



Department of Dermatology

CURRICULUM AND POLICIES

**Residency Training Program
in Dermatology**

**Department of Dermatology
The University of North Carolina at Chapel Hill
and The University of North Carolina Hospitals**

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INTRODUCTION

Our residency is a nationally accredited, three-year program, which meets all training requirements. As of January 16, 2016, sixteen 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 or transitional internship, have also 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. 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.

I. Educational Program

As approved by the ACGME, 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. (Refer to Appendix B for a copy of our evaluation forms.) This plan should include:

- a. 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;
- b. mechanisms for providing regular and timely performance feedback to residents, and
- c. a process involving use of assessment results to achieve progressive improvements in residents' competence and performance.

III. Program Evaluation

- a. The residency program should use resident performance and outcome assessment results in their evaluation of the educational effectiveness of the residency program.
- b. 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 remained as professor emeritus. His successor, Dr. Luis A. Diaz, was named the Professor and Chairman of the department January 1, 2000. After Dr. Diaz's retirement December 31, 2016, he remains at UNC Dermatology as an active attending physician. Dr. Nancy Thomas became Chair of the Department January 1, 2017, after moving through the academic ranks at UNC Dermatology.

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 Genome Science 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 science 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 is consistently ranked among the top 15 US programs receiving NIH grants. 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.

The department has several approved fellowships to include pediatric dermatology and micrographic surgery and dermatologic oncology. In addition to receiving outstanding clinical training, UNC Dermatology Fellows enhance the residency training program through their frequent clinical and didactic interactions with residents.

Overall UNC Dermatology Goals and Objectives 2019-2020

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, and
 - 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, and
 - b. KOH examination.
- (4) will demonstrate knowledge and competence in
 - a. Photomedicine,
 - b. Phototherapy, and
 - 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, and
 - 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, and
 - vi. chemical peels.
 - c. residents will demonstrate knowledge through education relating to certain cosmetic techniques in:
 - i. liposuction,
 - ii. scar revision, and
 - 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, and
 - 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. intralesional injections, and
 - e. phototherapy.
- (9) will demonstrate knowledge and competence in the diagnosis and age-appropriate management of
 - a. birthmarks,
 - b. genodermatoses, and
 - 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 2019-2020 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, and
 - 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, and
 - h. Perform electrodesiccation 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, and
 - 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, and
 - 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 4 on speaker score

Practice-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, and
 - 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, and

- h. Perform electrodesiccation 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, and
 - 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 art and science of consultative dermatology on all types of patients
- 16. 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, and
 - 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, and
 - 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, and
 - 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 patch testing
13. Become familiar with chronic wounds, their evaluation, care, and types of dressings
14. Know the principles of and be able to perform laser therapy
15. Know the principles of an excision by the Mohs' technique
16. Expand diagnostic capabilities in histopathology
17. Know the principles of research methodology, and participate (if interested) in a research project, clinical, or basic science activity
18. Know the art and science of consultative dermatology on all types of patients
19. Be familiar with the current literature of dermatology, to include *Journal of American Academy of Dermatology* and *JAMA Dermatology*
20. Manage inpatients in the care of the dermatologic patient
21. Recognize immunofluorescent patterns on histology, and be familiar with immunoperoxidase diagnostics
22. Be increasingly familiar with cosmetic procedures performed in the outpatient dermatology settings (Botox injections, chemical peels, sclerotherapy, soft tissue augmentation)
23. 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 5 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

Practice-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, and
 - 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, and
 - h. Perform electrodesiccation 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, and
 - 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, and
 - 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, and
 - 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, and
 - 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 genodermatoses
 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 6 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

Practice-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 2019-2020

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:

- Alopecia/Hair Disorders
- Consultation Service
- Contact Dermatitis
- Cosmetic Dermatology
- Cutaneous Lymphoma
- Dermatological Surgery (non-Mohs)
- Dermatopathology
- General Adult Dermatology
- Hidradenitis Suppurativa & Follicular Disorders
- High Risk Skin Cancer
- Immunodermatology/Autoimmune Disorders
- Laser Services
- Mohs Surgery
- Pediatric Dermatology
- Piedmont Health Services
- Pigmented Lesion/Melanoma
- Resident Continuity Clinics

Alopecia/Hair Disorders

Goals:

- 1. To develop basic clinical skills in approaching the diagnosis, work up and management of hair loss**
- 2. Develop diagnostic approach for each patient**
- 3. To establish therapeutic algorithms of various categories of hair loss**
- 4. To provide thoughtful and patient-centric education about hair loss to clients seen in this clinic that both informs them and sets appropriate expectations**

Objectives:

Dermatology Year 1

Patient Care

1. Obtain pertinent history of hair loss including pertinent positive and negatives
2. Review medication list to look for new start/recent discontinuation
3. Review PMH to look for pertinent positive and negative
4. Review Alopecia intake sheet for completeness and understand the rationale behind the various questions
5. Assist in scalp biopsy
6. Assist with hair pull and evaluation of trichogram
7. Become familiar with how to evaluate alopecia using dermoscopy

Medical Knowledge

1. Start to recognize primary and secondary hair loss and start to be able to categorize hair loss into broad categories including: scarring and nonscarring

Systems-Based Practice

1. Be able to coordinate care with primary care/subspecialists when necessary

Communication

1. Provide accurate but thoughtful information on diagnoses discussed in clinic with assistance
2. Acknowledge when patient's are unable to accept a diagnosis

Practice-Based Learning and Improvement

1. Self-assess strengths and weaknesses and ask for clarity and explanation when needed

Dermatology Year 2 – to include all the above, in addition to what is listed below

Patient Care -

1. Ask additional clarifying questions when necessary to obtain a thorough and complete HPI; and comprehensive review of PmHZ, medications.
2. Ask targeted questions to address your working diagnosis
3. Complete a hair pull, and evaluate trichogram
4. Complete scalp biopsy including the selection of the site to illustrate the pathogenic

- process
5. Use dermoscopy to evaluate for various types of hair loss and be able to recognize: scarring and nonscarring characteristics, miniaturization of hairs, exclamation point hairs, peripilar casts
 6. Become increasingly capable of using and understanding therapy to include:
 - a. Topical steroids, topical sensitizers
 - b. systemic immunosuppressant: steroids and methotrexate
 - c. Anti-androgens
 - d. 5-alpha reductase inhibitors

Medical Knowledge

1. Have a thorough understanding of scarring and nonscarring processes including the subtle clinical features from a physical exam
2. Have a differential diagnosis that can include, when relevant, more than single processes
3. Know the risks/benefits of oral therapies, and topical therapies
4. Know the absolute contraindications for some of the frequently used oral medications
5. Be familiar with the pregnancy category of the frequently used medications

Professionalism

1. Approach Alopecia patients with empathy and compassion and realize this is a deeply emotional disease for most
2. Wear professional attire during clinical activities.
3. Ask the attending for assistance in times of need, ask clarifying questions

Systems-Based Practice

1. Know the value of other Alopecia specialists including the role of hair transplant
2. Coordinate care between appointments if necessary including following up on labs, communication to subspecialists, PCPs when necessary

Communication

1. Begin to provide clear and accurate expectation management

Practice-Based Learning and Improvement

1. Be receptive to feedback on how to approach things differently

Dermatology Year 3 – in addition to all expectations for Year 2

Patient Care

1. Assimilate patient history, intake questionnaire and begin to form a working differential diagnosis, and ask clarifying questions to target the most likely diagnosis
2. Research patient's chart to add additional information including prior notes and labs if relevant
3. Do a full evaluation of the scalp, and other pertinent areas
4. Conduct a goals of care discussion with patients to obtain, in their words, what they would like to accomplish with this evaluation/treatment

Medical Knowledge

1. Have an in-depth knowledge of major subtypes of hair loss within each category of scarring and nonscarring processes
2. Know therapeutic algorithm for all major subtypes and any new therapeutics supported in literature
3. Recognize primary and secondary lesions and group skin diseases in diagnostic categories.
4. Create independently a treatment recommendation and present this to the attending, to include all modalities that are appropriate for the patient.
5. Have a sense of the expense and availability of treatment options recommended and be able to assist patient in navigating obtaining them
6. Have a sense of when patient has reached treatment failure and when it is appropriate/necessary to change therapies
7. Be able to interpret alopecia histology and put into a clinical context from patient's physical exam.

Professionalism, Systems-based practice, Communication, Practice-based learning and improvement:

As above for 2nd year residents

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 in the hospitalized setting.**
- 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 on every patient.
 - a. Identify key portions of the history and associated questions
 - b. Accurately perform a physical exam
1. Develop a clear, concise and comprehensive presentation
2. Demonstrate the ability to generate a differential diagnosis
3. Appropriately interpret lab and other diagnostic diagnosis
4. Perform routine diagnostic laboratory tests to include:
 - a. KOH examination
 - b. Viral culture
 - c. Fungal culture
 - d. Bacterial culture
 - e. Ectoparasitic scraping
6. Perform basic surgical techniques to include:
 - a. Punch biopsy
 - b. Shave biopsy
 - c. Local anesthesia
7. Appropriately interpret and apply dermatopathology results
8. Select appropriate therapeutics for the disease, taking into account the individual patient
9. Become increasingly capable of using and understanding systemic therapy to include but not limited to:
 - a. Traditional immunosuppressives
 - b. Retinoids
 - c. Biologic therapy
10. Communicate diagnostic considerations and therapeutic options with primary hospital teams and outpatient dermatologic providers through timely, appropriate verbal and written communication and photographic documentation in the chart.

11. Coordinate timely and appropriate follow-up care in the outpatient setting.
12. Identify and classify drug eruptions and recognize the clinical manifestations of a systemic drug eruption; use drug charts to identify potential drug culprits.
13. Identify and classify cutaneous manifestations of systemic disease and carry out appropriate diagnostic workup and intervention.
14. Understand complications of organ/bone marrow transplantation, cancer chemotherapy and immunosuppressive medications.
15. Identify and classify paraneoplastic syndromes to carry out diagnostic workup and intervention.
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.

Medical Knowledge

1. Recognize primary and secondary lesions and group skin diseases in diagnostic categories.
2. Utilize attending and latest medical literature to learn the advantages and disadvantages of different diagnostic and therapeutic considerations in hospitalized patient care
3. Recognize common categories of skin disease, such as:
 - a. Inflammatory diseases
 - b. Infectious disease
 - c. Cutaneous malignancies
 - d. Papulosquamous disease
 - e. Connective tissue diseases
 - f. Vesiculobullous diseases
 - g. Diseases of hair and nails
 - h. Diseases of mucosa
 - i. Pigmented lesions
4. Learn basic therapeutic options for common dermatologic processes.
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. Recognize the cutaneous manifestations of systemic disease.
7. Know the principles of and be able to perform ulcer care.
8. Present cases to medical students, residents and attendings at Consult Case discussions.

Professionalism

1. Maintain a consultation log for patient care and biopsy follow up.
2. Work effectively with other medical students, residents, fellows, attending physicians, nurses, technicians, administrators, and other interprofessional health care providers.
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. Coordinate timely and appropriately follow-up care in the outpatient setting.

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 weaknesses at 6 month and annual reviews.
2. Create individual learning plan to address weaknesses or deficiencies at end-of-year evaluation.
3. Utilize attending and latest medical literature to learn the advantages and disadvantages of different diagnostic and therapeutic considerations in hospitalized patient care.

Dermatology Year 3 (all Year 2 goals plus the following)

Patient Care

1. Identify and classify cutaneous manifestations of HIV disease, infectious and inflammatory and carry out appropriate diagnostic workup and therapeutic intervention.
2. Identify unusual infections in the immunosuppressed host and carry out appropriate diagnostic workup and therapeutic intervention.
3. Identify atypical or severe presentations of common dermatologic disorders, neoplasms and infections.
4. Develop expertise in the management of hospitalized patients with severe dermatologic disease including the use of systemic medications.
5. Communicate diagnostic considerations and therapeutic options with primary hospital teams and outpatient dermatologic providers through timely, appropriate verbal, written communication and photo-documentation in the chart.
6. Coordinate timely and appropriate followup care in the outpatient setting.
7. Supervise medical students and PGY2 dermatology residents in basic dermatologic diagnostic procedures.
8. Identify key portions of the history and associated questions.
9. Accurately perform a physical exam.
10. Develop a clear concise and comprehensive presentation.
11. Appropriately interpret lab and diagnostic test results.
12. Appropriately interpret and apply dermatopathology results in the context of the individual patient.
13. Select appropriate therapeutics for the disease, taking into account the individual patient.
14. Demonstrate the ability to generate a comprehensive differential diagnosis and management plan.

15. Demonstrate overall independent responsibility for directing service and patient care decisions.

Medical Knowledge

1. Utilize clinic attending and latest medical literature to learn and advantages and disadvantages of different diagnostic and therapeutic considerations regarding hospital patient care.
2. Demonstrate knowledge in advanced differential diagnosis and patient therapeutic/patient care.
3. Will be familiar with advanced therapeutics: radiation therapy, systemic therapy for psoriasis, and antineoplastic therapy.
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.
7. Will demonstrate ability to correlate clinical and pathologic findings.
8. Present cases to medical students, residents and attendings at Consult Case discussions.

Professionalism

1. Maintain a consultation log for patient care and biopsy follow up.
2. Work effectively with other medical students, residents, fellows, attending physicians, nurses, technicians, administrators, and other interprofessional health care providers.
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. Will demonstrate ability to instruct peers and interact with other physicians on problems relative to dermatology.
7. 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. Coordinate timely and appropriate follow-up care in the outpatient setting.
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.

Practice-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. Utilize attending and latest medical literature to learn the advantages and disadvantages of different diagnostic and therapeutic considerations in hospitalized patient care.
4. Incorporate information learned from UNC/Duke conferences into patient care.
5. 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

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

Professionalism

1. Interact with patients in a professional manner.

Systems-Based Practice

1. Learn how to manage patients with complex eczematous disorders.

Communication

1. Educate patients and families regarding the use of patch testing.

Practice-Based Learning and Improvement

1. Self-critique interactions with patients for personal improvement.

Dermatology Years 2 and 3

Patient Care and Medical Knowledge

1. List the most common plants to cause irritant contact dermatitis, allergic contact dermatitis and phytophotodermatitis.
2. Describe the clinical and immunologic differences between irritant and allergic contact dermatitis.
3. Understand the procedure of patch testing placement.
4. Know how to read patch testing.
5. Identify the most common allergens causing eyelid dermatitis, facial dermatitis, lip dermatitis and hand and foot dermatitis.

6. Evaluate the patient and discuss with Dr. L-S.
7. Observe the nurse when he/she applies the patch tests.
8. Read at least one of the follow-up visits.
9. Learn how to use the CAMP link on the American Contact Dermatitis Society site to create handouts for the patients.
10. Be able to select appropriate patch tests.
11. Demonstrate satisfactory knowledge of the patch test series of allergens available.
12. Be able to distinguish between irritant and allergic reactions.
13. Understand the concept of the relevance of patch test reactions for the patient and communicating that information to them.
14. Distinguish various patterns of dermatitis (especially of the hands).
15. Basic knowledge of the immunology of contact reactions.
16. Interpret hazard data sheets.
17. Have an understanding of writing reports for occupational dermatology patients.

Professionalism

1. Interact with patients in a professional manner.

Systems-Based Practice

5. Learn how to manage patients with complex eczematous disorders.

Communication

1. Educate patients and families regarding the use of patch testing.
2. Interpret hazard data sheets.
3. Have an understanding of writing reports for occupational dermatology patients.

Practice-Based Learning and Improvement

1. Self-critique interactions with patients for personal improvement.
2. Interpret hazard data sheets.
3. Have an understanding of writing reports for occupational dermatology patients.

Contact Dermatitis Curriculum

Dermatology Residents

Contact Dermatitis Elective

Allergy Fellows

Lectures:
Contact Dermatitis
Pathophysiology
rubber
acrylates
plants
fragrances
hand dermatitis
Cases

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.

Rotation:
True test allergens, interpretation of results, read book,
knowledge of NA-65,
observe nurse placing allergens, knowledge of CAMP link for handouts

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

1. Learn about advances in dermatology concerning the biochemical basis for the aging face.
2. 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.
3. Appropriate patient selection, mechanisms of action, risks/benefits and technique for microdermabrasion.
4. Appropriate patient selection, mechanisms of action, risks/benefits and technique for sclerotherapy with/without Doppler ultrasound for varicose veins.
5. Appropriate patient selection, mechanisms of action, risks/benefits and technique for lasers for the treatment of vascular anomalies, pigmentary changes and tattoos.
6. Appropriate patient selection, mechanisms of action, risks/benefits and technique for the use of Botox for axillary, palmar, and plantar hyperhidrosis.
7. Develop knowledge of tumescent liposuction, collagen augmentation, laser resurfacing, and use of botulinum toxin through observation, participation, and/or performance.

Professionalism

1. Interact with patients in a professional manner.

Systems-Based Practice

1. Learn how to manage patients with complex medical problems.

Communication

1. Learn to deliver accurate expectations to patients and families.

Practice-Based Learning and Improvement

1. Self-critique interactions with patients for personal improvement.

Dermatology Years 2 and 3

Patient Care and Medical Knowledge

1. Learn about advances in dermatology concerning the biochemical basis for the aging face.
2. 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.
3. Appropriate patient selection, mechanisms of action, risks/benefits and technique for microdermabrasion.
4. Appropriate patient selection, mechanisms of action, risks/benefits and technique for sclerotherapy with/without Doppler ultrasound for varicose veins.

5. Appropriate patient selection, mechanisms of action, risks/benefits and technique for lasers for the treatment of vascular anomalies, pigmentary changes and tattoos.
6. Appropriate patient selection, mechanisms of action, risks/benefits and technique for the use of Botox for axillary, palmar, and plantar hyperhidrosis.
7. Develop knowledge of tumescent liposuction, collagen augmentation, laser resurfacing, and use of botulinum toxin through observation, participation, and/or performance.

Professionalism

1. Interact with patients in a professional manner.

Systems-Based Practice

1. Learn how to manage patients with complex medical problems.

Communication

1. Learn to deliver accurate expectations to patients and families.

Practice-Based Learning and Improvement

1. Self-critique interactions with patients for personal improvement.

Cutaneous Lymphoma

Goals:

- 1. Develop clinical skills in the identification and diagnosis of cutaneous lymphomas**
- 2. Develop procedural skills to appropriately biopsy suspected cutaneous lymphomas**
- 3. Develop ability to appropriately stage patients with primary cutaneous lymphomas, including a thorough physical exam, review of systems, laboratory testing, and the selection and interpretation of imaging studies**
- 4. Develop familiarity with the interpretation of cellular and molecular testing needed to appropriately diagnose and stage cutaneous lymphomas (e.g. peripheral blood flow cytometry, TCR gene rearrangement, etc)**
- 5. Develop familiarity with the treatment of primary cutaneous lymphomas. Expertise is expected primarily in skin-directed therapies, systemic medications, and local excision (when appropriate), although a peripheral understanding of local radiation, ECP, and chemotherapy should also be achieved.**
- 6. Demonstrate clinical skills to monitor patient's for evidence of disease progression or complications (e.g. bacterial superinfection)**
- 7. Demonstrate expertise in assessing a patient's disease prognosis and communicating this to patients and families**

Objectives:

Dermatology Year 1

Patient Care

1. Obtain pertinent history and perform a thorough examination that includes a full exam of the skin, lymph nodes, and abdomen.
2. Perform basic surgical procedures for the diagnosis of suspected cutaneous lymphomas
 - a. Shave biopsy (patch/plaque lesions)
 - b. Punch/excisional biopsy (indurated nodules or tumors)
3. Order and interpret reported results of staging work-up of cutaneous lymphomas:
 - a. Immunohistochemistry/tissue pathology
 - b. T cell receptor gene rearrangement by PCR, B cell receptor IGH/IGK by PCR
 - c. Routine laboratory testing (CBCw/diff, chemistries, LDH, etc)
 - d. Peripheral blood flow cytometry w/ or w/o manual Sezary prep
 - e. Imaging studies when appropriate (CXR, CT, CT-PET, etc)
4. Know the basics of diagnosing, staging and treating cutaneous lymphomas
5. Begin to build comfort counseling patients on diagnosis, prognosis and treatment plan

Medical Knowledge

1. Understand the work-up of suspected cutaneous lymphomas
2. Understand the management of early stage mycosis fungoides
3. Become familiar with skin-directed therapies to include:
 - a. Topical steroids,
 - b. topical nitrogen mustard
 - c. topical imiquimod
 - d. phototherapy

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
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 interdisciplinary team, including medical oncology, surgical oncology, ENT, and radiation oncology

Communication

1. Provide counseling on diagnosis, prognosis, and treatment.
2. Work within a team of nurses, students, and physicians.

Practice-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 thorough examination that includes a full exam of the skin, lymph nodes, and abdomen.
2. Perform basic surgical procedures for the diagnosis of suspected cutaneous lymphomas and, when appropriate, perform therapeutic excision of localized disease
 - a. Shave biopsy (patch/plaque lesions)
 - b. Punch/excisional biopsy (indurated nodules or tumors)
 - c. Excision with layered repair of localized primary cutaneous lymphoma lesions
3. Order and interpret reported results of staging work-up of cutaneous lymphomas:
 - a. Immunohistochemistry/tissue pathology
 - b. T cell receptor gene rearrangement by PCR, B cell receptor IGH/IGK by PCR
 - c. Routine laboratory testing (CBCw/diff, chemistries, LDH, etc)
 - d. Peripheral blood flow cytometry w/ or w/o manual Sezary prep
 - e. Imaging studies when appropriate (CXR, CT, CT-PET, etc)
4. Become increasingly comfortable with the diagnosis, staging and treatment of cutaneous lymphomas
5. Become increasingly comfortable counseling patient on diagnosis, prognosis and treatment plan

Medical Knowledge

1. Understand the work-up of suspected cutaneous lymphomas
2. Understand the management of early, moderate and late stage mycosis fungoides

3. Understand the management of CD30+ cutaneous lymphoproliferative disorders
4. Understand the management of primary cutaneous B cell lymphomas
3. Become increasingly capable prescribing and monitoring response to skin-directed therapies to include:
 - a. Topical steroids,
 - b. topical nitrogen mustard
 - c. topical imiquimod
 - d. phototherapy
4. Become familiar with systemic therapies to include:
 - a. systemic retinoids
 - b. low dose methotrexate

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 and 1 pm).
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 with healthcare system.
3. Learn method to refer to interdisciplinary team, including medical oncology, surgical oncology, ENT, and radiation oncology.

