The ACGME IRC will alert the respective RRC. If notice is provided to the ACGME, the DIO will notify the ACGME IRC ED when the extreme emergent situation has been resolved.

IV. The DIO and GMEC will meet with affected Program Directors to establish monitoring to ensure the continued safety of residents and patients through the duration of the situation, to determine that the situation has been resolved, and to assess additional actions to be taken (if any) to restore full compliance with each affected resident’s completion of the educational program requirements.
V. The Office of Graduate Medical Education will maintain a master contact list for ACGME staff, Program Directors, hospital administration, all residents and emergency contacts, and will update the list annually.

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POLICY AND PROCEDURE

UNIVERSITY OF NORTH CAROLINA HOSPITALS
GRADUATE MEDICAL EDUCATION
POLICY ON MEDICAL LICENSE REQUIREMENTS

1. All residents and subspecialty residents will be required to have a resident training license or a permanent medical license issued from the North Carolina Medical Board.

2. It is the requirement of the State of North Carolina that all medical licenses be registered annually.

3. It is the policy of UNC Hospitals that licenses must be registered by the date of birth of the individual physician.

4. If the license is not registered by the date of birth then the resident will be removed from all clinical duties and will forfeit the resident’s pro rata stipend payments during the time his/her license has not been registered.

5. UNC Hospitals Office of Graduate Medical Education will repeatedly notify the physician, program directors and program coordinators at least 30 days prior to the expiration date of any license.
6. All residents who engage in any type of moonlighting must have a full, unrestricted license, as one of the requirements for eligibility to moonlight.

7. All faculty members who supervise residents must have a full, unrestricted medical license from the North Carolina Medical Board.
POLICY AND PROCEDURE
UNIVERSITY OF NORTH CAROLINA HOSPITALS
GRADUATE MEDICAL EDUCATION POLICY ON ADDRESSING RESIDENTS’ CONCERNS

It is incumbent that each and every resident understands that there are many avenues by which the Housestaff can address concerns in a confidential and protected manner without fear of retaliation.

1) The Designated Institutional Official (DIO) and the Director of the Office of Graduate Medical Education are readily available to hear such concerns in a private and confidential environment. The DIO may be reached at (919) 966-1072. The Director may be reached at (919) 966-1072.

2) A GME Hotline is available to all residents to register anonymous concerns and issues; however, if a resident leaves contact information, he/she will be contacted. The Hotline number is (919) 966-1772. The GME Office will investigate concerns and issues as appropriate.
3) UNC Hospitals has a Compliance Office that can be reached through the Compliance/Abusive Behavior Hotline at (800) 362-2921. The Compliance Office will investigate any concerns regarding disruptive or inappropriate behavior. After a thorough investigation, the Compliance Office may contact the Designated Institutional Official, the Office of Graduate Medical Education, and/or the Employee Relations Office for UNC Hospitals.

4) The Human Resources Department has an Employee Relations Division that handles issues and Concerns for UNC Hospitals’ employees in a private and confidential manner.

5) UNC Hospitals Housestaff Council meets quarterly, and confidential problems can be addressed with the officers present at the meeting and the administrative staff of the Office of Graduate Medical Education at UNC Hospitals. The Housestaff Council has elected officers, and emails and telephone numbers are distributed to all the residents. The officers can be contacted at any time in regard to areas that need to be discussed.

Over the years, UNC Hospitals residents have utilized the resources listed above in a safe, confidential, and effective manner. All inquiries are made in a confidential manner with autonomy, confidentially, privacy and safety of the individual being paramount.

Originating Unit: Graduate Medical Education Advisory Committee
Approval: 01/16/02
Medical Staff Approval: February 4, 2002
GMEC Reviewed and Approved: December 17, 2003
GMEC Reviewed and Approved: December 17, 2008
Medical Staff Approval: January 12, 2009
GMEC Reviewed and Approved: October 19, 2011
Medical Staff Approval: December 12, 2011
POLICY AND PROCEDURE
UNIVERSITY OF NORTH CAROLINA HEALTHCARE
FIT FOR DUTY POLICY FOR ACGME TRAINEES

Purpose
UNC Health Care’s mission is to provide all employees, other workers, patients and visitors a safe environment for delivery of the highest quality of patient care. We recognize that all forms of impairment may lead to increased unintentional injuries, risks to patient care, and decreased productivity. Our purpose is to identify and address problems associated with substance abuse or other impairment and encourage rehabilitation.

Covered Employees
This policy applies to all duly appointed residents and subspecialty residents appointed to ACGME accredited programs at University of North Carolina Hospitals and non-ACGME trainees appointed through the Office of Graduate Medical Education (all of whom will be hereinafter referenced as “trainees”).

- UNC Health Care will refer Visiting Residents to the sponsoring institution for corrective action. UNC Health Care may restrict Visiting Residents or other non-UNC Health Care employees from working at UNC Health Care as a result of failure to comply with UNC
Health Care’s requirement that trainees report for work fit for duty and participate in a Fitness for Duty Assessment when requested.

**Fit for Duty Policy**

1. The following rules and practices apply to all trainees:
   a. No trainee shall report to the work site impaired for any reason, including but not limited to, personal stress, medical condition, use of alcohol or controlled substances, including drugs prescribed by a physician, use of over-the-counter medication, or use of any other controlled substance.
   b. No trainee shall use, sell, possess, distribute, dispense, divert or manufacture alcohol, controlled substances, prescription drugs without a valid prescription, or any other controlled substance, on UNC Health Care property or UNC Health Care time. Using such substances is also prohibited during non-working time to the extent that it impairs a trainee’s ability to perform his/her job upon arrival at work, interferes with regular attendance, or threatens the reputation or integrity of UNC Health Care.
   c. Violations of criminal drug statues occurring in the workplace will be reported immediately to Hospitals Police.
   d. Operating a UNC Health Care vehicle or a personal vehicle while on UNC Health Care business while impaired is prohibited.
   e. Trainees who consume alcohol or controlled substances under any circumstances and return to UNC Health Care or resume UNC Health Care activities that work day are subject to evaluation under this policy.
   f. Trainees must not consume alcohol while officially “on call” including “at home call”.
   g. Trainees arrested for DUI must self-report their arrest to their program director (or to the Office of Graduate Medical Education if the program director is not available) no later than the end of the first business day after the arrest. Further, in the event of a DUI arrest, trainees must not report for duty until at least 12 hours have passed from the time of the DUI arrest. Failure to self-report may result in disciplinary action up to and including automatic dismissal for trainees and may result in automatic prohibition from returning to the work place for Visiting Residents.
   h. A trainee convicted of any felony criminal drug or alcohol offense must notify his/her program director and the Office of Graduate Medical Education no later than five (5) calendar days after such conviction. Failure to provide notification may result in disciplinary action up to and including automatic dismissal for trainees and may result in automatic prohibition from returning to the work place for Visiting Residents.
   i. UNC Hospitals, in accordance with North Carolina Physicians Health Program, Employee Assistance Program principles, and the Office of Graduate Medical Education will support the responsible action of an employee seeking help for an alcohol or controlled substance problem. An employee’s efforts to obtain help through his/her department and the Office of Graduate Medical Education will be handled in confidence, to the extent permitted by law.
2. Sanctions for failure to abide by this policy include, but are not limited to:
   a. Removal from the workplace;
   b. Corrective action, if appropriate, up to and including dismissal from training;
   c. Referral for criminal prosecution, if appropriate;
   d. Reporting to licensing agencies or boards;
   e. Referral to the Office of Graduate Medical Education and the NC Physicians Health Program for UNC Health Care residents and subspecialty residents and the ComPsych UNC Health Care’s EAP program for other trainees appointed through the Office of Graduate Medical Education; and
   f. Other action as deemed appropriate by UNC Health Care officials;
   g. All trainees who test positive in a second drug or alcohol test shall be dismissed. Any trainee who is permitted to return to training at the workplace after a positive drug or alcohol test and who tests positive in a second drug or alcohol test shall be prohibited from ever returning to the training program or the workplace.

3. All individuals performing duties at UNC Health Care have a duty to immediately report observed and suspected violations of this policy to their supervisor, department management, or attending physician.

4. Gifts of alcohol received on the UNC Health Care premises should not be opened and should be taken off the premises as soon as possible.

Definitions

Controlled Substances – Include, but are not limited to, marijuana, opiates, amphetamines, barbiturates, heroin, and similar drugs whose possession and use are prohibited under state or federal law; prescription drugs unless validly prescribed by an employee’s physician and used as prescribed; so-called “designer drugs,” “look-alikes,” synthetic drugs, and similar substances; and other substances whose use may be abused although they are available legally (such as cough syrup and other over-the-counter medications, and substances not intended for human consumption (such as glue)).

Positive Test – Positive results from testing for the presence of controlled substances or an unacceptable level of alcohol or legally-prescribed drugs. For illicit substances, any positive test of a controlled substance in its pure form or its metabolites at or above the specified cutoff levels (Appendix 7) violates this policy. For alcohol, any positive test of at least 0.02 violates this policy.

Impaired – State of an individual who is affected by consumption of alcohol, or controlled substances, or personal stress, or medical condition as determined by a physician. Individuals taking medications prescribed by a physician or over-the-counter medications should adhere to the terms of the prescription and to any activity restrictions recommended by the physician or manufacturer.
Controlled substance examination – Any and all actions related to testing conducted for the purpose of determining if an individual has recently used or is using controlled substances or alcohol.

Screening – Initial examination performed for the purpose of assessing impairment.

Fit for Duty Testing Categories

A. Pre-Employment/Pre-Service Substance Testing

Substance abuse testing will be conducted on all trainees to whom an offer of appointment to Graduate Medical Education and employment has been made and to other trainees appointed or employed through the Office of Graduate Medical Education. All appointments and offers of employment are subject to the terms and conditions of this policy. Failure to cooperate in such a test will result in a withdrawal of the appointment or offer of employment. Any trainee who refuses to submit to or tampers with a controlled substance/alcohol test shall be ineligible for appointment or hire.

If the test is positive, the information will be forwarded to the Office of Graduate Medical Education, NC Physicians Health Program, if appropriate, and a Medical Review Officer for assessment. Unless satisfactory reasons exist for a “positive” test result (e.g., taking prescribed medications, false positive result, etc.), the offer of appointment to Graduate Medical Education or offer of employment for other trainees appointed through the Office of Graduate Medical Education will be withdrawn and the trainee will not be considered for training or employment. A trainee who suspects a false positive test result may request a follow-up test from the split sample. If satisfactory reasons appear for the false positive result, the individual may be subject to follow-up random testing for continued confirmation of appropriate use of medications. Test results will be reviewed in confidence by the Office of Graduate Medical Education, who will convey the results directly to those with a need to know.

Similarly, all individuals, whether they are employees of UNC Health Care or not, will be tested for controlled substances and alcohol prior to providing duties for UNC Health Care. Failure to cooperate in such a test, or tampering with such a test, will result in the worker’s employer being advised and the worker being told not to report to duty at UNC Health Care.

If a Visiting Resident tests positive, the information will be forwarded to the Office of Graduate Medical Education for assessment. Unless satisfactory reasons exist for a “positive” test result (e.g., taking prescribed medications, false positive result, etc.), the Visiting Resident will not be permitted to return to UNC Health Care and the training will end immediately. The Visiting Resident’s sponsoring institution will be notified. Further action and discussions will be the responsibility of the Visiting Resident’s sponsoring institution.

B. Accident-Related Testing

• Motor Vehicle Accident – A trainee who is the driver and is involved in a motor vehicle accident while on duty or on UNC Health Care business is responsible for immediately notifying his/her Program Director and the Office of Graduate Medical Education. A trainee who is a driver involved in a motor vehicle accident as described above shall be escorted to or shall report to Occupational
Health (or the ED after hours) for a fitness for duty assessment and, if appropriate, substance abuse.

- Unsafe Act – A trainee who is involved in an unsafe act resulting in harm or personal injury to self, a patient, a visitor, or a co-worker, or whose unsafe act results in damage to UNC Health Care property, under circumstances raising reasonable suspicion that the trainee is not fit for duty, shall be escorted to or shall report to Occupational Health (or the ED after hours) for a fitness for duty assessment and, if appropriate, substance abuse testing.

- Post-accident alcohol testing should be done within two (2) hours of the accident. If a test cannot be done within eight (8) hours, it should not be done. However, a sample of blood should be saved if consent for the testing cannot be obtained within the eight-hour period so that the trainee has a chance to consent at a later period.

- Post-accident controlled substances testing must be done within twenty-four (24) hours of the accident. If a test cannot be done within twenty-four hours, it should not be done. However, a sample of blood should be saved if consent for the testing cannot be obtained within the twenty-four-hour period so that the trainee has a chance to consent at a later period.

- If these timelines are not met because of the individual’s recalcitrance or refusal to be timely tested, s/he will be subject to the consequences of a positive test result.

C. Reasonable Suspicion Testing
Reasonable suspicion that a trainee is impaired may be based upon indicators such as the following:

1. Direct observation by anyone and corroborated by a supervisor or designee of a trainee’s abnormal, erratic, or otherwise problematic behavior, which may include, but is not limited to, difficulty with concentrating, confusion, tears, combativeness, holding onto objects for support, less than coherent speech, severe mood swings, overreactions to real or imagined criticism, safety violations, careless or reckless operation of equipment, actions inappropriate to the circumstances, chronic absenteeism, and reporting to work in an otherwise abnormal condition.

2. Direct observation by anyone and corroborated by a supervisor or designee of a trainee’s use of possession of a prohibited or restricted substance while on duty or on UNC Health Care business.

3. Suspicion of drug diversion based on a report of suspected drug diversion by pharmacy investigation, unit report, or hospital police investigation.

The timelines set forth in the preceding section should be observed for testing based on reasonable suspicion.

Fit for Duty Procedures
The following procedures shall be followed in each instance of violation of this policy.

The Program Director/designee shall:
• Document problematic behavior by completing the “Request for FFD Assessment Form” (see Appendix 1).

• Explain to the trainee why his/her behavior necessitates a fit for duty evaluation.

• During regular business hours, bring the “Request for FFD Assessment Form” to the Office of Graduate Medical Education and to OHS and escort the trainee to OHS.

• During non-business hours, bring the “Request for FFD Assessment Form” to the Emergency Department and escort the trainee to the Emergency Department. [See After Hours Screening Protocol.] If the UNC HCS location if off campus, such as WakeMed, the supervisor/manager should contact our EMSI Emergency Services Hotline at 1.800.421.3674 and provide the following information to the coordinator who answers the call:
  ▪ Identify company name UNC Healthcare
  ▪ Provide EMSI account number 284570000
  ▪ Provide your name
  ▪ Provide a telephone number with area code where you can be reached
  ▪ Reason for your call (i.e., post-accident situation, reasonable cause, etc.)(
  ▪ City and State where the incident occurred.

• The EMSI Emergency Coordinator will contact the appropriate EMSI facility and arrange to have one of their EMSI Technicians go to the collection site. At that time, the EMSI Emergency Coordinator will provide the caller with an estimated time of arrival. The caller is responsible for providing the EMSI Coordinator with a designated location meeting the following criteria:
  ▪ Restroom facilities with separate toilet and running water (with restriction capabilities) during the course of collection.
  ▪ A facility with an available electrical outlet.
  ▪ A telephone for notification purposes should positive test results occur.

A member of OHS shall:
• Review the reason for the FFD assessment (reasonable suspicion), which requires contacting an attorney in the UNC health Care Legal Department by calling 919-966-3041 during regular business hours or the attorney on call after regular business hours at 919-216-0813.

• Explain that testing for controlled substances/alcohol is a required part of the FFD assessment.

• Explain that the trainee will be on paid administrative leave until the test results are received by the Medical Director of OHS/Medical Review Officer and a decision is made as to whether the trainee can return to work. Visiting Residents will be returned to their home institutions.

• Explain that the Medical Director of OHS/MRO shall contact the trainee at the telephone number on the consent form upon receipt of the test results.

• Describe the importance of cooperating with the collection site personnel.

• Describe the limited confidentiality of individual test results.

• Describe the consequences of refusing to sign the consent form, failing to submit to testing, failing to report for a specimen collection, tampering or attempting to
tamper with a sample or test, failing to communicate with the Medical Director of OHS/MRO, or receiving a verified positive test.

- Advise the trainee of the method(s) of testing which may be used and the substances that may be identified.
- Review the “Substance Test Consent Form” (Appendix 2) with the trainee and obtain the trainee’s signature.
- Advise the DIO and Office of Graduate Medical Education that a FFD assessment is being initiated; inform the sponsoring institution of a Visiting Resident that a FFD assessment is being initiated.
- If psychiatric crisis is apparent, OHS will contact the DIO and Office of Graduate Medical Education and arrange for referral to the Crisis Intervention Team and accompany the trainee to the UNC Psychiatric Crisis Clinic.

If the trainee refuses to participate in the FFD Assessment:
OHS shall:

- Advise the trainee that he/she is being placed on paid investigatory suspension due to failure to follow UNC Health Care’s FFD policy. Advise a Visiting Resident that he/she is not on paid investigatory suspension but cannot return to the workplace and that his/her sponsoring institution will be so notified. Suspension of a resident requires notification to the North Carolina Medical Board, but the Graduate Medical Education Office should make this notification.
- Advise the Program Director that the trainee refused to participate in the FFD Assessment.
- Advise the Director of the Office of Graduate Medical Education that the trainee refused to participate in a FFD Assessment.
- Ensure that the trainee has satisfactory transportation to his/her off-site destination. The trainee may leave if capable of safely returning to his/her off-site destination, or the trainee’s Program Director or hospital police may arrange for alternate transportation, if needed. Taxi vouchers will be available, if necessary, to assure safe transport of the trainee.

The Program Director shall:

- Place the UNC Health Care trainee on paid investigatory suspension and the Graduate Medical Education Office will notify the North Carolina Medical Board of the suspension.
- In consultation with the DIO and Director of the Office of Graduate Medical Education, initiate the appropriate corrective action/dismissal from training steps for UNC Health Care trainees.
- If the trainee is a Visiting Resident, the Program Director will provide relevant information to the Visiting Resident’s sponsoring institution and explain that the Visiting Resident’s training has been terminated.

If the trainee participates in the FFD Assessment:
OHS shall:
Administer the FFD assessment, including a standard chemical test panel, following OHS’s internal protocol.

Ensure that the trainee has satisfactory transportation to the off-site destination. The trainee may leave if capable of safely returning to his/her off-site destination, or the trainee’s Program Director or hospital police may arrange for alternate transportation, if needed. Taxi vouchers will be available, if necessary, to assure safe transport of the trainee.

Following screening, advise the Program Director that the trainee has participated in the drug/alcohol test.

Advise the Program Director that the trainee will be on administrative leave until results of evaluation and any pertinent follow-up are completed by the Medical Director of OHS/MRO.

The Program Director and DIO and Office of Graduate Medical Education shall:

- Place the trainee on paid administrative leave pending receipt of FFD assessment. Advise the Sponsoring Institution that the Visiting Resident will not be permitted to return to work unless the results of the test are negative.
- Upon receipt of negative test results (i.e., no alcohol or controlled substances), the trainee will be advised as to when to return to duty.

Duties of the MRO/Medical Director of OHS:

- Advise the trainee and Program Director of the results of the FFD assessment and the chemical test. The MRO/Medical Director of OHS shall advise the trainee that he/she may return to work after coordinating a return-to-work date with the Program Director and Director of the Office of Graduate Medical Education.
- Advise the DIO and Office of Graduate Medical Education of the results of the FFD assessment and chemical test.
- If the MRO/Medical Director of OHS cannot reach the trainee at the designated phone number, the MRO/Medical Director of OHS will make one more attempt the following day. If the second attempt is unsuccessful, the MRO/Medical Director of OHS will so advise the DIO and Office of Graduate Medical Education.
- Note: If other information is identified that impacts the trainee’s ability to return to work, the MRO/Medical Director of OHS may present such information to the Director of the Office of Graduate Medical Education.
- Note: All records surrounding this incident shall be removed from the trainee’s personnel file upon return of negative test results; however, records for all testing done are kept in a confidential OHS file.

Duties of the DIO and Office of Graduate Medical Education:

- If the MRO/Medical Director of OHS has successfully contacted the trainee and the trainee may return to work, the DIO and Office of Graduate Medical Education will so advise the Program Director and have the Program Director arrange with the trainee for the return to work.
- If the MRO/Medical Director of OHS has presented other information that impacts the trainee’s ability to return to work, the DIO and Office of Graduate Medical Education will so advise the Program Director and have the Program Director arrange with the trainee for the return to work.
Medical Education will identify applicable actions and resources that are outside of this procedure.

Duties of the Program Director:
- Upon notification to do so by the DIO and Office of Graduate Medical Education, contact the trainee and coordinate his/her return to work
- Take the trainee off administrative leave, effective the date of the Medical Director of OHS/MRO’s successful contact with the trainee.

Upon receipt of positive test results (i.e., alcohol or controlled substances identified): Duties of the MRO/Medical Director of OHS:
- Advise the trainee of the results of the FFD assessment and the chemical test, including the substance(s) identified.
- If the MRO/Medical Director of OHS cannot reach the trainee at the designated phone number, the MRO/Medical Director of OHS will make one more attempt the following day. If the second attempt is unsuccessful, the MRO/Medical Director of OHS will so advise the DIO and Office of Graduate Medical Education.
- Advise the DIO and Office of Graduate Medical Education of the positive test results, including the substance identified.
- If other information is identified that impacts the trainee’s ability to return to work, the MRO/Medical Director of OHS may present such information to the DIO and Office of Graduate Medical Education.

Duties of the DIO and Office of Graduate Medical Education:
- Advise the Program Director of the FFD assessment, including positive test results and the substance(s) identified.
- In consultation with the Program Director, determine the appropriate response, taking into consideration the guidelines below.
- If appropriate, advise the NC Physicians Health Program of a pending referral.
- If the MRO/Medical Director of OHS has been unable to successfully contact the trainee, the DIO and Office of Graduate Medical Education will advise the Program Director of the FFD assessment results and will advise the Program Director to follow the standard protocol for dismissal from training. If the trainee is a Visiting Resident, the DIO and Office of Graduate Medical Education will advise the Program Director to contact the Visiting Resident’s sponsoring institution to provide the test results and explain that the Visiting Resident’s rotation is no longer approved at UNC Health Care.
- If other information is identified that impacts the trainee’s ability to return to work or participate in customary treatment, the Office of Graduate Medical Education will coordinate other actions/resources outside of this policy, such as an accommodation, sick leave, short term or long term disability, etc.
Guidelines in response to impairment of a UNC Health Care trainee with no prior warnings, either verbal or written, for related issues (Note: These guidelines do not apply to Visiting Residents):

- If a trainee tests positive for alcohol or controlled substance(s), he/she shall, at a minimum, be placed in an educational enhancement plan, and is subject to immediate probation or dismissal from training depending on the circumstances. If placed on educational enhancement or probation, the trainee will be subject to random follow-up testing administered by the NC Physicians Health Program or the Office of Graduate Medical Education, shall successfully complete any return-to-duty requirements monitored by the NC Physicians Health Program, and shall participate in a Return to Work Agreement (Appendix 6) for continued training and employment. The test results will be reported to appropriate licensing organizations, such as the North Carolina Medical Board or Dental Licensing Board, by the Office of Graduate Medical Education. If the licensing organization revokes the trainee’s license, the trainee’s continued appointment with the UNC Health Care will be terminated.

- If a trainee tests positive for a drug where there is indication that such drug has been diverted, the trainee shall be dismissed from training. Such test results/actions will be reported to appropriate licensing organizations, such as the NC Medical Board and Dental Licensing Board, by the Office of Graduate Medical Education.

- A trainee who tests positive for legally prescribed medications will be referred to his/her own physician. The trainee may return to work when the physician provides appropriate information to the DIO and Office of Graduate Medical Education and MRO/Medical Director of OHS.

- If a trainee is identified as impaired due to other medical issues, the MRO will consult with the DIO and Office of Graduate Medical Education to identify appropriate resources.

Guidelines in response to impairment of a trainee with prior warning, either verbal or written, for related issues:

A trainee who tests positive for alcohol or controlled substance(s) after having received any kind of prior warning for related issues shall be dismissed from training.

Return to Work (This section applies only to UNC Health Care trainees.)
The Program Director shall:

- Prepare the Return to Work Agreement, as required, in consultation with the DIO and Office of Graduate Medical Education and the NC Physicians Health Program.
- Review the Return to Work Agreement, if required, with the trainee and obtain the trainee’s signature on it. Refusal to sign a Return to Work Agreement shall result in dismissal from training.
- If required, direct the trainee to meet with the NC Physicians Health Program and explain that the NCPHP will manage and monitor the trainee’s return to work.
- Direct the trainee to arrange a visit to Occupational Health to be released back to work by the Medical Director.
• Direct the trainee to take a copy of the signed Return to Work Agreement to the NC Physicians Health Program.
• Submit one copy of the signed Return to Work Agreement to the Program Director and the Office of Graduate Medical Education.

Incapacity to Consent to Testing
If the trainee, while on duty or on UNC Health Care business, presents in the ED with red alert trauma under circumstances raising reasonable suspicion of controlled substance or alcohol use and is incapable of consenting to testing under this policy, when the trainee regains capacity to consent he/she shall consent to disclosing to his/her Program Director, the DIO, and the Office of Graduate Medical Education the relevant results of any blood or urine screens obtained during his/her treatment pursuant to the UNC Hospitals policy “Routine Lab Diagnostics for Trauma Alert” (see Appendix 8). Refusal to consent to disclosure will be treated in the same manner as refusal to consent to testing as described elsewhere in this policy.