Communication

1. Provide counseling on diagnosis, prognosis, and treatment.
2. Work within a team of nurses, students, and physicians.
3. Communicate with physicians in other specialties (e.g. oncology) to coordinate patient care.

Practice-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 3

Patient Care

1. Obtain pertinent history and perform a thorough examination that includes a full exam of the skin, lymph nodes, and abdomen.
2. Perform basic surgical procedures for the diagnosis of suspected cutaneous lymphomas and, when appropriate, perform therapeutic excision of localized disease
 - a. Shave biopsy (patch/plaque lesions)
 - b. Punch/excisional biopsy (indurated nodules or tumors)
 - c. Excision with layered repair of localized primary cutaneous lymphoma lesions

3. Order and interpret reported results of staging work-up of cutaneous lymphomas:
 - a. Immunohistochemistry/tissue pathology
 - b. T cell receptor gene rearrangement by PCR, B cell receptor IGH/IGK by PCR
 - c. Routine laboratory testing (CBCw/diff, chemistries, LDH, etc)
 - d. Peripheral blood flow cytometry w/ or w/o manual Sezary prep
 - e. Imaging studies when appropriate (CXR, CT, CT-PET, etc)
4. Demonstrate competency in the diagnosis, staging and treatment of cutaneous lymphomas
5. Capable of counseling patients on diagnosis, prognosis and treatment plan

Medical Knowledge

1. Understand the work-up of suspected cutaneous lymphomas
2. Understand the management of early, moderate and late stage mycosis fungoides
3. Understand the management of CD30+ cutaneous lymphoproliferative disorders
4. Understand the management of primary cutaneous B cell lymphomas
3. Demonstrate the skills to appropriately prescribe and monitor response to skin-directed therapies to include:
 - a. Topical steroids
 - b. topical nitrogen mustard
 - c. topical imiquimod
 - d. phototherapy
4. Become increasingly comfortable with systemic therapies to include:
 - a. systemic retinoids
 - b. low dose methotrexate
5. Develop knowledge of treatments offered outside of our department including:
 - a. extracorporeal photopheresis
 - b. external beam radiation
 - c. histone deacetylase inhibitors
 - d. cytotoxic chemotherapy

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 and 1 pm).
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. Will demonstrate ability to instruct peers and interact with other physicians on problems relevant to cutaneous oncology/cutaneous lymphomas.
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 interdisciplinary team, including medical oncology, surgical oncology, ENT, and radiation oncology
4. Will demonstrate ability to instruct peers and interact with other physicians on problems relevant to cutaneous oncology/cutaneous lymphomas.
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.

Communication

1. Provide counseling on diagnosis, prognosis, and treatment.
2. Work within a team of nurses and physicians.
3. Communicate with physicians in other specialties (e.g. oncology) to coordinate patient care.
4. Will demonstrate ability to instruct peers and interact with other physicians on problems relevant to cutaneous oncology/cutaneous lymphomas.
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.

Practice-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. Will demonstrate ability to instruct peers and interact with other physicians on problems relevant to cutaneous oncology/cutaneous lymphomas.
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.

Dermatologic Surgery (non-Mohs)

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

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

Professionalism

1. Interact with patients, staff and colleagues in a professional manner.

Systems-Based Practice

1. Appreciate importance of accurate and timely referral to surgery.
2. Learn the economics of surgical approaches.

Communication

1. Educate patients and family members on expectations of procedures.
2. Obtain informed consent.
3. Discuss wound care.

Practice-Based Learning and Improvement

1. Receive criticism and feedback on surgical technique.
2. Assess outcomes of surgeries.

Dermatology Year 2 (PGY-3)

Patient Care and Medical Knowledge

1. 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.
2. Gain confidence in selecting the appropriate treatment for benign and malignant skin lesions.
3. Participate in a variety of complex closures (local flaps, full and split thickness skin grafts, interpolation flaps).
4. Gain direct experience using lasers in dermatology.
5. Observe Mohs surgery and assist in the subsequent repairs, gaining experience with repairs of head and neck defects.
6. Learn to perform cosmetic dermatologic procedures.
7. Learn techniques for nail biopsy and surgery.

Professionalism

1. Interact with patients, staff and colleagues in a professional manner.

Systems-Based Practice

1. Perform accurate and timely referral to surgery
2. Know the economics of surgical approaches

Communication

1. Educate patients and family members on expectations of procedures.
2. Obtain informed consent.
3. Discuss wound care.
4. Deliver pathology results of procedure effectively to patient/family.

Problem-Based Learning and Improvement

1. Perform self-criticism on surgical technique
2. Assess outcomes of surgeries

Dermatology Year 3 (PGY-4)

Patient Care and Medical Knowledge

1. 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.
2. Be able to independently select appropriate treatment for benign and malignant skin lesions.
3. Be able to independently perform standard excision and complex repairs with mastery of suturing techniques in all anatomic locations.
4. Be comfortable performing skin grafts.
5. Develop confidence with the independent selection of appropriate lasers as well as their use.
6. Develop confidence with the correct selection of patients for aesthetic procedures and the utilization of neuromodulators and fillers in facial rejuvenation.

Professionalism

1. Interact with patients, staff and colleagues in a professional manner.

Systems-Based Practice

1. Perform accurate and timely referral to surgery.
2. Know the economics of surgical approaches.

Communication

1. Educate patients and family members on expectations of procedures.
2. Obtain informed consent.
3. Discuss wound care.
4. Deliver pathology results of procedure effectively to patient/family.

Practice-Based Learning and Improvement

1. Perform self-criticism on surgical technique.
2. Assess outcomes of surgeries.

Dermatopathology

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

Objectives:

Dermatology Year 1

Patient Care

1. Apply pathological findings to patient care.

Medical Knowledge

1. Evaluate tissue at the microscope.
2. Recognize the normal anatomy of the skin by site, tissue, and adnexa.
3. Provide a basic differential diagnosis.
4. Recognize the histochemistry and immunodiagnostics of dermatopathology, tissue markers, and basic electromicroscopy.
5. Appreciate the clinicopathologic relations of clinical and histological features.
6. Learn how to biopsy a lesion to obtain optimal results.

Professionalism

1. Be on time for derm path sessions.

Systems-Based Practice

1. Learn to apply pathological results to the patient clinical scenario.

Communication

1. Discuss cases with pathologist in an effective manner.

Practice-Based Learning and Improvement

1. Receive feedback and critically evaluate biopsy technique.

Dermatology Years 2 and 3

Patient Care

1. Apply pathological findings to patient care.

Medical Knowledge

1. Evaluate and teach from tissue at the microscope.
2. Be knowledgeable of the normal anatomy of the skin by site, tissue, and adnexa.
3. Provide a comprehensive differential diagnosis.
4. Understand the histochemistry and immunodiagnostics of dermatopathology, tissue markers, and basic electromicroscopy.
5. Understand the clinicopathologic relations. Be able to see the clinical and predict the histological features.
6. Know how to biopsy a lesion to obtain optimal results:
 - a. Select the proper lesion or lesional area,
 - b. Obtain the specimen with the proper depth, and

- c. Identify technical problems during tissue processing.

Professionalism

1. Be on time for derm path sessions.

Systems-Based Practice

1. Apply pathological results to the patient clinical scenario.

Communication

1. Discuss cases with pathologist in an effective manner.

Practice-Based Learning and Improvement

1. Receive feedback and critically evaluate biopsy technique.

General Adult 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, and
 - 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, and
 - h. Perform electrodesiccation 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, and
 - 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, and
 - 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 and 1 pm).
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.

Practice-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, and
 - 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, and
 - h. Perform electrodesiccation 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, and
 - 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, and
 - 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. Antiacne medications, and

- 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, and
 - 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 and 1 pm).
- 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.

Practice-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, and
 - 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, and
 - h. Perform electrodesiccation 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, and
 - 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, and
 - 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, and
 - 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, and
 - 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 and 1 pm).
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.

Practice-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.

Hidradenitis Suppurativa & Follicular Disorders

Goals:

- 1. Develop basic clinical and procedural skills in the evaluation and treatment of hidradenitis suppurativa.**
- 2. To equip the trainee with the basic surgery skills needed to address limited surgical interventions for hidradenitis suppurativa and determine what type of intervention is most appropriate.**
- 3. Develop expertise in the diagnosis, treatment, and management of patients with hidradenitis suppurativa**
- 4. Demonstrate ability to apply fundamental knowledge of hidradenitis suppurativa in the clinical setting.**

Objectives:

Dermatology Year 1

Patient Care

1. Obtain pertinent history and perform a complete dermatologic examination with appropriate assessment of disease severity and lesion type.
2. Perform surgical techniques with close oversight:
 - a. Punch unroofing or removal of small nodules and sinuses
 - b. Simple and complex incision and drainage procedures
 - c. Nd:YAG and alexandrite laser treatment of hidradenitis suppurativa
 - d. Local excision of sinuses with planned complex closures or second intention healing
 - e. Unroofing of limited sinuses
4. Know the basics of how to perform local anesthesia.
5. Provide counseling on disease pathogenesis and available treatments

Medical Knowledge

1. Recognize nodules, abscesses, and cutaneous sinuses
2. Recognize common diseases associated with hidradenitis suppurativa skin diseases
 - a. pyoderma gangrenosum
 - b. inflammatory arthritis
 - c. acne
 - d. pilonidal sinus
 - e. inflammatory bowel disease
3. Learn basic therapeutic options for hidradenitis suppurativa
4. Become familiar with topical medications to include:
 - a. topical antibiotics
 - b. chlorhexidine gluconate
6. Become familiar with systemic medications to include:
 - a. clindamycin +/- rifampin
 - b. minocycline/doxycycline
 - c. levofloxacin/metronidazole
 - d. adalimumab
 - e. spironolactone

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 and 1 pm).
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 when referral to other specialists is appropriate

Communication

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

Practice-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 with appropriate assessment of disease severity and lesion type.
2. Perform surgical techniques with oversight during key portions of procedures:
 - a. Punch unroofing or removal of small nodules and sinuses
 - b. Simple and complex incision and drainage procedures
 - c. Nd:YAG and alexandrite laser treatment of hidradenitis suppurativa
 - d. Local excision of sinuses with planned complex closures or second intention healing
 - e. Unroofing of limited sinuses
4. Know the basics of how to manage wounds and post-operative complications for HS

Medical Knowledge

1. Recognize nodules, abscesses, and cutaneous sinuses
2. Recognize common diseases associated with hidradenitis suppurativa skin diseases
 - a. pyoderma gangrenosum
 - b. inflammatory arthritis
 - c. acne
 - d. pilonidal sinus
 - e. inflammatory bowel disease
3. Learn basic therapeutic options for hidradenitis suppurativa
4. Become familiar with topical medications to include:
 - a. those listed under year 1 objectives
5. Know the appropriate use of local anesthetics for HS procedures
6. Become increasingly capable of using and understanding systemic therapy to include:

- a. those listed in year 1 objectives and,
 - b. anakinra
 - c. infliximab
 - d. ustekinumab
 - e. finasteride
 - f. hormonal contraception
8. Know the principles of and be able manage wounds and post-operative complications following procedures for hidradenitis suppurativa

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 and 1 pm).
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.

Practice-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 3

Patient Care

1. Obtain pertinent history and perform a complete dermatologic examination with appropriate assessment of disease severity and lesion type.
2. Plan and perform surgical techniques with limited oversight:
 - a. Punch unroofing or removal of small nodules and sinuses
 - b. Simple and complex incision and drainage procedures
 - c. Nd:YAG and alexandrite laser treatment of hidradenitis suppurativa
 - d. Local excision of sinuses with planned complex closures or second intention healing
 - e. Unroofing of limited sinuses
4. Know the basics of how to manage wounds and post-operative complications for HS
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.

Medical Knowledge

1. Recognize nodules, abscesses, and cutaneous sinuses
2. Recognize common diseases associated with hidradenitis suppurativa skin diseases
 - a. pyoderma gangrenosum
 - b. inflammatory arthritis
 - c. acne
 - d. pilonidal sinus
 - e. inflammatory bowel disease
3. Learn basic therapeutic options for hidradenitis suppurativa
4. Become familiar with topical medications to include:
 - a. those listed under year 1 objectives
5. Know the appropriate use of local anesthetics for HS procedures
6. Become increasingly capable of using and understanding systemic therapy to include:
 - a. those listed in year 1 and 2 objectives
 - b. pain management options for HS including the limited use of opiate analgesics
8. Know the principles of and be able manage wounds and post-operative complications following procedures for hidradenitis suppurativa
9. Should be familiar with the economics and ethics of dermatology.
10. Will demonstrate ability to instruct peers and interact with other physicians on problems related to dermatology.
11. Will be able to teach the principles of all program objectives to those residents of lower rank.
12. Will demonstrate overall independent responsibility for directing service and patient care decisions.
13. 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 and 1 pm).
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. 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.

Practice-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.

High Risk Skin Cancer

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, and
 - 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, and
 - b. Learn how to use the ablative setting on the laser to treat NMSC on the lip and actinic cheilitis (vermilionectomy).
6. Intralesional 5-fluorouracil (5-FU)
 - a. Learn how to select patient subsets who would benefit from intralesional therapy to skin cancers and other squamoproliferative lesions like warts, and
 - 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, and

- 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, and
 - 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, and
 - f. Sirolimus.
5. Other systemic medications that confer increased risk of both melanoma and NMSC
 - a. TNF-alpha inhibitors, and
 - 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), and
 - 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, and
 - b. Understand rationale for using CO2 laser as a drug delivery tool for other agents (efudex, aldera, 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.

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 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

Practice-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

Immunodermatology/Autoimmune Disorders

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

Objectives:

Dermatology Year 1

Patient Care and Medical Knowledge

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

Professionalism

1. Interact with patients in a professional manner.

Systems-Based Practice

1. Learn how to manage patients with immunobullous dermatoses.

Communication

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

Practice-Based Learning and Improvement

1. Self-critique interactions with patients for personal improvement.

Dermatology Years 2 and 3

Patient Care and Medical Knowledge

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

Professionalism

1. Interact with patients in a professional manner.

Systems-Based Practice

1. Learn how to manage patients with immunobullous dermatoses.

Communication

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

Practice-Based Learning and Improvement

1. Self-critique interactions with patients for personal improvement.

Laser Rotation

Goals:

- 1. Develop competence in the execution and appropriate patient selection, mechanisms of action, risks/benefits and technique for lasers for treatment of vascular anomalies, pigmentary changes, benign skin neoplasms, tattoos, Hidradenitis Suppurativa, and other inflammatory skin conditions.**

Objectives:

Dermatology Years 1-3

1. ***Patient Care and Procedural Skills:*** Residents will be required to demonstrate:
 - a. the ability to engage in productive directive conversation with the laser patient regarding lesions and how best to treat them. “Productive directive conversations” includes the following components:
 - i. Assess the impact of the lesions on the patient’s self-image and lifestyle
 - b. competence in all aspects of common laser procedures including:
 - i. laser resurfacing
 - ii. pulsed dye laser
 - iii. ipl/photofacial
 - iv. ktp
 - v. diode laser
 - vi. microdermabrasion
 - vii. laser resurfacing/ablative laser
 - viii. q-switched lasers
 - ix. laser treatment of Hidradenitis Suppurativa
2. ***Medical Knowledge:*** Residents will be required to:
 - a. expand knowledge base regarding current understanding of the different therapeutic interventions to modify skin lesions via laser treatment.
3. ***Practice-Based Learning and Improvement:*** Residents will be required to:
 - a. research issues encountered with patients
 - b. appropriately apply current knowledge to the care of patients
 - c. measure improvement resulting from implementation of a change in routine approach
4. ***Interpersonal and Communication Skills:*** Residents are required to:
 - a. demonstrate effective use of technology to communicate with patients and referring physicians
 - b. appropriate timing of communication
 - c. effectively direct the care of patients requiring a multidisciplinary approach to successfully manage their laser concern
5. ***Professionalism:*** Residents will be required to:
 - a. fulfill assigned duties during the rotation
 - b. make ethical decisions in interactions with patient, their families and other members of the care team

c. show sensitivity towards the patient's concerns

6. ***Systems-Based Practice:*** Residents will be required to:
- a. demonstrate understanding of coding, billing and patient payer induced restriction in care allowed
 - b. determine how to maximize resident's ability to care for the patients within the financial and social constraints placed on the patient and resident's ability to care for the patient
 - c. mobilize all necessary resources to facilitate optimal care for the resident's patients

Mohs Surgery Rotation

Goals:

1. **Develop the skills that enable the execution and appropriate use of the Mohs surgical technique for removal of various skin cancers in all applicable anatomic locations.**
2. **Develop competence in the design and execution of layered closures, flaps and grafts for repair of post-Mohs surgical defects.**
3. **Be able to successfully manage patients with complex medical conditions prior to, during and after skin surgery.**
4. **Enhance the ability to diagnose skin cancer on the basis of clinical and/or histologic findings.**
5. **Understand the requirements for setting up and running a Mohs histology laboratory.**
6. **Develop proficiency in decisions regarding instances in which the patient should be referred to a different specialty or individual.**

Objectives:

Dermatology Years 1-3

1. ***Patient care and Procedural Skills:*** The resident will be required to demonstrate:
 - a. mature caring, compassionate, appropriate, respectful attitudes and actions towards patients, families of patients, coworkers, and staff
 - b. competencies in all aspects of Mohs surgery including:
 - i. diagnosing skin cancer including early identification of benign premalignant and malignant skin lesions
 - ii. consideration of all appropriate forms of therapy for different skin cancers
 - iii. indications for Mohs surgery
 - iv. execution of the Mohs surgical technique in tumor removal from a variety of body sites
 - v. grossing in Mohs specimens and labeling glass slides
 - vi. cutting frozen Mohs sections
 - vii. preparing frozen Mohs sections for reading under the microscope
 - viii. accurate interpretation-diagnosis of Mohs frozen section histology
 - ix. mapping the findings from Mohs histologic sections
 - x. location of positive margins using Mohs sections and correctly executing subsequent stages of excision
 - xi. implementation of immunostains in Mohs surgery, especially MART1 for melanoma and cytokeratin staining for challenging squamous cell carcinoma
 - c. competence in surgical repair techniques including:
 - i. determining when best to allow wounds to heal by second intention
 - ii. layered primary closure-including intermediate and complex repair
 - iii. development of suture technique necessary for optimal outcomes in reconstruction
 - iv. random pattern and axial flap repair
 - v. graft techniques including full and split thickness grafts as well as xenografts
 - vi. staged reconstructive techniques such as interpolation/staged pedicle flaps
 - d. competence in evaluation and management skills for all cutaneous surgical patients regardless of diagnosis, including preoperative, perioperative, and postoperative

evaluation

e. certification in basic life support (BLS)

2. **Medical Knowledge:** The resident will be required to demonstrate:
 - a. in-depth knowledge of clinical diagnosis, biology, and pathology of skin tumors, as well as laboratory interpretation related to diagnosis and surgical treatment
 - b. knowledge of related disciplines including surgical anatomy, sterilization of equipment, aseptic technique, anesthesia, closure materials, and instrumentation
3. **Practice-Based Learning and Improvement:** The resident will be required to:
 - a. research issues you encounter with your patients—systemically analyze practice using quality improvement methods, and implement changes with the goal of practice improvement
 - b. appropriately apply current knowledge to the care of your patients – locate, appraise, and assimilate evidence from scientific studies related to the patients’ health problems
4. **Interpersonal and Communication Skills:** The resident will be required to:
 - a. demonstrate effective use of technology to communicate with patients and referring physicians
 - b. appropriate timing of communication
 - c. effectively direct the care of patients requiring a multidisciplinary approach to successfully manage their lesion
5. **Professionalism:** The resident will be required to:
 - a. fulfill duties
 - b. make ethical decisions
 - c. show sensitivity towards diverse cultural, political and religious views
6. **Systems-Based Practice:** The resident will be required to:
 - a. demonstrate understanding of proper and ethical coding and billing of medical services
 - b. determine how to maximize ability to care for the patients within the financial and social constraints placed on the patient and the resident’s ability to care for the patient
 - c. mobilize all necessary resources to facilitate optimal care for the patients

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

1. Evaluate and treat common pediatric dermatology conditions including warts, acne, molluscum, atopic dermatitis, and tinea capitis.
2. Learn to correctly classify pediatric vascular lesions as vascular tumors or vascular malformations.
3. Perform with supervision potassium hydroxide preparations, Tzanck smears, skin biopsies, and fungal cultures on children.
4. Develop awareness of cutaneous markers of underlying syndromes including: neurofibromatosis, tuberous sclerosis, McCune-Albright, incontinentia pigmenti, etc.
5. 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.
6. 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.
7. 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.
8. 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.
9. Comfort with cryotherapy and skin biopsy technique in infants and children; observe and when possible assist in laser dermatologic procedures.
10. Understand methods of anesthesia, analgesia, distraction techniques, and methods of restraint for procedures in pediatric dermatology
11. 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.
12. Learn postoperative management of pediatric patients including techniques in child-friendly wound care and control of postoperative pain.
13. Learn the indications and use of the pulsed dye laser, and other lasers in the treatment of vascular and other skin lesions in children.
14. Learn the evaluation and formulation of therapeutic strategies for pediatric patients referred for dermatologic surgery.