Shy Bladder or Inability to Provide a Sufficient Quantity of Urine
If the individual is unable to provide a sufficient quantity of urine for testing, the collection site person shall instruct the donor to drink not more than 40 ounces of fluids and, after a period of no longer than two (2) hours, again attempt to provide a complete sample using a fresh collection container. If the donor is still unable to provide a sufficient quantity of urine, then blood testing should be done.

Counseling and Rehabilitation
It has been recognized and accepted that early treatment is a key to rehabilitation for substance abusers. Trainees are encouraged to voluntarily request counseling or rehabilitation. No trainee will have job security jeopardized by a request for counseling or assistance, which requests are strictly confidential; however, a trainee will not avoid corrective action for policy violations which have already occurred or that may occur during or after counseling or rehabilitation. Requests for paid leave or time off without pay in order to participate in approved counseling and rehabilitation programs will be considered on a case-by-case basis. NCPHP is available to provide referral services.

Work time lost due to counseling or rehabilitation will be paid according to eligibility for Graduate Medical Education leave policies, as appropriate, and short-term and long-term disability benefits.

Access to Records and Confidentiality
The following requirements are intended to protect the rights of trainees and to provide the federal government and others access as needed for oversight purposes.
• Except as required by law, UNC Health Care will not externally release information contained in any of the records of controlled substance and alcohol testing.
• Upon written request, a trainee can obtain copies of his/her testing records.
• UNC Health Care must provide test results to the federal government, upon request, if required under the Drug Free Workplace Act, or to any other state or federal officials with regulatory authority over UNC Health Care who have a statutory right to such results.
• Testing records will be provided to a trainee’s future employer only upon written authorization of the trainee.
• UNC Health Care can disclose testing records to a decision-maker in a lawsuit, grievance, or other proceeding initiated by or on behalf of the trainee that arises from test results or the violation of either alcohol or controlled substance prohibitions.
• UNC Health Care can disclose testing records to others not specifically listed above only upon written authorization of the employee, or as permitted under North Carolina law.

All UNC Health Care Property Subject to Search
UNC Health Care declares that offices, desks, files, lockers, computers, cabinets, and other stationary containers provided by UNC Health Care are not private areas, and shall not be treated as private areas. Therefore, UNC Health Care may search an office, desk, file, locker, computer, cabinet, or other stationary container provided by UNC Health Care.
APPENDIX 1
REQUEST FOR FIT FOR DUTY ASSESSMENT FORM

This form should always accompany a request for substance screening.

<table>
<thead>
<tr>
<th>Trainee Name</th>
<th>UNC Health Care Medical Record #</th>
</tr>
</thead>
<tbody>
<tr>
<td>Department</td>
<td>Date: _________________________</td>
</tr>
<tr>
<td>Program Director</td>
<td>Program Director phone #:</td>
</tr>
<tr>
<td>Date of Observation</td>
<td>Time of Observation:</td>
</tr>
</tbody>
</table>

**Please check all that apply**

1. **Odor of alcohol present?**  
   Yes ______ No ________

2. **Changes in behavior?**  
   Slurred speech ______ Stumbling/falling ______  
   Falling asleep at work ______ Confusion ______  
   Inattention to personal hygiene _____________  
   Sudden changes in mood ________________  
   Excessive crying ______ Anger ______________  
   Loud speech patterns ______ Withdrawn __  
   Disruptive ____________________________  
   Other ____________________________  
   Explain: ________________________________

3. **Errors in work judgment?**  
   Safety violations _____________  
   Careless operation of equipment ________  
   Other ____________________________  
   Explain: ________________________________

4. **Motor Vehicle accident while conducting hospital business?**  
   Type of vehicle involved:  
   UNC HC vehicle _____ Personal vehicle _____

5. **Injury or incident causing personal injury requiring hospitalization?**  
   Explain: ________________________________

6. **Suspicion of drug diversion?**  
   Explain: ________________________________

7. **Post Rehabilitation testing?**  
   Explain: ________________________________

**Additional comments:** ________________________________

Disposition of trainee - (circle one) home, hospitalized, returned to work

Program Director/Designee (print name) __________________________  Date

Signature of Program Director/Designee ____________________________

Corroborating Supervisor/OHS (print name) ________________________  Date

Signature of Corroborating Supervisor/OHS ________________________
APPENDIX 2

SUBSTANCE TEST CONSENT FORM

Part 1 – Completed by Representative of Occupational Health Services or Emergency Department

☐ I have explained to the trainee the reason for the FFD assessment based on the behaviors/circumstances indicated on the Request for FFD Assessment Form.
☐ I have explained that testing for alcohol and controlled substances is a required part of the FFD assessment.
☐ I have explained that the trainee will be on paid administrative leave until test results are received by the Director of Occupational Health/Medical Review Officer. (I have explained to a Visiting Resident that he/she will not be on paid administrative leave until test results are received, but cannot return to the workplace unless negative test results are received.)
☐ I have explained that the Director of Occupational Health/Medical Review Officer will contact the trainee at the telephone number indicated below upon receipt of the test results.
☐ I have explained that failure to cooperate with the collection site personnel is considered a violation of this policy and will result in dismissal from training.
☐ I have explained the limited confidentiality of the test results, i.e., the test results may be communicated to the trainee’s Program Director, the DIO, and the Office of Graduate Medical Education or designees, or others on a need to know basis.
☐ I have explained that refusing to sign the consent form, failing to submit to testing, failing to report for a specimen collection, tampering or attempting to tamper with a sample or test, failing to communicate with the Director of Occupational Health/MRO will result in dismissal from training. I have explained that a positive test will result in disciplinary action up to and including dismissal.
☐ I have explained the method(s) of testing which may be used and the substances that may be identified.

(Name) ____________________________ (Date) ____________________________

Part 2 – Completed by trainee

I, ________________________________, do hereby give my consent to UNC Health Care to collect from me a sample of
☐ urine
☐ blood
☐ other (specify ____________________________)
I further give my consent to UNC Health Care to forward the sample(s) to an approved laboratory for the performance of appropriate tests thereon to screen for the presence of drugs, alcohol, or other substances.

I furthermore give the approved laboratory my permission to release the results of such testing to UNC Health Care’s Occupational Health Services, the DIO, the Office of Graduate Medical Education and also to release the results of such testing to:

For UNC Health Care Trainees:

I also understand that, if I refuse to consent to testing, I will automatically be placed on paid investigatory suspension while my training status is being considered, and my suspension will be reported to the North Carolina Medical Board.

Trainee Signature

Witness Signature

Date

Date

Trainee EID

Trainee Telephone Number
**APPENDIX 3**

**AFTER HOURS DRUG SCREENING PROTOCOL**

The following steps should be taken when a trainee is suspected of being impaired during work hours or when a trainee has had a motor vehicle accident while on UNC HCS business either in a state-owned vehicle or their personal vehicle and such accident falls within the parameters described above, and when the Department of Occupational Health Services (OHS) is unavailable (i.e. nights, weekends, holidays):

- Employees/trainees who believe that a co-worker’s behavior is impaired or suggests substance/alcohol use must report their observations to an attending physician immediately. If the attending physician also observes the described behavior, the attending physician, or designee to whom the report is made, will complete the “Request for Fit for Duty Assessment Form” and will relieve the trainee of his/her duties.

- If the trainee is located offsite, such as at WakeMed, the protocols/procedures in Appendix 9, EMSI Procedures, should be followed, in addition to obtaining the “Request for Fit for Duty Assessment Form,” obtaining approval from the legal department (attorney on call), obtaining the signature of the trainee on the Consent for Substance Abuse testing form, and making sure the trainee has safe transport home.

- If the trainee is located onsite, the attending physician, UNC Hospitals Police, house supervisor or Department head, will escort the trainee to the Emergency Department (ED). The completed “Request for Fit for Duty Assessment Form” will be provided to the triage nurse or attending physician in the ED.

- The attending physician, UNC Hospitals Police, or house supervisor obtains approval for reasonable suspicion testing by calling an attorney in the UNC health Care Legal Department (919-966-3041) or paging the attorney on call after regular business hours (919-216-0813).

- Prior to any substance testing, the trainee must sign the Consent for Substance Abuse testing form. If this consent is not signed, the trainee may not be tested. An original of the signed consent form must be included in the package sent to OHS.

- The ED physician will evaluate the trainee. The physician should provide diagnosis and care for all diseases/illnesses as appropriate.

- The physician, after making sure informed consent has been obtained from the trainee, will order urine tests #764875 and #761141 based on OHS guidelines (See Lab tests to be ordered per Protocol; Appendix 4) using pre-printed orders, or blood testing as appropriate.

- The attending physician or designee will be responsible for obtaining the informed consent from the trainee, obtaining the appropriate urine/blood specimens, completing the “Chain of Custody” form and transferring the COC form and evidence to Hospital Police (see Procedure for Collection, Appendix 5). If the trainee refuses to consent to testing, the attending physician or designee will advise the trainee that he/she is being placed on paid investigatory suspension due to failure to follow UNC Health Care’s FFD policy. The attending physician or designee will also notify UNC Health Care Police. If the trainee is a Visiting Resident and refuses to consent to testing, the attending physician will provide relevant information to the Program Director and Office of Graduate
Medical Education. The Program Director will explain to the Visiting Resident and the Visiting Resident’s sponsoring institution that the Visiting Resident’s training at UNC Health Care is no longer approved.

- The house supervisor will fax a copy of the “Request for Fit for Duty Assessment Form” to the Medical Director of OHS at 966-6326.
- UNC Health Care Police will be responsible for maintaining chain of custody of all specimens taken for testing. Such specimens will be placed in the locked refrigerator in OHS for transport to a testing facility the next working day.
- The trainee’s supervisor or the UNC Health Care Police will be responsible for arranging safe transport home for the impaired trainee.
- The trainee will remain out of the workplace on paid administrative leave pending completion of lab testing. A Visiting Resident will remain out of the workplace until a negative test result is received.
APPENDIX 4

LAB TESTS TO BE ORDERED PER PROTOCOL

(Test packets are available in the Nursing supervisor office, UNC Hospitals, and ED supervisor office):

<table>
<thead>
<tr>
<th>Test#</th>
<th>Blood/Urine</th>
<th>Amount needed</th>
</tr>
</thead>
<tbody>
<tr>
<td>764875 MedPro Profile</td>
<td>Urine</td>
<td>45ml Urine collection Container (split Specimen)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Test#</th>
<th>Blood/Urine</th>
<th>Amount needed</th>
</tr>
</thead>
<tbody>
<tr>
<td>761141</td>
<td>Urine</td>
<td>May be included in above urine sample</td>
</tr>
</tbody>
</table>

Additional blood testing is available per the discretion of the OHS Medical Director. The above urine tests are to be used for all reasonable suspicion and post-accident screening.

**Blood Testing Protocols**

<table>
<thead>
<tr>
<th>Test#</th>
<th>Test</th>
<th>Blood/Urine</th>
<th>Amount needed</th>
</tr>
</thead>
<tbody>
<tr>
<td>#791722 5-test screen</td>
<td>Amphetamines, Cannabinoids, Cocaine, Opiates, Phencyclidine (PCP)</td>
<td>Blood-20mls Serum sep. tubes</td>
<td></td>
</tr>
<tr>
<td>#799700</td>
<td>Amphetamines, Cocaine, Cannabinoids, Opiates, Phencyclidine (PCP), Alcohol</td>
<td>Urine</td>
<td></td>
</tr>
<tr>
<td>#791590 8-test screen</td>
<td>Amphetamines, Barbituates, Benzodiazepines, Cannabinoids, Cocaine, Opiates, Phencyclidine (PCP)</td>
<td>Blood-20mls Serum sep. tubes</td>
<td></td>
</tr>
<tr>
<td>#017996</td>
<td>Bld Ethanol (Alcohol) level</td>
<td>Blood-10ml Serum sep. tube</td>
<td></td>
</tr>
</tbody>
</table>
APPENDIX 5

PROCEDURE FOR COLLECTION:

1. Complete Chain of Custody form and include:
   - Donor EID or PID
   - Reason for testing: “post-accident” or “reasonable suspicion”
   - Daytime and evening phone number of donor
   - Test requested. Check each test that is being requested. Failure to identify the tests will result in delay of testing at the laboratory.

2. Obtain urine specimen from donor
   - Check specimen temperature (urine) within 4 minutes of collection
   - Mark temperature of specimen on COC form (step 3)
   - Affix numbered labels to specimens across the top of the specimen – large label is for outside of collection bag. Use “A” AND “B” labels for urine samples. Be sure that the collector dates the seals and the donor initials the seals.
   - Check appropriate tests to be done. (Standard protocol is #764875 drug profiles and #761141 fentanyl)
   - If blood tests are done, make a label marked “C” and affix to the top of the of the specimen. Use betadine, not alcohol, to swab the site for venipuncture.

3. Collector signs and dates the COC form (step 5)
   The collection site location is:
   UNC OCCUPATIONAL HEALTH SERVICE
   101 MANNING DRIVE, CHAPEL HILL, NC  27514
   919-966-4480

4. Donor completes COC form with printed name, signature, initials and date (step 7).

5. Collector gives specimen and COC form to UNC Hospitals Police and signs form to transfer the specimen (step 6).

6. The COC forms are to remain with the specimen but should be accessible for transfer to LabCorp courier (KEEP THE COC FORM IN THE OUTSIDE UNSEALED POUCH OF THE SPECIMEN BAG).

7. UNC Hospitals Police receive specimen and COC form, sign for transfer (step 6) and put specimen into OHS locked refrigerator (PUT SIGN ON FRIDGE).

8. Specimen is sent to lab for testing by OHS staff the next business day.
9. Results of testing will be reported to the Medical Director of Occupational Health/MRO who will then notify the DIO and Office of Graduate Medical Education.

10. Trainee will be given results of testing by Medical Director/MRO or designee of OHS.
APPENDIX 6
RETURN TO WORK AGREEMENT

I, __________________________, hereby acknowledge that I have violated UNC Health Care’s Fit for Duty Policy. I recognize my obligation to meet appointment standards of UNC Health Care to maintain my eligibility for appointment. Therefore, I agree to satisfactorily participate in any evaluation, treatment, assistance, or counseling programs required. I also agree to refrain from consuming alcohol such that I will still be affected by it when I report to duty, and I agree to abstain from drugs unless medically prescribed.

I understand that I am responsible for providing a request for FMLA leave, which must include a start date and end date for treatment, if required. The request for FMLA leave must be signed by a health care provider at the selected treatment facility by a person who is knowledgeable regarding the length of my treatment program. My absence due to treatment or related follow-up will be managed in accordance with the provisions of the FMLA and UNC Health Care’s Graduate Medical Education Office Leave Policy, i.e., I am responsible for exhausting any benefit time that I have accrued, and when my benefit time is exhausted, I will be on unpaid FMLA leave (if eligible). Failure to return to work at the completion of treatment will result in dismissal from training.

Further, when requested by UNC Health Care officials, I agree to submit to periodic unannounced drug/alcohol testing for two years from today’s date, or until the end of my training program if less than two years remain, and to cooperate with other investigative requests including, but not limited to, interviews and searches.

I further consent to release to the UNC Health Care Occupational Health Office, the North Carolina Physicians Health Program, DIO, Office of Graduate Medical Education and to my Program Director information concerning my participation in treatment and abstinence from drugs and alcohol, to the extent that I will still be affected by it when I report to duty, and/or related information.

I understand that refusal or failure to submit to a drug/alcohol test or a positive finding on such test shall be cause for immediate dismissal from my training program because of failure to meet UNC Health Care policies as well as the terms of this Agreement. I further understand that failure or refusal to cooperate with the terms of this Agreement or other violations of UNC Health Care’s Fit for Duty Policy will be cause for disciplinary action up to and including dismissal from training.

I understand and agree to the above terms and conditions of appointment, and I understand that I am also responsible for complying with all other UNC Health Care Graduate Medical Education Office rules and standards, including expected levels of job performance and attendance. I acknowledge that this Agreement does not constitute a contract or promise of appointment.

I understand that trainees undergoing rehabilitation or who have completed rehabilitation are required to abide by all UNC Health Care and Graduate Medical Education Office rules and standards, including expected levels of job performance.

Trainee Signature

_________________________________________

Date

____________________________

DIO Signature

Date
<table>
<thead>
<tr>
<th>Drug</th>
<th>LabCorp Standard Screening Cut-off Level</th>
<th>LabCorp Standard GC/MS Confirmation Cut-off Level</th>
<th>Detection Time in Urine</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>STIMULANTS</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Amphetamine</td>
<td>1000 ng/mL</td>
<td>500 ng/mL</td>
<td>1 to 2 days</td>
</tr>
<tr>
<td>Also known as: speed&lt;br&gt;Pharmaceutical names: Dexedrine, Benzedrine</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Methamphetamine</td>
<td>1000 ng/mL</td>
<td>1000 ng/mL</td>
<td>1 to 2 days</td>
</tr>
<tr>
<td>Also known as: speed, ice, crystal, crank&lt;br&gt;Pharmaceutical names: Desoxyn, Methedrine</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MDMA (Methylendioxymethamphetamine)</td>
<td>500 ng/mL</td>
<td>250 ng/mL</td>
<td>1 to 2 days</td>
</tr>
<tr>
<td>Also known as: ecstasy, XTC, ADAM, lover’s speed</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cocaine</td>
<td>300 ng/mL</td>
<td>150 ng/mL</td>
<td>2 to 4 days</td>
</tr>
<tr>
<td>Also known as: coke, crack, rock cocaine</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>HALLUCINOGENS</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Marijuana/Cannabinoids</td>
<td>50 ng/mL</td>
<td>15 ng/mL</td>
<td>Single use: 2 to 7 days&lt;br&gt;Prolonged use: 1 to 2 months</td>
</tr>
<tr>
<td>Also known as: dope, weed, hemp, hash, Colombian, sinsemilla&lt;br&gt;Pharmaceutical name: Marinol</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Phencyclidine</td>
<td>25 ng/mL</td>
<td>25 ng/mL</td>
<td>14 days&lt;br&gt;Up to 30 days in chronic users</td>
</tr>
<tr>
<td>Also known as: PCP, angel dust</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>NARCOTICS/ANALGESIC/OPiates</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Codeine</td>
<td>2000 ng/mL</td>
<td>2000 ng/mL</td>
<td>2 days</td>
</tr>
<tr>
<td>Morphine and/or Heroin</td>
<td>2000 ng/mL</td>
<td>2000 ng/mL</td>
<td>2 days</td>
</tr>
<tr>
<td>Heroin also known as: smack, tar, chasing the tiger&lt;br&gt;Pharmaceutical names: Duramorph, Roxanol</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Methadone</td>
<td>300 ng/mL</td>
<td>300 ng/mL</td>
<td>3 days</td>
</tr>
<tr>
<td>Also known as: fizzies&lt;br&gt;Pharmaceutical names: Amidone, Dolophine</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Propoxyphene</td>
<td>300 ng/mL</td>
<td>300 ng/mL</td>
<td>6 hours to 2 days</td>
</tr>
<tr>
<td>Pharmaceutical names: Darvon, Darvocet, Novopropoxyn</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>DEPRESSANTS/SEDATIVES/HYPNOTICS</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Barbiturates</td>
<td>200 ng/mL</td>
<td>200 ng/mL</td>
<td>Short acting: 2 days</td>
</tr>
<tr>
<td>Also known as: downers, bars, goof balls, reds, yellow jackets&lt;br&gt;Pharmaceutical names: Amobarbital (Amytal), Butalbital (Fiorinal), Pentobarbital (Nembutal), Phenobarbital (Donnatal), Secobarbital (Seconal)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Benzodiazepines</td>
<td>200 ng/mL</td>
<td>200 ng/mL</td>
<td>Therapeutic dose: 3 days&lt;br&gt;Extended dosage or chronic use (1 or more years): 4 to 6 weeks</td>
</tr>
<tr>
<td>Also known as: bennies&lt;br&gt;Pharmaceutical names: Diazepam (Valium), Oxazepam (Serax), Chlorazepoxide (Librium), Alprazolam (Xanax), Chlorazepate (Tranxene), Temazepam (restoril)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ethyl Alcohol</td>
<td>0.02% (20 mg/dL)</td>
<td>0.02% (20 mg/dL)</td>
<td>In urine: 1 to 12 hours&lt;br&gt;In serum and plasma: 1 to 12 hours</td>
</tr>
<tr>
<td>Also known as: liquor, distilled spirits, beer, wine, booze, hooch&lt;br&gt;Pharmaceutical name: Ethanol</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## Specimen Validity Testing

<table>
<thead>
<tr>
<th>Validity Marker</th>
<th>Commercial Product</th>
<th>Method of Introduction to Urine</th>
<th>Mode of Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Creatinine</td>
<td>N/A</td>
<td>In vivo, or in vitro, this substance is always present in urine but is used to indicate dilute or substituted specimens.</td>
<td>Creatinine is excreted from the body at a constant rate and there are expected values for creatinine in urine. When abnormally large quantities of fluids are consumed (in vivo), the urine becomes dilute and the creatinine levels are substantially reduced, as well as other urine constituents including drugs and their metabolites. Alternately, a donor may try to beat a test by adding water to the urine cup (in vitro) to dilute the drug level. Creatinine levels are used in conjunction with a specific gravity determination to identify the specimen as dilute or substituted.</td>
</tr>
<tr>
<td>Nitrites</td>
<td>Klear, Whizzies</td>
<td>In vitro, donor adds potassium nitrite to urine in collection cup</td>
<td>Nitrites are also oxidizing agents that attach the drug molecules when present at high concentrations. The key effect of nitrites is, when present, they will interfere with the GC/MS confirmation of a cannabinoid positive.</td>
</tr>
<tr>
<td>pH</td>
<td>N/A</td>
<td>In vivo by ingestion of materials that would change the urinary pH outside of a normal range (next to impossible), or in vitro, where the donor adds a substance to the urine to modify the pH of the specimen dramatically.</td>
<td>The pH of the sample may influence enzymatic test methods used in drug screening. An extreme pH, either very high (&gt;11) or very low (&lt;3) may depress the enzyme rate. Another influence is that extreme pH conditions may adversely affect the stability of the drug being tested, and the drug may not be detectible during retest or confirmation.</td>
</tr>
<tr>
<td>Specific Gravity</td>
<td>N/A</td>
<td>In vivo, donor consumes large quantities of liquids, or in vitro, the donor adds something to the urine in the cup.</td>
<td>Normal urine has an expected range of specific gravity values. When donors consume large quantities of liquids to dilute their urine, their urine specific gravity may dip to low levels.</td>
</tr>
</tbody>
</table>

**NOTE:** Many variables may affect duration of detectability, such as drug metabolism and half-life, subject’s physical condition, fluid balance and state of hydration, and route and frequency of ingestion.

**NOTE:** Tests for other substances will be made if appropriate.
APPENDIX 8

UNIVERSITY OF NORTH CAROLINA HOSPITALS
LEVEL 1 TRAUMA CENTER

A. RED alert initial routine labs:
1) ABG w/Hemoglobin and lactate
2) CBC w/differential
3) Electrolytes (Na, K, Cl, CO₂, Glucose, BUN, Creatinine)
4) PTT/APTT
5) PT including INR
6) Urine Pregnancy (females > age 11)
7) Urinalysis
8) Blood Alcohol Screen (patients > age 12 unless indicated)
9) Urine Toxicology Screen (patient > age 12 unless indicated)
10) Type and Screen

B. Labs/Order when indicated:
1) Amylase & Lipase
2) Cardiac Enzymes
3) Other labs as indicated, including type and cross

C. YELLOW alert initial routine labs (FOR INTUBATED YELLOW ALERT PATIENTS PLEASE DO RED ALERT LAB PANEL):
1) CBC with differential
2) Electrolytes (Na, K, Cl, CO₂, Glucose, BUN, Creatinine)
3) PTT/APTT
4) PT including INR
5) Urine pregnancy (females > age 11)
6) Blood alcohol screen (patients > age 12 unless otherwise indicated)
7) Urinalysis
8) Urine Toxicology Screen (patients > age 12 unless otherwise indicated)
9) Type and screen unless cancelled by trauma resident

Reviewed and Approved by GMEC: 9/17/08
Reviewed and Approved by MSEC: 10/13/08
Reviewed and Approved by GMEC: 3/16/11
Reviewed and Approved by MSEC: 4/11/11
GMEC Approval: August 21, 2013
MSEC Approval: September 9, 2013
APPENDIX 9

EMSI Procedures

24-Hour Emergency Service Procedures
1. Call the EMSI Emergency Service Hotline at 1.800.421.EMSI (3674). An EMSI Emergency Coordinator will answer the phone and request that the caller provide the following information:
   - Identify company name UNC Healthcare
   - Provide EMSI account number 284570000
   - Provide your name
   - Provide a telephone number with area code where you can be reached
   - Reason for your call (i.e., post-accident situation, reasonable cause, etc.)
   - City and State where the incident occurred

2. The EMSI Emergency Coordinator will then ask for more detailed information as follows:
   - Nature of the request
   - Number of individuals to be testing
   - Location of incident and location of testing
   - Services to be performed (drug screen, alcohol screen, DOT or non-DOT)
   - Availability of appropriate collection supplies
   - Additional contact names and phone numbers

3. The EMSI Emergency Coordinator will contact the appropriate EMSI facility and arrange to have one of our EMSI Technicians go to the collection site. At that time, the EMSI Emergency Coordinator will provide the caller with an estimated time of arrival.

4. In the event of an on-site collection, the caller is responsible for providing the EMSI Coordinator with a designated location meeting the following criteria:
   - Restroom facilities with separate toilet and running water (with restriction capabilities) during the course of collection.
   - A facility with an available electrical outlet.
   - A telephone for notification purposes should positive breath alcohol test results occur.
   - The facility management must be in agreement to utilize the facility for the purpose of specimen collection and/or breath alcohol testing.

EMSI Personnel will be unable to provide the following:
   - “Roadside” testing is not permitted. Only facilities with the above listed requirements are acceptable.
   - Donor transportation (either in an EMSI staff persons’ vehicle, or ride with a donor in their own personal vehicle)
• Perform services at roadside “rest areas,” or any other facility at which the safety of EMSI personnel is perceived to be in jeopardy.

Important Note:
• Any emergency services occurring during normal business hours, 8:00 am – 5:00 pm, Monday through Friday, may be completed as an in-office emergency collection at the closest EMSI facility.
• All emergency services occurring after 5:00 pm and before 8:00 am and all weekend services are performed on a mobile basis.

GMEC Approval: August 21, 2013
MSEC Approval: September 9, 2013
GMEC Approval: September 17, 2014
MSEC Approval: October 13, 2014
POLICY AND PROCEDURE
UNIVERSITY OF NORTH CAROLINA HOSPITALS
GRADUATE MEDICAL EDUCATION
POLICY ON INTERNATIONAL ROTATIONS

POLICY:

All international rotations must receive approval from: 1) the Resident/Subspecialty Resident’s Program Director; 2) the department chair; and 3) the Office of Graduate Medical Education before a resident is able to participate in the rotation. International resources must also receive prior RRC/ACGME approval, as appropriate.

I. All requests for international rotations must meet the following criteria for approval:

A. The rotation must have educational value that cannot be obtained at UNC Hospitals or through an affiliation agreement with a rotation site in the United States;

B. The rotation must be of excellent educational quality;
C. The goals and objectives of the rotation must meet RRC/ACGME applicable Institutional, Common, and Specialist-specific program requirements, and a copy of the goals and objectives must be attached to the special projects application;

D. A copy of the curriculum (service and educational), and list of core and miscellaneous responsibilities should also be included; and

E. A letter from the program director stating whether or not the resident will received credit for this rotation and procedure/case logs from this rotation toward completion of the program. If full credit will not be given, this letter must outline the terms of the extension of the period of training that will be required for completion of the program.

II. During approved rotations Residents/Subspecialty Residents shall abide by the UNC and ACGME/RRC policies, rules and regulations governing their residency programs including, but not limited to, those rules that address duty hours.

III. A Letter of Agreement similar to the sample below is required between UNC Health Care System and the receiving Program/Institution, to include the following:

A. Receiving program/institution accepts responsibility for resident training, supervision, evaluation and staying within ACGME/RRC guidelines on duty hours;

B. The supervising physician(s) at the host institution must have skills sufficient to provide appropriate supervision (i.e. experience with medical education, competencies, etc.); and

C. The resident must complete the Release and Hold Harmless Agreement attached to this policy.

IV. Residents/Subspecialty Residents must provide a full disclosure of their financial support pertinent to their trip (e.g. university, private company grants) as part of the approval process. All trip-related expenses are the responsibility of the resident, unless such expenses are paid by the training program and agreed to prior to the rotation.

V. Residents/Subspecialty Residents participating in elective international rotations must sign a release similar to the sample below absolving the University of North Carolina Hospitals, the University of North Carolina at Chapel Hill, and the University of North Carolina Health Care System, and the respective employees and agents of each from any and all liability in connection with the rotation. The release must include an acknowledgement that the resident has reviewed Consular Information Sheets issued by the United States Department of State and provided by the Office of Graduate Medical Education concerning the country in which the rotation will take place, and that the resident understands and accepts the risks associated with such travel. The release must be witnessed by someone not affiliated with UNC.
VI. Residents/Subspecialty Residents are solely responsible for obtaining travel immunizations, medications, visas, passports, travel insurance (if desired), and meeting other administrative travel requirements. Residents/Subspecialty Residents must provide the Residency Coordinator with an emergency contact in the United States and a means to contact them while out of the country.

VII. Residents/Subspecialty Residents are prohibited from the following:

A. Using any financial resources provided by foundations or companies that have direct ties with pharmaceutical, formula, or biomedical companies;

B. Visiting any country with a U.S. State Department “travel warning”;

C. Engaging in any activities that have direct political, military or religious implications on foreign soil while in training as an UNC resident on an international rotation;

D. Practicing any medical procedures or treatments that clearly contradict the standards of ethical practice in the United States or the program or UNC Health Care System; or

E. Distributing controlled substances as part of a plan of patient care without appropriate authorization in accordance with the laws and regulations of the country in which the rotation takes place.

VIII. After the rotation:

A. Residents must provide the Program Director with a minimum of one evaluation at the end of their trip, using core ACGME competencies and goals and objectives for the rotation. This one competency-based evaluation must be completed by the supervising physician who directly observed the resident in the international location. The resident must also supply a letter of completion from the host institution’s supervising physician in order to receive credit for the rotation; and

B. Residents must provide the Program Director with a report/journal of their activities, functions, achievements, social, medical, and educational impact/contribution at the end of their rotation.
SAMPLE LETTER OF AGREEMENT
BETWEEN
THE UNIVERSITY OF NORTH CAROLINA HEALTH CARE SYSTEM
AND
«FACILITY NAME»

This correspondence is a Letter of Agreement by and between the University of North Carolina Health Care System (“UNC HCS”), for and on behalf of its University of North Carolina Hospitals (“UNC Hospitals”) and its clinical patient care program of the Department of «RESIDENCY PROGRAM DEPARTMENT» of the School of Medicine of the University of North Carolina at Chapel Hill (the “University”), and «FACILITY NAME», concerning activities to be undertaken with «FACILITY NAME» by «RESIDENT(S) NAME(S)», currently a «RESIDENCY PROGRAM NAME» resident with UNC HCS. This Letter outlines the parties’ responsibilities as they relate to the rotation. «RESIDENT(S) NAME(S)» will be assigned to «FACILITY NAME» from the ____ day of __________________, 200__ through the ____ day of __________________, 200__. This experience will provide «RESIDENT(S) NAME(S)» with the opportunity to «SPECIFIC EDUCATIONAL GOAL OF ROTATION».

The specific objectives for this rotation are:

1. 
2. 
3. 

«FACILITY NAME» accepts responsibility for training, supervising, and evaluating «RESIDENT(S) NAME(S)». «FACILITY NAME» shall provide «NAME or TITLE» to serve as site director for «FACILITY NAME» for purposes of this Letter of Agreement and who shall assume administrative, educational and supervisory responsibility for the resident(s) while assigned to «FACILITY NAME». The site director will facilitate communication among the parties and coordinate scheduling and activities of the residents to specific clinical cases and experiences, including their attendance at selected conferences, clinics, courses, and programs. All correspondence regarding schedules will be distributed and communicated with the UNC HCS supervising faculty member. A written evaluation of each resident’s performance will be provided to UNC HCS at the end of the rotation at «FACILITY NAME». «FACILITY NAME» shall provide a sufficient number of attending physicians with documented qualifications (e.g., experience with medical education, competencies) to instruct and supervise the clinical education experiences of all residents rotating to «FACILITY NAME» under this Agreement. «FACILITY NAME» acknowledges and agrees that all patient care will be supervised by qualified «FACILITY NAME» attending physicians.

UNC Hospitals shall maintain responsibility for the quality of the educational experiences and retains authority over the residents’ activities. The Residency Program Director for the Department of «RESIDENCY PROGRAM DEPARTMENT» shall be responsible for overseeing the quality of didactic and clinical education residents will receive at «FACILITY NAME». UNC HCS shall maintain in full force and effect self-insurance professional liability, including medical malpractice, for residents in amounts not less than $100,000 per occurrence, and for itself in amounts not less than required by the North Carolina Tort Claims Act. «FACILITY NAME» shall be responsible for its negligence and the negligence of its employees and agents in accordance with applicable law.

«FACILITY NAME» shall promptly notify UNC HCS of any lawsuit(s) or claim(s) filed by or on behalf of a patient of «FACILITY NAME» against it, its physicians, and its employees, if any, which involve
the services of a resident, at the address below to the attention of Brian Goldstein, MD. In the event of such lawsuit(s) or claim(s), «FACILITY NAME» will provide UNC HCS with any information related to such lawsuits of claim(s) that is reasonably requested by UNC HCS.

In the event that the Accreditation Council for Graduate Medical Education (ACGME) should request information and/or a site visit, the parties will cooperate with ACGME and promptly furnish any information reasonably requested and make the «FACILITY NAME»s’ premises available for reasonable inspection as may be requested by ACGME.

«FACILITY NAME» acknowledges and agrees that UNC HCS residents who are authorized to distribute controlled substances in accordance with «COUNTRY» law in will not be able to distribute controlled substances as part of a plan of treatment of patients at «FACILITY NAME».

«FACILITY NAME» agrees to monitor «RESIDENT(S) NAME(S)’s activities to ensure that «RESIDENT(S) NAME(S)» stays within ACGME/RRC guidelines on duty hours during this rotation. Duty hours are defined as all clinical and academic activities related to the residency program (e.g., patient care, both inpatient and outpatient), administrative duties relative to patient care, the provision for transfer of patient care, time spent in-house during call activities, and scheduled activities such as conferences and must be limited to 80 hours per week, averaged over a four (4) week period, inclusive of all in-house call activities. Duty hours do not include reading and preparation time spent away from the duty site. Duty hours of PGY1 residents must not exceed sixteen hours in duration. Duty periods of PGY2 residents and above may be scheduled to a maximum of twenty-four hours of continuous duty at «FACILITY NAME». However, residents must not be assigned additional clinical responsibilities after twenty-four hours of continuous in-house duty. Moreover, «FACILITY NAME» shall allow for strategic napping, especially after sixteen hours of continuous duty and between the hours of 10:00 p.m. and 8:00 a.m., when appropriate. Adequate time for rest and personal activities must be provided. All residents should have ten hours, and must have eight hours, free of duty between scheduled duty periods. Upper level residents must have at least fourteen hours free of duty after twenty-four hours of in-house duty. Residents must be scheduled for a minimum of one day free of duty every week (when averaged over four weeks). At-home call cannot be assigned on these free days. One day is defined as one continuous twenty-four-hour period free from all clinical, educational, and administrative duties. Residents must not be scheduled for more than six consecutive nights of night float.

In the event that «FACILITY NAME» is a hospital, or in the event that part of this rotation includes on-call coverage, PGY2 residents and above must be scheduled for in-house call no more frequently than every third night (when averaged over a four-week period). PGY1 residents must not take call. Continuous on-site duty, including in-house call, must not exceed twenty-four consecutive hours. Assigned residents may remain on duty for up to six additional hours to participate in didactic activities, transfer care of patients, conduct outpatient clinics, and maintain continuity of medical and surgical care. No new patients may be accepted by assigned residents after twenty-four hours of continuous duty. At-home call must not be so frequent or taxing as to preclude rest or reasonable personal time for each resident. Time spent in the hospital by residents on at-home call must count toward the 80-hour maximum weekly hour limit. The frequency of at-home call is not subject to the every third night limitation, but must satisfy the requirement for one day in seven free of duty, when averaged over four weeks. Residents are permitted to return to the hospital while on at-home call to care for new or established patients. Each episode of this type of care, while it must be included in the 80-hour weekly maximum, will not initiate a new “off-duty period.” Assigned residents taking at-home call must be provided with one day in seven completely free from all educational and clinical responsibilities, averaged over a four-week period. When assigned residents are called into the hospital from home, the hours residents spend in-house are counted toward the 80-hour limit.

Signatures to follow
Please sign this Letter and return one original to UNC HCS for our files. At the end of this rotation, we ask that you provide an evaluation of «RESIDENT(S) NAME(S)>> work on this project by way of a letter to «RESIDENCY DIRECTOR NAME» at the following address:

Thank you for your cooperation.

FOR AND ON BEHALF OF
THE UNIVERSITY OF NORTH CAROLINA HEALTH CARE SYSTEM

FOR AND ON BEHALF OF «FULL FACILITY NAME»

Brian P. Goldstein, MD, MBA, FACP
Executive Vice President and COO
UNC Hospitals
Date: ____________________________

Signature
Title: ____________________________
Date: ____________________________

Address: 101 Manning Drive
CB#7600
Chapel Hill, N.C. 27514

Dept of «SOM DEPARTMENT» Program Director
Date: ____________________________

Site Director
Date: ____________________________

cc: UNC Hospitals Graduate Medical Education Office
101 Manning Drive
1st Floor, 1107-G West Wing
CB#7600
Chapel Hill, N.C. 27514

And

UNC Hospitals Reimbursement/Cost Accounting Department
211 Friday Center Drive
Suite 2104
CB#7600
Chapel Hill, N.C. 27517
RELEASE AND HOLD HARMLESS AGREEMENT
[Program] Residency Special Project

NAME (PLEASE PRINT)

As part of the consideration for being allowed to do my [Program] Residency Special Project in [Location of Rotation], I hereby release, hold harmless, and forever discharge The University of North Carolina Hospitals, The University of North Carolina at Chapel Hill, and The University of North Carolina Health Care System, and the respective employees and agents of each from any and all liability, claims, demands, actions, and causes of action whatsoever arising out of or related to any loss, property damage, or personal injury, including death, that may be sustained by me or to any property belonging to me while I am traveling in connection with this trip.

I understand and acknowledge that, while I have chosen to fulfill this Special Project by gaining exposure to medicine in an international setting, an international special project is not a Residency Review Committee requirement of my [Program] Residency Program, nor does the UNC [Program] Residency Program require me to travel to [Location of Rotation], nor does it require me to obtain my practicum experience in [Location of Rotation]. I understand that I would be able to fulfill this requirement successfully and completely without participating in this trip or these particular activities. I acknowledge that I have been advised against travel to [Location of Rotation] for participation in this activity and that my participation in this activity is elected by me and not required.

I acknowledge, understand and accept the risks of travel in [Location of Rotation], including those listed on the attached Consular Information Sheet issued by the United States Department of State on [Issue Date] (receipt of which is hereby acknowledged), and that it is my responsibility to obtain current safety information on travel to, and within [Location of Rotation] from the U.S. State Department web page http://travel.state.gov/.

I understand that I may be entitled to receive compensation under the North Carolina Workers’ Compensation Act for personal injury I may sustain as a direct result of a specific traumatic incident of the work assigned and/or accident arising out of and in the normal course of the employment, excluding disease in any form, except where it results naturally and unavoidably from the accident. However, I hereby waive any and all claims against UNC Hospitals, UNC at Chapel Hill and UNC Health Care System for any injury I sustain as a result of any act of war, any act of terror, or any act of hostility related to this trip.

I have read and I understand this document, including the release and hold harmless portions of it. I understand and agree that it is binding on myself, my heirs, my assigns, and personal representatives. I acknowledge that I am 18 years old or more.

This the _____ day of ______, 20__.

_________________________ (Seal)                     Date: ______________________
Signature of Resident Physician

_________________________ (Seal)                     Date: ______________________
Signature of Witness

_________________________
Printed name of Witness
I. Description
To address the use of social media, including but not limited to communications over the internet, on personal websites or web pages, and in online communications, by employees, faculty members, residents, students, volunteers, and contractors of the UNC Health Care System (“UNC HCS”) that identify or relate to any aspect of UNC HCS.

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II. Rationale
The purpose of this policy is to ensure that the use of Social Media by employees, faculty members, residents, students, volunteers, and contractors of the UNC HCS (referred to as “UNC Social Media...
HCS Representatives”), whether done on or off duty, that is directly or indirectly related to UNC HCS or that identifies the use as related to UNC HCS, is:

1. Consistent with UNC HCS policies and applicable federal and state laws, including laws regarding protected health information (“PHI”), personal identifying information (“PII”), privacy, confidentiality, and intellectual property;
2. Not reflected as representative of or endorsed by UNC HCS, unless the user has received prior authorization from the appropriate UNC HCS department or patient to post or make specific comments; and
3. Ethically appropriate and factually accurate, demonstrating good judgment and professionalism.

The main principle applicable to UNC HCS Representatives’ use of social media is that the same basic policies apply in these spaces as in other types of conduct. This policy is meant to help UNC HCS Representatives understand how UNC HCS policies apply to these newer technologies for communication, so they can communicate with confidence using Social Media. (Suggested “best practice guidelines” are included as Exhibit B.)

III. Policy
A. The Use of Social Media
1. What is Social Media?
As used in this policy, the term “Social Media” includes any of a variety of different forms of electronic media, including but is not limited to collaborative projects (e.g., Wikipedia), blogs and microblogs (e.g., Twitter), content communities (e.g., YouTube), social networking sites (e.g., Facebook), virtual game worlds (e.g., World of Warcraft), and virtual social worlds (e.g., Second Life). Technologies include, but are not limited to, wikis, blogs, picture-sharing and video-sharing, vlogs, wall postings, e-mail, instant messaging, and music-sharing – whether used during work or personal time, on personal computers and devices, or on UNC HCS-owned computers and devices.

Because Social Media and other forms of electronic communications are rapidly evolving and changing, the examples contained in this policy are meant to be illustrative, but by no means represent the entire field of Social Media. As technology changes and newer forms of communication develop, this policy shall apply to the various forms of electronic communication that are available.

2. UNC HCS Use of Social Media
UNC HCS recognizes that appropriate use of Social Media can have beneficial effects both within UNC HCS and among the general public. Accordingly, departments and employees within UNC HCS, with the guidance and assistance of UNC HCS’s Public Affairs and Marketing Department, are encouraged to use the various forms of UNC HCS-sponsored Social Media as tools to communicate internally within UNC HCS and externally with other providers, patients, and the general public. Such use of UNC HCS-sponsored Social Media should be preapproved by the appropriate individual or department with authority. For use of UNC HCS-sponsored Social Media, see “UNC Health Care Social Media Terms of Use,” available at http://news.unchealthcare.org/unc-health-care-social-media-terms-of-use, and related guidelines, attached to this policy as Exhibit A. If there are questions contact Public Affairs & Marketing (PA&M) at paffairs@unch.unc.edu.
These restrictions do not apply to the use of e-mail communications for treatment or business purposes that are consistent with applicable UNC HCS policies (see, e.g., Electronic Mail, ADMIN #0065).

B. Guidelines & Procedures for UNC HCS Representatives’ Use of Social Media

1. Applicable Policies

Communications using Social Media that are directly or indirectly related to UNC HCS should be consistent with the mission, values, policies, and procedures of UNC HCS, and with all applicable laws and regulations. Applicable policies include:

- Privacy and Confidentiality of Protected Health Information (Admin #0139)
- Use and Disclosure of PHI Based on Patent Authorization (Admin #0015)
- Information Security (Admin #0082)
- Minimum Necessary Standard for Accessing, Disclosing, and Requesting PHI (Admin #0101)
- Release of Patient Information to the News Media (Admin #0148)
- Verbal Release of PHI (Admin #0156)
- Release of PHI from the Patient’s Medical Record (MIM Policy)
- Electronic Mail (Admin #0065)
- Code of Conduct (Admin #0204)
- Confidentiality of Patient Information (Admin #0026)
- Identity Theft Prevention, Red Flag Program (Admin #0202)
- Identity Theft Protection (Admin #0088)
- Internet Usage and Connectivity (Admin #0085)
- Notice of Privacy Practices (Admin #0117)
- Photographs and Motion Pictures (Admin #0133)
- Conflict of Interest (Admin #0037)
- Corrective Action (HR #1201)
- Unlawful Harassment (HR #0204)

2. Patient Information

Communications using Social Media may not divulge confidential or proprietary information about UNC HCS and may not violate patient privacy and confidentiality policies and laws. Such communications must never contain any information that directly or indirectly identifies a patient. This may include information that does not directly identify a patient, but would permit someone to identify a patient, either through the identification of a disease or health condition; an event precipitating the patient’s health condition, such as an accident or other trauma; the patient’s or provider’s location within UNC HCS; the names and or specialties of the patient’s health care team; the patient’s language or country of origin; or any other detail that alone or in combination with other facts in the public or private domain might allow a third party to identify the patient.

This prohibition includes patient photos, whether such photo directly or indirectly identifies a patient or only includes non-identifiable patient images, such as wounds, diseases, the results of diagnostic tests, or similar images. Unless in the context of providing treatment or educational use, it is never permissible to photograph or disclose
any photograph of a patient or his or her anatomy or test results without a signed release, available from PA&M at paffairs@unch.unc.edu.

These restrictions do not apply to the use of patient information or images for treatment purposes or for internal educational purposes, consistent with HIPAA and authorized by the patient in the General Consent to Treatment and the Consent to Operation/Procedure.

3. **Confidential Business Information**
Communications using Social Media must not contain confidential or proprietary UNC HCS information, including but not limited to business, personnel, and trade secret information.

4. **UNC HCS Logo**
UNC HCS Representatives may not use the UNC HCS logo or other UNC HSC trademarked information without prior approval from PA&M. If you have questions contact PA&M at paffairs@unch.unc.edu.

5. **Inappropriate Language**
Communications using UNC HCS Social Media must not include information that is obscene, defamatory, profane, libelous, threatening, harassing, abusive, hateful, disparaging, or humiliating to fellow employees, business partners, competitors, patients, students, volunteers, or other representatives of UNC HCS. Such communications may violate other UNC HCS policies even when posted or communicated on personal sites.

6. **Reporting**
Violations or suspected violations of this Policy may be reported to the UNC HCS Privacy Officer at 919-966-9659 (office number) or 919-619-8512 (cell).

C. **Consequences Related to the Misuse of Social Media**
Any UNC HCS Representative who makes any defamatory statement regarding UNC HCS or UNC HCS Representatives, shares confidential patient or business information, or who otherwise violates this policy, will be held personally responsible and will be subject to corrective action consistent with UNC HCS Corrective Action policies.

Nothing in this policy is intended to prohibit or discourage any employee from exercising his or her right to express opinions about matters of public concern.

Individuals who have concerns regarding workplace conduct or inappropriate behavior regarding internet postings or the use of Social Media are encouraged to contact their immediate supervisor or one or more of the following departments: UNC HCS Employee Relations; Legal; Compliance; or the Privacy Office.

D. **Questions?**
Contact the UNC HCS Privacy Officer at 966-9659 (office number) or lacy_farrell@unchealthcare.org.
Exhibit A

UNC Health Care Social Media Terms of Use

These terms of use outline participation criteria for postings and published commentary on any UNC Health Care-sponsored social media site, including Facebook, Twitter and YouTube.

Our intention for using these social media sites is to create an open dialog with the community about UNC Health Care. We encourage open, honest and authentic conversation. Please use your real name and email address. We moderate all comments received and we reserve the right to immediately remove any content we deem inappropriate. In addition, all posted content becomes the property of UNC Health Care and can be licensed, reproduced, distributed, published, displayed, or edited. Derivative work also can be created from such postings or content as well as used for any purpose in any form and on any media.

Terms and Conditions

By commenting or including content on any UNC Health Care social media site, you agree to the following terms.

I will not:

- Infringe on the rights of any third-party, including photos, intellectual property, private/confidential collateral or publicity rights
- Post material that is unlawful, obscene, defamatory, threatening, abusive, slanderous, or embarrassing to any other person or entity as determined by UNC Health Care in its sole discretion
- Impersonate another person
- Allow any other person or entity to use my identification for posting or viewing comments
- Post the same note more than once or “spam”
- Post chain letters, pyramid schemes, advertisements or solicitations of business
- Post phone numbers or email addresses belonging to me or any other individual or entity
- Post private health information or other confidential information that is not my own
- Post solicitations for fundraising efforts not sponsored by or benefiting UNC Health Care or involving an official UNC Health Care team.

UNC Health Care reserves the right to:

- Remove communications that violate these Terms and Conditions
- Edit or delete any communications posted regardless of whether such communications violate these standards
- Ban future posts from people who violate these Terms and Conditions
UNC Health care does not give medical advice via its Website or social media sites. If you are seeking specific medical advice, please contact a doctor’s office or call 911 in the case of any emergency.

**UNC Health Care Social Media Terms of Use Guidelines**

1. **Use of Social Media by UNC HCS Employees, Faculty, Residents, Students, Volunteers and Contractors ("UNC HCS Representatives")**

UNC HCS recognized that UNC HCS Representatives may use Social Media to participate in professional networks, and such use may be appropriate during work time and on UNC HSC equipment because of its connection to the work of those individuals.

UNC HCS also recognizes that UNC HCS Representatives may use Social Media for purely personal reasons. Where such use directly or indirectly relates to UNC HCS in a manner that violates law, regulations, or UNC HCS policy – regardless of whether such use is personal or professional, done while on duty or during personal time, using work or personal computers or devices – UNC HCS may require that the UNC HCS Representative discontinue such use consistent with applicable policies.