15. Participate in the preoperative assessment of patients, in the education and preparation of families for surgery, and in the postoperative management of surgical patients.
16. Residents will develop skills in pediatric diagnostic and therapeutic procedures in the clinic setting including, but not limited to:
 - a. Skin biopsy techniques,
 - b. Potassium hydroxide examinations,
 - c. Tzanck examinations,
 - d. Mineral oil examinations,
 - e. Hair mounts,
 - f. Fungal cultures,
 - g. Cryotherapy,
 - h. Laser therapy, and
 - i. Development of a therapeutic plan for children with both acute and chronic skin diseases.

Professionalism

1. Appropriately dress for patient care
2. Appropriately interact with patients and parents
3. Appropriately interact with visiting residents

Systems-Based Practice

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

Communication

1. Discuss the natural history of hemangiomas and congenital melanocytic nevi with families.
2. 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.
3. Educating parents in the management of dermatologic problems.
4. Communication with children and parents.

Practice-Based Learning and Improvement

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

Dermatology Year 2

Patient Care and Medical Knowledge

1. Evaluate and treat common pediatric dermatology conditions including warts, acne, molluscum, atopic dermatitis, and tinea capitis.

2. Correctly classify pediatric vascular lesions as vascular tumors or vascular malformations.
3. Independently perform potassium hydroxide preparations, Tzanck smears, skin biopsies, and fungal cultures on children.
4. Develop awareness of cutaneous markers of underlying syndromes including: neurofibromatosis, tuberous sclerosis, McCune-Albright, incontinentia pigmenti, etc.
5. 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.
6. 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.
7. 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.
8. 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.
9. Comfort with cryotherapy and skin biopsy technique in infants and children; observe and when possible assist in laser dermatologic procedures.
10. Understand methods of anesthesia, analgesia, distraction techniques, and methods of restraint for procedures in pediatric dermatology.
11. 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.
12. Learn postoperative management of pediatric patients including techniques in child-friendly wound care and control of post-operative pain.
13. Learn the indications and use of the pulsed dye laser, and other lasers in the treatment of vascular and other skin lesions in children.
14. Learn the evaluation and formulation of therapeutic strategies for pediatric patients referred for dermatologic surgery.
15. 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.
16. Residents will develop skills in pediatric diagnostic and therapeutic procedures in the clinic setting including, but not limited to:
 - a. Skin biopsy techniques,
 - b. Potassium hydroxide examinations,
 - c. Tzanck examinations,
 - d. Mineral oil examinations,
 - e. Hair mounts,
 - f. Fungal cultures,
 - g. Cryotherapy,

- h. Laser therapy, and
- i. Development of a therapeutic plan for children with both acute and chronic skin diseases.

Professionalism

1. Appropriately dress for patient care
2. Appropriately interact with patients and parents
3. Appropriately interact with visiting residents

Systems-Based Practice

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

Communication

1. Discuss the natural history of hemangiomas and congenital melanocytic nevi with families.
2. 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.
3. Educating parents in the management of dermatologic problems
4. Communication with children and parents

Practice-Based Learning and Improvement

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

Dermatology Year 3

Patient Care and Medical Knowledge

1. Evaluate and treat common pediatric dermatology conditions including warts, acne, molluscum, atopic dermatitis, and tinea capitis.
2. Correctly classify pediatric vascular lesions as vascular tumors or vascular malformations.
3. Independently perform potassium hydroxide preparations, Tzanck smears, skin biopsies, and fungal cultures on children.
4. Develop awareness of cutaneous markers of underlying syndromes including: neurofibromatosis, tuberous sclerosis, McCune-Albright, incontinentia pigmenti, etc.
5. 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.

6. 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.
7. 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.
8. 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.
9. Comfort with cryotherapy and skin biopsy technique in infants and children; observe and when possible assist in laser dermatologic procedures.
10. Understand methods of anesthesia, analgesia, distraction techniques, and methods of restraint for procedures in pediatric dermatology.
11. 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.
12. Learn postoperative management of pediatric patients including techniques in child-friendly wound care and control of post-operative pain.
13. Learn the indications and use of the pulsed dye laser, and other lasers in the treatment of vascular and other skin lesions in children.
14. Learn the evaluation and formulation of therapeutic strategies for pediatric patients referred for dermatologic surgery.
15. 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.
16. Residents will develop skills in pediatric diagnostic and therapeutic procedures in the clinic setting including, but not limited to:
 - a. Skin biopsy techniques,
 - b. Potassium hydroxide examinations,
 - c. Tzanck examinations,
 - d. Mineral oil examinations,
 - e. Hair mounts,
 - f. Fungal cultures,
 - g. Cryotherapy,
 - h. Laser therapy, and
 - i. Development of a therapeutic plan for children with both acute and chronic skin diseases.

Professionalism

1. Appropriately dress for patient care
2. Appropriately interact with patients and parents
3. Appropriately interact with visiting residents

Systems-Based Practice

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

Communication

1. Discuss the natural history of hemangiomas and congenital melanocytic nevi with families.
2. 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.
3. Educating parents in the management of dermatologic problems
4. Communication with children and parents

Practice-Based Learning and Improvement

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

Piedmont Health Services

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, and
 - e. Ectoparasitic scraping.
3. Perform basic surgical techniques to include:
 - a. Punch biopsy,
 - b. Shave biopsy,
 - c. Perform cryosurgery,
 - d. Scissor excision, and
 - e. Perform electrodesiccation 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, and
 - 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, and
 - 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, and
 - e. Ectoparasitic scraping.
- 3. Perform basic surgical techniques to include:
 - a. Punch biopsy,
 - b. Shave biopsy,
 - c. Perform cryosurgery,
 - d. Scissor excision, and
 - e. Perform electrodesiccation 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, and
 - 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, and
 - 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, and
 - 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, and
 - 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, and
 - e. Ectoparasitic scraping.
3. Perform basic surgical techniques to include:
 - a. Punch biopsy,
 - b. Shave biopsy,
 - c. Perform cryosurgery,
 - d. Scissor excision, and
 - e. Perform electrodesiccation 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, and
 - 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.
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 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, and
 - 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, and
 - 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, and
 - 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.
14. Will be familiar with advanced therapeutics: radiation therapy, systemic therapy for psoriasis, and antineoplastic therapy.
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.
7. 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.

Pigmented Lesion/Melanoma

Goals: Develop expertise in the diagnosis, treatment, and management of patients with pigmented lesions.

Objectives:

Dermatology Year 1

Patient Care and Medical Knowledge

1. Evaluate and treat pigmented lesions such as common acquired nevi, congenital nevi, dysplastic nevi, Spitz nevi, blue nevi, and melanoma.
2. Accurately diagnose pigmented lesions.
3. Learn how to evaluate pigmented lesions using state-of-the art methods of diagnosis, including digital imaging and dermoscopy.
4. Learn about the controversies in the diagnosis of Spitz nevi and dysplastic nevi.
5. Learn the appropriate biopsy methods for pigmented lesions. Perform biopsies of pigmented lesions.
6. Learn how to appropriately stage melanoma patients.
7. Learn about the availability of Sentinel Lymph Node biopsy.
8. Learn the appropriate surgical treatments for patients with melanoma.
9. Learn about treatments available to patients with melanoma.
10. Learn the appropriate follow-up care for patients with dyplastic nevi and melanoma.

Professionalism

1. Interact with patients in a professional manner.

Systems-Based Practice

1. Learn how to manage patients with complex pigmented lesions.

Communication

1. Learn to deliver bad news to patients and families.

Practice-Based Learning and Improvement

1. Self-critique interactions with patients for personal improvement.

Dermatology Years 2 and 3

Patient Care and Medical Knowledge

1. Evaluate and treat pigmented lesions such as common acquired nevi, congenital nevi, dysplastic nevi, Spitz nevi, blue nevi, and melanoma.
2. Accurately diagnose pigmented lesions.
3. Learn the appropriate biopsy methods for pigmented lesions. Perform biopsies of pigmented lesions.
4. Learn how to appropriately stage melanoma patients.
5. Learn about the availability of Sentinel Lymph Node biopsy.
6. Learn the appropriate surgical treatments for patients with melanoma.
7. Learn about treatments available to patients with melanoma.

8. Learn the appropriate follow-up care for patients with dysplastic nevi and melanoma.

Professionalism

1. Interact with patients in a professional manner.

Systems-Based Practice

1. Learn how to manage patients with complex pigmented lesions.

Communication

1. Learn to deliver bad news to patients and families.

Practice-Based Learning and Improvement

1. Self-critique interactions with patients for personal improvement.

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, and
 - 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, and
 - f. Perform electrodesiccation 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, and
 - 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, and
 - 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. Antiacne medications, and
 - 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, and
 - d. Biologic therapy.
 8. Become increasingly capable of using and understanding systemic therapy to include:
 - a. Antineoplastic Therapy,
 - b. Retinoids,
 - c. Phototherapy, and
 - 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

Practice-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, and
 - 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, and
 - f. Perform electrodesiccation 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, and
 - 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, and
 - 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, and
 - 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, and
 - 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 pathological 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

Practice-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

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 practices in future years.

RESIDENT EXPECTATIONS

Clinical teaching and education are two-way streets. Faculty 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 16 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, Burlington, and Rex may be attended by all trainees, starting with their first year.
- Electives are typically reserved for our second and third year (senior) residents.

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. Give the receipts to the Residency Coordinator.

Chief Resident(s): The Chief Resident(s) is/are 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(s) participate(s) 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(s) perform(s) 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(s) serve(s) 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(s) 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 BASIC and CORE examinations 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. 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 appropriately 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 and continuity 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 30 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.

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 monthly. In this conference, interesting patients with attendant teaching value are reviewed. Residents and faculty members are responsible for referring challenging and/or interesting patients to 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(s) is/are 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(s) 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 (20-25 days) 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, completed in advance of the elective.

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 (20 days) of elective outside of the North American continent, they will accrue one additional week (5 days) 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://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 up to 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.

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.

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 educational activities. Residents also evaluate satellite clinics (rotations). This is accomplished through anonymous evaluations filled out online via MedHub. The Residency Coordinator prints the MedHub 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, and the Chief Resident(s) meet on an annual basis to address the overall educational objectives of the program with feedback from program/educational activities/rotation evaluations and resident performances on the ABD BASIC and CORE examinations.

Program Evaluation of Residents

Each resident will be evaluated individually by self, peers, faculty and staff, 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 **BASIC Examination** is administered yearly in the Spring to first-year dermatology residents according to the guidelines set by the American Board of Dermatology, and is informational only. This examination measures the residents' dermatology fundamentals. 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. Throughout the year, the **CORE Examination** is administered to second and third-year dermatology residents, to help prepare them for the traditional Certification Examination, testing more advanced knowledge of the senior residents about dermatology's major clinical areas.

Third-year residents take an Online Practice Exam in the Spring, which tests the residents' ability to apply knowledge in clinical situations.

Milestones Evaluation

Each resident will be evaluated twice per year via a **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 MedHub. Patient evaluations are captured by PressGaney and a patient feedback form, and then is entered into MedHub, for one all-inclusive evaluation.

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 and expected to be greater than 90%.

Clinical Skills Evaluation (Sept.)

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

Personal Feedback (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



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Dermatology and Skin Cancer Centers

Appointments
984-974-3900

Southern Village

410 Market Street, Suite 400
Chapel Hill, N.C. 27516
Fax: 984-974-3692

Dermatology at Hillsborough

460 Waterstone Drive
Hillsborough, NC 27278
Fax: 919-595-5943

Dermatology at Rex

3921 Sunset Ridge Rd, Ste. 202
Raleigh, NC 27607
Fax: 984-974-0910

Dermatology at Burlington

1522 Vaughn Rd
Burlington NC 27217
Fax: 336-905-6191

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 MedHub 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 MedHub. 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.

PROCEDURE

REQUEST FOR 80-HOUR DUTY LIMIT EXCEPTION

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.

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Carolyn Ziemer, MD

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Emma Beckham
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Immunodermatology

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Dermatology and Skin Cancer Centers

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Fax: 919-595-5943

Dermatology at Rex

3921 Sunset Ridge Rd, Ste. 202
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Dermatology at Burlington

1522 Vaughn Rd
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POLICY AND PROCEDURE

UNIVERSITY OF NORTH CAROLINA HOSPITALS GRADUATE MEDICAL EDUCATION POLICY ON PROFESSIONAL DRESS ATTIRE

I. Description

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

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

Professional Business Attire, Retrieved 05/28/19. Official copy at <http://unchealthcare-uncmc.policystat.com/policy/4984311/>. Copyright © 2019 UNC Medical Center

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

- A. [Identification and Access Control Card Policy in UNC Health Care Policy Manual](#)
- B. [Personal Protective Equipment Policy in UNC Health Care Policy Manual](#)

PolicyStat ID: 4984311		
	Origination:	02/2014
	Effective:	07/2018
	Last Approved:	07/2018
	Last Revised:	02/2014
	New Review:	07/2021
	Owner:	Candace Glass: HR Executive
	Policy Area:	Human Resources
	Policy Tag Groups:	
	Applicability:	UNC Medical Center



DEPARTMENT OF DERMATOLOGY

Faculty

Nancy E. Thomas, MD, PhD
The Irene & Robert Alan Briggaman
Distinguished Professor & Chair

Edith Bowers, MD, PhD
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Craig N. Burkhart, MD
Sarah Corley, MD
Donna Culton, MD, PhD
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Megan Evans, MD
Amy W. Fox, MD
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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 MedHub, 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 UNC Hospitals-affiliated entities such as WakeBrook, for example 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, including moonlighting at any UNC Health Care System affiliate (including Rex Healthcare, Chatham Hospital, Caldwell Memorial Hospital, High Point Regional Health, Johnston Health, Nash Healthcare, Pardee Hospital), as the activity is outside the scope of graduate medical education employment to UNC Hospitals. Trainees who are not moonlighting at UNC Hospitals or UNC Hospitals-affiliated entities 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 entity) provider number and billing, and training, and must meet any other requirements for clinical privileging at the employment site.

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 MedHub.
- 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., *Carolinas 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.

PolicyStat ID: 4753671		
	Origination:	05/1992
	Effective:	03/2018
	Last Approved:	03/2018
	Last Revised:	05/2015
	New Review:	03/2021
	Owner:	Cynthia Trinidad Mitchell: Dir, Grad Medical Educ
	Policy Area:	GME and Other Training Programs
	Policy Tag Groups:	
	Applicability:	UNC Medical Center

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 MedHub (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)

Resident Name:	
PGY Level:	
Program Name:	
Program Director:	
Chair of Department:	
<i>Detailed</i> Description of Activity (must include a description of what your actual duties will be during a typical moonlighting shift)	
Site of Activity and Service	
Beginning/Ending Dates of Activity *	
Estimated Hours/Shift	
Estimated Shifts/Month	
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 MedHub. 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 MedHub.**

_____ 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 DUTYHOURS 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: _____



MOONLIGHTING SERVICES AGREEMENT

THIS MOONLIGHTING SERVICES AGREEMENT (the “**Agreement**”), is entered into and is effective the ___ day of _____ 20XX (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 _____ [specify 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 _____ [specify 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.

3.2.3. 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.

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

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

3.2.6. 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

Hospital

Clark Denniston, MD
Designated Institutional Official

Date: _____

Date: _____



Exhibit A

SAMPLE PHYSICIAN ACTIVITY SUMMARY

Name: _____

Address: _____

Month Ending: _____

City, State, Zip: _____

DESCRIPTION OF SERVICES	SPECIFY ACTIVITY	DATE(S) OF SERVICE	NUMBER OF HOURS

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



DEPARTMENT OF DERMATOLOGY

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POLICY AND PROCEDURE

UNIVERSITY OF NORTH CAROLINA HOSPITALS GRADUATE MEDICAL EDUCATION PAID TIME OFF

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.

PolicyStat ID: 4754724		
	Origination:	11/1998
	Effective:	03/2018
	Last Approved:	03/2018
	Last Revised:	03/2007
	New Review:	03/2021
	Owner:	Cynthia Trinidad Mitchell: Dir, Grad Medical Educ
	Policy Area:	GME and Other Training Programs
	Policy Tag Groups:	
	Applicability:	UNC Medical Center



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POLICY AND PROCEDURE

UNIVERSITY OF NORTH CAROLINA HOSPITALS GRADUATE MEDICAL EDUCATION/DERMATOLOGY INSTITUTIONAL POLICY ON LEAVES OF ABSENCE (EFFECTS ON COMPLETION OF RESIDENCY PROGRAM)

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.

PolicyStat ID: 4754742		
	Origination:	01/2002
	Effective:	03/2018
	Last Approved:	03/2018
	Last Revised:	02/2008
	New Review:	03/2021
	Owner:	Cynthia Trinidad Mitchell: Dir, Grad Medical Educ
	Policy Area:	GME and Other Training Programs
	Policy Tag Groups:	
	Applicability:	UNC Medical Center



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POLICY AND PROCEDURE

RESIDENT AND SUBSPECIALTY RESIDENT FAMILY MEDICAL LEAVE

Applicability: This policy applies to all medical residents in a program accredited by the Accreditation Council for Graduate Education (“ACGME”) and all dental residents in a program accredited by the Commission on Dental Accreditation (“CODA”) appointed through the UNC Hospitals’ Graduate Medical Education office.

All duly appointed residents and subspecialty residents within a UNC Hospitals' graduate medical education program who have worked for UNC Hospitals for at least 12 months and have worked at least 1,250 hours during the previous 12 month period are eligible for leave under the Family and Medical Leave Act (FMLA) for one or more of the qualifying reasons listed below.¹

¹ NOTE: If a resident is not eligible for FMLA, the resident may be eligible for leave under the GME Serious Medical Illness and Parental Leave Policy.

If leave is taken under the Family and Medical Leave Act (FMLA), depending on the length of time a resident is on leave, **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 the case of emergency, prior to beginning FMLA leave, 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.

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

Qualifying Reasons for Leave and Length of Leave

Eligible residents may take up to **12 weeks** of leave in a 12-month period for one or more of the following reasons:

- The birth of a son or daughter and to care for the newborn child (must be taken within 12 months of the birth of the child and must be continuous);
- The placement of a son or daughter with the resident for adoption or foster care (must be taken within 12 months of the placement of the child and must be continuous);
- To care for a spouse, son, daughter, or parent who has a serious health condition²;
- For a serious health condition that makes the resident unable to perform the essential functions of his or her job; or
- For a qualifying exigency arising out of the fact that a spouse, son, daughter, or parent is a military member on covered active duty or call to covered active duty status. A qualifying exigency includes leave to address issues that arise from a short-notice deployment; attend an official ceremony related to the covered active duty; to arrange for alternative childcare or enroll a child in a new school; to make or update financial or legal arrangements to address the military member's absence; to attend counseling; to spend time with the military member who is on short-term, temporary, rest and recuperation leave during the period of deployment (leave taken for this purpose can be used for a period of 15 calendar days); for post-deployment activities; or to provide care or arrange for a parent of the military member.

An eligible resident may take up to **26 weeks** of leave during a single 12-month period to care for a covered service member with a serious injury or illness, when the resident is the spouse, son, daughter, parent or next of kin of the service member.

- A covered service member is a current member of the Armed Forces, including a member of the National Guard or Reserves, who is receiving medical treatment, recuperation, or therapy, or is in outpatient status, or is on the temporary disability retired list for a serious injury or illness.

² "Serious health condition" means an illness, injury, impairment or physical or mental condition that involves inpatient care (an overnight stay in a medical care facility) or continuing treatment by a health care provider. Ordinarily, unless complications arise, the common cold, the flu, ear aches, upset stomach, minor ulcers, headaches other than migraine, routine dental or orthodontia problems, periodontal disease, etc., are examples of conditions that do not meet the definition of a serious health condition and do not qualify for FMLA leave.

- A serious injury or illness is one that is incurred by a service member in the line of duty on active duty that may cause the service member to be medically unfit to perform the duties of his or her office, grade, rank, or rating. A serious injury or illness also includes injuries or illnesses that existed before the service member's active duty and that were aggravated by service in the line of duty on active duty.
- The "next of kin" of a current service member is the nearest blood relative, other than the current service member's spouse, parent, son, or daughter, in the following order of priority: (1) a blood relative who has been designated in writing by the service member as the next of kin for FMLA purposes; (2) a blood relative who has been granted legal custody of the service member; (3) brothers and sisters; (4) grandparents; (5) aunts and uncles; (6) first cousins.

An eligible resident is limited to a combined total of 26 weeks of leave for any FMLA-qualifying reasons during the single 12-month period. Up to 12 of the 26 weeks may be for an FMLA-qualifying reason other than military caregiver leave. Military caregiver leave is available to an eligible resident once per service member, per serious injury or illness. However, an eligible resident may take an additional 26 weeks of leave in a different 12-month period to care for the same service member if he or she has another serious injury or illness.

Payment During FMLA

Residents are eligible to receive paid FMLA leave per 12-month period in the following amount, which will be applied at the beginning of the resident's FMLA leave:

- If the resident's program provides 3 or fewer weeks of PTO, the resident will receive an additional 3 weeks of paid FMLA leave;
- If the resident's program provides 4 weeks of PTO, the resident will receive an additional 2 weeks of paid FMLA leave;
- If the resident's program provides 5 weeks of PTO, the resident will receive an additional 1 week of paid FMLA leave;
- If the resident's program provides 6 weeks of PTO, the resident will not receive any additional paid FMLA leave.

After the resident exhausts his or her paid FMLA leave entitlement, the resident may choose to use his or her available paid time off ("PTO") concurrently with the remaining FMLA leave.

After the resident's paid FMLA leave entitlement is exhausted, and after the resident's PTO is exhausted (or if the resident chooses to not use available PTO), then the remaining FMLA leave will be unpaid.

NOTE: Interaction with paid leave under the UNC GME Resident and Subspecialty Resident Serious Medical Illness and Parental Leave (SMIPL) Policy

A resident may only receive the full amount of paid FMLA leave designated above if the resident has not received paid leave under the UNC GME Serious Medical Illness and Parental Leave (SMIPL) policy within the prior 12 months. If a resident has received paid SMIPL leave within the prior 12 months, then his or her entitlement to paid FMLA will be reduced by the amount of paid SMIPL that the resident received in the prior 12 months.

Measurement Period

The 12-month period for purposes of measuring FMLA leave is a “rolling” 12-month period measured backward from the date an employee uses any FMLA; except that, for purposes of leave to care for a covered service member, the single 12-month period begins on the first day the eligible resident takes FMLA to care for a covered service member and ends 12 months after that date.

Holidays: For purposes of determining the amount of leave used by a resident, the fact that a holiday may occur within a week taken as FMLA has no effect; the week is counted as a week of FMLA. However, if a resident is using FMLA in increments of less than one week, the holiday will not count against the resident’s FMLA entitlement unless the resident was otherwise scheduled and expected to work during the holiday.

Spouses: When two spouses work for the same employer, they are only entitled to a combined total of 12 weeks of leave (or up to 26 weeks of leave to care for a covered service member) during any 12-month period if the leave is taken to care for the resident’s parent with a serious health condition, for the birth of the resident’s son or daughter, or for placement of a son or daughter for adoption or foster care.

Intermittent Leave or Reduced Schedule Leave

If there is a medical need for leave that can be best accommodated through an intermittent or reduced schedule, FMLA leave may be taken intermittently (separate blocks of time) or on a reduced schedule (fewer hours than the resident’s usual schedule) if the leave is for one of the following reasons: a resident’s own serious health condition; to care for a spouse, parent, son or daughter with a serious health condition; or to care for a covered service member with a serious injury or illness. **Intermittent leave is not permitted for the birth of a child, to care for a newborn child (except if the child has a serious medical illness), or the placement of a son or daughter with the resident for adoption or foster care.** Leave due to a qualifying exigency may be taken on an intermittent or reduced schedule basis. Examples of intermittent leave would include leave taken for medical appointments related to a serious health condition, such as chemotherapy.

If a resident needs leave intermittently or on a reduced schedule basis for planned medical treatment, then the resident must make a reasonable effort to schedule the treatment so as not to disrupt unduly the employer’s operations. The resident may be reassigned to an alternative position with equivalent pay and benefits for the duration of the intermittent leave.

Residents who return to work on a reduced or intermittent schedule are required to use time off benefits in order to be paid for a full day. This does not jeopardize the classification of residents as exempt.

Requirements of intermittent leave:

- a) All residents are required to contact the GME office within 24 hours of an absence due to intermittent FML.
- b) All residents must follow their department/hospital attendance or “call in” policy when on intermittent leave.

- c) When calling in, residents must state that they are taking leave under the FMLA on an intermittent basis so it will be designated properly in the Graduate Medical Educational Residency Management System (MedHub).

If a resident works on 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.

PROCEDURE

Before taking leave for an FMLA qualifying reason, a resident or subspecialty resident must give written notice to the Office of Graduate Medical Education that FMLA leave is being requested. The resident's written notice must explain the reason for the requested leave so that the GME Office can determine whether the leave qualifies as FMLA leave. An FMLA leave request letter is available in the residents' library on MedHub that residents should use when requesting FMLA leave. If a resident or subspecialty resident takes leave for an FMLA-qualifying reason, the leave will be designated as FMLA leave.

Birth or Adoption: The resident shall give the Office of Graduate Education 30 days notice in writing using the GME Request for Family Medical Leave Form 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 a spouse, son, daughter, or parent who has a serious health condition, the resident must give written notice to the Office of Graduate Medical Education of the intention to take leave 30 days in advance (or as many days as is feasible) using the GME Request for Family Medical Leave Form.

Medical Emergency: In the case of a medical emergency requiring leave because of a resident's own serious health condition, or the unexpected need to care for a spouse, son, daughter, or parent who has a serious health condition, advance notice is not required. The resident (or if incapacitated, his/her representative) should communicate with the Office of Graduate Medical Education as soon as is feasible. It generally should be practicable for the resident to provide notice of unforeseen leave within the time prescribed by the residency program's usual and customary notice requirements using the GME Request for Family Medical Leave Form.

Certification

When a resident requests FMLA leave for one of the following reasons, the resident is required to provide certification from a health care provider in support of the leave request:

- Leave due to the resident's own serious health condition;
- Leave to care for a covered family member's serious health condition; or
- Leave to care for a covered service member with a serious injury or illness.

Leave because of adoption of foster care must also be supported by reasonable proof of adoption or foster care. The GME office will provide the appropriate certification forms for the resident to complete and return. Residents are responsible for providing a complete and sufficient certification at the time the resident gives notice of the need for leave or within five business

days. It is the responsibility of the resident to make sure the physician portion of the paperwork is completed and returned to the GME office within these time limits.

In some instances, a resident may be required to recertify the need for leave, at the resident's own expense. In the event that the GME office requests an employee to recertify, the resident must provide the requested certification to the GME office within 15 calendar days. Where the GME office has a reason 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 GME office, at the GME Office's expense. Where the second opinion differs from the opinion in the original certification, the GME office may require the resident to get the opinion of a third doctor chosen by the GME Office and the resident.

FMLA will not be approved until all paperwork is received. Failure to submit FMLA paperwork by the above described timeframe may result in the delay or denial of FML.

The employer may retroactively designate continuous leave as FML, provided that doing so will not cause hard or injury to the resident.

Reinstatement

The resident shall be reinstated to the same position held when the leave began or an equivalent position with equivalent benefits, pay, and other terms and conditions of employment.

The GME office may require that the resident report periodically on the employee's status and intent to return to work.

If the resident's leave was for the resident's own serious health condition, then the resident must provide a fitness-for-duty certification before returning to work that addresses the resident's ability to perform the essential functions of his or her job.

Failure to Return to Work

If the resident does not intend to return to work after the period of FMLA leave, the resident must notify the Program Director and GME office in writing immediately. Failure to report to work at the expiration of the leave, unless an extension has been requested, may be considered a resignation.

Health Benefits

During FMLA leave, the GME Office or Department (depending on salary funding source) will maintain the resident's coverage under any group health plan on the same conditions as coverage would have been provided if the resident had been continuously employed during the entire leave period.

Any share of group health plan premiums which were paid by the resident prior to FMLA leave must continue to be paid by the employee during the FMLA leave period. During any period of FML that is unpaid, the resident must make arrangements with the GME office to continue to pay the resident's portion of health plan premiums. 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.

Recovery of Premiums

The GME Office or 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.

Non-Discrimination

The GME Office will not interfere, restrain, deny any right, discharge or in any other way discriminate against any resident because he or she exercises any rights under the FMLA.

Interaction With Other Policies

Residents should consult the GME short term disability policy to ascertain whether they may qualify for short term disability benefits while on FMLA leave.

If a resident is on a workers' compensation absence due to an on-the-job injury or illness which also qualifies as a serious health condition under the FMLA, then the workers' compensation absence and FMLA leave will run concurrently.

FMLA leave shall not accumulate nor be carried forward from year to year, shall not be allowable as terminal leave when the resident leaves the GME program, and shall not be used to extend years of creditable state service for retirement benefit purposes.

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	Policy Area:	GME and Other Training Programs
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POLICY AND PROCEDURE

RESIDENT AND SUBSPECIALTY RESIDENT SERIOUS MEDICAL ILLNESS AND PARENTAL LEAVE

Applicability:

This policy applies to all medical residents in a program accredited by the Accreditation Council for Graduate Medical Education (“ACGME”) and all dental residents in a program accredited by the Commission on Dental Accreditation (“CODA”) appointed through the UNC Hospitals’ Graduate Medical Education office.

All duly appointed residents and subspecialty residents within a UNC Hospitals’ Graduate Medical Education (“GME”) program who are not eligible for leave under the Resident and Subspecialty Resident Family and Medical Leave Act Policy may be eligible for leave under this Serious Medical Illness and Parental Leave (“SMIPL”) Policy for one or more of the qualifying reasons listed below. Residents who qualify for leave under the GME FMLA Policy are not eligible to take leave under the SMIPL Policy.

If SMIPL leave is taken, depending on the length of time a resident is on leave, **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, prior to beginning SMIPL, 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.

A resident is prohibited from moonlighting while on SMIPL leave.

Qualifying Reasons for Leave and Length of Leave

Eligible residents may take up to **12 work weeks** of leave in a 12-month period (a rolling 12-month period) for one or more of the following reasons:

- (1) For a serious health condition¹ that makes the resident unable to perform the essential functions of his or her job; and
- (2) For birth of a son or daughter and to care for the newborn child (must be taken within 12 months of the birth of the child).

Leave under this policy can only be authorized by the Program Director (or Department Chair, if appropriate) in conjunction with the Designated Institutional Official for GME.

When two spouses work for the same employer, they are only entitled to a combined total of 12 weeks of leave during any 12-month period if the leave is taken for the birth of the resident's son or daughter.

Payment During Serious Medical Illness and Parental Leave (SMIPL)

Residents are eligible to receive paid SMIPL leave per 12-month period in the following amount, which will be applied at the beginning of the resident's SMIPL leave:

- If the resident's program provides 3 or fewer weeks of PTO, the resident will receive an additional 3 weeks of paid SMIPL leave;
- If the resident's program provides 4 weeks of PTO, the resident will receive an additional 2 weeks of paid SMIPL leave;
- If the resident's program provides 5 weeks of PTO, the resident will receive an additional 1 week of paid SMIPL leave;
- If the resident's program provides 6 weeks of PTO, the resident will not receive any additional paid SMIPL leave.

After the resident exhausts his or her paid SMIPL leave entitlement, the resident may choose to use her or her available paid time off ("PTO") concurrently with the remaining SMIPL leave.

After the resident's paid SMIPL leave entitlement is exhausted, and after the resident's PTO is exhausted (or if the resident chooses to not use available PTO), then the remaining SMIPL leave will be unpaid.

NOTE: Interaction with paid leave under the UNC GME Resident and Subspecialty Resident Family and Medical Leave Act (FMLA) Policy

A resident may only receive the full amount of paid SMIPL leave designated above if the resident has not received paid leave under the UNC GME Family and Medical Leave Act (FMLA) policy within the prior 12 months. If a resident has received paid FMLA leave within the prior 12 months, then his or her entitlement to paid SMIPL will be reduced by the amount of paid FMLA that the resident received in the prior 12 months.

¹ "Serious health condition" means an illness, injury, impairment or physical or mental condition that involves inpatient care (an overnight stay in a medical care facility) or continuing treatment by a health care provider. Ordinarily, unless complications arise, the common cold, the flu, ear aches, upset stomach, minor ulcers, headaches other than migraine, routine dental or orthodontia problems, periodontal disease, etc., are examples of conditions that do not meet the definition of a serious health condition.

Intermittent Leave or Reduced Schedule Leave

If there is a medical leave that can be best accommodated through an intermittent or reduced schedule, Serious Medical Illness leave may be taken intermittently (separate blocks of time) or on a reduced schedule (fewer hours than the resident’s usual schedule). Parental leave cannot be taken on an intermittent or reduced schedule basis.

If a resident needs Serious Medical Illness leave intermittently or on a reduced schedule basis for planned medical treatment, then the resident must make a reasonable effort to schedule the treatment so as not to disrupt unduly the employer’s operations.

Procedure

Before taking leave, a resident or subspecialty resident shall give written notice to the Office of Graduate Medical Education that SMIPPL leave is being requested. The resident’s written notice must explain the reason for the requested leave so that the Hospital can determine whether the leave qualifies as SMIPPL leave under this policy. If a resident or subspecialty resident takes leave for a reason that qualifies under this policy, the leave will be designated as such.

The resident shall give the Office of Graduate Medical Education 30 days notice in writing of the intent to take SMIPPL. For medical emergencies, the resident should provide this notice as soon as feasible.

Certification

When a resident requests Serious Medical Illness Leave, the resident is required to provide certification from a health care provider in support of the leave request. The GME office will provide the appropriate certification forms for the resident to complete and return. Residents are responsible for providing a complete and sufficient certification at the time the resident gives notice of the need for leave or within five business days. It is the responsibility of the resident to make sure the physician portion of the paperwork is completed and returned to the GME office within these time limits.

Health Benefits

During the paid portion of a resident’s SMIPPL leave, the resident’s coverage under any group health plan will continue on the same conditions as during the resident’s active employment. However, once paid leave is exhausted, the resident may continue coverage under the residents’ health plan coverage only by paying the full premium cost (no contribution by the employer).

The obligation to maintain health plan coverage stops if the resident’s premium payment is more than 30 days late.

The GME office may recover the insurance premiums it paid toward the resident’s insurance if the resident fails to return to work after the resident’s SMIPPL leave expired for a reason other than the continuation, recurrence, or onset of a serious medical illness, or other circumstances beyond the resident’s control.

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POLICY AND PROCEDURE

UNIVERSITY OF NORTH CAROLINA HOSPITALS GRADUATE MEDICAL EDUCATION

POLICY ON RESIDENT ELIGIBILITY AND SELECTION FOR RECRUITMENT AND APPOINTMENT; PROMOTION; AND SUSPENSION, NON-RENEWAL, NON- PROMOTION OR DISMISSAL

I. Applicability

This policy affects the programs indicated by a “X” in the list below:

X	Medical Residents and Fellows Appointed through GME Office	Occupational Therapy
X	Dental Residents Appointed through GME Office	Physical Therapy
	Pharmacy Residents	Speech Therapy
	Pastoral Care	Medical Physics

II. Description

This policy describes the minimum eligibility requirements for applicants to residency programs appointed through Graduate Medical Education and the process that programs should use in decisions regarding selection, promotion, suspension, non-renewal, non-promotion, and dismissal.

III. Rationale

All residency programs (“Programs”) should select residents from a pool of applicants who meet the eligibility requirements established by the ACGME or CODA, as applicable to the program’s specialty. University of North Carolina Hospitals is a participating member of the National Resident Matching Program and Dental National Matching Service. 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.

IV. Policy

- A. Applicants must meet one of the following minimum requirements in order to be considered for a residency position:
 - 1. Graduate of medical or dental school in the United States and Canada accredited by the Liaison Committee on Medical Education (LCME) or CODA,
 - 2. Graduate of college of osteopathic medicine in the United States accredited by the American Osteopathic Association (AOA),
 - 3. Graduate of medical school outside the United States and Canada who have either:
 - i. a currently valid certificate from the Educational Commission for Foreign Medical Graduates or
 - ii. a full and unrestricted license to practice medicine in North Carolina.
 - 4. Graduate of medical school outside the United States and have completed a Fifth Pathway program provided by an LCME-accredited medical school.
 - 5. Graduate of medical school outside the United States and meet the requirements to obtain a North Carolina Intern Permit from the North Carolina State Board of Dental Examiners.
- B. 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.

- C. 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.
1. 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.
 2. Each Program must have a written policy for resident selection and recruitment.
 3. 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 that 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 the 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.

- D. Each Program should consider the following in their selection process:
1. 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.
 2. For Programs participating in an organized matching program, the DIO, or his/her designee(s) from the Office of Graduate 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 OGME must approve all such candidates before any offer is made.

3. Programs participating in the Electronic Application Service (ERAS) may accept application materials as provided through ERAS for the Match only;
 4. 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 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;
 5. The selection process should be broad-based to include participation by faculty, residents and tour of facilities; and
 6. 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.
- E. Each Program must include the following for applicants invited for interviews:
1. 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.
 2. After a resident has been selected and matched, the resident folder must retain all letters of recommendation and references.
- F. All selected applicants will be required to submit the following:
1. UNC Hospitals Application for Appointment to Graduate Medical Education,

2. 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 Chairman or designee in the chosen specialty at the Medical/Dental School from which the applicant graduated.
 - iii. A third letter of reference must be mailed from someone who has knowledge of the applicant's experience, ability, educational accomplishments and character.
3. 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).
4. An official Medical/Dental School transcript, from the Registrar of the School of Medicine/Dentistry subsequent to graduation. A photocopy is not acceptable.
5. Signed Authorization for Release of Information (included with the application).
6. Pre-employment drug screening.
7. Signed background check verification.
8. Current curriculum vitae that includes date or anticipated date of medical/dental school graduation and name of the UNC Hospitals residency program the applicant hopes to enter.
9. Any resident who has special restrictions on his/her medical license **must** report this information to the Program Director and the OGME no later than the first day his/her residency program begins.
10. Any resident who has a disability may request an accommodation by contacting his or her Program Director or OGME.

G. 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.

H. Appointment

UNC Hospitals and the Program Directors shall ensure 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.

I. Promotion

1. All information regarding promotion contained in the policy shall be used as minimum criteria for promotion. More detailed promotion criteria shall be delineated by each Program in its respective Program-specific promotion policy.
2. The decision whether to not to reappoint and promote a resident to the next level of post-graduate training shall be made annually by the Program Director, in conjunction with recommendations from the Clinical Competency Committee, based upon a comprehensive review of the resident's performance against criteria determined by the Program.
3. In evaluating whether or not to reappoint and promote a resident to the next level of post-graduate training, the Program Director shall consider all feedback and evaluations of the resident's performance (refer to [University of North Carolina Hospitals Graduate Medical Education Policy on the Evaluation of Residents](#)) and any other criteria deemed appropriate by the Program/Program Director.
4. Each year, the OGME will request promotional decisions from the Program Directors beginning on or about February 1. OGME should be notified immediately upon a Program's decision to not reappoint and promote.

5. If necessary, a Program Director may decide to defer a final decision on whether to promote a resident until after February 1. In this situation, the Program Director should issue a Letter of Deficiency to the resident pursuant to the [UNC Hospitals Graduate Medical Education Resident and Subspecialty Resident Academic Improvement Policy](#).
 6. The Program Director may elect to extend the resident’s appointment pending satisfactory completion of academic requirements. In this event, the decision to promote will be deferred until satisfactory completion of the educational program is confirmed.
 7. A decision not to promote a resident must follow the procedures set forth below in XI, Suspension, Non-Renewal, Non-Promotion, or Dismissal. In no case may a resident not be promoted unless the Program has first provided the resident written notice of intent to not promote and followed the appropriate policies, which set forth the requirements for due process prior to non-promotion.
- J. Suspension, Non-Renewal, Non-Promotion, or Dismissal
1. If a resident is suspended, non-renewed, non-promoted, or dismissed for reasons related to misconduct, the [UNC Hospitals Graduate Medical Education Residency and Subspecialty Resident Misconduct Policy](#) shall be followed.
 2. If a resident is suspended, non-renewed, non-promoted or dismissed for reasons related to academic issues, the [UNC Hospitals Graduate Education Resident and Subspecialty Resident Academic Improvement Policy](#) shall be followed.
 3. If a resident is suspended, non-renewed, non-promoted, or dismissed for any other reason, such suspension, non-renewal, non-promotion or dismissal may not occur unless:
 - i. The resident is given written notice of the intent to take such action; and
 - ii. The resident is given an opportunity to respond to the proposed action prior to the institution of such action.