Additionally, UNC HCS Representatives who must comply with an ethical code of conduct associated with their profession, such as the American Nurses Association’s Code of Ethics or the American Medical Association’s Physician Code of Medical Ethics, should be mindful of the applicability of such codes to their use of Social Media. In particular, health care providers must be aware of how such codes guide communications with current or former patients and any conflicts of interest between personal and professional boundaries.

2. **Personal Opinions**

Unless the user is an approved, UNC HCS spokesperson, communications using Social Media do not officially represent UNC HCS. If any UNC HCS Representative seeks to represent UNC HCS in his or her Social Media communication, he or she must first obtain approval from UNC HCS’s PA&M. Otherwise, communications using Social Media that also identify the author as a UNC HCS Representative should, when appropriate, reflect the user’s personal opinions and experiences and identify them as such. (Suggested language: The comments and viewpoints expressed in this [blog, website] reflect my own opinions and perspectives and are not in any way sponsored, endorsed, or authorized by the UNC Health Care.) Such disclaimers, however, do not permit the disclosure of patient or other confidential information, as described above.

3. **Use of UNC HCS Email**

UNC HCS Representatives who communicate using Social Media outside of the UNC HCS for purposes unrelated to their professional role should use a personal email address (not their UNC...
Social Media

HCS address) as their primary means of identification. Just as a UNC HCS Representative would not use UNC HCS stationary for a letter to the editor with his/her personal views, he/she may not use a UNC HCS e-mail address for personal views.

4. Use of Social Media at UNC HCS’s Direction
In some instances, a UNC HCS department may ask a UNC HCS Representatives to participate in an online forum or to use some form of Social Media in relation to his or her job or volunteer duties. Prior to participation, the individual should discuss involvement with his/her supervisor, receive approval, and agree on the parameters for the project as well as the length of participation and the types of communication that are appropriate. As appropriate, the department, supervisor, or UNC HCS Representative should seek guidance from the UNC HCS Legal Department, Compliance Department, Employee Relations, and/or PA&M.
UNC Health Care System (“UNC HCS”) believes, as expressed in our Visions and Values statement, that “we must be deeply and broadly engaged with the people of North Carolina and the nation to meet their health care challenges.” Our Vision and Values statement also calls for us to “be innovators in research, development and implementation of new means for improving the health of North Carolinians and sharing that knowledge with a national audience.” In order to meet those goals, we believe that the effective and responsible use of Social Media by UNC HCS is absolutely essential. More specifically:

- We believe that Social Media does not create a new world of communication and responsibilities, but only creates new tools. As a representative of UNC HCS, you are still responsible for protecting our patients and yourself every day.
- We want to use social media to engage employees, patients and our community in conversations that will help us to improve people’s lives by personalizing health care.
- We believe that we all have a responsibility to ensure the effective and efficient operation of UNC HCS by abiding by our policies and completing the work we are paid to accomplish.
- We believe that you, as a UNC HCS Representative, should understand what it means to be a health care professional and that your professional reputation is reaffirmed daily. You are responsible for protecting that professional reputation.

UNC HCS has developed these guidelines to help employees and managers deal with the novel questions that arise from the use of Social Media and other online tools in a health care environment.

“Institution use” is the use of Social Media in the name of, sanctioned by, or using the identity of any UNC Health Care entity that has been authorized by your manager or Public Affairs and marketing Department (PA&M). Institutional use may also include the use of Social Media to participate in professional networks that are relevant to your work for UNC Healthcare. “Personal use” is all other uses of Social Media.

1. **Institutional Use**

UNC HCS recognizes that UNC HCS Representatives may use social media to participate in professional networks or conduct research, and such use may be appropriate during work time and on UNC HCS equipment because of its connection to the work of those individuals. If you are formally representing UNC HCS or are responsible for UNC HCS-sponsored social media, however, such use should be authorized by and executed in collaboration with PA&M and your manager. There can be no UNC HCS sites or pages on YouTube, Twitter, Facebook, etc., unless they are developed or authorized by PA&M. As necessary, PA&M or your manager will identify person(s) to be content owners or various UNC HCS Social Media sites. By identifying
Social Media

yourself as part of the UNC HCS community in such a network, be aware that you are now connecting yourself to your colleagues, managers and even UNC Health Care patients and donors.

If you are contacted by a member of the accredited media about a posting or comment on a social networking site, you should immediately contact the UNC HCS News Office at 919-966-3367 before responding.

Content Owners: Content owner will be directed by PA&M and is responsible for monitoring and maintaining Web content in the following manner. Content owner should:

a) Follow all applicable UNC HCS policies;
b) Develop a “listen first” strategy. Know what is being said about you and understand what your target audience values before you engage in social media;
c) Ensure that content is current and accurate;
d) Link directly to original source material and online references;
e) Respond to e-mails and comments when appropriate;
f) Delete comments that contain profanity, are selling or promoting a product, are span, or contain material that is unlawful, hateful, threatening, harassing, abusive or slanderous;
g) Forward comments expressing dissatisfaction to the appropriate area and copy PA&M for response and follow-up;
h) Delete communications that would not be acceptable in the UNC HCS workplace, would violate copyrights or other intellectual property protections, or would reveal proprietary financial, intellectual property, patient care or similar sensitive or private information;
i) Be aware that any Social Media conversation, whether public or private, may be subject to Public Records requests under North Carolina law (direct any such Public records requests to UNC HCS Legal Department);
j) Secure the express consent of all involved parties for distribution or publication of free and/or paid rights recordings, photos, images, video, text, PowerPoint presentations, artwork and advertisements;
k) Obtain executed authorization forms for the release of protected health information from patients or their representative before releasing any information about the patient including, but not limited to, name, photograph, text, video, or any information that might lead anyone to identify the patient, including the description of a trauma or other publicly known incident. Releases are available by contacting the UNC Health Care News Office. Complete releases are to be kept on file in the News Office;
l) Be aware that only patients may divulge their own health information anywhere on the Internet (unless the patient has otherwise allowed disclosure by someone else using a HIPAA-compliant authorization form);
Social Media

m) De-identify comments that identify a patient unless authorization from a patient is obtained. All identifying information must be edited out of the post and a notation added that identifying information was removed;

n) Be responsive when patients, customers, or employees ask a question, and respond in a timely manner, even if to say you will get back to them shortly. Be sure to follow up with all involved parties.

2. Personal Use

Personal Use of Social Media should happen only during non-work time and in strict compliance with all other UNC HCS policies. (Incidental and occasional personal use is permitted as long as the use does not detract from an employee’s performance and productivity. See ADMIN 0065 and ADMIN 0085.

Following these guidelines will ensure that your actions reflect our core values of integrity, teamwork, innovation, excellence, and leadership while exhibiting a level of professionalism that our customers expect and deserve. When on-line you are speaking in your personal capacity unless you have prior authorization from your manager or PA&M to speak for the UNC HCS.

What You Should Do:

- Be smart. Be respectful.
- Be authentic. When you post or comment in social media always state your name.
- Be transparent. State that it is your opinion. Unless authorized to speak on behalf of the UNC HCS you must state that the views expressed are your own.
- Be careful. Protect what personal; information you share online.
- Be responsible and act ethically. When you are at work, your primary responsibility is the work of UNC HCS.
- Report violations or suspected violations to the Privacy Officer at 966-9659 (office number) or 919-619-8512 (cell).

What You Should Never Disclose:

- Confidential UNC HCS Information: If you find yourself wondering whether you can talk about something you learned at work – don’t.
- Patient Information: Do not talk about patients or release patient information or any information that reasonably could identify a patient.
- Personnel Information: Do not refer to your co-workers in an abusive or harassing manner.
- Legal Information: Do not disclose anything to do with a legal issue, legal case, or attorneys.
- Materials that belong to someone else: Stick to posting your own creations. Do not share copyrighted publications, photos, logos or other images that are trademarked. If you do use someone else’s material, give them credit. In some cases you may also need their permission.
I. Description
A policy that outlines limitations on the use of the Freedom Pay Blue Tag by UNC Healthcare medical school residents.

II. Rationale
To identify limitations on the use of the Freedom Pay Blue Tag by UNC Healthcare medical school residents.
III. Policy/Procedure

A. Policy
The Freedom Pay Blue Tag may not be used to purchase non-food items at any of the Nutrition and Food Services retail venues including Starbucks, The Corner Café, The Overlook Café, The Terrace Café, and The ACC Courtyard Café.

B. Procedure
UNC Healthcare medical school residents may use Freedom Pay blue tags to purchase ready to eat food items; however, they may NOT use Freedom Pay blue tags to purchase any non-food items including but not limited to:
1. Starbucks merchandise such as mugs, drink cups, drink cup holders, brewing supplies, and other seasonal non-food merchandise
2. Starbucks promotional gift sets/packages including those containing food items
3. Starbucks Coffee beans and tea bags
4. Starbucks Gifts Cards
5. Holiday Evergreen Trees

IV. References (or Related Policies)
Director of Nutrition and Food Services
Associate Director of Retail Services

VI. Original Policy Date and Revisions

VII. Archived Date
I. Description
Requirements for bringing shadow students or visitors to UNC HCS.

II. Rationale
It is part of the mission of the University of North Carolina Health Care System (“UNC HCS”) to provide educational opportunities to the community and to members of the health care profession. The purpose of this policy is to address the privacy and security requirements for “shadow” students/visitors and other special visitors (collectively referred to herein as “shadow visitors”), and to enable UNC HCS to ensure patient confidentiality rights are respected, patient safety is optimized, and UNC HCS policies and procedures are followed.

1. A shadow visitor is a person who is not part of a formal clinical training program, but is interested in observing the hospital environment for a continuous period of six weeks or less. Individuals who will observe for a continuous period greater than six weeks must: i) be part of a formal clinical training program; ii) arrange with the sponsoring department to execute a Student Affiliation Agreement (which can be obtained through the sponsoring department); and iii) complete the requisite Student affiliation requirements, including immunizations and criminal background checks.

2. Shadow visitors include, but are not limited to, elementary, middle, high school students, community college students and other community and professional observers, but do not included students participating in a contracted program of study with UNC HCS.
3. Shadow visitors may not perform functions that are otherwise performed by employees or registered volunteers, or engage in patient care in any way. Shadow visitors may only observe.

4. Each shadow visitor must have a sponsoring UNC HCS department and individual escort. The UNC Hospitals Volunteer Services Department (“Volunteer Services”) is not responsible for obtaining a sponsoring department or an escort for shadow visitors.

III. Policy
   A. Procedure
      1. Shadow visitor experiences are coordinated through the sponsoring department and Volunteer Services. The following requirements apply to shadow visitors:
         a. All shadow visitors must register with Volunteer Services.
         b. Each shadow visitor falls into categories 2b and 2c below will be required to take the brief online tutorial in privacy requirements (“Observer Tutorial”), which is located on the Volunteer Services website. The sponsoring department is responsible for ensuring the Observer Tutorial is completed prior to starting the shadow experience.
         c. Each shadow visitor who falls into categories 2b and 2c below will be required to provide proof that the shadow visitor is current on the immunizations as set forth in the form attached as Appendix 1, “Immunization Review Form for Shadow Visitors.” Shadow visitors are responsible for obtaining these vaccines at their own cost.

         Shadow visitors should submit the completed form to Volunteer Services, which will review the form for completeness. If there are any questions regarding whether the shadow visitor has provided the requisite proof of the required vaccinations, Volunteer Services should consult with Occupational Health Services. In addition, if a shadow visitor claims a medical contraindication to a vaccine, Volunteer Services should consult with Occupational Health Services.

         Shadow visitors will not be able to begin the shadowing experience without providing proof of the required vaccinations. There will be no religious exemptions to the vaccination requirements for shadow visitors.

         d. All shadow visitors are required to sign a UNC HCS Confidentiality Statement and provide it to Volunteer Services. The sponsoring department will keep a copy of the signed Confidentiality Statement, and the original will be kept at Volunteer Services.

         e. Each shadow visitor must obtain and wear a badge identify him/her as a shadow visitor. Badges are provided by Volunteer Services. **Badge requests must be made by the sponsoring department to Volunteer Services at least 24 hours in advance of the shadow visitor’s arrival.** Shadow visitors will not be able to begin the shadowing experience without a badge. The shadow visitor must obtain the badge from Volunteer Services. In order to obtain the badge, the shadow visitor must show photo identification, present the signed Confidentiality Statement, and, if required, provide proof of completion of the Observer Tutorial and the completed immunization Review Form for Shadow Visitors.
2. There are several categories of shadow visitors. Placement in one of these categories will determine the requirements for such individuals or groups.

a. Shadow Visitors Touring in Primarily Non-patient Care Areas
   Individuals or groups who come to UNC HCS for a staff-accompanied tour in primarily non-patient care areas (such as Carolina Air Care helicopter pad, Lobby and other public areas, etc.) will not be required to complete any formalized training, but such individuals of groups will be registered with Volunteer Services. As appropriate, the tour guide will remind touring visitors to retain any Protected Health Information (PHI) in confidence.

b. Shadow Visitors Observing in Patient Care Areas or Areas Containing Patient Information
   Individuals or groups who come to UNC HCS to observe in patient care areas or areas (or systems) that contain patient information, but who will not observe specific procedures, will be required to be registered with the sponsoring department and Volunteer Services as set forth above. Admission to procedure rooms depends on the applicable departmental policies and procedures. Currently, shadowing in the operating rooms is not permitted. These individuals or groups must complete the Observer Tutorial, provide proof of the required vaccinations, and will be required to follow applicable departmental policies and procedures. When possible, the patient and/or family members will be asked for permission by the observer’s sponsor to bring shadow visitors into the patient care area.

c. Shadow Visitors Observing Specific Procedures
   Individuals or groups who come to UNC HCS to observe specific procedures in patient care areas will be required to be registered with the sponsoring department and Volunteer Services as set forth above. Admission to procedure rooms depends on the applicable departmental policies and procedures. Currently, shadowing in the operating rooms is not permitted. These individuals or groups must complete the Observer Tutorial, provide proof of the required vaccinations, and will be required to follow applicable departmental policies and procedures. In addition, the patient whose specific procedure will be observed must sign an Authorization Form allowing the observation.

d. Special Events
   If the participants for a special event, such as a phone-a-thon, seminar or other specific volunteer event, will not be specifically observing patient care, they will not be required to complete any formalized training, but such individuals or groups will be registered with the Volunteer Services Department. For all other groups, Volunteer Services will determine, in consultation with other departments (such as Occupational Health Services or the Legal Department), whether or not the Observer Tutorial or proof of vaccinations is required.

Anyone with questions or reports of violations of these procedures should contact the Volunteer Services Department at (919) 966-4793.
**Immunization Review Form for Shadow Visitors**

All information must be completed (Print or type)

<table>
<thead>
<tr>
<th>Name (Last, First, MI)</th>
<th>Date of Birth (Mo/Date/Year)</th>
<th>Home Phone</th>
<th>Shadowing Date(s)</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Age</th>
<th>Gender</th>
<th>Weight</th>
<th>Height</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Street Address</th>
<th>City</th>
<th>State</th>
<th>Zip</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Sponsoring Department Name</th>
<th>Location</th>
</tr>
</thead>
</table>

**Telephone #**

**PROOF OF IMMUNIZATIONS IS REQUIRED!!**

This Required Immunization and Screening Form must be completed and returned to UNC HCS Volunteer Services.

The immunization section must be completed and signed and you need to provide personal documentation of immunizations (school transcript, vaccine history card, etc.)

All shadow visitors must be immune (unless there is a medical contraindication, as described by CDC/ACIP) to measles, mumps, rubella, varicella and pertussis. All shadow visitors must receive influenza vaccine annually unless there is a medical contraindication, as described by CDC/ACIP. Influenza vaccine exemptions will be evaluated on an individual basis each year and must be resubmitted annually.

**Required Immunizations and Screenings**

**MEASLES, MUMPS AND RUBELLA (MMR)** If you were born before 1/1/1957, you are age-exempt from MMR vaccines and/or titers. (Except Rubella if female of childbearing potential)

<table>
<thead>
<tr>
<th>MMR #1</th>
<th>MMR #2</th>
</tr>
</thead>
</table>

1. **MEASLES** (Vaccine or titer)

2. **MUMPS** (Vaccine or titer)

3. **RUBELLA** (Vaccine or titer)

Provide documentation of two (2) live measles, two (2) mumps and one (1) rubella immunization

Or serological evidence of immunity – Serology Date: __________________________

2. **CHICKEN POX (VARICELLA)**

   Have you had Chicken Pox or shingles? (circle appropriate answer)  
<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>Unknown</th>
</tr>
</thead>
</table>

   Or received Varicella Vaccine?  Dates  
   | #1 | #2 |

   __________________________  __________________________
Shadow Students or Visitors

Or Serological evidence of immunity? – Serology Date: ____________________________

3. HEPATITIS B (if potential for contact with blood or body fluids) - OPTIONAL
   Dates of Hepatitis B immunizations #1 #2 #3
   Serology (Anti-HBsAg) Yes No Unknown Titer _________

4. Tetanus/Diphteria, ACELLULAR PERTUSSIS (Tdap) (circle appropriate answer)
   Yes No Date ____________________

5. Influenza Vaccine (required during influenza season) (circle appropriate answer)
   Yes No If yes, indicate Date of vaccine ____________________

6. TUBERCULOSIS
   (TB testing will be accepted if done within 12 months prior to assignment at UNC)

   HAFVE YOU HAD ANY OF THE FOLLOWING IN THE LAST MONTH?
   Fever Yes No Cough (for >3 weeks) Yes No
   Chills Yes No Weight Loss Yes No
   Night Sweats Yes No Sputum Production Yes No
   Fatigue Yes No Blood in Sputum Yes No

   EXPLAIN ALL “Yes” ANSWERS __________________________

   WHEN WAS YOUR LAST TST? (TB skin test) blood test for TB
   DATE: ______ PLACED (LFA/RFA): ________
   STRENGTH: __________________ LOT #: _______
   RESULT: __________________ (MM OF INDURATION)

   HAVE YOU RECEIVED BCG (VACCINE FOR TUBERCULOSIS)?
   Yes No If yes, when and where (country of birth)? __________________________

   *If you have received BCG vaccine and have no documentation of TB testing, medication for latent TB
   infection, or no documentation of a negative Chest X-Ray, a TB blood test is required.

   IF YOU HAVE HAD A POSITIVE SKIN TEST, ANSWER THE FOLLOWING:
   Date: __________ Chest X-Ray: Normal____ Abnormal____
   Treatment with INH/other meds (name) ________________ Yes No ______ Months______

Please have this form filled in and signed below by your healthcare provider or you may complete the
form and bring in copies of valid documentation affixed to this form.

Name and Title (Please Print): __________________________

Date: mm/dd/yyyy

Signature: __________________________
APPENDICES

A. Core Competency Curriculum
B. Evaluation Forms
C. Minutes from Program Evaluation Committee
D. Action Plan for Upcoming Year
E. Department of Dermatology “Report Card”
APPENDIX A

Core Competency Curriculum
<table>
<thead>
<tr>
<th>Domain</th>
<th>Competency Objectives</th>
<th>Opportunities and Methods For Learning</th>
<th>Expected Behavioral Outcomes</th>
<th>Method of Evaluation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doctor-patient relationship</td>
<td>▪ Demonstrate caring and respectful Behavioral Outcomes through effective communication</td>
<td>▪ Didactic sessions</td>
<td>▪ Open-ended questions</td>
<td>▪ ABD</td>
</tr>
<tr>
<td></td>
<td>▪ Incorporate patient education, counseling, and informed decision-making throughout practice</td>
<td>▪ Clinical Experiences</td>
<td>▪ Waiting for pt response</td>
<td>▪ In-Training exam</td>
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<tr>
<td></td>
<td></td>
<td>▪ Modeling</td>
<td>▪ Clarification</td>
<td>▪ Procedure log</td>
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<td></td>
<td></td>
<td>▪ Conferences</td>
<td>▪ Eye contact</td>
<td>▪ Portfolio</td>
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<td>▪ Open body language</td>
<td>▪ Sept Clinical skills assessment</td>
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<td></td>
<td></td>
<td></td>
<td>▪ Asking for patient input</td>
<td>▪ Faculty personal feedback card</td>
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<td></td>
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<td></td>
<td>▪ Explanations that are understood</td>
<td>▪ Milestones</td>
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<td></td>
<td></td>
<td></td>
<td>▪ Provides patient handouts or other written instructions</td>
<td></td>
</tr>
<tr>
<td>Gathering information and synthesis into action</td>
<td>▪ Gather essential and accurate biopsychosocial information</td>
<td>▪ Clinic presentations/ performance</td>
<td>▪ Obtains complete history or appropriately focused/problem-based history</td>
<td>▪ ABD</td>
</tr>
<tr>
<td></td>
<td>▪ Develop and carry out patient management plans (diagnostic and therapeutic) based on patient information and preferences, up-to-date scientific evidence, and clinical judgment</td>
<td>▪ UNC/Duke Conferences</td>
<td>▪ Follows information transfer with cogent assessment and plan</td>
<td>▪ In-Training exam</td>
</tr>
<tr>
<td></td>
<td>▪ Use information technology to support patient care decisions and patient education</td>
<td>▪ Conferences</td>
<td>▪ Provides reference for action plan</td>
<td>▪ Procedure log</td>
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<td></td>
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<td>▪ Conducts literature reviews</td>
<td>▪ Portfolio</td>
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<td></td>
<td>▪ Sept Clinical skills assessment</td>
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<td></td>
<td>▪ Faculty personal feedback card</td>
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<td></td>
<td>▪ Milestones</td>
</tr>
<tr>
<td>Comprehensive care</td>
<td>▪ Incorporate prevention and health maintenance throughout practice</td>
<td>▪ Presentations to preceptor</td>
<td>▪ Specific referral question(s) and reasons for referral stated</td>
<td>▪ ABD</td>
</tr>
<tr>
<td></td>
<td>▪ Coordinate patient-focused care with all other healthcare disciplines</td>
<td>▪ Referral experiences</td>
<td>▪ Uses ancillary healthcare services</td>
<td>▪ In-Training exam</td>
</tr>
<tr>
<td></td>
<td></td>
<td>▪ Conferences</td>
<td>▪ Follows up on referral recommendations</td>
<td>▪ Procedure log</td>
</tr>
<tr>
<td>Psychomotor skills</td>
<td>▪ Perform competently physical exams and all procedures appropriate to Dermatology</td>
<td>▪ Modeling by faculty preceptors and attendings</td>
<td>▪ Can perform physical exams and procedures correctly under supervision</td>
<td>▪ Portfolio</td>
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<td></td>
<td></td>
<td>▪ Direct clinical teaching</td>
<td></td>
<td>▪ Sept Clinical skills assessment</td>
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<td></td>
<td>▪ Faculty personal feedback card</td>
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<td></td>
<td></td>
<td>▪ Milestones</td>
</tr>
<tr>
<td>Domain</td>
<td>Competency Objectives</td>
<td>Opportunities and Methods for Learning</td>
<td>Expected Behavioral Outcomes</td>
<td>Method of Evaluation</td>
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</tbody>
</table>
|        | • Demonstrate a “critical thinking” approach to clinical situations  
• Demonstrate sound scientific and clinical knowledge base appropriate to Dermatology | • Hideaway Conference  
• Didactic Conferences  
• UNC/Duke Conferences  
• Independent reading/study | • Active participation in conferences  
• Articulates reasoning behind patient care plans  
• Provides medically appropriate care  
• Patient complaints i.e. quality of care minimal or of minor nature only  
• No standard of care violations through risk management process | • ABD  
• In-Training  
• Faculty personal feedback card  
• Milestones |
<table>
<thead>
<tr>
<th>Domain</th>
<th>Competency Objectives</th>
<th>Opportunities and Methods for Learning</th>
<th>Expected Behavioral Outcomes</th>
<th>Method of Evaluation</th>
</tr>
</thead>
</table>
| Gathering information and synthesis into action | ▪ Obtain and use population and community-based information  
▪ Demonstrate evidence-based approach to practice  
▪ Apply critical principles to investigate diagnostic and therapeutic options | ▪ UNC/Duke Conferences  
▪ Didactic conference presentations  
▪ Independent Study | Completes required projects and presentations | ▪ ABD  
▪ Portfolio  
▪ In-Training exam  
▪ Portfolio  
▪ Faculty personal feedback card  
▪ Milestones |
| Maintaining Quality                | ▪ Demonstrate practice-based learning  
▪ Apply principles of quality care to outpatient and inpatient practice | ▪ Quality Assurance Conference participation  
▪ Conferences | ▪ Quality Assurance Conference participation | ▪ ABD  
▪ In-Training exam  
▪ Portfolio  
▪ Milestones |
| Teaching and Learning              | ▪ Facilitate the learning of others  
▪ Use information technology effectively in all aspects of practice and continuing education | ▪ Preceptor Modeling  
▪ Clinical experiences  
▪ Computing resources  
▪ Presentations  
▪ Conferences | ▪ Active participation in conferences  
▪ Progressive leadership and teaching skills development  
▪ Medical student teaching  
▪ Uses computing resources | ▪ ABD  
▪ In-Training exam  
▪ Portfolio  
▪ Speaker score  
▪ Milestones |
<table>
<thead>
<tr>
<th>Domain</th>
<th>Competency Objectives</th>
<th>Opportunities and Methods for Learning</th>
<th>Expected Behavioral Outcomes</th>
<th>Method of Evaluation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doctor-Patient Relationship</td>
<td>▪ Create and sustain a therapeutic and ethically sound relationship with patients</td>
<td>▪ Preceptor Modeling</td>
<td>▪ Open-ended questions</td>
<td>▪ ABD</td>
</tr>
<tr>
<td></td>
<td>▪ Use effective listening skills and elicit and provide information using effective nonverbal, explanatory, questioning, and writing skills</td>
<td>▪ Clinical experiences</td>
<td>▪ Waiting for pt response</td>
<td>▪ In-training exam</td>
</tr>
<tr>
<td></td>
<td></td>
<td>▪ Conferences</td>
<td>▪ Clarification</td>
<td>▪ Speaker score</td>
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<td></td>
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<td></td>
<td>▪ Eye contact</td>
<td>▪ Sept Clinical skills assessment</td>
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<td></td>
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<td>▪ Open body language</td>
<td>▪ Faculty personal feedback card</td>
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<td></td>
<td>▪ Asking for patient input</td>
<td>▪ Milestones</td>
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<td>▪ Explanations that are understood</td>
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<td>▪ Provides written instructions when appropriate</td>
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</tr>
<tr>
<td>Professional Relationships</td>
<td>▪ Demonstrate effective teamwork</td>
<td>▪ Advancing roles as leaders to conferences and clinics</td>
<td>▪ Satisfactory evaluations from nurses, other staff, and peers</td>
<td>▪ ABD</td>
</tr>
<tr>
<td></td>
<td></td>
<td>▪ Faculty modeling</td>
<td>▪ Progressive leadership skills as advances through each year level</td>
<td>▪ In-training exam</td>
</tr>
<tr>
<td></td>
<td></td>
<td>▪ Conferences</td>
<td>▪ Active participation in departmental meetings, and partnerships</td>
<td>▪ Speaker score</td>
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<td>▪ Sept Clinical skills assessment</td>
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<td>▪ Faculty personal feedback card</td>
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<td>▪ Milestones</td>
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</tbody>
</table>
### 5) Professionalism