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POLICY AND PROCEDURE

UNIVERSITY OF NORTH CAROLINA HOSPITALS GRADUATE MEDICAL EDUCATION/DERMATOLOGY POLICY ON ACCOMMODATION OF RESIDENTS WITH DISABILITIES

I. Applicability

This policy affects the programs indicated by a “X” in the list below:

X	Medical Residents and Fellows Appointed through GME Office	Occupational Therapy
X	Dental Residents Appointed through GME Office	Physical Therapy
	Pharmacy Residents	Speech Therapy
	Pastoral Care	Medical Physics

II. Description

This policy describes the process residents/subspecialty residents with known disabilities should follow to request reasonable accommodations in order to meet the clinical and academic requirements of their residency programs.

III. Rationale

A residency program is a structured employment and 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.

IV. 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.

A. Definitions

Disability: According to the Americans with Disabilities Act of 1990, the term “disability” means a physical or mental impairment that substantially limits one or more of the major life activity.

Reasonable Accommodation: Modifications or adjustments to the work environment, or to the manner in which the job is customarily performed, that enables qualified individuals with disabilities to perform the essential functions of that position. Accommodation options may include modification of training materials or policies; modification of equipment; acquisition of adaptive software or assistive technology and equipment; and/or telephones compatible with hearing aids.

An accommodation is NOT required if it would be unreasonable, or if it imposes an undue hardship to the hospital, or if it alters the fundamental nature or requirements of the residency program, or if it 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: elimination of an essential function of the job, or job restructuring that compromises duty hours for other residents of has a negative effect on the training of other residents in the program.

V. Procedure

Request for Accommodation - Residents are responsible for requesting reasonable accommodations, providing medical documentation appropriate to verify the existence of the disability, identifying and assessing potential reasonable accommodations. Requests should be directed to the Office of Graduate Medical Education, residency program director, and the Designated Institutional Official (DIO). If it is determined that medical information is needed,

the resident will be provided with any forms/questionnaires necessary for his/her health care provider to complete. The Office of Graduate Medical Education will evaluate information to determine eligibility within the guidelines of ADA.

The Office of Graduate Medical Education, residency program director and/or 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 engage in the interactive process to identify 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 (on a need-to-know basis), 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 to the extent necessary to make the determinations they are required to make in connection with a request for an accommodation.

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 should 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. Engaging in the interactive process to identify an agreed-upon accommodation that will allow the resident to perform the essential functions of the position.
4. Providing adequate medical documentation, if necessary. 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 qualifies as a disability and supports the need for a requested accommodation. Each accommodation request may require additional

documentation. The resident is responsible for complying in a timely manner with any request for documentation or information from the Office of Graduate Medical Education.

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

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	Policy Area:	GME and Other Training Programs
	Policy Tag Groups:	
	Applicability:	UNC Medical Center



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POLICY AND PROCEDURE

UNIVERSITY OF NORTH CAROLINA HOSPITALS GRADUATE MEDICAL EDUCATION POLICY ON CONSENSUAL AMOROUS RELATIONSHIPS BETWEEN FACULTY AND RESIDENT/SUBSPECIALTY RESIDENTS

I. Applicability

This policy affects the programs indicated by an “X” in the list below:

X	Medical Residents and Fellows Appointed through GME Office	Occupational Therapy
X	Dental Residents Appointed through GME Office	Physical Therapy
	Pharmacy Residents	Speech Therapy
	Pastoral Care	Medical Physics

II. Description

This policy describes the concerns involved when a supervisor and a trainee engage in a consensual amorous relationship and the process the supervisor, the trainee, and the residency program should follow:

III. Rationale

Interactions between supervisors and trainees (as defined below) in education training programs sponsored by the University of North Carolina Hospitals are guided by mutual trust, confidence, and professional ethics. Because professional relationships between supervisors and trainees have a power differential that must exist for appropriate training to occur, personal relationships that may develop between supervisors 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 supervisors and their trainees raise concerns: 1) because of inherent inequalities in the status and power that supervisors wield in relation to trainees; and 2) because other healthcare team members may perceive such relationships as providing a trainee with preferential treatment from the supervisor or the supervisor's colleagues, both of which may adversely affect patient care, as well as UNC Hospitals' ability to provide appropriate training, in general. Accordingly, amorous relationships between a trainee and a supervisor, even when consensual, are not acceptable regardless of the degree of supervision in any given situation.

IV. Policy

It is the policy of UNC Hospitals that supervisors shall not engage in consensual relationships with trainees whenever the supervisor 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 supervisor member is in a position of authority, the supervisor and/or the trainee must terminate the position of authority.

This policy will also apply to relationships between trainees during rotations/experiences in which a trainee evaluates the performance of another trainee.

A. Definitions

1. **Supervisor** refers individually or collectively to full or part-time personnel who evaluate trainee performance, including but not limited to full or part-time faculty.
2. **Trainee** refers individually or collectively to full or part-time residents, subspecialty residents, and students participating in clinical education rotations at UNC Hospitals (including but not limited to students enrolled in a course approved by the UINC School of Medicine or Eshelman School of Pharmacy)..
3. **Position of authority** includes situations in which a supervisor is responsible for supervision and/or evaluation of the performance of a trainee or when a trainee is responsible for supervision and/or evaluation of the performance of another trainee. Instruction that does not have a supervision and/or evaluation component is not included.

V. Procedure

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 or termination includes, but is not limited to: removing any supervisory, teaching, evaluating, advising, coaching, or counseling

responsibilities between the supervisor 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. Supervisors and 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.

A. 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.

B. 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 supervisor, 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.

C. Faculty Rights

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

D. Amorous Relationships Outside the Official Supervisory or Evaluative Context

Even when a supervisor has no professional responsibility for a trainee, the supervisor should be sensitive to the perceptions of other healthcare team members that a trainee who has a consensual relationship with a supervisor may receive preferential treatment from the supervisor or the supervisor’s colleagues. In particular, when the supervisor 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 supervisor may face serious conflicts of interest. In any such situation, therefore, supervisors should be most careful to remove themselves from involvement with any decisions that may reward or penalize trainees. Supervisors 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.

E. Appropriate Relationships

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

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	Policy Area:	GME and Other Training Programs
	Policy Tag Groups:	
	Applicability:	UNC Medical Center



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POLICY AND PROCEDURE

UNIVERSITY OF NORTH CAROLINA HOSPITALS GRADUATE MEDICAL EDUCATION POLICY ON CONFIDENTIAL SUPPORT SERVICES

I. Applicability

This policy affects the programs indicated by an “X” in the list below:

X	Medical Residents and Fellows Appointed through GME Office	Occupational Therapy
X	Dental Residents Appointed through GME Office	Physical Therapy
X	Pharmacy Residents	Speech Therapy
	Pastoral Care	Medical Physics

II. Description

This policy describes the mechanism for a resident or their spouse/significant other to access support services in a completely confidential manner.

III. Rationale

UNC Hospitals is committed to the health and well-being of our residents, 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 residents to have a completely confidential means of seeking assistance without the knowledge of their program of the Office of Graduate Medical Education.

IV. Policy

The UNC Healthcare System has an Employee Assistance Program (EAP) to handle any concerns confidentially. The EAP can be reached at (855) 394-5547. A link to the EAP policy with contact information is available at the following web address:
http://hr.intranet.unchealthcare.org/assistance/index_html

The North Carolina Physicians Health Program (NCPHP) can be reached at (919) 870-4480. The NCPHP handles any medical, psychiatric, substance abuse or behavioral concerns that impact healthcare professionals’ ability to practice. Treatment programs and monitoring programs are conducted under the direction of the NCPHP medical director, allowing professionals get the evaluation and help they need in a protected, confidential manner that allows them to keep practicing without sanctions from relevant licensure boards as long as the professional adheres to the terms of their NCPHP contract. Additional information is available at the NCPHP website: <http://www.ncphp.org/>

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POLICY AND PROCEDURE

UNIVERSITY OF NORTH CAROLINA HOSPITALS GRADUATE MEDICAL EDUCATION POLICY ON THE EVALUATION OF RESIDENTS

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 MedHub 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 MedHub.

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POLICY AND PROCEDURE

UNIVERSITY OF NORTH CAROLINA HOSPITALS GRADUATE MEDICAL EDUCATION MISCONDUCT POLICY

I. Applicability

This policy affects the programs indicated by an “X” in the list below:

X	Medical Residents and Fellows Appointed through GME Office	Occupational Therapy
X	Dental Residents Appointed through GME Office	Physical Therapy
	Pharmacy Residents	Speech Therapy
	Pastoral Care	Medical Physics

II. Description

This policy describes the process that should be followed when investigating allegations of resident/subspecialty resident misconduct and the due process to which residents and subspecialty residents are entitled.

III. Rationale

To establish a policy and procedures for Graduate Medical Education programs at UNC Hospitals to use when allegations of misconduct are made against a resident or subspecialty resident, and to set forth the due process to which a resident/subspecialty resident is entitled in cases of suspension, non-renewal, non-promotion or dismissal as a result of misconduct.

IV. Policy

A. Definitions

Misconduct – Improper behavior, intentional wrongdoing; violation of a law, standard of practice, or policy of the program, department, or hospital, including, but not limited to, violations of the [UNC Hospitals Disruptive and Inappropriate Behavior Policy](#) and [Code of Conduct Policy](#).

Misconduct may be either a single act or the cumulative effect of individual acts based on the frequency and severity of the conduct. Where misconduct also constitutes unprofessional behavior, action under the GME Academic Improvement Policy may proceed concurrently.

V. Procedure

A. Allegations of Misconduct: A resident/subspecialty resident, employee of the UNC Healthcare System; attending physician, patient, or any other person who believes that a resident/subspecialty resident has engaged in misconduct or improper behavior of any kind should immediately report his/her concerns to his/her supervisor, or any other supervisor in the UNC Healthcare System, who in turn should communicate the allegations to the resident/subspecialty resident's Program Director.

B. Investigation: Upon receipt of a complaint regarding the conduct of a resident/subspecialty resident, the Program Director (or Chair or Chair's designee if the Program Director has a conflict of interest) should conduct an investigation, including the following steps, as appropriate:

1. Meet with the person complaining of the misconduct to understand the nature of the complaint and any related information, including identifying potential witnesses and collecting witness statements where applicable.
2. Meet with the resident/subspecialty resident to advise the residents/subspecialty resident of the existence of the complaint, to give the resident/subspecialty resident an opportunity to respond to the allegations, and to identify any potential witnesses to the alleged misconduct. The resident/subspecialty resident may submit a written statement in response to the allegations.
3. Based on the information received from the complainant and the information received from the resident/subspecialty resident, the Program Director must determine if further investigation needs to take place in order to reach a conclusion in the matter. In order to do this, the Program Director should talk with the Office of Graduate Medical Education and Designated Institutional Official to review the situation and determine proper direction. If further investigation is not warranted, then with the consent of the Designated Institutional Official, one does not need to be conducted and the resident/subspecialty resident will be notified in writing of the outcome of the initial investigation.
4. If further investigation is warranted, the Program Director should consult with the Designated Institutional Official to determine whether others should be contact or included in the investigation process as appropriate based on the facts and circumstances of each case, and what additional information may need to be reviewed. For example, Human Resources, Compliance, Security, or other departments may need to be included. All allegations of unlawful harassment will be reported to the Human Resources

Department in accordance with the UNC Healthcare System's Unlawful Harassment Policy.

5. If further investigation is warranted, the Program Director, in consultation with the Office of Graduate Medical Education and the Designated Institutional Official (with assistance from Human Resources or other departments if deemed appropriate), will conduct that investigation. Information learned during the investigation will be prepared by the Program Director into a written report which will include the final decision regarding further action(s), and that report will be provided to the Designated Institutional Official.

6. The Program Director, in consultation with the Designated Institutional Official, can place the accused resident/subspecialty resident on administrative leave (with or without pay) pending the outcome of the investigation. If the resident/subspecialty resident is placed on unpaid administrative leave, the resident/subspecialty resident's pay will be reinstated in full if no findings of misconduct are found.

C. The program may take actions including, without limitation, the following:

1. A verbal or written warning (non-reportable)
2. Give written notice that one or more of the following actions (each of which are considered "Reportable Actions") will be taken:
 - a. Suspension
 - b. Election not to promote to the next PGY level
 - c. Requiring the repeat of a rotation that in turn extends the required period of training
 - d. Extension of contract, which may include extension of the defined training period
 - e. Non-renewal of contract
 - f. Denial of credit for previously completed rotations
 - g. Election to non-reappoint at the conclusion of the current academic year
 - h. Dismissal from the residency or subspecialty residency program

D. Reportable Actions: Reportable Actions (listed in Section C(2) above) are those disciplinary actions that the Program must disclose to others upon request, including, without limitation, future employers, privileging hospitals, and licensing and specialty boards. Resident/Subspecialty residents who are subject to a Reportable Action may request a review of the decision as provided in this Policy.

E. Request for Review: A review of the decision to take a Reportable Action may be requested by the resident/subspecialty resident. A written request for review must be submitted to the Office of Graduate Medical Education/Designated Institutional Official within fifteen (15) days of the resident learning of the Reportable Action. Upon receipt of a request for review, the Office of Graduate Medical Education/Designated Institutional Official will first determine whether the matter is reviewable under this Policy, and if so, will activate the review process. The review process is conducted by the UNC Health Care System Chief Medical Officer (UNCHCS CMO) and the UNC Hospitals Senior Vice President of Operations (UNC SVPO), unless the UNCHCS CMO and/or UNC SVPO were previously involved in the matter and cannot serve as a neutral reviewer, in such a case, the President and CEO of UNC Hospitals or their designee will appoint a substitute neutral reviewer. The two neutral reviewers will then:

- a. Review the resident/subspecialty resident's written request for review
- b. Meet with the resident/subspecialty resident
- c. Review the resident/subspecialty resident's file and the investigation report

- d. Meet with the Program Director
- e. Consider any extenuating circumstances
- f. Consult with others, as appropriate, to assist in the decision making process; and
- g. Determine whether this Policy was followed. That is, that the resident/subspecialty resident received notice and an opportunity to be heard, and the decision to take the Reportable Action was reasonably made.

The decision resulting from this review is a final and binding decision. A written report will be provided to the resident and the Program Director, and others as appropriate.

VI. No Retaliation:

Initial and full inquires will be conducted with due regard for confidentiality to the extent practicable. Under no circumstances may anyone retaliate against, interfere with or discourage anyone from participating in good faith in an investigation conducted under this policy. A resident/subspecialty resident who believes he/she may have been retaliated against in violation of this policy should immediately report it to his/her supervisor, the Office of Graduate Medical Education/Designated Institutional Official, or any other supervisor.

VII. Related Policies

[Disruptive and Inappropriate Behavior Policy](#)

[Code of Conduct](#)

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	Applicability:	UNC Medical Center



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POLICY AND PROCEDURE

UNIVERSITY OF NORTH CAROLINA HOSPITALS GRADUATE MEDICAL EDUCATION ACADEMIC IMPROVEMENT POLICY

I. Applicability

This policy affects the programs indicated by an “X” in the list below:

X	Medical Residents and Fellows Appointed through GME Office	Occupational Therapy
X	Dental Residents Appointed through GME Office	Physical Therapy
	Pharmacy Residents	Speech Therapy
	Pastoral Care	Medical Physics

II. Description

This policy describes the process that should be followed when a resident or subspecialty resident is not meeting a residency program’s academic expectations and the due process to which the resident/subspecialty resident is entitled.

III. Rationale

To establish a policy and process for all Graduate Medical Education programs at UNC Hospitals to use in the normal process of evaluating and assessing competence and progress of residents and subspecialty residents. Specifically, this policy will address the process to be utilized when a resident/subspecialty resident is not meeting the academic expectations of a program.

IV. Policy

A. Definitions

1. Objective Feedback

Assessments and evaluations that are typically structured and scored or rated based on pre-determined criteria that are uniformly applied. Examples include but are not limited to tests, shelf exams, USMLE scores, OSCEs, etc.

2. Subjective Feedback

Assessments and evaluations that are made by faculty and other evaluators, structured or unstructured, based on their professional judgments and opinions. Examples include but are not limited to rotational evaluations, verbal feedback, 360 evaluations, etc.

V. Procedure

A. Performance Feedback

All residents/subspecialty residents must be provided with routine feedback regarding their performance that is consistent with the educational program, and as specified by the ACGME and CODA requirements. Some examples of feedback include verbal feedback, rotational evaluations, semi-annual evaluations, unsolicited feedback, and mentoring.

B. Clinical Competence Committee

Each ACGME medical residency program must have a Clinical Competence Committee (“CCC”). The CCC is responsible for routinely assessing resident/subspecialty resident performance based on ACGME Milestones and making recommendations to the Program Director.

C. “Letter of Deficiency”

When a resident does not show improvement following routine feedback (verbal, written, structured or unstructured), a letter of deficiency from the Program Director must be prepared and delivered to the resident/subspecialty resident. The purpose of the letter of deficiency is to emphasize and clearly articulate the residents/subspecialty resident’s deficiencies and the repercussions for failing to meet expectations. Letters of deficiency should be competency based. The letter of deficiency should provide the resident/subspecialty resident with clear notice of the identified deficiency(s) and an opportunity to improve. Letters of deficiency generally require the resident/subspecialty resident to develop an independent learning plan that will be discussed and endorsed by the Program Director or advisor. A letter of deficiency is simply feedback, and not considered discipline, and thus is not a Reportable Action (as defined below); however, letters of deficiency will be included in the resident’s departmental file and, therefore, may be disclosed to third parties if required by law or if authorized by the current or former resident. Letters of deficiency must be prepared by the Program Director (or in rare circumstances, after consultation with the Office of Graduate Medical Education and the Designated Institutional Official, an alternate faculty member of the program), and specifically outline the expectations and outcomes necessary for correction of the deficiency(s), the timeline for correction, and the potential repercussions for failing to meet expectations.

D. Failure to Cure the Deficiency and Further Action

After providing a letter of deficiency, if the Program Director determines that a resident/subspecialty is not meeting academic standards, or has failed to satisfactorily correct the deficiencies, it is considered a Failure to Cure the Deficiency, and the resident/subspecialty

resident will be given written notice as outlines below in sections D(1) and D(2). In determining whether there has been a Failure to Cure, the Program Director may consider the following:

- review of the entire academic record
- subjective and objective assessments and evaluations
- feedback from the faculty
- feedback from the Clinical Competence Committee

In the event of a Failure to Cure, the Program Director may elect, after consultation with the Office of Graduate Medical Education and Designated Institutional Official, to take further action, which may include one or more of the following steps:

1. Provide an Additional Letter of Deficiency, OR
2. Give written notice that one or more of the following actions (each of which are considered “Reportable Actions”) will be taken:
 - a. Election not to promote to the next PGY level
 - b. Requiring the repeat of a rotation that in turn extends the required period of training
 - c. Extension of contract, which may include extension of the defined training period
 - d. non-renewal of contract
 - e. Denial of credit for previously completed rotations
 - f. Election to non-reappoint at the conclusion of the current academic year
 - g. Suspension from the residency or subspecialty residency program
 - h. Dismissal from the residency or subspecialty residency program

E. Reportable Actions

Reportable Actions (listed in Section D(2) above) are those actions that the Program must disclose to others upon request, without limitation, future employers, privileging hospitals, and licensing and specialty boards. Resident/subspecialty residents who are subject to a Reportable Action may request a review of the decision as provided in this Policy.

When warranted, Reportable Actions may be taken without being preceded by a letter of deficiency; however, a letter of deficiency will precede all cases of non-renewal of contract, non-promotion to the next level of training, or dismissal from the residency or subspecialty residency program. For example, where a rotation is too short to provide a letter of deficiency and opportunity to improve within the same rotation period, a denial of credit for the previously completed rotation may be appropriate.

F. Request for First-Level Review

A review of the decision to take a Reportable Action may be requested by the resident/subspecialty resident. A written request for review must be submitted by the resident to the Office of Graduate Medical Education/Designated Institutional Official within fifteen (15) days of learning of the Reportable Action. Upon receipt of a request for review, the Office of Graduate Medical Education/Designated Institutional Official will first determine whether the matter is reviewable under this Policy, and if so, will activate the review process. The review process is conducted by the UNC Hospitals Chief Medical Office (CMO) and the Senior Vice President of Operations (SVPO), unless the CMO and/or SVPO were previously involved in the matter and cannot serve as a neutral reviewer; in such a case, the President and CEO of UNC Hospitals or their designee will appoint a substitute neutral reviewer. The two neutral reviewers will then:

1. Review the resident/subspecialty resident’s written request for review

2. Meet with the resident/subspecialty resident
3. Review the resident/subspecialty resident’s entire academic record in the training program
4. Discuss with the Program Director
5. Consider any extenuating circumstances
6. Interview and/or consult with others, as appropriate, to assist in the decision making process; and
7. Determine whether this Policy was followed. Specifically, that the resident/subspecialty resident received notice and an opportunity to cure, and the decision to take the Reportable Action was reasonably made.

The review process by the CMO and SVPO will be completed and a decision rendered within seven (7) days after all the necessary review steps have concluded. The decision at that time will be:

1. Uphold the Reportable Action;
2. Overturn the Reportable Action, at which point the resident/subspecialty resident returns to the normal course of their training without the Reportable Action; or
3. Fail to reach a decision (see below).