<table>
<thead>
<tr>
<th>Domain</th>
<th>Competency Objectives</th>
<th>Opportunities and Methods for Learning</th>
<th>Expected Behavioral Outcomes</th>
<th>Method of Evaluation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Values</td>
<td>▪ Demonstrate respect, compassion, and integrity</td>
<td>▪ Faculty modeling</td>
<td>▪ Professional attire</td>
<td>▪ ABD</td>
</tr>
<tr>
<td></td>
<td>▪ Demonstrate a responsiveness to the needs of patients and society that supercedes self-interest</td>
<td>▪ Lectures</td>
<td>▪ Active listening</td>
<td>▪ In-training exam</td>
</tr>
<tr>
<td></td>
<td>▪ Demonstrate accountability to patients, society, and the profession</td>
<td>▪ Conferences</td>
<td>▪ Assesses patient understanding</td>
<td>▪ Sept Clinical skills assessment</td>
</tr>
<tr>
<td></td>
<td>▪ Demonstrate a commitment to excellence and ongoing professional development</td>
<td></td>
<td>▪ Explains issues in non-condescending fashion</td>
<td>▪ Faculty personal feedback card</td>
</tr>
<tr>
<td></td>
<td>▪ Demonstrate sensitivity and responsiveness to patients’ culture, age, gender, and disabilities</td>
<td></td>
<td>▪ Works effectively with nurses/staff</td>
<td>▪ Milestones</td>
</tr>
</tbody>
</table>

- Shows interest in “patient as a person”
- Honesty
- Keeps commitments
- Steps up to the plate when needed
- Follows through on patient initiated requests
- Stays at the hospital or clinic until all critical patient care issues are addressed
- Timely completion of all administrative tasks (licensure, etc.)
- Adherence to all clinical responsibilities (no missed clinics, etc.)
- Discusses principles of cultural sensitivity
- Treats all patients with equal care
- Respects all patients, staff, colleagues, faculty
<table>
<thead>
<tr>
<th>Ethics</th>
<th>Lectures</th>
<th>Conferences</th>
<th>ABD</th>
<th>In-training exam</th>
<th>Faculty personal feedback card</th>
<th>Milestones</th>
</tr>
</thead>
<tbody>
<tr>
<td>Demonstrates a commitment to ethical principles pertaining to provision or withholding of clinical care, confidentiality of patient information, informed consent, and business practices</td>
<td>Defines the principles of beneficence, autonomy, justice, and nonmalficence</td>
<td>Displays ethically defensible approaches to dealing with cases involving withholding care, confidentiality, informed consent, and competing principles of the business model of care</td>
<td>ABD</td>
<td>In-training exam</td>
<td>Faculty personal feedback card</td>
<td>Milestones</td>
</tr>
<tr>
<td>Domain</td>
<td>Competency Objectives</td>
<td>Opportunities and Methods for Learning</td>
<td>Expected Behavioral Outcomes</td>
<td>Method of Evaluation</td>
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<tr>
<td>Models of Care</td>
<td>• Understand the integration of individual practice with the medical system at-large</td>
<td>• Faculty modeling</td>
<td>• Appropriate referral pattern</td>
<td>• ABD</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Know how types of medical practice and delivery systems differ from one another,</td>
<td>• Clinical experiences</td>
<td>• Integration with community services, home health agencies</td>
<td>• In-training exam</td>
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<td></td>
<td>including methods of controlling health care costs and allocating resources</td>
<td>• Conferences</td>
<td>• Appropriate response to referral request</td>
<td>• Portfolio</td>
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<tr>
<td></td>
<td>• Use multidisciplinary approach to coordinate care for individuals and families</td>
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<td></td>
<td>• Sept Clinical skills assessment</td>
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</tr>
<tr>
<td>Cost Consciousness</td>
<td>• Practice cost-effective, high quality health care and resource allocation</td>
<td>• Modeling by faculty</td>
<td>• Articulates choices based on cost awareness</td>
<td>• Faculty personal feedback card</td>
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<tr>
<td></td>
<td></td>
<td>• Coding seminars</td>
<td>• Appropriate coding</td>
<td>• Milestones</td>
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<td></td>
<td></td>
<td>• Conferences</td>
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<tr>
<td>Patient-Centered</td>
<td>• Advocate for, and assist patients in achieving quality care in larger system</td>
<td>• UNC/Duke Conferences</td>
<td>• Articulates strategies when confronted with care barriers</td>
<td>• ABD</td>
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<td></td>
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<td>• Faculty modeling</td>
<td></td>
<td>• In-training exam</td>
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<td></td>
<td></td>
<td>• Conferences</td>
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<td>• Portfolio</td>
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</tr>
</tbody>
</table>

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APPENDIX B

Evaluation Forms
Clinical Competency Committee (CCC)  
Description and Responsibilities

Overview:
The Clinical Competency Committee (CCC) is primarily a faculty advisory group appointed by the Program Director to assist in evaluating program trainees’ clinical competency based on the ACGME milestones as identified by the RRC. The CCC is comprised of no fewer than three (3) members of the program faculty. Faculty from other programs and non-physician faculty are permitted to serve on the CCC at the discretion of the Program Director as long as they are actively involved in trainee education. Faculty mentors for trainees, where identified, may contribute to CCC discussions, but typically will not participate in CCC deliberations about their trainee mentee.

Purpose:
The CCC actively monitors, evaluates and provides reporting on program trainees as they advance through the training program and provide constructive feedback based on this assessment system. The goal of the CCC is to assure that trainees are progressing so that they are prepared to practice core specialty and/or subspecialty professional activities without supervision upon successful completion of the program.

Composition of the CCC:
The Program Director appoints program faculty members, including core faculty to the CCC. Faculty appointed to the CCC observe and evaluate the trainees in multiple and varied experiences and environments and are actively involved in trainee education. Faculty are knowledgeable about ACGME milestones when identified by the RRC, and/or other objective measures of performance (e.g., end of rotation evaluations, multi-source evaluations, self and peer evaluations, in-training test scores, attendance records, among other evaluation tools).
Others eligible for appointment to the CCC are faculty from other programs and non-physician members of the health care team.

The CCC is chaired by Dean Morrell, MD, Professor of Dermatology and Program Director. Other members of the committee include Luis Diaz, MD, Professor and Chair of Dermatology, Puneet Jolly, MD, PhD, Assistant Professor Dermatology, and Christopher Sayed, MD, Assistant Professor of Dermatology.

**Responsibilities of the CCC:**
1. Reviews and understands the Milestones identified by the RRC and/or other applicable and objective measures of trainee performance;
2. Assesses and discusses each trainee’s evaluations and performance no less frequently than semi-annually;
3. Prepares report to the ACGME on specialty specific educational Milestones identified by the RRC and/or other applicable and objective measures of trainee performance that includes, but is not limited to:
   a. Feedback from faculty evaluations for each rotation or educational assignment at the completion of the assignment;
   b. Feedback using multiple methodologies (in-training test scores, attendance records, entrustable professional activities, procedural skills) and multiple evaluators (faculty, peers, patients, self, other healthcare professionals) based on Milestones that have been identified by the RRC and/or other applicable and objective measures of performance formally;
   c. Feedback based on the objective assessments of competence in:
      i. Patient care and procedural skills
      ii. Medical knowledge
      iii. Practice based learning and improvement
      iv. Interpersonal and communication skills
      v. Professionalism
      vi. Systems based practice
4. Establishes thresholds of performance that required remediation and provides recommendations on trainee progress to the Program Director based on areas of concern (if any) identified. Progression may include promotion, remediation, and dismissal, and/or non-renewal of the trainee’s contract.
5. Monitors each trainee’s performance through the continuum of their educational training.

**Responsibilities of the Program Director:**
1. The Program Director has the final authority to make determinations about actions that will be taken based on the CCC’s recommendations about each trainee’s performance.
2. The Program Director has the final authority to make determinations about changes to the educational program based on the CCC’s recommendations.
3. The Program Director or designee provides formal feedback to each trainee no less frequently than semi-annually.
4. The Program Director provides the final summative evaluation of each trainee’s performance.
5. The Program Director assures that trainees have appropriate access to review their final evaluations and feedback when they desire to do so. Trainees do not have access to the CCC’s confidential meeting minutes.

Created June 11, 2014
The Dermatology Milestone Project

A Joint Initiative of
The Accreditation Council for Graduate Medical Education
and
The American Board of Dermatology

November 2013
The Dermatology Milestone Project

The Milestones are designed only for use in evaluation of resident physicians in the context of their participation in ACGME accredited residency or fellowship programs. The Milestones provide a framework for the assessment of the development of the resident physician in key dimensions of the elements of physician competency in a specialty or subspecialty. They neither represent the entirety of the dimensions of the six domains of physician competency, nor are they designed to be relevant in any other context.
Dermatology Milestones Working Group

George W. Turiansky, MD, Chair
Daniel Loo, MD, Vice Chair
Eileen Anthony, MJ
Anna Bruckner, MD
Roy Colven, MD
Marsha Henderson, MD, Resident Member
Antoinette Hood, MD
Steven P. Nestler, PhD
Amy Susan Paller, MD
Jack Resneck Jr., MD
Randall Roenigk, MD
Julie Schaffer, MD
Erik Stratman, MD
R. Stan Taylor, MD
Milestone Reporting

This document presents milestones designed for programs to use in semi-annual review of resident performance and reporting to the ACGME. Milestones are knowledge, skills, attitudes, and other attributes for each of the ACGME competencies organized in a developmental framework from less to more advanced. They are descriptors and targets for resident performance as a resident moves from entry into residency through graduation. In the initial years of implementation, the Review Committee will examine Milestone performance data for each program's residents as one element in the Next Accreditation System (NAS) to determine whether residents overall are progressing.

For each reporting period, review and reporting will involve selecting the level of milestones that best describes each resident's current performance level in relation to milestones. Milestones are arranged into numbered levels. Selection of a level implies that the resident substantially demonstrates the milestones in that level, as well as those in lower levels. (See the diagram on page v.) A general interpretation of levels for the Dermatology Milestones is below.

**Level 1:** The resident demonstrates milestones expected of an incoming or early beginning resident who has had some education in dermatology.

**Level 2:** The resident is advancing and demonstrating additional milestones.

**Level 3:** The resident continues to advance, and is demonstrating additional milestones; the resident consistently demonstrates the majority of milestones targeted for residency.

**Level 4:** The resident has advanced so that he or she now substantially demonstrates the milestones targeted for residency. This level is designed as the graduation target.

**Level 5:** The resident has advanced beyond performance targets set for residency, and is demonstrating "aspirational" goals which might describe the performance of someone who has been in practice for several years. It is expected that only a few exceptional residents will reach this level.
Additional Notes

Level 4 is designed as the graduation target but does not represent a graduation requirement. Making decisions about readiness for graduation is the purview of the residency program director. (See the following NAS FAQ for educational milestones on the ACGME's NAS microsite for further discussion of this issue: "Can a resident graduate if he or she does not reach every milestone?") Study of milestone performance data will be required before the ACGME and its partners will be able to determine whether Level 4 milestones and milestones in lower levels are in the appropriate level within the developmental framework, and whether Milestone data are of sufficient quality to be used for high stakes decisions.

Some milestone descriptions include statements about performing independently. These activities must follow the ACGME supervision guidelines. For example, a resident who performs a procedure or takes independent call must, at a minimum, be supervised through oversight.

Answers to Frequently Asked Questions about the Next Accreditation System (NAS) and milestones are available on the ACGME's NAS microsite: http://www.acgme-nas.org/assets/pdf/NASFAQs.pdf.
The diagram below presents an example set of milestones for one sub-competency in the same format as the Milestone Report Worksheet. For each reporting period, a resident's performance on the milestones for each sub-competency will be indicated by:

- selecting the level of milestones that best describes the resident's performance in relation to the milestones
- or,
- selecting the “Has not Achieved Level 1” option

<table>
<thead>
<tr>
<th>ICS2. Having Difficult Conversations</th>
<th>Level 1</th>
<th>Level 2</th>
<th>Level 3</th>
<th>Level 4</th>
<th>Level 5</th>
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<tbody>
<tr>
<td>Has not Achieved Level 1</td>
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<tr>
<td>Describes the general approach to difficult conversations with patients and families, but usually needs guidance to recognize these situations and to respond appropriately</td>
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<tr>
<td>Recognizes the circumstances related to having difficult conversations with patients and families</td>
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<tr>
<td>Begins to effectively communicate in routine clinical situations, but requires guidance in complex or unusual circumstances</td>
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<tr>
<td>Usually communicates effectively in difficult conversations with patients and families, including some complex or unusual circumstances</td>
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<tr>
<td>Consistently communicates effectively in difficult conversations with patients and families in routine and complex circumstances</td>
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<tr>
<td>Role models an effective and sensitive approach to difficult conversations with patients and families</td>
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<tr>
<td>Is regularly sought out by junior learners, peers and other members of the health care team for his/her ability to have difficult conversations in complex or unusual circumstances</td>
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</table>

Comments: 

Selecting a response box in the middle of a level implies that milestones in that level and in lower levels have been substantially demonstrated.

Selecting a response box on the line in between levels indicates that milestones in lower levels have been substantially demonstrated as well as some milestones in the higher level(s).
<table>
<thead>
<tr>
<th>Has not Achieved Level</th>
<th>Level 1</th>
<th>Level 2</th>
<th>Level 3</th>
<th>Level 4</th>
<th>Level 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>With guidance, consistently able to identify key historical or physical examination findings and recognize their significance.</td>
<td>Consistently obtains accurate, targeted history and examination for routine conditions efficiently; needs guidance with subtle or complex findings.</td>
<td>Consistently able to extract difficult-to-elicit but pertinent information and clinical findings; occasionally needs guidance with subtle or complex findings.</td>
<td>Consistently identifies information and subtle clinical patterns to diagnose complex disorders.</td>
<td>Role models and teaches how to obtain a history and physical examination, and is regularly sought out by other members of the health care team.</td>
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</tr>
<tr>
<td>Consistently demonstrates use of basic dermatologic terminology, but often needs guidance with precise description of skin disease morphology.</td>
<td>Usually gives a targeted presentation using appropriate terminology and providing pertinent negatives.</td>
<td>Consistently gives targeted and precise presentation with pertinent negatives.</td>
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<tr>
<td>Presentations are often unfocused.</td>
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</table>

Comments:
## PC2. Diagnostic Tests

<table>
<thead>
<tr>
<th>Has not Achieved Level 1</th>
<th>Level 1</th>
<th>Level 2</th>
<th>Level 3</th>
<th>Level 4</th>
<th>Level 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Occasionally able to perform and interpret in-office tests, such as KOH preparations and scrapings for ectoparasites</td>
<td>Usually performs in-office tests proficiently and consistently selects clinically-appropriate laboratory and imaging tests</td>
<td>Consistently performs in-office tests proficiently and interprets results correctly</td>
<td>Consistently accurately interprets laboratory and imaging test results</td>
<td>Teaches junior learners to accurately interpret laboratory and imaging test results, including the selection of tests that are evidence-based and cost-effective</td>
<td>Is a role model for the performance and interpretation of in-office tests</td>
</tr>
</tbody>
</table>

Comments:
### PC3. Dermatopathology Application

<table>
<thead>
<tr>
<th>Has not Achieved Level 1</th>
<th>Level 1</th>
<th>Level 2</th>
<th>Level 3</th>
<th>Level 4</th>
<th>Level 5</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Seeks clinicopathologic correlation</td>
<td>Usually interprets and applies findings to clinical care accurately for common neoplasms</td>
<td>Usually interprets and applies findings to clinical care accurately, including for uncommon neoplasms and common inflammatory dermatoses</td>
<td>Consistently interprets and correlates specimens accurately Articulates the limitations and challenges of dermatopathologic interpretation</td>
<td>Performs at the level of someone with advanced education in dermatopathology and teaches clinicopathologic correlation</td>
</tr>
<tr>
<td></td>
<td>Ensures accurate completion of pathology requisition forms</td>
<td>Reviews own biopsy slides</td>
<td>Usually interprets the results of special stains</td>
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</tbody>
</table>

Comments:
### PC4. Medical Treatment

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<tr>
<th>Has not Achieved Level 1</th>
<th>Level 1</th>
<th>Level 2</th>
<th>Level 3</th>
<th>Level 4</th>
<th>Level 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consistently able to prescribe medications, but usually requires guidance for indications, contraindications, dosing, and monitoring</td>
<td>Usually selects appropriate medications for common dermatologic disorders</td>
<td>Consistently selects appropriate medication and changes to medical therapy and usually selects appropriate systemic medication for management of complex diseases</td>
<td>Usually able to select alternative medications for patients with recalcitrant disease or significant side effects from therapy</td>
<td>Role models appropriate medical management</td>
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</tr>
<tr>
<td>Consistently selects correct vehicle and quantity for topical medications</td>
<td>Consistently prescribes and manages systemic medications for common dermatologic disease</td>
<td>Consistently monitors for side effects, including ordering appropriate tests</td>
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<tr>
<td>Usually recognizes common and serious side effects, but needs direction in ordering monitoring tests</td>
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Comments:
## PCS. Pediatric Treatment

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<th>Level 3</th>
<th>Level 4</th>
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</thead>
<tbody>
<tr>
<td>Seeks to integrate age and developmental status when managing or evaluating children</td>
<td>Occasionally integrates age, development status, and psychosocial factors into care</td>
<td>Usually integrates age, development status, and psychosocial factors into care of common disorders</td>
<td>Consistently integrates age, development status, and psychosocial factors into care of common, uncommon, and complex patients</td>
<td>Performs at the level of someone with <strong>advanced education</strong> in pediatric dermatology and serves as a role model</td>
<td></td>
</tr>
<tr>
<td><strong>Consistently</strong> uses weight-based dosing with guidance when prescribing medications for children</td>
<td><strong>Consistently</strong> uses weight-based dosing when prescribing medications for children</td>
<td><strong>Consistently</strong> performs simple procedures on children independently</td>
<td><strong>Consistently</strong> counsels patients and families with certain disorders, such as birthmarks and genodermatoses</td>
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<tr>
<td>Seeks input on medicolegal issues (e.g., prescribing to unaccompanied minors, child abuse, etc.)</td>
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**Comments:**

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<table>
<thead>
<tr>
<th>Has not Achieved Level 1</th>
<th>Level 1</th>
<th>Level 2</th>
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<th>Level 4</th>
<th>Level 5</th>
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<tbody>
<tr>
<td>Consistently implements universal precautions; obtains informed consent for biopsy; performs antisepsis; and administers local anesthesia for common procedures</td>
<td>Consistently able to assess and counsel patients for basic procedures</td>
<td>Consistently able to assess and counsel patients for advanced procedures, such as Mohs micrographic surgery and laser therapy; able to assess patients for minimally-invasive cosmetic dermatologic procedures</td>
<td>Usually able to assess patients for invasive cosmetic procedures, such as laser resurfacing, hair transplantation, and liposuction</td>
<td>Consistently able to surgically treat most skin cancers by demonstrating a knowledge of relevant anatomy to guide intra-operative surgical decision-making</td>
<td>Serves as a role model in performing basic and advanced procedures with consistent high quality outcomes with low complication rates</td>
</tr>
<tr>
<td>Consistently demonstrates proficiency in basic procedures such as cryotherapy and biopsy</td>
<td>Usually able to perform a pre-operative assessment and to set up surgical instrumentation</td>
<td>Usually able to perform skin preparation and to administer local anesthesia for more complex procedures</td>
<td>Usually able to prepare a patient for advanced procedures (e.g., use of pre- and post-operative antibiotics, sedatives, and narcotics; choice of appropriate anesthetic agent, including arrangement for general anesthesia if required)</td>
<td>Consistently able to perform basic procedures, such as malignant destruction and excision sutured by layered closure</td>
<td>Performs at the level of someone with advanced education in procedural dermatology</td>
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<tr>
<td>Consistently completes documentation for basic surgical procedures</td>
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<td>Consistently able to manage post-operative care and minor complications</td>
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<tr>
<td><strong>Usually performs</strong></td>
<td>complex reconstruction, such as flaps and grafts, <strong>with guidance</strong></td>
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<tr>
<td><strong>Observes or assists in Mohs micrographic surgery and non-invasive cosmetic procedures, such as soft tissue augmentation, botulinum toxin injections, and laser</strong></td>
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<tr>
<td><strong>Consistently able to manage most complications related to surgery</strong></td>
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**Comments:**
### PC7. Diagnosis, Management Decisions and Patient Education

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<tr>
<th>Has not Achieved Level 2</th>
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<tbody>
<tr>
<td>Consistently formulates a limited differential diagnosis, but usually needs guidance in prioritizing diagnoses</td>
<td>Consistently develops a differential diagnosis that includes common disorders and some more complex conditions and only occasionally needs guidance for prioritization</td>
<td>Consistently develops a comprehensive and weighted differential diagnosis</td>
<td>Usually educates patients with common and complex disorders with guidance</td>
<td>Consistently makes independent management decisions, including customizing care in the context of patient preferences, overall health, and ability to comply</td>
<td>Models and teaches development of a comprehensive and weighted differential diagnosis</td>
</tr>
<tr>
<td>Occasionally able to formulate an appropriate management plan for common disorders, but usually needs guidance</td>
<td>Occasionally counsels patients about prevention, disease expectations, treatment, and longitudinal care</td>
<td>Usually makes management decisions for patients with common disorders, but usually needs guidance for patients with complex disorders; consistently tailors counseling and management decisions for individual patient needs and preferences</td>
<td>Consistently seeks appropriate specialist consultations</td>
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</tr>
<tr>
<td>Usually suggests appropriate specialist consultations</td>
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<td></td>
<td>Consistently seeks appropriate specialist consultations</td>
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Comments:

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<th>Level 1</th>
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<th>Level 3</th>
<th>Level 4</th>
<th>Level 5</th>
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</thead>
<tbody>
<tr>
<td>Demonstrates rudimentary knowledge of common skin disorders</td>
<td>Demonstrates knowledge of the clinical and laboratory manifestations, expected course, and management options of common medical dermatologic disorders; distinguishes most urgent from non-urgent dermatological conditions</td>
<td>Usually demonstrates knowledge of the clinical and laboratory manifestations, expected course, and management options of common, uncommon, and complex medical dermatologic disorders; identifies and usually manages urgent dermatological conditions</td>
<td>Consistently demonstrates comprehensive knowledge of the clinical and laboratory manifestations, expected course, and management options of common, uncommon, and complex medical dermatologic disorders; identifies and manages urgent dermatological conditions</td>
<td>Demonstrates mastery of and teaches the clinical and laboratory manifestations, expected course, and management options of common, uncommon, and complex medical dermatologic disorders, preventive care, and socio-behavioral aspects of medical dermatologic disorders</td>
</tr>
<tr>
<td>Rudimentary knowledge of the value of preventive care and socio-behavioral aspects of medical dermatologic disorders (for example, health care economics and medical ethics)</td>
<td>Demonstrates rudimentary knowledge of preventive care and the socio-behavioral aspects of common and complex medical dermatologic disorders</td>
<td>Consistently recognizes the value of preventive care and demonstrates sophisticated understanding of the socio-behavioral aspects of medical dermatologic disorders</td>
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</table>

**Comments:**

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### MK2. Pediatric Dermatology