G. Opportunity for a Final Review: If the reviewers in the first-level review fail to reach a decision, a Final Review will automatically occur. If the resident/subspecialty resident disagrees with the decision of the first-level review, he or she can request a final review of the decision to take a Reportable Action. This final review is conducted by the President and CEO of UNC Hospitals or their designee, *and may include the designation of a second senior leader to assist with the review.* A request for final review shall be submitted to the President and CEO of UNC Hospitals within fourteen (14) days of learning of the first level review decision.

The role of the Final Reviewer(s) and the process are generally the same as described in the “Request for Review” above, however, the report of the first-level review will be utilized in this decision making process. The Final Reviewer(s) will seek to determine additional information, extenuating circumstances, or matters that were not covered in the initial review process. The decision of the Final Reviewer(s) constitutes a final and binding decision. Upon conclusion of the review, a report of the final review will be provided to both the resident/subspecialty resident and the Program Director.

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POLICY AND PROCEDURE

UNIVERSITY OF NORTH CAROLINA HOSPITALS GRADUATE MEDICAL EDUCATION POLICY ON SPECIALTY AND SUBSPECIALTY RESIDENT SUPERVISION

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 a part of the annual program evaluation reporting.

C. UNC DERMATOLOGY SPECIFIC SUPERVISION AND PROGRESSIVE RESPONSIBILITY POLICY

1. Outpatient Clinics

Supervision is exercised through a variety of methods. Clinical activities at Southern Village, Rex, Hillsborough, Burlington, 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. Inpatient 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. *TRANSITIONS 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 7:45am 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).*

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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 GMCEC, 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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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.

PolicyStat ID: 4754771		
	Origination:	07/2002
	Effective:	03/2018
	Last Approved:	03/2018
	Last Revised:	07/2002
	New Review:	03/2021
	Owner:	Cynthia Trinidad Mitchell: Dir, Grad Medical Educ
	Policy Area:	GME and Other Training Programs
	Policy Tag Groups:	
	Applicability:	UNC Medical Center



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POLICY AND PROCEDURE UNIVERSITY OF NORTH CAROLINA HOSPITALS GRADUATE MEDICAL EDUCATION POLICY ON VISAS

University of North Carolina Hospitals will accept resident physicians into ACGME programs 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. Appointments to School of Dentistry training programs may be eligible with F1 OPT and F1 CPT visas.

PolicyStat ID: 5100771		
	Origination:	07/2018
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	Last Approved:	07/2018
	Last Revised:	07/2018
	New Review:	07/2021
	Owner:	Cynthia Trinidad Mitchell: Dir, Grad Medical Educ
	Policy Area:	GME and Other Training Programs
	Policy Tag Groups:	
	Applicability:	UNC Medical Center



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POLICY AND PROCEDURE

UNIVERSITY OF NORTH CAROLINA HOSPITALS GRADUATE MEDICAL EDUCATION POLICY FOR MEDICAL RECORD AND ADMINISTRATIVE REASSIGNMENT

I. Description

Requirements for completion of medical records and description of the Administrative Reassignment process.

II. Rationale

The licensed independent professional (“LIP”) shall be responsible for the preparation of a complete medical record for each patient and shall ensure that he/she and all LIPs under his/her supervision have completed all chart requirements in accordance with the timeframes set forth in the attached [Exhibit 1](#).

III. Policy

Medical Record Completion and Administrative Reassignment. Retrieved 05/28/2019. Official copy at <http://unchealthcare-uncmc.policystat.com/policy/5199794/>. Copyright © 2019 UNC Medical Center

Page 1 of 3

- A. A complete medical record shall include items approved by the Clinical Documentation Committee (“CDC”). No medical record shall be filed until it is complete, except on order of the CDC.
- B. All entries in the medical record must be dated, timed, author identified, and authenticated according to departmental/UNC Health Care policies and the Rules and Regulations of the Bylaws of the Medical Staff (“Rules and Regulations”). All entries in a paper medical record should be made using black ink. No entries should be made using pencil.
- C. Regardless of whether documentation is made in a paper record or an electronic health record, any amendments, corrections or addenda must:
 - 1. Clearly and permanently identify any amendment, correction, or delayed entry as such;
 - 2. Clearly indicate the date and author of any amendment, correction or delayed entry; and
 - 3. Not delete but instead clearly identify all original content.
- D. Corrections in a paper medical record must be corrected by the individual making the entry by drawing a single line through the error or incorrect entry, making certain the original entry is still legible. Enter the correction above or near the original entry. The individual making the correction must date and sign the revision. If there is any question as to why the entry is being corrected, explain the reason (e.g., “wrong patient record”). **Never** use white-out when making corrections in a paper medical record. Amendments or delayed entries to paper records must also be clearly signed, dated, and timed upon entry into the record.
- E. Amendments, corrections or delayed entries in an electronic health record must:
 - 1. Distinctly identify any amendment, correction or delayed entry; and
 - 2. Provide a reliable means to clearly identify the original content, the modified content, and the date and authorship of each modification of the record.
- F. A discharge summary shall be entered by the responsible physician at discharge. A Final Progress Note may be substituted for a discharge summary in cases of patients with problems of a minor nature who required less than a 48-hour period of hospitalization and in cases of normal newborn infants and uncomplicated obstetrical deliveries. A discharge summary is required on all patients who expire or leave against medical advice regardless of length of stay.
- G. Operative reports should be entered in the medical record within 24 hours of surgery if a brief Operative Note is completed, or when the procedure is completed and prior to the patient transferring to the next level of care and should contain a description of the findings, the technical procedures used, the specimen removed, the postoperative diagnosis, and the name of the primary surgeon and any assistants. The Department Chair and/or Division Chief will be notified of all operative reports not dictated after surgery. See attached [Exhibit 1](#).
- H. When an autopsy is performed, a provisional anatomic diagnosis must be entered in the medical record within 3 working days. The final autopsy report will be considered delinquent if it has not been entered in the record by the responsible pathologist within 60 days after the death of the patient. See attached [Exhibit 1](#).

- I. Medical records that are not completed within 14 days after discharge shall be considered delinquent. See attached [Exhibit 1](#).
- J. The names of LIPs having records not completed within 14 days after discharge will be forwarded to the Departmental Chair or Division Chief. In addition, LIPs will be notified by 1st reminder and 2nd reminder letters. See attached [Exhibit 2](#).
- K. Each clinical Department Chair or his/her designee will enforce Administrative Reassignment as set forth in Section 18 of the Rules and Regulations by notifying LIPs who remain delinquent in completing medical records after the 2nd reminder letter that their clinical duties are administratively reassigned. See attached [Exhibit 2](#) Under Administrative Reassignment, the following occurs:
 - 1. LIPs cannot schedule new elective admissions.
 - 2. LIPs cannot schedule new elective surgical procedures.
 - 3. LIPs may not use the Emergency Department.
 - 4. Residents and subspecialty residents shall, among other appropriate actions, be removed from all clinical activities (subject to ACGME requirements) and required to use PTO (subject to ACGME requirements) until all delinquent medical records are completed.
 - 5. LIPs must complete all delinquent (14 day old) records in order to be taken off of Administrative Reassignment.
- L. The CDC/Health Information Management Department submits to the Credentialing Committee each instance of an LIP's Administrative Reassignment. See attached [Exhibit 2](#).
- M. Repeated Administrative Reassignments that have the effect of being detrimental to the operations of the Hospital may also subject an LIP to Corrective Action or disciplinary action, as appropriate. See attached [Exhibit 2](#).

Approval Signatures

Step Description	Approver	Date
Policy Stat Administrator	Patricia Ness: Nurse Educator	04/2019
On behalf of MSEC	Thomas Ivester: CMO/VP Medical Affairs	04/2019
	Erin Moran-Gunter: HCS Exec Dtr/Health Information Mgmt [JP]	04/2019
	Samantha Williams: HCS Dtr/HIM Operations	03/2019
	Hannah Tilley: HCS-Mgr HIM Operations-U	03/2019

PolicyStat ID: 5199794		
	Origination:	01/2017
	Effective:	04/2019
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	Last Revised:	04/2019
	New Review:	04/2022
	Owner:	Hannah Tilley: HCS Mgr HIM Operations
	Policy Area:	Health Information Management
	Policy Tag Groups:	
	Applicability:	UNC Medical Center



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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 or 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:
 - 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.
- II.
- 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 GMED 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 Area:	GME and Other Training Programs
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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.

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Dermatology and Skin Cancer Centers

Appointments
984-974-3900

Southern Village

410 Market Street, Suite 400
Chapel Hill, N.C. 27516
Fax: 984-974-3692

Dermatology at Hillsborough

460 Waterstone Drive
Hillsborough, NC 27278
Fax: 919-595-5943

Dermatology at Rex

3921 Sunset Ridge Rd, Ste. 202
Raleigh, NC 27607
Fax: 984-974-0910

Dermatology at Burlington

1522 Vaughn Rd
Burlington NC 27217
Fax: 336-905-6191

POLICY AND PROCEDURE

UNIVERSITY OF NORTH CAROLINA HOSPITALS GRADUATE MEDICAL EDUCATION POLICY ON ADDRESSING RESIDENTS' CONCERNS

I. Applicability

This policy affects the programs indicated by an "X" in the list below:

X	Medical Residents and Fellows Appointed through GME Office	Occupational Therapy
X	Dental Residents Appointed through GME Office	Physical Therapy
X	Pharmacy Residents	Speech Therapy
	Pastoral Care	Medical Physics

II. Description

This policy describes the confidential resources available to residents/subspecialty residents for raising concerns and grievances.

III. Policy

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

- A. A resident may submit a grievance at the program or institutional level by any of the following means:
1. The resident may submit a grievance in writing to the resident's Program Director.
 2. The resident may submit a grievance to the Designated Institutional Official (DIO) and/or the Director of the Office of Graduate Medical Education. They are readily available to hear such concerns in a private environment where confidentiality is maintained to the extent possible. The DIO may be reached at (984) 974-1072. The Director may be reached at (984) 974-1072. They will ensure that any grievances by non-medical or non-dental residents are appropriately routed.
 3. The GME Hotline is available to all residents to register anonymous grievances, concerns and issues; however, if a resident leaves contact information, he/she will be contacted. The Hotline number is (984) 974-2620. The GME Office will investigate grievances, concerns and issues as appropriate, and will ensure that any grievances by non-medical or non-dental residents are appropriately routed.
 4. Grievances may be submitted to the UNC Hospitals Compliance Office, which 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, the relevant Program Director, and/or the Employee Relations Office for UNC Hospitals.
 5. Grievances may be submitted to the Human Resources Department's Employee Relations Division, which handles issues and concerns for UNC Hospitals' employees in a private environment where confidentiality is maintained to the extent possible.
 6. UNC Hospitals Housestaff Council meets quarterly, and grievances and 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 medical and dental residents. The officers can be contacted at any time in regard to areas that need to be discussed. Grievances and problems by non-medical or non-dental residents will be routed as appropriate.

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	Owner:	Cynthia Trinidad Mitchell: Dir, Grad Medical Educ
	Policy Area:	GME and Other Training Programs
	Policy Tag Groups:	
	Applicability:	UNC Medical Center



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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, use of marijuana prescribed or obtained legally in another state, 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 statutes 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 work place 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 work place.
1. 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.
2. 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 (even if prescribed or obtained legally in another state), 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, including marijuana prescribed or obtained legally in another state. 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.

For those trainees who live in states where marijuana may be legally prescribed or obtained, a positive test **prior to** the start of duties will not result in a withdrawal of offer of employment; however, such trainees will be retested thirty days after start of duties and a positive test at that time will be handled as provided for in this policy.

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 (excluding marijuana), 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 (excluding marijuana), 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, uncontrollable 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, including marijuana prescribed or obtained legally in another state, 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. [Appendix 3: After Hours Screening Protocol.] If the UNC HCS location is 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 984-974-3041 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 work place 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 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, and 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) (including marijuana prescribed or obtained legally in another state), 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 (including marijuana) 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. Medical marijuana is not authorized for use by trainees at UNC Hospitals; alternative medication will have to be prescribed/substituted.
- 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.

PolicyStat ID: 4850400		
	Origination:	08/2013
	Effective:	03/2018
	Last Approved:	03/2018
	Last Revised:	08/2013
	New Review:	03/2021
	Owner:	Cynthia Trinidad Mitchell: Dir, Grad Medical Educ
	Policy Area:	GME and Other Training Programs
	Policy Tag Groups:	
	Applicability:	UNC Medical Center

**APPENDIX 1
REQUEST FOR FIT FOR DUTY ASSESSMENT FORM**

This form should always accompany a request for substance screening.

Trainee Name:	UNC Health Care Medical Record #:
Department:	Date:
Program Director:	Program Director phone #:
Date of Observation:	Time of Observation:

Please check all that apply

<p>1. Odor of alcohol present? Yes _____ No _____</p>	<p>2. Changes in behavior? Slurred speech _____ Stumbling/falling _____ Falling asleep at work _____ Confusion _____ Inattention to personal hygiene _____ Sudden changes in mood _____ Excessive/uncontrolled crying _____ Anger _____ Loud speech patterns _____ Withdrawn _____, Disruptive _____ Other _____ Explain: _____</p>
<p>3. Errors in work judgment? Safety violations _____ Careless operation of equipment _____ Other _____ Explain _____</p>	<p>4. Motor Vehicle accident while conducting hospital business? _____ Type of vehicle involved: UNC HC vehicle _____ Personal vehicle _____</p>
<p>5. Injury or incident causing personal injury requiring hospitalization? Explain: _____</p>	<p>6. Suspicion of drug diversion? Explain: _____</p>
<p>7. Post Rehabilitation testing? _____ Explain: _____</p>	<p>Additional comments:</p>

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

UNC Health Care

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 work place 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 (such as the NC Medical Board or Physicians Health Program).
- 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, the NC Medical Board, if necessary, and the NC Physicians Health Program, 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 (if necessary), 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 (984-974-3041) 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 Hospitals Police, either for purposes of chain of custody or for purposes of getting the trainees safely off campus and back home. 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 984-974-7414.
- UNC Hospitals 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 Hospitals 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 Police office, and ED supervisor office):

Test#		Blood/Urine	Amount needed
764875 MedPro Profile	Amphetamines, Methamphetamine, Benzodiazepines (Alprazolam, Clonazepam, Flurazepam, Lorazepam, Nordiazepam, Oxazepam, Temazepam, Triazolam), Cannabinoids (THC Metabolite), Cocaine (as Benzoylecgonine), Ethanol (Alcohol), Meperidine, Methadone, Opiates (Codeine, Hydrocodone, Hydromorphone, Morphine, Oxycodone), Phencyclidine, Propoxyphene, Tramadol	Urine	45ml Urine collection Container (split Specimen)
761141	Fentanyl (only if suspected)	Urine	May be included in above urine sample

Additional blood testing is available per the discretion of the OHS Medical Director or ED physician in charge of medical assessment of the trainee being tested. The above urine tests are to be used for all reasonable suspicion and post-accident screening.

Blood Testing Protocols

#791722 5-test screen	Amphetamines, Cannabinoids, Cocaine, Opiates, Phencyclidine (PCP)	Blood-20mls Serum sep. tubes
#799700	Amphetamines, Cocaine, Cannabinoids, Opiates, Phencyclidine (PCP), Alcohol	Urine
#791590 8-test screen	Amphetamines, Barbituates, Benzodiazepines, Cannabinoids, Cocaine, Opiates, Phencyclidine (PCP)	Blood-20mls Serum sep. tubes
#017996	Bld Ethanol (Alcohol) level	Blood-10ml Serum sep. tube

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
984-974-4480
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 (except marijuana, which is not authorized for trainee use at UNC Health Care).

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, GME office, 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 (including marijuana legally prescribed in another state) 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

APPENDIX 7
TESTING CUTOFF LEVELS

Drug	LabCorp Standard Screening Cut-off Level	LabCorp Standard GC/MS Confirmation Cut-off Level	Detection Time in Urine
STIMULANTS			
Amphetamine Also known as: speed Pharmaceutical names: Dexedrine, Benzedrine	1000 ng/mL	500 ng/mL	1 to 2 days
Methamphetamine Also known as: speed, ice, crystal, crank Pharmaceutical names: Desoxyn, Methedrine	1000 ng/mL	1000 ng/mL	1 to 2 days
MDMA (Methylenedioxyamphetamine) Also known as: ecstasy, XTC, ADAM, lover's speed	500 ng/mL	250 ng/mL	1 to 2 days
Cocaine Also known as: coke, crack, rock cocaine	300 ng/mL	150 ng/mL	2 to 4 days
HALLUCINOGENS			
Marijuana/Cannabinoids Also known as: dope, weed, hemp, hash, Colombian, sinsemilla Pharmaceutical name: Marinol	50 ng/mL	15 ng/mL	Single use: 2 to 7 days Prolonged use: 1 to 2 months
Phencyclidine Also known as: PCP, angel dust	25 ng/mL	25 ng/mL	14 days Up to 30 days in chronic users
NARCOTICS/ANALGESIC/OPIATES			
Codeine	2000 ng/mL	2000 ng/mL	2 days
Morphine and/or Heroin Heroin also known as: smack, tar, chasing the tiger Pharmaceutical names: Duramorph, Roxanol	2000 ng/mL	2000 ng/mL	2 days
Methadone Also known as: fizzes Pharmaceutical names: Amidone, Dolophine	300 ng/mL	300 ng/mL	3 days
Propoxyphene Pharmaceutical names: Darvon, Darvocet, Novopropoxyn	300 ng/mL	300 ng/mL	6 hours to 2 days
DEPRESSANTS/SEDATIVES/HYPNOTICS			
Barbiturates Also known as: downers, barbs, goof balls, reds, yellow jackets Pharmaceutical names: Amobarbital (Amytal), Butalbital (Fiornal), Pentobarbital (Nembutal), Phenobarbital (Donnatal), Secobarbital (Seconal)	200 ng/mL	200 ng/mL	Short acting: 2 days
Benzodiazepines Also known as: bennies Pharmaceutical names: Diazepam (Valium), Oxazepam (Serax), Chlormiazepoxide (Librium), Alprazolam (Xanax), Chlorazepate (Tranxene), Temazepam (Restoril)	200 ng/mL	200 ng/mL	Therapeutic dose: 3 days Extended dosage or chronic use (1 or more years): 4 to 6 weeks
Ethyl Alcohol Also known as: liquor, distilled spirits, beer, wine, booze, hooch Pharmaceutical name: Ethanol	0.02% (20 mg/dL)	0.02% (20 mg/dL)	In urine: 1 to 12 hours In serum and plasma: 1 to 12 hours

Specimen Validity Testing			
Validity Marker	Commercial Product	Method of Introduction to Urine	Mode of Action
Creatinine	N/A	In vivo, or in vitro, this substance is always present in urine but is used to indicate dilute or substituted specimens.	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.
Nitrites	Klear, Whizzies	In vitro, donor adds potassium nitrite to urine in collection cup	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.
pH	N/A	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.	The pH of the sample may influence enzymatic test methods used in drug screening. An extreme pH, either very high (>11) or very low (<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 detectable during retest or confirmation.
Specific Gravity	N/A	In vivo, donor consumes large quantities of liquids, or in vitro, the donor adds something to the urine in the cup.	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.

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

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.



DEPARTMENT OF DERMATOLOGY

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Appointments
984-974-3900

Southern Village

410 Market Street, Suite 400
Chapel Hill, N.C. 27516
Fax: 984-974-3692

Dermatology at Hillsborough

460 Waterstone Drive
Hillsborough, NC 27278
Fax: 919-595-5943

Dermatology at Rex

3921 Sunset Ridge Rd, Ste. 202
Raleigh, NC 27607
Fax: 984-974-0910

Dermatology at Burlington

1522 Vaughn Rd
Burlington NC 27217
Fax: 336-905-6191

POLICY AND PROCEDURE

UNIVERSITY OF NORTH CAROLINA HOSPITALS GRADUATE MEDICAL EDUCATION POLICY ON INTERNATIONAL ROTATIONS

Applicability

This policy affects the programs indicated by an “X” in the list below:

X	Medical Residents and Fellows Appointed through GME Office	Occupational Therapy
X	Dental Residents Appointed through GME Office	Physical Therapy
X	Pharmacy Residents	Speech Therapy
	Pastoral Care	Medical Physics

Description

This policy describes the process residents/subspecialty residents must follow to obtain approval for an international rotation and the criteria the rotation must meet.

Policy

All international rotations must receive approval from the Resident's Program Director. Medical residents and dental residents must also receive prior approval from: 1) the department chair; 2) the Office of Graduate Medical Education; and 3) RRC/ACGME, as appropriate. Pharmacy residents must also receive prior approval from the Clinical Manager for Academic Enterprises and Residency Programs.