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<thead>
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<th>Has not Achieved Level 1</th>
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<th>Level 2</th>
<th>Level 3</th>
<th>Level 4</th>
<th>Level 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Demonstrates rudimentary knowledge of common skin disorders in pediatric patients</td>
<td>Demonstrates knowledge of the clinical and laboratory manifestations, expected course, and management options of common pediatric dermatologic disorders</td>
<td>Demonstrates knowledge of clinical and laboratory manifestations, expected course, and management options of common and some complex pediatric dermatologic disorders, including neonatal dermatoses, birthmarks and vascular anomalies, and genetic disorders</td>
<td>Demonstrates comprehensive knowledge of clinical and laboratory manifestations, expected course, and management options of common, uncommon, and complex pediatric dermatologic disorders, including neonatal dermatoses, birthmarks and vascular anomalies, and genetic disorders</td>
<td>Demonstrates mastery of knowledge of clinical and laboratory manifestations, expected course, and management options of common, uncommon, and complex pediatric dermatologic disorders, including socio-behavioral aspects and the value of preventive care in pediatric dermatology</td>
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</table>

**Comments:**
## MK3. Dermatologic Surgery

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<tr>
<th>Has not Achieved Level 1</th>
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<th>Level 2</th>
<th>Level 3</th>
<th>Level 4</th>
<th>Level 5</th>
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</thead>
<tbody>
<tr>
<td>Demonstrates knowledge of the <em>basic concepts</em> of antisepsis, pharmacokinetics of local anesthesia, and wound healing, including management of clean wounds and signs of infection</td>
<td>Demonstrates knowledge of suturing material used in the skin and <em>complex concepts</em> of wound healing, including chronic ulcers and other complex wounds</td>
<td>Demonstrates knowledge of tissue biomechanics and optimal wound closure, including the design of flaps and grafts</td>
<td>Demonstrates mastery in identifying topical anatomy and relevant underlying structures</td>
<td>Demonstrates knowledge of the methodology of procedures such as Mohs micrographic surgery, soft tissue augmentation, botulinum toxin injections, and laser</td>
<td>Demonstrates mastery of and teaches the indications, cost effectiveness, and efficient execution of all steps in basic cutaneous surgical procedures, including biopsy, excision, electrosurgery, cryosurgery, vascular lasers, and simple, intermediate or complex repairs, including flaps and grafts</td>
</tr>
<tr>
<td>Recognizes the reasons for protocol-driven procedural safety, including universal precautions and informed consent</td>
<td>Demonstrates knowledge of topical anatomy and relevant underlying structures</td>
<td>Demonstrates knowledge of the science of device-tissue interaction for commonly used tools in dermatologic surgery, including liquid nitrogen, electrosurgical devices, and laser physics</td>
<td>Demonstrates knowledge of the concepts and principles of non-invasive cosmetic procedures, such as botulinum toxin injections, soft tissue augmentation, and some light-based therapies</td>
<td>Demonstrates mastery of and teaches the indications and costeffectiveness of Mohs micrographic surgery, and performs this procedure at the level of someone with advanced training in procedural dermatology</td>
<td>Demonstrates mastery of and teaches the</td>
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</table>

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|   | Recognizes the indications for pre- and post-operative antibiotic use |   | appropriate indications for a diversity of cosmetic dermatologic procedures, and performs these procedures at the level of someone with advanced training in procedural dermatology |   |

Comments:
## MK4. Dermatopathology

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<tbody>
<tr>
<td>Identifies basic histology of the skin and inflammatory cells</td>
<td>Recognizes histologic patterns of inflammatory disease and common neoplastic conditions</td>
<td>Occasionally identifies histopathologic findings of common skin disorders correctly</td>
<td>Usually identifies histopathologic findings of common skin disorders correctly; occasionally identifies less common disorders correctly</td>
<td>Consistently identifies histopathologic findings of uncommon skin disorders correctly</td>
<td>Formulates an exhaustive differential diagnosis for inflammatory and non-inflammatory disorders; fulfills and maintains CLIA requirements and regulations</td>
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<td>Formulates a limited differential diagnosis of pathologic findings</td>
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<td>Discriminates when to obtain special stains, immunofluorescence, and immunohistochemistry, and/or expert consultation for less common or difficult disorders</td>
</tr>
<tr>
<td></td>
<td>Demonstrates knowledge of direct and indirect immunofluorescence tests and correct locations for biopsies</td>
<td>Demonstrates knowledge of relevant special stains</td>
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<td>For dermatologists sending biopsy specimens to outside laboratories: recognizes and appraises the limitations of the laboratory processes and the qualifications of physician signing-out cases</td>
</tr>
</tbody>
</table>

**Comments:**

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</thead>
<tbody>
<tr>
<td>Demonstrates <em>rudimentary</em> knowledge of basic science relevant to dermatologic conditions</td>
<td>Occasionally applies basic science knowledge to dermatologic disorders</td>
<td>Usually applies basic science knowledge to dermatologic disorders, and relates advances in basic science to clinical practice</td>
<td>Consistently demonstrates ability to <em>organize, present, and apply</em> relevant basic science knowledge to the care of dermatology patients</td>
<td>Organizes, teaches, and models application of relevant and recent basic science knowledge in the care of dermatology patients</td>
<td></td>
</tr>
<tr>
<td>Needs frequent guidance in applying basic science knowledge to dermatologic disorders</td>
<td>Occasionally formulates clinical questions raised by new basic science information</td>
<td>Usually formulates clinical questions raised by new basic science information</td>
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</table>

Comments:
**SBP1. Adapts easily and works effectively in various health care delivery settings and systems**

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<tr>
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<tbody>
<tr>
<td></td>
<td>Completes all required tasks for residency and first rotation site orientation</td>
<td>Utilizes electronic medical record (EMR) efficiently and independently</td>
<td>Effectively navigates systems to overcome obstacles to optimal patient care (for example, facilitating access to care)</td>
<td>Recognizes the differences between a system change and a work-around (a bypass of a recognized system fault that attempts to improve efficiency)</td>
<td>Adapts learning from one system or setting to another, and in this way, can effect or stimulate improvements in a system, and does so when the need arises</td>
</tr>
<tr>
<td></td>
<td>Articulates health care missions at participating sites</td>
<td>Adapts to clinical work in different sites and health care systems (for example, VA, university medical center, etc.)</td>
<td>Identifies target patient populations, differences in demographics, and can utilize the appropriate agencies/resources to address specific needs of these populations</td>
<td>Identifies at least one work-around, explores opportunities for change, and when possible, takes steps to improve the system fault that incited it</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Maintains access to all needed systems</td>
<td>Identifies target patient populations, and the differences in demographics and needs of these populations at each participating site</td>
<td></td>
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</tr>
<tr>
<td></td>
<td>Identifies target patient populations, and the differences in demographics and needs of these populations at each participating site</td>
<td>Accesses support services appropriately at different practice sites</td>
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</table>

**Comments:**

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**SBP2. Works effectively within an interprofessional team**

<table>
<thead>
<tr>
<th>Level 1</th>
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</thead>
<tbody>
<tr>
<td>Has not</td>
<td>Identifies members of the team who coordinate patient care</td>
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<tr>
<td>Achieved</td>
<td>Describes own role as member of the health care team</td>
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<tr>
<td>Level 1</td>
<td>Utilizes and consults with other health care providers in coordination of patient care</td>
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<td>Appropriately communicates and coordinates care with the primary care and/or referral provider(s)</td>
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<td>Describes unique contributions (knowledge, skills, and attitudes) of other health care professionals, and seeks their input for appropriate issues</td>
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<tr>
<td></td>
<td>Describes the use of checklists and briefings to prevent adverse events in health care; recognizes the roles of team members and participates in briefings</td>
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<tr>
<td></td>
<td>Delegates tasks appropriately to members of the health care team</td>
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<td></td>
<td>Attends and contributes to academic department/division retreats (or similar organizational venue), as well as to clinic team/staff meetings at participating sites</td>
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<td></td>
<td>Facilitates checklist-guided briefings (for example pre-procedure timeouts) in health care activities</td>
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<td>Demonstrates how to manage, utilize, and coordinate the interprofessional team</td>
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<td></td>
<td>Participates in an interdisciplinary team meeting for clinic or program improvement</td>
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<td>Leads an interdisciplinary team</td>
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</thead>
<tbody>
<tr>
<td>Articulates understanding of the limitations of the health care system and potential for systems errors</td>
<td>Participates in discussion during conferences that highlight systems errors</td>
<td>Leads discussion during conferences that highlight systems errors</td>
<td>Consistently encourages open and safe discussion of error, and begins to identify and analyze error events</td>
<td>Consistently encourages open and safe discussion of errors, and characteristically identifies and analyzes error events, habitually approaching medical errors with a system solution methodology</td>
<td>Actively and routinely engages with teams and processes through which systems are modified to prevent medical errors</td>
</tr>
<tr>
<td>Articulates understanding of institutional risk-management resources available</td>
<td>Begins to identify the social/governmental services necessary for vulnerable populations, including determination of eligibility for services and delivery of some aspects of care</td>
<td>Articulates understanding of the intersection of the legal system and health care system in the context of medical errors</td>
<td>Consistently identifies the social/governmental services necessary for vulnerable populations, including determination of eligibility for services and delivery of some aspects of care</td>
<td>Advocates to improve patient care provided by health care, social, community, and governmental systems, including for vulnerable populations</td>
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<tr>
<td>Begins to advocate for optimal patient care in the setting of interdisciplinary interactions (for example, discussions with insurance companies or care providers in other specialties)</td>
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<td>Consistently advocates for optimal patient care in the setting of interdisciplinary interactions</td>
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**SBP3. Improves health care delivery by identifying system errors and implementing potential systems solutions**

**Advocates for quality patient care and optimal patient care systems**

Notes: [Insert notes here]

Comments:

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<tr>
<td>Articulates awareness of health care costs</td>
<td>Demonstrates knowledge of how a patient’s health care is paid for, and how this affects the patient’s care</td>
<td>Articulates awareness of common socio-economic barriers that impact patient care</td>
<td>Articulates an awareness of current debates/issus of health care financing and how it will affect patients, providers, third party payers, and other stakeholders</td>
<td>Demonstrates the incorporation of cost-awareness principles into complex clinical scenarios</td>
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<tr>
<td>Considers cost of medical and surgical therapies, and incorporates this into therapy decisions and discussions with the patient</td>
<td>Articulates awareness of costs for common diagnostic or therapeutic tests, including the cost of performing and interpreting skin biopsies</td>
<td>Articulates understanding of how cost-benefit analysis is applied to patient care (that is, via principles of screening tests and the development of clinical guidelines)</td>
<td>Identifies the role of various health care stakeholders, including providers, commercial and government payers, and pharmaceutical industry and medical device companies, and their varied impact on the cost of and access to health care</td>
<td>Identifies inherent biases of interactions with pharmaceutical and medical device industries</td>
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<tr>
<td>Demonstrates awareness of minimizing unnecessary care, including tests, procedures, therapies, and ambulatory or hospital encounters</td>
<td>Usually applies principles</td>
<td>Consistently applies principles of coding (ICD-9/10) and reimbursement</td>
<td>Demonstrates the incorporation of cost-awareness principles into standard clinical judgments and decision-making</td>
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<table>
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<tr>
<th>of coding (ICD-9/10) and reimbursement (E&amp;M levels/procedures) appropriate to medical record documentation</th>
<th>(E&amp;M levels/procedures) appropriate to medical record documentation</th>
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Identifies and minimizes unnecessary care, including tests, procedures, therapies, and ambulatory or hospital encounters

Comments:
### PBU1: Appraise and assimilate scientific evidence

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<tbody>
<tr>
<td>Navigates electronic databases of indexed citations and abstracts to medical sciences journal articles</td>
<td>Identifies well conducted research that impacts patient care</td>
<td>Actively participates by leading article review discussion and by asking appropriate questions during journal club/journal review activities</td>
<td>Incorporates principles and basic practices of evidence-based practice and information mastery into clinical practice</td>
<td>Independently teaches and assesses evidence-based medicine and information mastery techniques</td>
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<tr>
<td>Describes basic concepts in clinical epidemiology, biostatistics, and clinical reasoning, and can categorize the study design of a research study</td>
<td>Identifies critical threats to study validity and generalizability when reading a research paper or study synopsis</td>
<td>Actively seeks appropriate resources to find dermatology information to answer clinical questions without being requested or assigned this task</td>
<td>Identifies alternative resources to answer clinical questions (for example, microbiology lab director, E&amp;M coding guidelines, Medicare policies, CDC reporting requirements)</td>
<td>Cites evidence supporting several common practices in his or her practice</td>
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<td>Provides appropriate reference lists for prepared hand-outs or other program-specific assignments</td>
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**Comments:**
### PBUI2. Continuously improve through self-assessment of competence

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<tbody>
<tr>
<td><strong>Usually asks for feedback</strong>&lt;br&gt;Relies on teachers and colleagues for immediate information needs</td>
<td><strong>Consistently asks for feedback</strong>&lt;br&gt;Reviews feedback, acknowledges gaps in personal knowledge and expertise, and uses feedback/assessments to develop learning plans with some assistance</td>
<td><strong>Self-assessment or learning plan demonstrates a balanced and accurate assessment of competence and areas for continued improvement</strong>&lt;br&gt;Identifies, in journal club or other educational venues, when new evidence, guidelines, or information should change how the resident or department functions (ordering tests, selecting therapies, etc.)</td>
<td><strong>Performs mostly self-directed learning, integrating multiple feedback and assessment sources, with little external guidance</strong>&lt;br&gt;Demonstrates an effective method, system, or process for staying current with relevant changes in clinical dermatology and dermatology medical knowledge</td>
<td><strong>Regularly seeks to determine and maintain knowledge of best evidence supporting common practices, demonstrating consistent behavior of regularly reviewing evidence in common practice areas</strong>&lt;br&gt;Demonstrates an effective method, system, or process for staying current with relevant changes in dermatology health policy and practice management</td>
<td><strong>Regularly completes self-assessments of medical knowledge gaps relevant to practice and patient population</strong>&lt;br&gt;Identifies personal gaps in achieving necessary or desired aspects of residency education and communicates these with program director</td>
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Comments:
### PBUI3. Integrate quality improvement concepts and activities in practice

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<tbody>
<tr>
<td>Identifies problems in health care delivery and sees the quality gap in care</td>
<td>Identifies the basic processes involved in quality improvement, identifies deviations from standards of dermatologic care (for example, identifies when guidelines of care were not followed, and when over- or under-utilization of diagnostic testing and therapy has occurred)</td>
<td>Reviews local gaps in quality, and identifies systems and human errors that contribute to gaps in quality</td>
<td>Critically appraises current or proposed quality improvement interventions</td>
<td>Assesses outcomes of quality improvement efforts, and applies these towards continuous quality improvement</td>
<td>Continues to engage in innovative quality improvement activities appropriate to practice venue, including activities that prepare the resident for Maintenance Of Certification, Component 4</td>
</tr>
</tbody>
</table>

Comments:

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### PBLU4. Teach others

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<tbody>
<tr>
<td>Provides education on a few basic dermatology topics to patients and other learners</td>
<td>Creates presentations that incorporate digital images</td>
<td>Summarizes complex medical topics through effective information synthesis and presentation of material</td>
<td>Assumes a significant role in clinically teaching learners</td>
<td>Continues to teach others, including non-dermatology providers, about dermatology</td>
<td></td>
</tr>
<tr>
<td>Actively participates in conferences</td>
<td>Able to synthesize medical topics, with some help, for presentations</td>
<td>Actively participates in activities designed to develop and improve teaching skills</td>
<td>Presents information in a well-rehearsed, confident manner within the allotted time</td>
<td>Seeks feedback on teaching others, and incorporates plan to address areas for teaching improvement</td>
<td></td>
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<tr>
<td></td>
<td>Seizes the teachable moment with others in the clinical setting</td>
<td>Seeks and receives feedback on clinical teaching and assesses this information to determine areas for teaching improvement</td>
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**Comments:**
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<tr>
<td></td>
<td>Truthfully documents and reports clinical information</td>
<td>Treats all patients with respect and dignity, regardless of socioeconomic, racial, or ethnic background or sexual orientation</td>
<td>Educates junior learners and ancillary staff members in, and models adherence to, institutional and departmental policies and procedures, proper use of social media, equitable and empathic treatment of all patients, and maintaining patient confidentiality</td>
<td>Demonstrates ethical and professional behavior, and manages real and potential conflicts of interest in all professional activities, including patient care, research, publication, and relationships with industry</td>
<td>Adheres to federal and state regulations regarding digital privacy, HIV privacy, access to medical records, and records storage</td>
</tr>
<tr>
<td></td>
<td>Reads and abides by formal policies and procedures (for example, program, departmental, GME, HIPAA, use of clinical images, social media)</td>
<td>Adheres to the American Board of Dermatology's (ABD) honor code and policies regarding academic honesty in preparing for and taking the annual in-service and certifying examinations</td>
<td>Adheres to state, institutional, and professional guidelines regarding physician relationships with industry</td>
<td>Has achieved sufficient self-awareness and understanding to manage work-life balance, and to recognize signs of impairment, mental illness, substance abuse, or burnout in oneself or one's colleagues to take appropriate action</td>
<td>Avoids inappropriate or problematic relationships with patients, staff members, other residents, and students</td>
</tr>
<tr>
<td></td>
<td>Completes institutional confidentiality training and maintains confidentiality of protected health information</td>
<td>Displays academic honesty and avoids plagiarism in talks, presentations, and publications</td>
<td>Does not engage in misleading statements or puffery or use false testimonials when promoting his or her practice</td>
<td>Bills honestly, avoiding dishonest upcoding or inflated documentation</td>
<td></td>
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<tr>
<td></td>
<td>Understands a physician's fiduciary obligation to patients, and consistently places patient care needs above self-interest</td>
<td>Performs all human subjects research in accordance with federal, state, and institutional regulations and guidelines</td>
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<tr>
<th>Version 11/2013</th>
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<tbody>
<tr>
<td>discloses obvious conflicts of interest in publications and presentations</td>
</tr>
<tr>
<td>Aware of pitfalls of self-care and care of family members and associates, and under what circumstances these are either inappropriate or illegal</td>
</tr>
<tr>
<td>Responds promptly and appropriately to clinical responsibilities (for example, timely reporting for duty, completion of medical records, returning patient phone calls, answering pages); carries out timely interactions with colleagues, patients, and their designated caregivers; promptly completes clinical, administrative, and curricular tasks</td>
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Comments:
### PROF2. Committed to lifelong learning and improvement

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<tbody>
<tr>
<td>Aware of personal errors</td>
<td>Admits to limitations and personal errors, and knows when and whom to ask for help</td>
<td>Develops self-improvement plan to address limitations and personal errors</td>
<td>Assists junior residents in recognizing their own limitations</td>
<td>Mentors residents/new graduates on how to recognize limitations and develop self-improvement plans</td>
<td></td>
</tr>
<tr>
<td>Usually elicits feedback from faculty members</td>
<td>Accepts constructive feedback and strives to improve</td>
<td>Provides feedback to junior residents and medical students</td>
<td>Describes key elements in how to provide effective feedback</td>
<td>Effectively provides feedback to peers, office staff, and other learners</td>
<td></td>
</tr>
<tr>
<td>Explains how teamwork benefits patient care</td>
<td>Explains the concept of leading by example</td>
<td>Assumes leadership role among the resident group (for example, as chief resident, project manager); serves as a role model for junior residents</td>
<td>Describes the fundamental skill set for effective leadership</td>
<td>Takes a leadership role within the practice/department or in regional, state, or national organizations</td>
<td></td>
</tr>
<tr>
<td>Requires direction in determining what is important in learning goals</td>
<td>Lists and organizes the topics and subtopics that must be learned for patient care and to pass the ABD certifying examination</td>
<td>Lists gaps of knowledge and devises plan for improvement</td>
<td>Capable of passing the ABD certifying examination</td>
<td>Understands the ABD Maintenance Of Certification program, and fulfills state licensure requirements</td>
<td></td>
</tr>
</tbody>
</table>

Comments:
## PROF3. Patient care is the first priority

<table>
<thead>
<tr>
<th>Has not Achieved Level 1</th>
<th>Level 1</th>
<th>Level 2</th>
<th>Level 3</th>
<th>Level 4</th>
<th>Level 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recognizes the challenges of balancing professional and personal life</td>
<td>May need assistance with time management and setting priorities, but all patient care activities are completed in a timely fashion</td>
<td>Establishes list of priorities and effective time management that enables successful pursuit of professional and personal goals</td>
<td>Adjusts priorities in response to changing demands</td>
<td>Provides advice and assistance for peers or other learners experiencing major changes affecting professional or personal life</td>
<td></td>
</tr>
<tr>
<td>Demonstrates empathy and compassion to patients; respects patient dignity and autonomy</td>
<td>Consistently demonstrates empathy and compassion to patients of all ages</td>
<td>Consistently demonstrates empathy and compassion to patients of all ages, including difficult or challenging patients</td>
<td>Anticipates the needs of patients, and works to meet those needs in daily practice</td>
<td>Is a proactive advocate for individual patients and their families</td>
<td></td>
</tr>
<tr>
<td>Describes common opportunities for patient advocacy in the outpatient setting</td>
<td>Seeks appropriate resources to advocate for individual patient needs with assistance</td>
<td>Demonstrates effective strategies to manage conflict when patient values differ from his or her own values</td>
<td>Effectively advocates for individual patient needs</td>
<td>Embraces the physician’s role in understanding and addressing causes of disparity in disease and suffering</td>
<td></td>
</tr>
<tr>
<td>Treats patients with dignity, civility and respect, regardless of race, culture, gender, ethnicity, age, sexual orientation, or socioeconomic status</td>
<td>Recognizes when patient values differ from his or her own values and how this might affect the physician-patient interaction</td>
<td>Discusses ideas and strategies to offset disparities in health care for specific dermatologic diagnoses</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Comments:**

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<table>
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<tr>
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<th>Level 2</th>
<th>Level 3</th>
<th>Level 4</th>
<th>Level 5</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ICS1. Communication and Rapport with Patients and Families</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Describes the concepts of communication in the clinical setting, but usually needs guidance in using them to build rapport in encounters with patients and families.</td>
<td>Usually communicates effectively and builds rapport with patients and families in routine encounters, but requires guidance in stressful encounters.</td>
<td>Consistently communicates effectively and builds rapport with patients and families in routine encounters, occasionally requiring guidance in stressful encounters.</td>
<td>Consistently communicates effectively and builds rapport with patients and families in routine and stressful encounters.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Begins to demonstrate sensitivity to sociocultural practices.</td>
<td>Occasionally recognizes non-verbal cues from patients and uses non-verbal skills to convey empathy, but requires guidance in time-pressed, complex, and stressful situations.</td>
<td>Usually recognizes non-verbal cues from patients, and uses non-verbal skills to convey empathy.</td>
<td>Consistently recognizes and effectively uses non-verbal communication skills in relating to patients and families.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Speaks in easily understandable language and avoids technical jargon.</td>
<td>Usually paces clinical interviews appropriately, spending extra time when indicated.</td>
<td>Consistently paces clinical interviews appropriately.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Actively seeks the patient’s and family’s perspective; uses patient hand-outs and/or diagrams to explain diseases and treatments when appropriate.</td>
<td>Consistently maintains composure in difficult patient and family encounters.</td>
<td>Consistently seeks out by junior learners, peers, and other members of the health care team for his or her ability to allay fears and effectively address the concerns of patients and families.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Counsels and provides clear and specific verbal and/or non-verbal communication.</td>
<td>Considers patient beliefs in shaping the patient-physician relationship and therapeutic plan.</td>
<td>Is regularly sought out by junior learners, peers, and other members of the health care team for his or her ability to allay fears and effectively address the concerns of patients and families.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Written Instructions to Patients Related to Diagnostic Tests, Risk/Benefits of Treatment, Treatment Alternatives, and Therapeutic Plans (Including Prescriptions), and Assesses Patient Comprehension</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adapts Patient/Family-Related Information Gathering to Social and Cultural Context</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Identifies Special Communication Needs of Vulnerable Populations (For Example, Pediatric and Elderly Patients, Persons with Disabilities or Illiteracy, Immigrants, Refugees, Veterans, Prisoners); Appropriately Uses Translators to Facilitate Communication with Patients and Families</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Demonstrates Appropriate Face-to-Face Interaction While Using the Electronic Medical Record or Completing the Patient Health Record</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Comments:
### ICS2. Having Difficult Conversations

<table>
<thead>
<tr>
<th>Has not Achieved Level 1</th>
<th>Level 1</th>
<th>Level 2</th>
<th>Level 3</th>
<th>Level 4</th>
<th>Level 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Describes the general approach to difficult conversations with patients and families, but usually <strong>needs guidance</strong> to recognize these situations and respond appropriately</td>
<td>Recognizes the circumstances related to having difficult conversations with patients and families</td>
<td>Usually communicates effectively in difficult conversations with patients and families, including <strong>some</strong> complex or unusual circumstances</td>
<td>Consistently communicates effectively in difficult conversations with patients and families in <strong>routine and complex</strong> circumstances</td>
<td>Role models an effective and sensitive approach to difficult conversations with patients and families</td>
<td>Is regularly <strong>sought out</strong> by junior learners, peers, and other members of the health care team for his or her ability to effectively handle difficult conversations in complex or unusual circumstances</td>
</tr>
</tbody>
</table>