Criteria for Approval of International Rotations

All requests for international rotations must meet the following criteria for approval:

1. 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;
2. The rotation must be of excellent educational quality;
3. The goals and objectives of the rotation must meet RRC/ACGME/ASHP applicable program requirements (including but not limited to Institutional, Common and Specialty-specific), and a copy of the goals and objectives must be provided;
4. A copy of the curriculum (service and educational), and list of core and miscellaneous responsibilities should also be included;
5. For medical and dental residents, a letter from the program director stating whether or not the medical/dental resident will receive 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; and
6. Documentation from the host institution or representative outlining the procedures for exposure to blood borne pathogens (specifically the availability of post-exposure prophylaxis for HIV) and/or other infectious diseases commonly encountered in patient care environments. HIV post-exposure management MUST be consistent with US Public Health Service guidelines (Kuhar D, et al. Infection Control Hospital Epidemiology 2013;34:875-892).
7. During approved rotations residents shall abide by the UNC and applicable ACGME/RRC policies, rules and regulations governing the residency program including, but not limited to, those rules that address duty hours.
8. A Letter of Agreement in the approved form 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 ASHP/ACGME/RRC guidelines on duty hours;
 - b. The supervising physician(s) at the host institution must have skills sufficient to provide appropriate supervision (e.g., experience with education and competencies);
 - c. The resident must complete the Voluntary Participation and Assumption of Risk Agreement attached to this policy.

9. 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.
10. Residents participating in elective international rotations must sign a Voluntary Participation and Assumption of Risk Agreement, similar to the sample attached to this policy, acknowledging that there are inherent risks in international travel, that participation is completely voluntary, and releasing UNC Hospitals, UNC at Chapel Hill, and the UNC Health Care System, from liability for property loss or personal injury incurred while participating in the program, except that the resident does not waive any rights they are entitled to under the North Carolina Workers' Compensation Act. The Agreement 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.
11. **Hospital-paid Residents** should contact UNCH Occupational Health Services 6-8 weeks before departing the country to receive a pre-travel medical evaluation, prescriptions for prophylactic medications as recommended by the Centers for Disease Control and Prevention (CDC), (e.g., malaria prophylaxis), and administration of necessary immunizations as per current CDC guidelines and administered through the UNC Travax portal. Residents are responsible for obtaining, personal medications, visas, passports, travel health and evacuation insurance (through Highway to Health/UNC) and meeting other administrative travel requirements, including completion of Office of International Activities educational modules and registering in the UNC global travel registry. Residents must provide an emergency contact in the United States and a means to contact them while out of the country. If these steps are not completed prior to travel, the Program Director will be made aware and the resident will not be allowed to travel.

University-paid Residents should contact the University Employee Occupational Health Clinic 6-8 weeks before departing the country to receive a pre-travel medical evaluation, prescriptions for prophylactic medications as recommended by the Centers for Disease Control and Prevention (CDC) (e.g., malaria prophylaxis), and administration of necessary immunizations as per current CDC guidelines and administered through the UNC Travax portal. Residents are responsible for obtaining personal medications, visas, passports, travel health and evacuation insurance (through Highway to Health/UNC) and meeting other administrative travel requirements, including completion of Office of International Activities educational modules, and registering in the UNC global travel registry. Residents must provide an emergency contact in the United States and a means to contact them while out of the country. If these steps are not completed prior to travel, the Program Director will be made aware and the resident will not be allowed to travel. Authorization for use of University travel services can be found at <http://ehs.unc.edu/ueohc/travel-immunizations/>.

Prohibited Activities

Residents may not:

1. Use any financial resources provided by foundations or companies that have direct ties with pharmaceutical, formula, or biomedical companies;
2. Visit any country with a U.S. State Department “*travel warning*” or on the UNC Global “no travel” country or area list;
3. Engage 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;
4. Practice 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
5. Distribute 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.

Residents’ Duties after Completion of the International Rotation

1. 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 supervisor in order to receive credit for the rotation; and
2. 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.
3. Hospital-paid Residents who develop post-travel illnesses should report to UNCH Occupational Health Services. University-paid Residents/Subspecialty Residents who develop post-travel illnesses will be seen at University Employee Occupational Health Clinic.

PolicyStat ID: 5831146		
	Origination:	01/2010
	Effective:	04/2019
	Last Approved:	04/2019
	Last Revised:	04/2019
	New Review:	04/2022
	Owner:	Cynthia Trinidad Mitchell: Dir, Grad Medical Educ
	Policy Area:	GME and Other Training Programs
	Policy Tag Groups:	
	Applicability:	UNC Medical Center

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 _____ 20__ through the ____ day of _____ 20__. 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 and 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 Glenn George. 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 not 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 PGY-1 residents must not exceed sixteen hours in duration. Duty periods of PGY-2 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, PGY-2 residents and above must be scheduled for in-house call no more frequently than every third night (when averaged over a four-week period). PGY-1 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**»

Signature
Title: _____

Signature
Title: _____

Date: _____

Date: _____

Address: 101 Manning Drive
CB#7600
Chapel Hill, N.C. 27514

Address: _____

Dept of «**SOM DEPARTMENT**» Program Director

Site Director

Date: _____

Date: _____

cc: UNC Hospitals Graduate Medical Education Office
101 Manning Drive
1st Floor, 1017 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)

In consideration for being approved to participate in the **[Program]** Residency Special Project in **[Location of Rotation]**, I hereby agree to the following:

1. My participation in the international rotation program is entirely voluntary. I understand and acknowledge that, while I have chosen to participate in this Special Project to gain exposure to medicine in an international setting, an international Special Project is not a requirement of my **[Program]** Residency Program. I understand that would be able to fulfill all requirements of my residency without participating in this trip or traveling internationally.
2. I acknowledge that foreign travel may entail risks of personal and/or bodily injury, property loss or death, including as a result of kidnapping, criminal activity, war, terrorist attacks, lack of access to health care, food or beverage contamination, public health problems, and unsafe local transportation.
3. I acknowledge, understand and accept the risks of travel to **[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/>.
4. I agree to assume all risks relating to this trip and I hereby waive any and all claims against UNC Hospitals, UNC at Chapel Hill, and the UNC Health Care System for 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, except that I do not waive any rights that I may have under the North Carolina Workers' Compensation Act.
5. I understand that I am personally responsible for all my visa, public health and customs compliance, and that if I am not a U.S. citizen or permanent resident alien, reentry to the United States may not be automatic.

I have carefully read this document with the opportunity to consult an attorney if I wish. I understand that it is binding on myself, my heirs, my assigns, and personal representatives.

**FOR AND ON BEHALF OF THE
UNIVERSITY OF NORTH CAROLINA
HEALTH CARE SYSTEM**

RESIDENT PHYSICIAN

Print Name

Print Name

Signature

Signature

Date

Date



DEPARTMENT OF DERMATOLOGY

Faculty

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The Irene & Robert Alan Briggaman
Distinguished Professor & Chair

Edith Bowers, MD, PhD
Robert A. Briggaman, MD, Emeritus
Craig N. Burkhart, MD
Sarah Corley, MD
Donna Culton, MD, PhD
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Distinguished Professor*
Megan Evans, MD
Amy W. Fox, MD
Lowell A. Goldsmith, MD, MPH, Emeritus
Paul Googe, MD
Heather Holahan, 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
Julie Mervak, MD
Jayson Miedema, MD
Dean S. Morrell, MD
Michelle Pearlstein, MD
Ye Qian, PhD
David S. Rubenstein, MD, PhD
Christopher J. Sayed, MD
Rajat Varma, MD
Carolyn Ziemer, MD

Administration

Emma Beckham
Associate Chair
For Administration

2352 Genome Science Bldg
250 Bell Tower Drive CB 7287
University of North Carolina
Chapel Hill, N.C. 27599-7287
Phone: 919-966-0785
Fax: 919-966-3898
<http://med.unc.edu/derm>

Research Laboratories

2nd Floor Green and Blue Pod
Genome Science Building
250 Bell Tower Drive Phone:
919-843-6756

Immunodermatology

Luis A. Diaz, MD
Donna Culton, MD, PhD
Phone: 919-843-5401
Fax: 919-843-5766

Dermatopathology

Paul Googe, MD
Jayson Miedema, MD
2144 Genome Science Bldg
University of North Carolina
Chapel Hill, NC 27599-7287
Phone: 919-966-0786
Fax: 919-843-2530

Dermatology and Skin Cancer Centers

Appointments
984-974-3900

Southern Village

410 Market Street, Suite 400
Chapel Hill, N.C. 27516
Fax: 984-974-3692

Dermatology at Hillsborough

460 Waterstone Drive
Hillsborough, NC 27278
Fax: 919-595-5943

Dermatology at Rex

3921 Sunset Ridge Rd, Ste. 202
Raleigh, NC 27607
Fax: 984-974-0910

Dermatology at Burlington

1522 Vaughn Rd
Burlington NC 27217
Fax: 336-905-6191

POLICY AND PROCEDURE

UNIVERSITY OF NORTH CAROLINA HOSPITALS GRADUATE MEDICAL EDUCATION POLICY ON SOCIAL MEDIA

I. Description

To address the use of social media, including but not limited to online communications by employees, health care providers, residents, students, volunteers, and contractors of the UNC Health Care System (collectively, “UNC HCS Representatives”) that identify or relate to any aspect of UNC HCS.

II. Rationale

The purpose of this policy is to ensure that the use of Social Media by UNC 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 applicable policies and 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 the appropriate prior authorization 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 the use of Social Media as in other types of conduct. This policy is meant to help UNC

HCS Representatives understand how UNC HCS policies apply so they can communicate with confidence using Social Media. For additional guidance on the distinction between Institutional and Personal Use of Social Media, consult [Exhibit A](#) to this policy.

III. Policy

The Use of Social Media:

A. What is Social Media?

As used in this policy, the term "Social Media" is an umbrella term that encompasses the various activities that integrate technology, social interaction, and content creation. Social Media exists in many forms, including but not limited to blogs, microblogs, vlogs, wikis, photo and video sharing, podcasts, social networks, mashups, wall postings, and virtual worlds. Examples include but are not limited to: Facebook, LinkedIn, YouTube, Vimeo, Vine, Reddit, Instagram, Figure 1, iTunes U, Snapchat, Yik Yak, Second Life, Wikipedia, Pinterest, and World of Warcraft.

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 exhaustive. As technology changes and newer forms of communication develop, this policy shall apply to the various forms of electronic communication that are available.

B. 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, UNC HCS departments and UNC HCS Representatives, with the guidance and assistance of UNC HCS's Communications, Marketing and External Affairs Department ("Marketing"), are encouraged to engage in Institutional use of the various forms of Social Media as a tool to communicate internally within the UNC HCS and externally with other providers, patients, and the general public. Such institutional use of Social Media should be preapproved by Marketing.

All Institutional use of Social Media will make available the [Terms of Use](#) which will outline what posts from community members are acceptable. The Social Media account administrator is responsible for ensuring that these terms of use are posted and followed. If there are questions, contact Marketing at paffairs@unchealth.unc.edu.

IV. Guidelines & Procedures

A. 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.

B. Patient Information

Communications using Social Media may not violate patient privacy and confidentiality policies and laws. Such communications must never contain any information that directly or indirectly identifies a patient unless the appropriate patient authorization has been obtained. (Consult Marketing, Privacy, or Legal for guidance.) 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 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 using patient photos in communications through Social Media, 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 within UNC HCS, it is never permissible to photograph or disclose any photograph of a patient or his or her anatomy or test results without a signed authorization. (Consult Marketing, Privacy, or Legal for guidance.)

C. 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.

D. UNC HCS Logo

UNC HCS Representatives may not use the UNC HCS logo or other UNC HSC trademarked information without prior approval from Marketing. If you have questions contact Marketing at paffairs@unchealth.unc.edu.

E. Inappropriate Language

UNC HCS Representatives must never post 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 on any Social Media site that references UNC HCS, including UNC HCS itself. Such communications may violate other UNC HCS policies even when posted or communicated on personal sites.

F. Reporting

Violations or suspected violations of this Policy may be reported to the UNC HCS Privacy Office at 984-974-1127 or by email (including a screenshot of the violation, if possible) to privacy@unchealth.unc.edu.

G. Consequences Related to the Misuse of Social Media

Any UNC HCS Representative who, through the use of Social Media, makes any defamatory statement regarding UNC HCS or UNC HCS Representatives, shares confidential patient or business information, or 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, or from engaging in concerted activity by law.

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.

V. Comments

Contact the UNCHCS Privacy Office at 984-974-1069. Or email the UNCHCS Privacy Office at privacy@unchealth.unc.edu.

Approval Signatures

Step Description	Approver	Date
Policy Stat Administrator	Patricia Ness: Nurse Educator	05/2019
	Jerylyn Williams: VP Chief Audit & Comp Officer	05/2019
	David Behinfar: HCS-Privacy Dir	05/2019

PolicyStat ID: 6433223		
	Origination:	03/2016
	Effective:	05/2019
	Last Approved:	05/2019
	Last Revised:	05/2019
	New Review:	05/2022
	Owner:	David Behinfar: HCS-Privacy Dir
	Policy Area:	Compliance – Privacy
	Policy Tag Groups:	
	Applicability:	UNC Medical Center

Exhibit A

Distinctions between Institutional and Personal Use of Social Media by UNCHCS Employees, Faculty, Health Care Providers, Residents, Students, Volunteers and Contractors (“UNCHCS Representatives”)

Institutional Use

Institutional 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 Communications, Marketing and External Affairs (Marketing).

This can include UNCHCS-branded sites or pages on YouTube, Twitter, Facebook, etc., where content editors post under the name of the institution.

Examples include activity on pages like:

- www.facebook.com/unchealthcare
- www.facebook.com/lineberger
- www.unchealthcare.org/uncorthopedics
- www.twitter.com/unc_health_care

Institutional use should always be strict compliance with all other UNCHCS policies. Some examples include: UNCHCS 4661994, “Internet Usage and Connectivity”, UNC HCS ADMIN 0139, “Privacy and Confidentiality of PHI”, and ADMIN 0204, “Disruptive and Inappropriate Behavior Policy.”

Personal Use

UNCHCS recognizes that UNCHCS Representatives may use Social Media for purely personal reasons. When any UNCHCS Representative identifies themselves as an employee or volunteer with UNC Health Care, they will be held to certain standards.

By identifying yourself as part of the UNCHCS 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. Your activity online can impact your personal reputation of the UNCHCS.

Personal activity online should reflect the user’s personal opinions and experiences and identify them as such by using a disclaimer.

A disclaimer may read as follows: *The comments and viewpoints expressed in this [blog, website, etc.] 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.

For example, a physician may have a personal blog that they use to comment on health care policy. If the physician identifies him/herself as a UNC Health Care physician, then the physician should include a statement like the one above, emphasizing that the physician does not speak for UNC Health Care.

UNCHCS 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.

Tips for Personal Use of social media:

- Never share PHI in a post or comment on social media.
- Do not engage with any kind of social media post or comment that contains personal health information (PHI) about a current or former patient, no matter who has posted the information.
- Posts that disparage the UNC Health Care System or your colleagues, even indirectly, may be violations of the Disruptive and Inappropriate Behavior policy. Think before your post about another co-worker or supervisor.
- Do not share any confidential information about the organization on social media. Even though it is not PHI, your professional integrity and your job are on the line.
- Check your privacy settings – are you sharing your posts with only those people who want to share your posts? Or is it a larger group than you realized? What information is available to people who you are connected to?
- Check your “about” information – understand what is visible to the public and what is visible only to your friends.
- Think before you “tag” – when you comment on a post, or tag someone else in a post, you are widening the circle of people who may see your comments or posts.

Use during work time, use of email to establish accounts

UNCHCS recognizes that UNCHCS Representatives may use Social Media to participate in professional networks, like LinkedIn, and such use may be appropriate during work time and on UNCHCS equipment because of its connection to the work of those individuals. This may also include setting up an account using an institutional email account. If the activity is related to professional work, UNCHCS Representatives are permitted to use their work email address to establish accounts.

Personal use of Social Media that is not connected to professional work should happen only during non-work time and in strict compliance with all other UNCHCS policies. Some examples include: UNCHCS 4661944, “Internet Usage and Connectivity”, UNCHCS ADMIN 0139, “Privacy and Confidentiality of PHI”, and ADMIN 0204, “Disruptive and Inappropriate Behavior Policy.” UNCHCS Representatives who communicate using Social Media for purposes unrelated to their professional role should use a personal email address (not their UNCHCS address) as their primary means of identification. Just as a UNC HCS Representative may not use UNCHCS stationery for a letter to the editor with his/her personal views, he/she may not use an UNCHCS email address for personal views.

Use of Social Media at UNCHCS’s Direction

In some instances, a UNCHCS department may ask a UNCHCS Representative to participate using personal social media accounts 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 UNCHCS Representative should seek guidance from the UNCHCS Legal Department, Compliance Department, Employee Relations, and/or Marketing.



DEPARTMENT OF DERMATOLOGY

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The Irene & Robert Alan Briggaman
Distinguished Professor & Chair

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Administration

Emma Beckham
Associate Chair
For Administration

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250 Bell Tower Drive CB 7287
University of North Carolina
Chapel Hill, N.C. 27599-7287
Phone: 919-966-0785
Fax: 919-966-3898
<http://med.unc.edu/derm>

Research Laboratories

2nd Floor Green and Blue Pod
Genome Science Building
250 Bell Tower Drive Phone:
919-843-6756

Immunodermatology

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Fax: 919-843-2530

Dermatology and Skin Cancer Centers

Appointments
984-974-3900

Southern Village

410 Market Street, Suite 400
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Dermatology at Rex

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Nutrition & Food Services Manual		
	Policy Name	UNC Health Care Resident Freedom Pay Blue Tag Program
	Policy Number	1000
	Date This Version Effective	05/31/2013
	Responsible for Content	Nutrition and Food Services

I. Description

A policy that outlines limitations on the use of the Freedom Pay Blue Tag by UNC Healthcare medical school residents.

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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



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UNC Health Care Code of Conduct

APPLICABILITY:

This policy applies to the following entities (Collectively referred to as “UNC Health Care” or “UNC HC” in this policy):

X	UNC Health Care System/UNC Medical Center*	X	Johnston Health
X	UNC Physicians Network	X	Lenoir Memorial Hospital
X	UNC Physicians Network Group Practices	X	Margaret R. Pardee Memorial Hospital
X	Rex Healthcare / Rex Hospital	X	Nash Healthcare System / Nash Hospitals
X	Chatham Hospital	X	Wayne Memorial Hospital
X	Caldwell Memorial Hospital		
X	UNC Rockingham Health Care / UNC Rockingham Hospital		

I. Description

Describes the Code of Conduct for UNC Health Care.

II. Definitions

Compliance Officer – the individual at a UNC Health Care entity responsible for implementing and overseeing the entity’s Compliance Program. ([Hospital Compliance Program Policy](#) and [Professional Compliance Program Policy](#))

III. Rationale

The U.S. Office of Inspector General (OIG) includes a Code of Conduct among the seven fundamental elements of an effective compliance program. The OIG expects the Code of Conducts to articulate a commitment to compliance and to summarize broad ethical and legal principles that must be upheld. The OIG expects governing boards, executive leaders, senior management, and representatives of the medical and clinical staff to be involved in the development of the Code of Conduct.

Accordingly, the Chief Audit & Compliance Officer, in consultation with applicable leadership, has developed this system-wide Code of Conduct to articulate the key ethical and compliance standards that guide UNC Health Care operations. The standards themselves are listed and explained in Appendix A while details about implementing the standards are captured in the body of this policy.

The Compliance Office provides guidance on Code of Conduct implementation. Concerns should be reported as described below in Section IV.G. – Questions and Concerns.

The purpose of this Code of Conduct is to reinforce UNC Health Care’s institutional values and to serve as a guide for moral, ethical, and legal behavior. Adherence to the Code of Conduct promotes UNC Health Care’s reputation for integrity and honesty in the community and also ensures that UNC Health Care is compliant with applicable laws, rules, and regulations.

IV. Policy

A. Code of Conduct Standards

In March 2016, UNC Health Care adopted twenty standards and explanations (in Appendix A) as its system-wide Code of Conduct.

B. Authority and Administration

The Code of Conduct was authorized and approved by the Finance, Audit and Compliance Committee of the UNC Health Care Board of Directors.

The Chief Audit and Compliance Officer is responsible for maintaining the Code of Conduct, as an element of the Compliance Program.

As needed, the Chief Audit and Compliance Officer submits revisions to the Code of Conduct to the appropriate system-level governing boards, committees, and leadership for approval.

C. Relation to Other Policies, Procedures, and Resources

UNC Health Care policies must be consistent with the Code of Conduct. In case of inconsistency, the Code of Conduct controls.

As applicable, UNC Health Care entities shall revise entity material that references a Code of Conduct, including, but not limited to, employee handbooks, new employee orientation, and annual compliance training, to incorporate the UNC Health Care Code of Conduct.

D. Availability

The Code of Conduct is available electronically at the following locations:

- UNC Health Care's PolicyStat system ([Code of Conduct](#));
- Poster summary on the UNC Health Care Compliance SharePoint site (<https://unchcs.intranet.unchealthcare.org/dept/ACP/compliance/Pages/Code-of-Conduct.aspx>);
- Chapter in the Compliance Handbook available on the UNC Health Care Compliance SharePoint site; and
- Downloadable chapter of applicable Employee Handbooks. For instance, at UNC Medical Center: <https://www.uncmmedicalcenter.org/uncmc/careers/about>.

In addition, a summary of the Code of Conduct may be displayed in poster format in physical training locations such as new employee orientation areas.