Comments:
### ICS3. Team Member Respect and Care Coordination

<table>
<thead>
<tr>
<th>Has not Achieved Level 1</th>
<th>Level 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recognizes the importance of the other members of the health care team and the need to communicate in ways that show appreciation for the skills and contributions of other professionals</td>
<td>Communicates effectively with health care team members in ways that demonstrate appreciation for their skills and contributions in routine situations, but requires guidance in difficult or contentious situations</td>
</tr>
<tr>
<td>Level 2</td>
<td>Level 3</td>
</tr>
<tr>
<td>Consistently communicates effectively with health care team members in ways that demonstrate appreciation for their skills and contributions in routine situations, occasionally requiring guidance in difficult or contentious situations</td>
<td>Consistently communicates effectively with health care team members in ways that demonstrate appreciation for their skills and contributions in routine and difficult or contentious situations</td>
</tr>
<tr>
<td>Level 4</td>
<td>Level 5</td>
</tr>
<tr>
<td>Role models communication that shows appreciation for all members of the health care team, including in difficult or contentious situations</td>
<td>Is regularly sought out by junior learners, peers, and other members of the health care team for his or her ability to communicate effectively in a team-based approach to care</td>
</tr>
</tbody>
</table>

Comments:
### ICS4. Communication and Consultation with Other Physicians

<table>
<thead>
<tr>
<th>Has not Achieved Level 1</th>
<th>Level 1</th>
<th>Level 2</th>
<th>Level 3</th>
<th>Level 4</th>
<th>Level 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Begins to recognize situations where consultation is needed, and the importance of effective communication with supervisors, consultants, and referring healthcare providers</td>
<td>Obtains and provides consultation and communicates effectively with supervisors, consultants, and referring providers in routine patient care situations, but <strong>needs guidance</strong> in complex or nuanced circumstances</td>
<td>Consistently obtains and provides consultation and communicates effectively and efficiently with supervisors, consultants, and referring providers in <strong>routine patient care situations</strong>, <strong>occasionally needing guidance</strong> in complex or nuanced situations</td>
<td>Consistently obtains and provides consultation <strong>independently</strong>, and communicates effectively and efficiently with supervisors, consultants, and referring providers in <strong>routine and complex or nuanced patient care situations</strong></td>
<td>Role models coordination and ongoing communication with supervisors, consultants, and referring providers</td>
<td>Is regularly sought out by junior learners, peers, and other members of the healthcare team for his or her skill in functioning effectively both as consultant and consultant</td>
</tr>
</tbody>
</table>

**Comments:**

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## ICSS. Medical Documentation

<table>
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<th>Level 4</th>
<th>Level 5</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Recognizes the importance of accuracy in documenting information in the patient record, as well as the use of medical records in patient care. Recognizes that accurate and prompt completion of patient records contributes to patient safety and reduces the risk of medical error.</td>
<td>Consistently documents office visits, consultations, letters to referring providers, procedures, and counseling with clearly written and relevant information for routine situations, but occasionally needs assistance with complex situations. Ensures that patient records and orders are accurate, comprehensive, timely, and legible with attention to preventing confusion and error.</td>
<td>Consistently ensures that patient records, including outpatient and inpatient consultations and transitions of care, are promptly and accurately documented for routine and complex situations.</td>
<td>Provides some examples of the medicolegal repercussions of inappropriate medical record documentation.</td>
<td>Serves as role model for, and consultant to, junior learners, peers, and other members of the health care team in patient record documentation.</td>
</tr>
</tbody>
</table>

Comments:
1. **In-Training Examination:**
   
   *Medical Knowledge* (knowledge and application of basic science)
   
   *Practice Based Learning and Improvement* (use of evidence from scientific studies, application of research and statistical methods, use of information technology)

<table>
<thead>
<tr>
<th>Raw score</th>
<th>Your Class average:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentile</td>
<td>Your Class average:</td>
</tr>
<tr>
<td>Strengths:</td>
<td>Weaknesses:</td>
</tr>
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</table>

2. **Clinical Competency Evaluation (Sept):**
   
   *Patient Care* (caring and respectful behavior, interviewing, counsel and educate patient and families, perform medical procedures, work within a team)
   
   *Medical Knowledge* (investigatory and analytical thinking, knowledge and application of basic science)
   
   *Practice Based Learning and Improvement* (facilitate learning of others)
   
   *Interpersonal and Communication Skills* (creation of a professional relationship with patients)
   
   *Professionalism* (respectful, altruistic, ethically sound practice, sensitive to culture, age, gender, and disability issues)
   
   *Systems Based Practice* (working within an university hospital medical system, understanding use of consultants in the care of patients, realizing the impact of insurance issues on the practice of medicine)

   Reviewed your score:    Your Class average:  

3. **360 Milestones Global Rating Evaluation (faculty, self, staff and peers)**
   
   *Patient Care* (caring and respectful behavior, interviewing, counsel and educate patient and families, perform medical procedures, work within a team)
   
   *Medical Knowledge* (investigatory and analytical thinking, knowledge and application of basic science)
   
   *Practice Based Learning and Improvement* (facilitate learning of others)
   
   *Interpersonal and Communication Skills* (creation of a professional relationship with patients)
   
   *Professionalism* (respectful, altruistic, ethically sound practice, sensitive to culture, age, gender, and disability issues)

   Your Winter Score:  

   Self-assessment completed and reviewed  

   Your Summer Score:  

273
4. **Personal Feedback (April):**

*Patient Care* (caring and respectful behavior, interviewing, counsel and educate patient and families, perform medical procedures, work within a team)
*Medical Knowledge* (investigatory and analytical thinking, knowledge and application of basic science)
*Practice Based Learning and Improvement* (facilitate learning of others)
*Interpersonal and Communication Skills* (creation of a professional relationship with patients)
*Professionalism* (respectful, altruistic, ethically sound practice, sensitive to culture, age, gender, and disability issues)
*Systems Based Practice* (working within an university hospital medical system, understanding use of consultants in the care of patients, realizing the impact of insurance issues on the practice of medicine)

Reviewed

5. **American Board of Dermatology Evaluation**

*Patient Care* (caring and respectful behavior, interviewing, counsel and educate patient and families, perform medical procedures, work within a team)
*Medical Knowledge* (investigatory and analytical thinking, knowledge and application of basic science)
*Practice Based Learning and Improvement* (facilitate learning of others)
*Interpersonal and Communication Skills* (creation of a professional relationship with patients)
*Professionalism* (respectful, altruistic, ethically sound practice, sensitive to culture, age, gender, and disability issues)
*Systems Based Practice* (working within an university hospital medical system, understanding use of consultants in the care of patients, realizing the impact of insurance issues on the practice of medicine)

Strengths include:

Areas to address:

6. **Speaker Score**

*Medical Knowledge* (investigatory and analytical thinking, knowledge and application of basic science)
*Practice Based Learning and Improvement* (facilitate learning of others)
*Interpersonal and Communication Skills* (creation of a professional relationship with patients)
*Professionalism* (respectful, altruistic, ethically sound practice, sensitive to culture, age, gender, and disability issues)

Score

Team average:

7. **Portfolio & Independent Learning Plan**

*Medical Knowledge* (investigatory and analytical thinking, knowledge and application of basic science)
*Practice Based Learning and Improvement* (use of evidence from scientific studies, application of research and statistical methods, use of information technology)
8. **Procedure Log**  
*Patient Care (perform medical procedures)*  
Reviewed and included

9. **Conference Attendance percentage:**  
*Professionalism* (respectful, altruistic, ethically sound practice, sensitive to culture, age, gender, and disability issues)  
Reviewed

Resident Signature and Date ______________________________

Program Director and Date ______________________________

Chair and Date ______________________________
### Medical Knowledge (Question 1 of 5 - Mandatory)

<table>
<thead>
<tr>
<th>N/A</th>
<th>Poor</th>
<th>Fair</th>
<th>Good</th>
<th>Very Good</th>
<th>Excellent</th>
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<tbody>
<tr>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
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### Professionalism (Question 2 of 5 - Mandatory)

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<th>Good</th>
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<th>Excellent</th>
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</thead>
<tbody>
<tr>
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### Patient Care (Question 3 of 5 - Mandatory)

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<th>Good</th>
<th>Very Good</th>
<th>Excellent</th>
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</thead>
<tbody>
<tr>
<td>0</td>
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### Interpersonal Communication Skills (Question 4 of 5 - Mandatory)

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<th>Excellent</th>
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### Comments (Question 5 of 5)
### Patient Evaluation (Through Bivarus)

#### Patient Feedback

<table>
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<th># of Responses</th>
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<tbody>
<tr>
<td>Communication</td>
<td>4.5</td>
<td>4.6</td>
<td>36</td>
</tr>
<tr>
<td>Patient Centered Care</td>
<td>4.6</td>
<td>4.5</td>
<td>30</td>
</tr>
<tr>
<td>Patient Safety</td>
<td>4.4</td>
<td>4.1</td>
<td>23</td>
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<tr>
<td>Provider Expertise &amp; Interpersonal Skills</td>
<td>4.7</td>
<td>4.5</td>
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#### Communication

<table>
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<th>Score</th>
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<th>95% Confidence Interval Upper Bound</th>
<th># of Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>My doctor explained my diagnosis.</td>
<td>4.63</td>
<td>5.00</td>
<td>4.53</td>
<td>5.47</td>
<td>4</td>
</tr>
<tr>
<td>My doctor explained my test results.</td>
<td>4.46</td>
<td>3.71</td>
<td>2.84</td>
<td>4.59</td>
<td>7</td>
</tr>
<tr>
<td>My doctor explained things in a way I could understand.</td>
<td>4.61</td>
<td>5.00</td>
<td>4.39</td>
<td>5.61</td>
<td>3</td>
</tr>
<tr>
<td>My doctor explained what procedures were being performed.</td>
<td>4.52</td>
<td>4.67</td>
<td>4.30</td>
<td>5.04</td>
<td>9</td>
</tr>
<tr>
<td>My doctor explained what tests he/she was ordering.</td>
<td>4.54</td>
<td>4.43</td>
<td>3.85</td>
<td>5.01</td>
<td>7</td>
</tr>
<tr>
<td>My doctor informed me of my treatment options.</td>
<td>4.58</td>
<td>4.67</td>
<td>4.19</td>
<td>5.15</td>
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#### Patient Centered Care

<table>
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<tr>
<th>Question</th>
<th>Average Peer Score</th>
<th>Score</th>
<th>95% Confidence Interval Lower Bound</th>
<th>95% Confidence Interval Upper Bound</th>
<th># of Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>My doctor did not seem rushed while with me.</td>
<td>4.41</td>
<td>3.86</td>
<td>3</td>
<td>4.71</td>
<td>7</td>
</tr>
<tr>
<td>My doctor included me in decisions about my care.</td>
<td>4.46</td>
<td>4.67</td>
<td>4.19</td>
<td>5.15</td>
<td>6</td>
</tr>
<tr>
<td>My doctor listened to me.</td>
<td>4.57</td>
<td>4.2</td>
<td>3.69</td>
<td>4.71</td>
<td>5</td>
</tr>
<tr>
<td>My doctor made me feel comfortable about asking questions.</td>
<td>4.66</td>
<td>4.78</td>
<td>4.44</td>
<td>5.12</td>
<td>9</td>
</tr>
<tr>
<td>While in my room, my doctor was focused on me/my issues.</td>
<td>4.8</td>
<td>5</td>
<td>4.39</td>
<td>5.61</td>
<td>3</td>
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</table>
### PATIENT SAFETY

<table>
<thead>
<tr>
<th>Question</th>
<th>Average Peer Score</th>
<th>Score</th>
<th>95% Confidence Interval Lower Bound</th>
<th>95% Confidence Interval Upper Bound</th>
<th># of Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>My doctor alerted me to things I should have checked immediately should they occur after surgery.</td>
<td>4.29</td>
<td>4.00</td>
<td>3.31</td>
<td>4.60</td>
<td>7</td>
</tr>
<tr>
<td>My doctor reviewed possible side effects of any procedure before starting.</td>
<td>4.32</td>
<td>4.50</td>
<td>3.93</td>
<td>5.07</td>
<td>10</td>
</tr>
<tr>
<td>Prior to starting, my doctor made it clear I was having a procedure.</td>
<td>4.47</td>
<td>3.67</td>
<td>2.69</td>
<td>4.64</td>
<td>6</td>
</tr>
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### PROVIDER EXPERTISE AND INTERPERSONAL SKILLS

<table>
<thead>
<tr>
<th>Question</th>
<th>Average Peer Score</th>
<th>Score</th>
<th>95% Confidence Interval Lower Bound</th>
<th>95% Confidence Interval Upper Bound</th>
<th># of Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>I would trust this doctor to care for my friends/family.</td>
<td>4.66</td>
<td>4.58</td>
<td>4.26</td>
<td>4.90</td>
<td>12</td>
</tr>
<tr>
<td>My doctor had a pleasant bedside manner.</td>
<td>4.74</td>
<td>4.67</td>
<td>3.91</td>
<td>5.42</td>
<td>3</td>
</tr>
<tr>
<td>My doctor had good medical knowledge.</td>
<td>4.58</td>
<td>4.20</td>
<td>3.50</td>
<td>4.90</td>
<td>5</td>
</tr>
<tr>
<td>My doctor was kind and caring.</td>
<td>4.64</td>
<td>4.27</td>
<td>3.88</td>
<td>4.67</td>
<td>11</td>
</tr>
<tr>
<td>My doctor’s overall appearance was professional.</td>
<td>4.76</td>
<td>4.75</td>
<td>4.14</td>
<td>5.36</td>
<td>4</td>
</tr>
</tbody>
</table>
**UNC DERMATOLOGY AND SKIN CANCER CENTER**

**Patient Comments**

**11/20/12 - 7/31/13**

<table>
<thead>
<tr>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>&quot;Everything was good!&quot;</td>
</tr>
<tr>
<td>&quot;Great docs and staff! Overall experience was very positive and the doc answered all our questions. Everyone there is so sweet. They all made my son who is autistic feel very comfy.&quot;</td>
</tr>
<tr>
<td>&quot;I have enjoyed visiting with the Carolina Doc. We came to UNC because the previous doctor we saw in Fayetteville was very out of touch with kids, and didn't work well with them. I was unhappy with their treatment plan and our son received great care from the Carolina Doc. Thanks!&quot;</td>
</tr>
<tr>
<td>&quot;I was very pleased with my last two visits.&quot;</td>
</tr>
<tr>
<td>&quot;Excellent experience. Kudos to all the staff!&quot;</td>
</tr>
<tr>
<td>&quot;It was a great visit. My child felt comfortable with the nurse, the resident doctor, and the supervising doctor. I would highly recommend this facility.&quot;</td>
</tr>
<tr>
<td>&quot;Doctor was very nice and patient with my 4 year old.&quot;</td>
</tr>
<tr>
<td>&quot;My doctor was seeing my three year old grandson and training someone to take notes at the same time. She apologized but it was distracting and I did not feel like I had her full attention. The fact that she kept turning to the note taker and instructing her made it hard for me to focus on what I wanted to ask her. As a result, I forgot I have been coming to the UNC Derm clinic for a while now and I choose to drive the 1 hr and 45 min drive from our home in Fayetteville because it has been such a wonderful experience. I am treating my son Ben for Molescums (sp?) and I have been overjoyed with her care. We left the Polley Clinic here in Fayetteville because we were not happy with their treatment, but Dr. Apel has been caring, knowledgeable, and always available.&quot;</td>
</tr>
<tr>
<td>&quot;The prescription that was supposed to be called in for me has still not been called in and it has been almost 36 hrs.&quot;</td>
</tr>
<tr>
<td>&quot;I was very satisfied. I got all my questions answered and got help for my particular problems. My doctor gave me something to help with my dry skin.&quot;</td>
</tr>
<tr>
<td>&quot;We are VERY pleased with the level and quality of service!&quot;</td>
</tr>
<tr>
<td>&quot;the doctor was very sweet even thought she was at the end of her pregnancy days! good luck!&quot;</td>
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Comments (Question 7 of 7)
Former residents are asked to evaluate the academic program after some time away from residency. This evaluation will become part of the agenda for the Education Committee in formulating changes in the program. We appreciate your feedback. You are asked to rate the areas as excellent, very good, good, fair, poor, and not applicable. Please add any additional comments that may help us improve our resident training.

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<td>B. Match of educational experience with program stated goals</td>
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Please fax completed survey to Cherie Ezuka at 919-966-6460
<table>
<thead>
<tr>
<th>PROGRAM DIRECTOR</th>
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## Clinical skills of faculty  
(Question 9 of 23 - Mandatory)

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## Teaching skills of faculty  
(Question 10 of 23 - Mandatory)

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## Accessibility  
(Question 11 of 23 - Mandatory)

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## Feedback from faculty  
(Question 12 of 23 - Mandatory)

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## RESIDENT INPUT

### Extent of feedback from faculty evaluations  
(Question 13 of 23 - Mandatory)

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### Resident input on patient care activities  
(Question 14 of 23 - Mandatory)

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### Resident ability to express concerns without fear of retaliation  
(Question 15 of 23 - Mandatory)

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## RESIDENT QUALITY OF LIFE

### Ability to balance residency demands and personal commitments  
(Question 16 of 23 - Mandatory)

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## SATISFACTION OF PROGRAM

### Extent to which educational experience prepares residents for career objectives  
(Question 17 of 23 - Mandatory)

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### PROGRAM DIRECTOR

**Effectiveness of program leadership** *(Question 1 of 20 - Mandatory)*

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**Availability to residents** *(Question 2 of 20 - Mandatory)*

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**Clarity of expectations of residents** *(Question 3 of 20 - Mandatory)*

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**Fairness and evaluation of the residents strengths and weaknesses** *(Question 4 of 20 - Mandatory)*

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**Quality of guidance in what the residents need to do to improve** *(Question 5 of 20 - Mandatory)*

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### RESIDENT SUPPORT

**Departmental staff effectiveness in dealing with resident issues** *(Question 6 of 20 - Mandatory)*

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### FACULTY

**Medical knowledge of faculty** *(Question 7 of 20 - Mandatory)*

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**Clinical skills of faculty** *(Question 8 of 20 - Mandatory)*

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### Teaching skills of faculty (Question 9 of 20 - Mandatory)

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### Accessibility (Question 10 of 20 - Mandatory)

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### Feedback from faculty (Question 11 of 20 - Mandatory)

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### RESIDENT INPUT

**Resident input on patient care activities (Question 12 of 20 - Mandatory)**

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**Resident ability to express concerns without fear of retaliation (Question 13 of 20 - Mandatory)**

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### RESIDENT QUALITY OF LIFE

**Ability to balance residency demands and personal commitments (Question 14 of 20 - Mandatory)**

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### SATISFACTION OF PROGRAM

**Extent to which educational experience prepares residents for career objectives (Question 15 of 20 - Mandatory)**

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### Resident role as a member of the team (Question 16 of 20 - Mandatory)

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### PROGRAM OVERALL

**Program Director (Question 17 of 20 - Mandatory)**

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| **Resident Quality of Life** (Question 19 of 20 - Mandatory) |
|---|---|---|---|---|---|
| N/A | Poor | Fair | Good | Very Good | Excellent |
| 0 | 1 | 2 | 3 | 4 | 5 |

| **Satisfaction with Program** (Question 20 of 20 - Mandatory) |
|---|---|---|---|---|---|
| N/A | Poor | Fair | Good | Very Good | Excellent |
| 0 | 1 | 2 | 3 | 4 | 5 |
## Department of Dermatology
### Resident of Faculty Evaluation

### Availability (Question 1 of 10 - Mandatory)

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### Effective Role Model (Question 2 of 10 - Mandatory)

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### Case Related Teaching (clinic, OR rounds) (Question 3 of 10 - Mandatory)

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### Didactic Teaching (conferences, lectures) (Question 4 of 10 - Mandatory)

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### Medical Student Teaching (Question 6 of 10 - Mandatory)

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### Helpfulness (Question 7 of 10 - Mandatory)

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Strengths (Question 8 of 10)
### Rotation by Resident

**Adequacy of various types of patients** *(Question 1 of 16 - Mandatory)*

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**Commitment to resident education** *(Question 2 of 16 - Mandatory)*

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**Quality of patient care experience** *(Question 3 of 16 - Mandatory)*

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**Working relationships between residents and faculty** *(Question 4 of 16 - Mandatory)*

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**Ability to exercise patient care responsibility commensurate with competence** *(Question 5 of 16 - Mandatory)*

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**Ability to get assistance from faculty with a patient when needed.** *(Question 6 of 16 - Mandatory)*

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**Frequency of service work rather than educational experience** *(Question 7 of 16 - Mandatory)*

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**Frequency of informal evaluation** *(Question 8 of 16 - Mandatory)*

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**Constructiveness of feedback received from informal evaluations** *(Question 9 of 16 - Mandatory)*

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**Your treatment by faculty/attendings** *(Question 10 of 16 - Mandatory)*

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### Educational Activities by Faculty

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### Journal Club

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### Journal Club - Comments

(Question 10 of 14)

### Evaluation Process

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## Educational Activities by Residents

(Question 1 of 26 - Mandatory)

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(Question 3 of 26 - Mandatory)

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(Question 23 of 26 - Mandatory)
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**DERMATOLOGY RESIDENT PERSONAL CLINICAL EVALUATION**

University of North Carolina, Department of Dermatology  
Resident Performance Rating Form

**Resident Name:** __________________________

**Attending:** __________________________

**Clinic:** __________________________

**Date:** __________________________

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<td><strong>Systems Based Practice</strong></td>
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<tr>
<td>Uses system resources well</td>
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Please list one specific way in which this resident could improve, or one thing to work on this week:

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

**Additional Comments:**

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

**Supervisor Signature:** __________________________
Program Evaluation Committee (PEC)
Description and Responsibilities

Overview:
The Program Evaluation Committee (PEC) is a faculty and resident advisory group appointed by the Program Director to assist in evaluating the educational activities of the program based on the RRC training requirements and program outcome measures. The PEC is comprised of no fewer than two (2) members of the program faculty and no fewer than two (2) resident physicians.

Purpose:
The PEC performs continuous on-going review and annual program evaluation. The goal of the PEC is to assure that the educational activities are progressing and meeting ACGME requirements.

Composition of the PEC:
The Program Director appoints program faculty members, including core faculty to the PEC, as well as resident physicians. The PEC is chaired by Dean Morrell, MD, Professor of Dermatology and Program Director. Other members of the committee include Aida Lugo-Somolinos, MD, Professor of Dermatology, Amy Fox, MD, Assistant Professor of Dermatology, and the Co-Chief Dermatology Residents.

Responsibilities of the PEC:
6. Review curriculum development and evaluation;
7. Revise competency-based goals and objectives;
8. Address areas of non-compliance no less frequently than quarterly;
9. Monitor progress on the previous year’s Action Plan;
10. Prepare report to the GMEC addressing the following required data points/elements (performed annually):
   a. Resident performance;
   b. Faculty development;
   c. Graduate performance (board pass rates, graduate survey);
   d. Program quality:
      i. Annual confidential evaluation of the program by residents
      ii. Annual confidential evaluation of the program by faculty
      iii. ACGME survey results (from both residents and faculty)
   e. Progress on previous Action Plan;

**Responsibilities of the Program Director:**
6. The Program Director ensures the final written plan is reviewed/approved by the teaching faculty.
7. The Program Director ensures the Action Plan is documented in the faculty meeting minutes.
8. The Program Director provides the Annual Program Evaluation with Action Plan to the GMEC.
9. The Program Director ensures that the Annual Program Evaluation with Action Plan is entered in the ADS, at the end of each fiscal year.

Created June 11, 2014
1. Evaluation of Residents
   a. Clinical Skills (Sept)
   b. Winter Milestones (December)
   c. In-Training Exam (Spring)
   d. Personal feedback card (May)
   e. ABD (June-July)
   f. Summer Milestones (June)
   g. Portfolio review (July)
      i. Reflective statement per entry
      ii. Independent learning plan and activities to address per resident each year
   h. Procedure Logs
   i. Speaker evaluation
      i. *Need to improve our tool*
   j. Attendance to educational sessions
   k. Resident Eval of evaluation process: 2.57 (2.43, 2.69, 2.58, 2.3, 2.4, 2.5) (Excellent=3, Adequate=2, Deficient=1)
   l. Faculty Eval of evaluation process: 2.93 (2.87, 2.77, 2.75, 2.82, 2.88, 2.8) (Excellent=3, Adequate=2, Deficient=1)

2. Review of resident performance
   a. Clinical Skills Sept assessment 4.56 (4.52, 4.54, 4.53) (1-5 scale; 5=excellent, 4=very good, 3=good)
      i. Yr1: 4.34 (4.3, 4.39, 4.3)
      ii. Yr2: 4.61 (4.6, 4.66, 4.5)
      iii. Yr3: 4.67 (4.64, 4.61, 4.7)
   b. Winter Milestones (Goals Yr 1: 1-2; Yr 2: 2-3; Yr 3: 3-4)
   c. In-training exam (average national %ile)

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d. Certifying Exam (national %ile)

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e. ABD graduates average deciles (9th is best)

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Procedural: 5
Basic science: 5.25

f. ABD: all reached competency
g. Summer Milestones (Goals Yr 1: 2; Yr 2: 3; Yr 3: 4)
   i. Yr 1: 2.8
   ii. Yr 2: 3.6
   iii. Yr 3: 4.3

h. Procedure logs
   i. Minimums established 2014 by RRC
   ii. Average Resident Speaker Score: 13.6 (13.1, 13.5, 12.2, 13.6, 13.6, 12.8) 0-14 scale
   j. Overall Resident Conference Attendance: 96 (96.7, 98, 98.6, 99.59, 97, 93.8, 93) goal > 90

3. Review of Program Evaluations
   a. Alumni review: 3.9 (4.69, 4.53, 4.3, 4.75, 4.38, 4.7, 4.5, 4.7) (Excellent=3, Adequate=2, Deficient=1)
      i. Biggest concerns of alumni (items below ‘Good’):
         1. Input on patient care activities 2.5
            a. Follow score after initiation of Resident Continuity Clinics
         2. Express concerns without fear of retaliation 2.5
            a. Discuss with Chief residents
   b. Overall Training rated by Residents: 2.79 (2.86, 2.85, 2.92, 2.8, 2.62, 2.2) (Excellent=3, Adequate=2, Deficient=1)
   c. Biggest concerns of residents:
      i. Educational Activities: Hideaway
         1. Change to monthly virtual of 3 excellent teaching cases
      ii. Program/Training: Input on patient care activities
         1. Dean to communicate at Faculty meeting
   d. Biggest concerns of faculty:
      i. Educational Activities: Hideaway
      ii. Program/Training: staff dealing with resident issues
         1. Chiefs to help define; Dean to communicate at Faculty meeting

4. Faculty evaluations by residents

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5. Curriculum
   a. Rotations overall
      i. 4.64 (4.63, 4.46, 4.11, 4.0; 1-5 scale)
      ii. Biggest concern: frequency of service work rather than education
         1. Dean to communicate at Faculty meeting

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b. Hideaway
   i. Overall Resident score: 2.0 (2.71, 2.62, 2.58, 2.4, 2.31, 2.2) (Excellent=3, Adequate=2, Deficient=1)
   ii. Attendance:
      1. Faculty
         a. Non-Mohs (expected >65%): 70 (74.4, 79, 89.5, 81.2, 87, 81%)
         b. Mohs (expected >30%): 7 (10, 59)
   iv. 1st Fridays 8:30-9:30am
      1. Virtual conference: 3 teaching cases per session provided by leading faculty member
      2. Decrease frequency to monthly
      3. Discussion with ~20 min per case

c. Dermatopathology
   i. Greensboro Path:
      1. Resident: 2.79 (2.79, 2.77, 2.75, 2.6, 2.85, 2.8) (Excellent=3, Adequate=2, Deficient=1)
      2. Resident attendance: 93 (95, 98, 95.8, 96.8%)
      3. Sept thru May Thursdays 8-930a except 4th Thursday
   4. Resident Coordinator: Dr. Miedema
   ii. Zedek sessions:
      1. Resident: 2.93 (3.0, 3.0, 3.0, 2.75, 2.69, 2.9) (Excellent=3, Adequate=2, Deficient=1)
      2. 3rd Fridays 8-900am
   iii. Sign-outs with Dan:
      a. Built into schedule 1st years on Thursday AMs when no Greensboro Path
         b. Call resident MTW
   iv. Mock-Boards:
      1. Resident: 2.93 (3.0, 2.85, 2.83, 2.9, 2.92, 2.9) (Excellent=3, Adequate=2, Deficient=1)
      2. Fourth Thursday 8-930 each month to view slides
      3. Following Friday 8-930 to review slides

d. Lectures:
   i. Resident: 2.86 (2.79, 2.77, 2.64, 2.44, 2.54, 2.3) (Excellent=3, Adequate=2, Deficient=1)
   ii. Attendance Percentage
      1. Clinicians expected >50%: 63 (63.5, 63, 78.6, 70.4, 78, 73%)
      2. Researchers: 23 (22.3, 28, 32.8, 26.5, 33, 17%)
      3. Residents: 99.4 (97.5, 100, 100, 100, 96, 86%)
   iii. Core Curriculum Lecture Series
      1. 10-11am UNC Derm (Fitz and JAAD CME-based)
      2. 830-930am Visiting faculty
      3. Speaker scores
         a. Derm Faculty: 13.7 (13.7, 13.6) (0-14 scale)
         b. Visiting Faculty: 13.5 (13.2, 13.2)
   iv. Faculty Mini-lectures Fridays 1130-1200 noon
      1. Increase peds and basic science
      2. Peds (9)
      3. Fatigue (1)
      4. Board Review (5)
      5. Basic Science (8)
      6. Procedural (9)
      7. Treatment algorithms (8)
v. Vascular Conference selected 5th Fridays (2)
   1. 8-10am
   2. Burkhart and Fellow to coordinate
vi. Resident Talks
   1. Major talk: only 3rd years

e. Kodachromes:
   i. Resident: 2.86 (2.93, 2.77, 2.92, 2.89, 2.92, 2.7) (Excellent=3, Adequate=2, Deficient=1)
   ii. Resident Attendance: 99.1 (98%)
   iii. Visual score on ITE 56 (64, 84, 53, 64, 52, 51)
   iv. AAD slide set last done 3 years ago (sets created by Dean)
v. More cases per session communicated by Dean
vi. Add Consult camera case review led by Dr. Sun 3rd Friday 9-930am

f. UNC/ Duke:
   i. Resident: 2.86 (2.79, 2.54, 2.5, 2.6, 2.77, 2.7) (Excellent=3, Adequate=2, Deficient=1)
   ii. Volume: 2015 (20); 2014 (20); 2013 (14); 2012 (12 patients)
   iii. Faculty attendance
      1. UNC Faculty attendance @ UNC
         a. 2014-15:
            i. Non-Mohs, non-research (expected >50%): 77.5%
            ii. Mohs (expected >25%): 0%
            iii. Researchers: 83.3%
         b. 2013-14:
            i. Non-Mohs (expected >50%): 71.1%
            ii. Mohs (expected >25%): 0%
         c. 2012-13:
            i. Non-Mohs (expected >50%): 73%
            ii. Mohs (Expected >25%): 25%
         d. 2011-12: 73%
         e. 2010-11: 81%
         f. 2009-10: 74%
   2. Resident attendance:
      a. UNC 100 (96.4, 98, 100, 100, 98, 88)%; Duke 83.3 (88.6, 88, 97.5, 100, 100, 67)%

g. QA Sessions
   i. 1st Fridays 800-830am
   ii. Resident: 2.50
   iii. Attendance
      1. Faculty: 52 (64.1, 77, 82.5, 82.6/75, 93/60, 86/48%)
      2. Residents: 90.5 (94.8, 100, 97.5, 100, 93, 87%)

h. Journal Clubs: 2nd Friday 8-830am
   i. Resident: 2.21 (2.57, 2.31, 2.33, 2.2, 2.54, 2.2) (Excellent=3, Adequate=2, Deficient=1)
   ii. Resident attendance: 94.1 (98, 100, 99, 99.3, 99, 85%)
   iii. Faculty leader presence: 100 (100, 100, 100, 98.5, 50%)
   iv. Selected faculty: Adamson (2), Fox (2), McShane (1), Culton (2), Sayed (2), Jolly (2), Bowers (1)
   v. Content selected by faculty leader
   vi. Resident coordinator: Hightower

6. Piedmont Health
   a. Resident: 4.83 (4.59, 4.6) (1-5 scale)
   b. Supervision: 4.83 (4.71, 4.6)
   c. Lugo and Diaz

7. Cosmetic Clinics
   a. Resident: 2.45 (2.45, 2.77, 2.89, 2.55, 1.75, 2.2) (Excellent=3, Adequate=2, Deficient=1)
   b. Aesthetic Solutions: 2.67
   c. Educational experiences:
      i. Senior resident cosmetic week @ Aesthetic Solutions
      ii. Thursday mornings (4) with Jackson
         1. Dr. Ziemer to coordinate solutions
         2. Exploring monthly sessions
      iii. Jackson 2 clinics per week

339
8. Derm Surgery
   a. Resident: 4.82 (4.82, 4.69, 4.5, 4.41, 4.06; 1-5 scale)
   b. Total procedures logged (all residents as of 5/15/15; perform+observe)
      i. 2014-15: 1562+1024
      ii. 2013-14: 1805+889
      iii. 2012-13: 1171+916
      iv. 2011-12: 783+45
      v. 2010-11: 330+0
   c. Procedures of residents as of 5/15/15
      i. Total excisions
         1. Individual senior logs throughout training years
            a. 2014-15: 132, 64*, 122, 160, 126, 113; total 714; average 120* (131)
            b. 2014: 107, 173, 120, 164; total 564; average 141
            c. 2013: 122, 110, 109, 71*; total: 412; average 103
            d. 2012: 153, 150, 157, 77*; total: 536; average 134
            e. 2011: 111, 147, 189; total: 447; average 149
            f. 2010: 134, 97, 121, 105, 136; total: 595; average 119
      2. Total of current residents, for this year of training
         a. 2015: 525
         b. 2014: 647
         c. 2013: 801
   3. Average reported excisional cases this year (2015 as of 5/15/15)
      a. 1st years: 27 (30, 17, 29, 22, 25, 21)
      b. 2nd years: 50 (56, 44, 36, 38, 67, 72)
      c. 3rd years: 36*, 41 (48, 33, 54, 70, 110, 118)
   4. Average half day surgical clinics (2015 as of 5/1/15)
      a. 1st years: 13 (26, 21, 24.5)
      b. 2nd years: 22 (30, 31, 23.8)
      c. 3rd years: 17 (20, 21, 27.8)
   5. Current resident schedule (76+) cases per month
      a. Monday Sayed: 2 residents (1st and 2nd) 6
      b. Tuesday Varma: 4 residents (2nds and 3rds) 12
      c. Friday Lugo (qow): usually 1-2 cases mixed in w/ general (1st or 2nd depending on patch patients) 1
      d. Late in year Sayed/Jolly HB bonus: 2
   6. Proposed resident schedule (92+) cases per month
      a. Monday Sayed: 2 residents (1st and 2nd) 6
      b. Tuesday Varma: 4 residents (2nds and 3rds) 12
      c. Friday Lugo (qow): usually 1-2 cases mixed w/ general (1st or 2nd depending on patch patients) 1
      d. Thursday Bowers: 2 residents 4
      e. Resident Continuity Clinic 1+ per day 2+
      ii. Flaps performed/observed
          1. Total of all current residents, this year: 14/66 (18, 8)
      iii. Grafts performed/observed
          1. 7/34 (22, 17)
      iv. Vascular laser performed/observed
          1. 49/12 (90, 148)
   d. ACGME Level 1 procedures (Perform) as of 5/15/15
      i. Excision benign
         1. Average senior residents’ logs: 55 (61, 35, 33.3, 52)
         2. Previous year national average: 54.7 (57.5, 55)
      ii. Excision malignant
         1. Average senior residents’ logs: 76.4 (80, 68, 101.5, 117.5)
         2. Previous year national average: 63.1 (63.2, 63)
   e. ACGME Level 2 (Perform+Observe)
      i. Closure repair
         1. Average senior residents’ logs: 145/53
         2. Previous year national average: 141/28
      ii. Flaps
1. Average senior residents’ logs: 3.6/20
2. Previous year national average: 15/9

iii. Grafts
1. Average senior residents’ logs: 3/8
2. Previous year national average: 6/3

iv. Vascular laser
1. Average senior residents’ logs: 19.2/3/4
2. Previous year national average: 13/5

v. Mohs reported experience
1. Total only academic year, all residents: 473 (590, 442, 151)
2. Senior residents, entire training: average: 107 (92.5, 75, 12.5)
3. Previous year national average grads: 113 (117, 115)
4. Planned scheduled blocks:
   a. 1st: two separated 1-week blocks within first 3 months
   b. 2nd: one 2-weeks block and one late in year 1-week block
   c. 3rd: two 2-weeks blocks (1 being later in year)

vi. Nail procedures
1. Total academic year: 32/4
2. Senior residents average: 5.2/1
3. Previous year national average: 5.1 (6.1)

vii. Hair removal laser
1. Total academic year: 39/2
2. Senior residents average: 8.6 (11.3, 8, 6.5)
3. Previous year national average: 10 (9.5, 9)

viii. Pigmented lesion laser
1. Total academic year: 16/2
2. Senior residents average: 6 (4.8, 13, 3.3)
3. Previous year national average: 6 (6.4, 6)

ix. Laser ablation/resurfacing
1. Total academic year: 49/12 (49, 70, 31, 10)
2. Senior residents average: 15.4 (10.5, 16, 9.3)
3. Previous year national average: 7.5 (7.3, 5)

x. Botox
1. Total academic year: 147 (67, 85, 33, 11)
2. Senior residents average: 36 (16.5, 24, 7.8, 9)
3. 2013 national average: 23.2 (23.7, 23)

xi. Soft tissue augmentation:
1. Total academic year: 83 (25, 63, 13, 5)
2. Senior residents average: 18.6 (8.3, 16, 3.5, 8.5)
3. 2013 national average: 15 (15.3, 14)

xii. Peels
1. Total academic year: 54(8, 13, 7, 5)
2. Senior residents average: 5.4 (3, 5, 0.8)
3. 2013 national average: 5.3 (5.5, 5)

f. ACGME Level 3 (Didactic)
   i. Liposuction 0 (0, 1, 0, 0)
   ii. Scar revision 0 (7, 0, 3, 0)
   iii. Dermabrasion 1 (3, 3, 4, 0)
   iv. Vein Surgery 0 (0, 2, 0, 0)
   v. Hair Transplantation 1 (0, 0, 0, 0)
   vi. Rhinophyma correction 0 (0, 0, 0, 0)
   vii. Lip excision/wedge/vermilinoectomy 1 (4, 2, 0, 0)

g. Grad class meeting new ACGME 2015 start training minimums
   i. Grads 2015: all have achieved

9. Clinics/Workload
   a. Bonus half days off: through May1, average 0.48 (0.66, 0.68, 0.86, 0.89, 1.05 , 0.77) half days
      off/week
   b. Duty hour violations: 0
   c. Clinics away from SV
      i. 1st: 66
ii. 2nd: 22
iii. 3rd: 42

d. Senior resident total patient visits
   i. 2015 grads average: 4046
   ii. 2014 grads: average 3855
   iii. 2013 grads: average 4528
   iv. 2012 grads: average 4098

10. Electives:
   a. Elective Committee approves
   b. 4 weeks total during training

<table>
<thead>
<tr>
<th>Activity</th>
<th>Days Current Year</th>
<th>Days Prior Years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mohs</td>
<td>19</td>
<td>38, 1, 27, 6, 7, 30</td>
</tr>
<tr>
<td>Academic Derm (non-UNC)</td>
<td>0</td>
<td>10 (Stanford, Yale), 0, 0, 0, 0, 24 (UCSF, Emory)</td>
</tr>
<tr>
<td>Brazil</td>
<td>0</td>
<td>0, 0, 0, 0, 20, 20</td>
</tr>
<tr>
<td>Contact Derm</td>
<td>0</td>
<td>5, 0, 5, 0, 0, 20</td>
</tr>
<tr>
<td>Path</td>
<td>19 (U), 13 (G)</td>
<td>9 (U), 5 (G), 5 (away); 6 (U), 22 (G); 13 (G), 6 (U); 8 (G), 1 (U); 16 (G), 11 (U); 14 (G)</td>
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<tr>
<td>Pigmented Lesions</td>
<td>0</td>
<td>0, 0, 0, 0, 0, 10 (Rabinowitz)</td>
</tr>
<tr>
<td>Cosmetic Derm</td>
<td>9</td>
<td>0, 12, 0, 8, 7, 8</td>
</tr>
<tr>
<td>General Derm</td>
<td>30</td>
<td>15, 9, 0, 0, 2, 7</td>
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<tr>
<td>Research</td>
<td>0</td>
<td>0, 0, 0, 0, 15, 0</td>
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<tr>
<td>Australia</td>
<td>0</td>
<td>0, 0, 0, 0, 20, 0</td>
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<tr>
<td>UNC non-Derm</td>
<td>4</td>
<td>0, 4, 15, 0, 11, 0</td>
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<tr>
<td>Carolina Vein</td>
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<td>0, 3, 0, 3, 3, 0</td>
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<tr>
<td>Conference/Course</td>
<td>26</td>
<td>36, 2, 3, 5, 0, 0</td>
</tr>
<tr>
<td>UNC Derm</td>
<td>0</td>
<td>5, 2, 0</td>
</tr>
<tr>
<td>AAD Camp</td>
<td>5</td>
<td>0</td>
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APPENDIX D

Action Plan for Upcoming Year
<table>
<thead>
<tr>
<th>TOPIC</th>
<th>ISSUE</th>
<th>PLAN</th>
<th>RESPONSIBLE PARTY</th>
<th>OUTCOME</th>
</tr>
</thead>
<tbody>
<tr>
<td>Speaker feedback</td>
<td>Need to improve feedback to resident presentations</td>
<td>Create a new UNC/Duke feedback from panel of faculty</td>
<td>Morrell, Lugo, others</td>
<td></td>
</tr>
</tbody>
</table>
| Procedural competence card    | Inconsistent reporting                          | 1. Emphasize at faculty meeting and resident orientation  
2. Faculty to take 1st years’ cards at beginning of clinic  
3. Morrell to collect at Sept. evaluations | Morrell                    |         |
| Procedural orientation        | Dealing with sharps, gloved hands, tools        | Procedural orientation session in addition to Mohs surgical skills                       | Fox and Mauro              |         |
| Hideaway                      | Poor patient quality and attendance             | Go virtual                                                                               | Faculty                    |         |
| Journal Club                  | What is our goal: review a journal or critical appraisal of 1-2 articles? | Discuss desired approach with each faculty leader, hoping for balanced approach          | Morrell                    |         |
| Resident input on patient care activities | Residents desire more                          | 1. Faculty meeting agenda item  
2. Culton as CC mentor                                                                 | Morrell                    |         |
| Faculty concerns about staff dealing with resident issues | Morrell to define from Chiefs and Faculty | Discuss at Faculty meeting and with Eileen, Emma, Dr. Fox                                | Morrell                    |         |
| Service work                  | Frequency rather than education                 | Morrell to define from Chiefs; will discuss at Faculty meeting                            | Morrell                    |         |
| Resident peds derm score on ITE | Decreased percentile score on ITE               | 1. Increase mini lectures to 9  
2. Repeat 2012-13 curriculum                                                              | Peds derm team             |         |
| Resident Basic score on ITE   | Decreased percentile score on ITE               | 1. Increase mini lectures to 9  
2. Add faculty to team                                                                   | Basic science team         |         |
| Resident visual ability       | Low visual score on ITE                         | 1. Return to AAD slides for kodachromes  
2. Add Consult camera monthly sessions                                                    | Kodachrome faculty         |         |
## 1. Curriculum

<table>
<thead>
<tr>
<th>Instrument</th>
<th>Definition</th>
<th>Mean</th>
<th>Standard</th>
<th>Met/not met</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Rotation evaluations by residents</strong></td>
<td>9 5 option</td>
<td>4.64 (4.43, 4.63, 4.46, 4.24, 4.0, 3.4, 4.3)</td>
<td>≥3</td>
<td><strong>Met</strong></td>
</tr>
<tr>
<td><strong>In-training exam</strong></td>
<td>Standardized test score</td>
<td>68 (57, 73, 55, 51, 52, 54.2, 56.8)%ile</td>
<td>Aggregate</td>
<td><strong>Met</strong></td>
</tr>
<tr>
<td><strong>Conference evaluations by residents</strong></td>
<td>45 3 option</td>
<td>2.33 (2.82, 2.7, 2.7, 2.8, 2.65, 2.55, 2.6, 2.7)</td>
<td>≥2</td>
<td><strong>Met</strong></td>
</tr>
<tr>
<td><strong>Conference evaluations by faculty</strong></td>
<td>6 3 option</td>
<td>2.76 (2.93, 2.8, 2.7, 3, 2.67, 2.75, 2.8, 2.8)</td>
<td>≥2</td>
<td><strong>Met</strong></td>
</tr>
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</table>

## 2. Faculty

<table>
<thead>
<tr>
<th>Instrument</th>
<th>Definition</th>
<th>Mean</th>
<th>Standard</th>
<th>Met/not met</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Evaluations by residents</strong></td>
<td>7 4 option</td>
<td>3.77 (3.68, 3.72, 3.69, 3.6, 3.4, 3.2, 3.6, 3.8)</td>
<td>≥2</td>
<td><strong>Met</strong></td>
</tr>
<tr>
<td><strong>Attendance at conferences</strong></td>
<td>Percent attended</td>
<td>Lectures 63 (63.5/22.3, 63/28, 79/33, 70/26, 78/33, 73/17, 80/15)</td>
<td>Clinicians</td>
<td><strong>Met</strong></td>
</tr>
<tr>
<td><strong>UNC/Duke 77</strong></td>
<td></td>
<td></td>
<td>&gt;50%</td>
<td><strong>Met</strong></td>
</tr>
<tr>
<td><strong>Hideaway 70</strong></td>
<td></td>
<td></td>
<td>&gt;65%</td>
<td><strong>Met</strong></td>
</tr>
<tr>
<td><strong>Speaker Eval</strong></td>
<td>4 14 option</td>
<td>13.7 (13.7, 13.6, 13.3, 13.6, 13.65, 12.57, 13)</td>
<td>≥10</td>
<td><strong>Met</strong></td>
</tr>
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## 3. Residents

<table>
<thead>
<tr>
<th>Instrument</th>
<th>Definition</th>
<th>Mean/Score</th>
<th>Standard</th>
<th>Met/not met</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Senior ABD evaluations</strong></td>
<td>Multiple option</td>
<td>All achieved</td>
<td>Achieved all competencies</td>
<td><strong>Met</strong></td>
</tr>
<tr>
<td>360 degree evaluations</td>
<td>Composite Milestones score 0-5</td>
<td>3.24</td>
<td>&gt;2</td>
<td>Met</td>
</tr>
<tr>
<td>------------------------</td>
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<tr>
<td>WINTER</td>
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<table>
<thead>
<tr>
<th>360 degree evaluations</th>
<th>Composite Milestones score 0-5</th>
<th>3.67</th>
<th>&gt;3</th>
<th>Met</th>
</tr>
</thead>
<tbody>
<tr>
<td>SUMMER</td>
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<table>
<thead>
<tr>
<th>Procedures logs updated</th>
<th>ABD requirement (All, All, All, All All except 1, All, All) submitted</th>
<th>All updated</th>
<th>Met</th>
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<table>
<thead>
<tr>
<th>Portfolio review</th>
<th>Entries with reflection and learning plan (All, All, All, All, lack 3, all) submitted</th>
<th>All residents with &gt; 5 entries with reflection/plan</th>
<th>Pending Fall 2015</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Attendance at conferences</th>
<th>Percent attended</th>
<th>Aggregate &gt;90%ile</th>
<th>Met</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>96 (96.7, 98, 98.6, 99.59, 97, 93, 93.8)%</td>
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<table>
<thead>
<tr>
<th>Speaker Eval</th>
<th>4 14 option</th>
<th>13.6 (13.1, 13.5, 12.2, 13.6, 13.65, 12.8)</th>
<th>≥10</th>
<th>Met</th>
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</table>

### 4. Overall program resources

<table>
<thead>
<tr>
<th>Instrument</th>
<th>Definition</th>
<th>Mean/Score</th>
<th>Standard</th>
<th>Met/not met</th>
</tr>
</thead>
<tbody>
<tr>
<td>ABD board scores</td>
<td>National percentile</td>
<td>P (22, 46, 81, 39, 62, 20, 19, 25)%ile</td>
<td>Aggregate &gt;50%ile</td>
<td>Pending Fall 2015</td>
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</table>

<table>
<thead>
<tr>
<th>ABD board failures</th>
<th>Failure to pass on first attempt</th>
<th>P (0, 0, 0, 0, 0, 1, 0, 0)</th>
<th>&lt;10%</th>
<th>Pending Fall 2015</th>
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</thead>
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<table>
<thead>
<tr>
<th>Resident recruitment</th>
<th>Last spot rank</th>
<th>5 (15, 8, 10, 16, 9, 10, 6, 11, 6)</th>
<th>Spots filled within 3 ranks per spot</th>
<th>Met</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Resident retention</th>
<th>Residents departing</th>
<th>None left</th>
<th>No departures</th>
<th>Met</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Alumni survey</th>
<th>34 5 option</th>
<th>3.9 (4.69, 4.53, 4.3, 4.75, 4.38, 4.7, 4.5, 4.7)</th>
<th>≥3</th>
<th>Met</th>
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</thead>
</table>

<table>
<thead>
<tr>
<th>Program evaluation by residents</th>
<th>34 5 option</th>
<th>4.64 (4.36, 4.7, 4.67, 4.07, 3.93, 4.5, 4.5, 4.5)</th>
<th>≥3</th>
<th>Met</th>
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</thead>
</table>

<table>
<thead>
<tr>
<th>Program evaluation by faculty</th>
<th>32 5 option</th>
<th>4.73 (4.8, 4.9, 4.67, 4.36, 4.5, 4.7, 4.7, 4.8)</th>
<th>≥3</th>
<th>Met</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>ACGME Resident/Faculty Surveys</th>
<th>Multiple option</th>
<th>4 non-compliance above national average</th>
<th>None above national average</th>
<th>Not met</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Graduates ACGME procedure log</th>
<th>National minimums per ACGME 2014</th>
<th>All achieved</th>
<th>All exceed on the 8 criteria</th>
<th>Met</th>
</tr>
</thead>
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