A paper copy of the Code of Conduct and related materials are available on request from compliance officers.

E. Attestation

As part of the onboarding process, new employees sign a Code of Conduct Attestation (Appendix B) in which they agree to read and comply with the Code of Conduct and acknowledge that failure to do so may result in disciplinary action, up to and including termination. Further, employees agree to bring all (real or suspected) violations of the Code of Conduct to the attention of the Compliance Office and/or the employee's supervisor.

In addition, employees attest to compliance with the Code of Conduct as part of annual compliance training.

F. Training and Education

The Chief Audit and Compliance Officer, local Compliance Officer, or designee conduct training to educate employees about the Code of Conduct and Compliance issues and expectations.

During new employee orientation, employees receive training on the Compliance Program, the Code of Conduct, and the process for reporting violations.

All employees must complete annual Compliance training which addresses various Compliance issues and expectations, with an emphasis on the Code of Conduct.

Managers are responsible for ensuring that all Compliance training and educational requirements, including a review of the Code of Conduct, are met annually by employees.

For more information, please review the system-wide [Employee Compliance Education Policy](#).

G. Questions and Concerns

Generally, employees should bring Code of Conduct concerns to their supervisor for resolution. However, employees are encouraged to contact the Compliance Office with unresolved questions and concerns about fraud, waste, or abuse.

Employees may contact the Chief Audit and Compliance Officer by:

1. Placing a direct phone call with the Chief Audit and Compliance Officer at 984-974-1027;
2. Placing an anonymous call to the Compliance Hotline at 1-800-362-2921;
3. Filing an incident report form at Hotline.unchealthcare.org;
4. Sending a direct email to the Chief Audit and Compliance Officer;
5. Emailing the Compliance Office at Compliance@unchealth.unc.edu; or
6. Mailing questions or concerns to: Compliance Office, UNC Health Care System, 211 Friday Center Drive, Suite G050, Chapel Hill, NC 27517.

The most current email and phone contact information for Compliance leadership (including the Chief Audit and Compliance Officer, System Directors of Compliance, Hospital Compliance Officers, and Associate Director of Professional Compliance) is available on the Audit, Compliance and Privacy Services SharePoint site. In addition, Hospital Compliance contact information is appended to the [Hospital Compliance Program Policy](#).

Answers to Frequently Asked Questions concerning the Code of Conduct are available in a Compliance Handbook available on the UNC Health Care Compliance SharePoint site (<https://unchcs.intranet.unchealthcare.org/dept/ACP>).

H. Duty to Report Violations

Potential or known violations of the UNC Health Care Code of Conduct or applicable policies, laws, or regulations must be reported to an appropriate supervisor, the Compliance Office, or the Compliance Hotline.

Compliance with all aspects of the Code of Conduct, including the duty to report violations, is a condition of employment. Failure to report a violation may result in corrective action, up to and including termination of employment or termination of staff privileges.

I. Confidentiality and Non-Retaliation

In accordance with the system-wide [Hospital Compliance Program Policy](#) and [Professional Compliance Program Policy](#), anyone has the right to report concerns in good faith to the Compliance Office. Confidentiality and anonymity will be maintained to the extent possible. Suspended retaliation should be reported immediately to the Compliance Office.

J. Enforcement

Compliance with the Code of Conduct is a condition of employment. Employees and managers who violate the Code of Conduct are subject to corrective action, up to and including termination.

The system-wide [Employee Compliance Education Policy](#) describes expectations for employees and managers regarding completion of annual compliance training. Employees and managers who fail to comply with this policy are subject to corrective action, up to and including termination.

Medical staff, volunteers, medical students, vendors, and other non-employees who violate the Code of Conduct or who fail to complete Compliance training by applicable deadlines may be disciplined as permitted under the medical staff bylaws or applicable policies, procedures, and agreements.

V. References

OIG, Compliance Program Guidance for Hospitals, 63 Fed. Reg. 8987 (Feb. 23, 1998).

OIG, Supplemental Compliance Program Guidance for Hospitals, 70 Fed. Reg. 4858 (Jan. 31, 2005).

OIG and AHLA, Corporate Responsibility and Corporate Compliance: A Resource for Health Care Boards of Directors (2003),

<https://oig.hhs.gov/fraud/docs/complianceguidance/040203CorpRespRscceGuide.pdf>.

VI. Related Policies

[Hospital Compliance Program](#)

[Professional Compliance Program](#)

[False Claims Education](#)

[Employee Compliance Education](#)

Approval Signatures

Step Description	Approver	Date
	Jerylyn Williams: VP Chief Audit & Comp Officer	07/2018
SYSTEM Site Administrator	Emilie Hendee: HCS-Sr Attorney	07/2018
	Leisa Powell: HCS-Assoc Dir HOSP Compliance	07/2018

PolicyStat ID: 5153523		
	Origination:	07/2017
	Effective:	07/2018
	Last Approved:	07/2018
	Last Revised:	07/2018
	New Review:	07/2021
	Owner:	Leisa Powell: HCS Assoc Dir HOSP Compliance
	Policy Area:	Compliance
	Policy Tag Groups:	
	Applicability:	UNC Health Care System (all owned and managed entities)

Appendix A: Code of Conduct Standards

In March 2016, UNC Health Care adopted the following twenty standards and explanations as its system-wide Code of Conduct:

1. Demonstrate Honesty, Integrity, and Professionalism at All Times

We display and promote the highest standards of professional and ethical conduct. We act with the competence, skill, and integrity expected of our professions. We behave with dignity and courtesy toward our patients, clients, coworkers, learners, and others in business-related activities. We are honest, fair, reasonable, and objective in our professional relationships.

2. Abide by the Code of Conduct and Applicable Laws, Regulations, Policies, and Procedures

Providing healthcare to a large community is an enormous responsibility. If each of us abides by this Code of Conduct and the laws, rules, regulations, policies, and procedures that apply to us, we will do our part to see that UNC Health Care operates with integrity. If you have questions about the legality or appropriateness of a situation, ask your supervisor or the Compliance Office for clarification.

3. Honor Patients' Rights

As healthcare providers, we have an ethical responsibility to make our patients feel secure in our care and to treat patients respectfully and with dignity. In addition to an ethical responsibility, we have a legal responsibility to comply with all applicable laws and regulations related to patients' rights. We must also comply with UNC Health Care policies, including policies regarding informed consent, advance directives, discharge planning, and patient participation in the care plan.

4. Provide Quality Care

As a healthcare provider, we dedicate ourselves to providing high quality care for our patients. Quality of care is a promise we deliver every day in every aspect of our work. We are committed to following all applicable policies, laws, and licensing / accreditation requirements relating to quality of care and patient safety. We uphold the professional standard of care, report patient safety concerns, and engage in quality improvement activities.

5. Provide Medically Necessary Care

At UNC Health Care, we provide care that is medically necessary. Medical necessity requires us to be prudent in the utilization of our resources, being mindful not to over-utilize or underutilize the services provided to our patients.

We follow the Emergency Medical Treatment and Active Labor Act (EMTALA) and similar regulations relating to the admission, transfer, and discharge of patients.

6. Preserve Confidentiality and Information Security

Protecting confidential information is a UNC Health Care priority. Confidential information includes health information about our patients, information in employee records, and proprietary information about UNC Health Care business. We access confidential information and share it with others only when authorized to do so and for the purpose of doing our job. We follow applicable laws and policies when releasing confidential information and report concerns to appropriate parties. We investigate and report breaches of patient information and take steps to secure our systems from unauthorized access and comply with information security policies.

Code of Conduct

7. Use Social Media and Technology Responsibly

UNC Health Care encourages an online and social media culture that complies with the law, internal policies, procedures, and ethical values. UNC Health Care employees may not disclose confidential or proprietary information about UNC Health Care, its patients, or its employees on social media (including, but not limited to, communications over the Internet, on personal websites or webpages, or in online communities). We do not take or transmit photographs or recordings of patients, visitors or staff in the workplace except as permitted by our policies. Any questions concerning the appropriate use of social media and technology should be directed, as applicable, to the Privacy Office or the Public Affairs and Marketing department.

8. Support Diversity and Inclusion

UNC Health Care supports a culture of diversity and inclusion. We treat everyone with respect. We do not tolerate illegal discrimination against anyone at UNC Health Care, including visitors, patients and fellow employees. We do not tolerate conduct that is disrespectful, hostile, intimidating, or harassing.

9. Work Safely

The health and safety of our patients and employees is a UNC Health Care priority. We comply with workplace health and safety laws and report safety concerns. We follow UNC Health Care policies for handling and disposing of hazardous materials and equipment. We only access, handle or prescribe controlled substances in accordance with UNC Health Care policy. We comply with fitness for duty policies. We maintain a work environment free from violence and disruptive behavior.

10. Compete Fairly

UNC Health Care is committed to antitrust compliance and fair competition. We do not make unlawful agreements with competitors about prices or charges, services that we provide, or who to buy from. We do not discuss related matters, such as pricing policies, purchasing practices, costs, salaries, marketing plans, or surveys with those outside of UNC Health Care. We comply with marketing policies and laws related to truth in advertising.

11. Record and Report Information Accurately

We keep accurate records about our patients, our employees, our physicians, clinical procedures, research trials, and financial transactions. It is the responsibility of each of us, when engaged in recordkeeping on behalf of UNC Health Care (including employee time cards, medical records, and patient bills), to be accurate and honest. For example:

- We do not sign another person's name to documents or share each other's passwords.
- We amend the medical record only in accordance with UNC Health Care policy and applicable law.
- We do not fabricate, falsify or plagiarize when proposing, conducting or reporting research.
- Our financial records conform to applicable accounting principles.

We retain documents for the length of time described in our document retention policies.

12. Document, Code, Bill, and Collect Appropriately

We handle claims for payment of services with integrity to avoid fraud, waste and abuse in

Code of Conduct

healthcare. All UNC Health Care personnel are expected to comply with federal healthcare program requirements, including, but not limited to, Medicare / Medicaid rules and federal and state False Claims Acts.

We bill only for medically necessary services rendered by eligible providers and properly documented and coded. We respond to patient and payer questions concerning charges in an accurate and timely manner. We correct any billing errors of which we have knowledge and refund payments received in error to third party payers and patients, with appropriate documentation.

If you become aware of inaccuracies, notify your supervisor so that the error can be corrected. If you see problems with claims that are not being corrected, contact the Compliance Office or Compliance Hotline.

13. Do Not Do Business with Excluded Individuals or Entities

We expect all individuals and entities associated with UNC Health Care to be appropriately credentialed, licensed and otherwise qualified to perform their duties. UNC Health Care does not do business with, employ, or bill for services rendered by individuals or entities that are excluded or ineligible to participate in federal healthcare programs. UNC Health Care personnel and vendors have a responsibility to report to their supervisor, Human Resources, Credentialing, or Purchasing (as applicable) if they are excluded, debarred, or otherwise ineligible to participate in healthcare programs.

14. Cooperate with Inquiries, Audits, and Investigations

We cooperate with government inquiries, as well as internal and external audits and investigations. When receiving non-routine requests, we consult with the Legal Department or Compliance Office to ensure that requests are handled properly. We do not alter or destroy records in violation of the law or UNC Health Care policy.

15. Use Resources Responsibly

We use UNC Health Care resources responsibly for UNC Health Care business purposes, not for personal gain. We spend UNC Health Care funds wisely, eliminate waste, and control operational costs without compromising patient care. We use physical assets like computers, vehicles, machinery, and work space for UNC Health Care business, and we protect those assets from loss, damage, and theft. We don't waste supplies, equipment, space, or time. We protect intellectual property and respect patents, software licensing, copyright, and other IP agreements.

16. Conduct Political Activity and Fundraising Appropriately

UNC Health Care respects employees' rights to participate in or refrain from political and fundraising activities on personal time. Employees must follow applicable policies relating to use of UNC Health Care resources for political activity, engagement in political activity while on work time, and similar issues. Employees may not inappropriately force, direct or encourage coworkers to support or contribute to a political cause, candidate, or party in violation of the law or applicable policies.

17. Disclose and Appropriately Manage Conflicts of Interest

We disclose and appropriately manage conflicts of interest. Employees must report any actual or potential conflict of interest. Conflicts of interest are situations in which personal considerations may affect, or have the appearance of affecting, our loyalty and ability to fulfill our responsibilities to UNC Health Care. Depending on the circumstances, a "conflict of interest" might include:

Code of Conduct

employment outside of UNC Health Care with a competitor or in violation of our policies, supervising a close relative, purchasing stocks based on confidential information, accepting gifts from a vendor, patient, or fellow provider, or causing UNC Health Care to contract with vendors with whom you have a personal or financial interest. If you have questions about what might be a conflict of interest, review UNC Health Care policies and speak with your supervisor or the Compliance Office.

18. Prohibit Bribes, Kickbacks, or Payment for Referrals

We do not offer or accept bribes or kickbacks. Bribes and kickbacks are money, gifts, or special treatment given to someone in exchange for a favor. The favor may be many things, from a promise to make patient referrals to a promise to use a particular vendor's product.

We also do not offer or accept "something of value" for patient referrals. "Something of value" includes money, services, gifts, entertainment, or anything else of value to the recipient.

As this is a highly complex area of the law, employees must take special care and promptly refer any questions to the Compliance Office or the Legal Department.

19. Prohibit Certain Inducements Affecting Patient Choice

The law prohibits UNC Health Care and its employees from offering certain inducements that may affect a patient's decision about where to seek care. For instance, it may be illegal to offer copayment waivers, free services, gifts, and other inducements to encourage patients to receive care at UNC Health Care. However, patient value initiatives associated with the UNC Health Alliance (our clinically integrated network) may not be precluded. As this is a highly complex area of the law, employees must take special care and promptly refer any questions to the Compliance Office.

20. Report Compliance Concerns Without Fear of Retaliation

Employees are encouraged to contact the Compliance Office whenever they need clarification or direction regarding Compliance issues (including this Code of Conduct). Employees are required to report suspected violations of the Code of Conduct, policies, procedures, the law, and regulations to a supervisor, the Compliance Office, or the confidential Compliance Hotline. Retaliation is not permitted against anyone who seeks advice, raises a concern, or reports misconduct in good faith. Such retaliation should be reported immediately to the Compliance Office.



Appendix B Code of Conduct Attestation

UNC Health Care and its affiliated Network Entities (individually and collectively called “UNC HC” herein) abide by a system-wide Code of Conduct.

The Code of Conduct is the cornerstone of our corporate culture and a key element of our Compliance Program. The Code of Conduct outlines behavior expected of our employees, management, vendors, volunteers and others who interact with the UNC HC.

The purpose of the Code of Conduct is to reinforce UNC HC’s institutional values and to serve as a guide for moral, ethical, and legal behavior. Adherence to the Code of Conduct promotes UNC HC’s reputation for integrity and honesty in the community and also ensures that UNC HC is compliant with applicable laws, rules, and regulations.

Attestation

1. I confirm that I have received a copy of the Code of Conduct.
2. I understand that it is my responsibility to read the Code of Conduct and I agree to do so.
3. I also understand that anything that was unclear to me in the **Code of Conduct can be clarified by my supervisor or Compliance Officer.**
4. I confirm I will carry out my day-to-day work within the spirit and letter of the Code of Conduct.
5. I understand that I have a personal duty to **bring all (real or suspected) violations of the Code of Conduct to the attention of my supervisor and/or Compliance Officer. Concerns may also be submitted to the Hotline (1-800-362-2921 or <http://hotline.unchealthcare.org>).**
6. I understand that it is against UNC HC policy to be punished or retaliated against for upholding the Code of Conduct and for obeying the laws and regulations that apply to my job. Retaliation should be reported immediately.

I agree that I have read, understand and will comply with the terms of this Code of Conduct Attestation and all applicable policies and procedures. I understand that my failure to comply with the Code of Conduct may result in disciplinary action, up to and including termination of employment or student status, or loss of UNC HC privileges or contractual or affiliation rights.

Name: _____ (please print)	Employee ID or work email address: _____
Entity (e.g., UNC Hospitals): _____	
Affiliation:	
<input type="checkbox"/> Employee <input type="checkbox"/> Temporary Employee <input type="checkbox"/> Contractor <input type="checkbox"/> Medical Staff <input type="checkbox"/> Resident <input type="checkbox"/> Referring Physician <input type="checkbox"/> Student	
<input type="checkbox"/> Other Providers <input type="checkbox"/> Volunteer <input type="checkbox"/> Vendor (specify): _____	
<input type="checkbox"/> Other (specify): _____	
Signature: _____	Date: _____

Last revised November 7, 2017



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POLICY AND PROCEDURE

UNIVERSITY OF NORTH CAROLINA HOSPITALS GRADUATE MEDICAL EDUCATION POLICY ON VENDOR RELATIONS

I. Description

Provides guidelines to the Health Care System (HCS) and the University for the School of Medicine Personnel on how to engage with industry in ways that protect personal and institutional integrity.

II. Rationale

A. Introduction

UNCHCS and the SOM share the goals of providing quality health care, first class medical education, and transformational research consistent with the highest principles of integrity. Interaction with Vendors (defined below) can support the mission of the UNCHCS and the SOM of service, education, and research, but should not compromise patient confidentiality, interfere with patient care, bias research results, or bias the education of residents, students, patients, or the public.

When conducted ethically and transparently, interactions with Vendors can result in benefits to our patients and trainees. It is appropriate and oftentimes necessary, for example, for faculty members to become involved at various stages of drug and device development so that they can assist with the development of products and services that will benefit their patients and society. Appropriate contacts with industry sales

representatives also provide learning opportunities about new therapeutic options, research products and other services or supplies.

In all these activities, the safety and well-being of our patients and the integrity of our institutions must be our foremost concern. This Policy, adopted jointly by the UNCHCS and the SOM, is designed to enable UNCHCS and SOM personnel to engage with Vendors in ways that protect personal and institutional integrity.

B. Definitions

Covered Personnel: all UNCHCS and SOM employees, students, trainees and faculty, regardless of work location to which they are assigned (collectively, “Covered Personnel”)

Educational Activities: activities, conferences, or meetings organized at or through the SOM or the UNCHCS, including continuing medical education (“CME”) events that are primarily dedicated to promoting scientific and Educational Activities and to furthering the knowledge of the attendees on the topic being presented.

External Professional Activities: activities that are not included within the Covered Personnel employment responsibilities, if performed for any entity, public or private, other than the Covered Personnel’s employer that are undertaken for compensation, monetary or in-kind, and are based upon the professional knowledge, experience and abilities of the employee.

Family Member: includes Covered Personnel’s spouse and dependent children. For the purposes of this Policy, “spouse” includes a person with whom one lives together or in the same residence and with whom one shares responsibility for each other’s welfare and financial obligations.

Financial Relationship: may exist whether the Covered Personnel is paid directly or whether compensation is routed through another legal entity, such as a limited liability company or non-profit organization. Financial relationships for Family Members of Covered Personnel are considered to be the same as the relationships of the Covered Personnel and are subject to disclosure and regulations as provided under this and related policies.

Ghostwriting: the practice of allowing someone other than the named author to write a paper or presentation delivered or reported to be written by the named author.

Speaker’s Bureau: panels of experts who deliver talks or papers for compensation in any form for the promotion of a product, service, or device manufactured or marketed by the entity directly or indirectly providing such compensation.

UNC General Administration (or UNC-GA): the administrative organization of the 17 campus University of North Carolina system

University: the University of North Carolina at Chapel Hill

Vendor: any business that provides or has potential to provide services or products to the UNCHCS or to the SOM

C. Applicability of Other UNCHCS, UNC Hospitals, UNC-GA and University Policies

This Policy supplements existing UNCHCS, UNC Hospitals, UNC-GA and University policies, including, but not limited to:

- [UNCHCS - Vendor Representatives Policy and Visitation Guidelines](#)
- UNC Hospitals SSPC 0001: [Surgical Value Analysis Committee](#)
- University EPAP Policy: External Professional Activities: Faculty and EPA Non-faculty
- UNC-GA: [Policy on Conflicts of Interest and Commitment and “Regulations on External Professional Activities for Pay by Faculty and Non-faculty EPA Employees”](#)
- University Policy on Individual Conflicts of Interest and Conflicts of Commitment
- University Research Code of Conduct Policy
- University Institutional Conflict of Interest Policy
- University Finance Policy 1211: Avoiding Vendor Conflicts of Interest
- [UNCHCS Policy - Medication Management: Drug Samples](#)

In the event of any discrepancy between the provisions of this Policy and provisions of the policies and procedures set out above, the requirements of the more rigorous policy shall apply.

III. Policy

A. Reporting of Financial Relationships

For purposes of this Policy, a “Financial Relationship” shall be the possession or receipt by Covered Personnel or a Family Member of:

- Income, in any form and in any amount and for any purpose, received from a Vendor.
- Ownership, if any form (including stock options or warrants) other than through a mutual fund in a Vendor.
- In-kind compensation from a Vendor such as the provision of goods, travel, or lodging.
- Revenue from patent, copyright or other intellectual property interests, including royalties received through the University, originating from a Vendor.
- Gifts made for the direct benefit of Covered Personnel by a Vendor to the SOM, the University for the SOM, UNCHCS, or any affiliated foundation of either entity.

A Financial Relationship may exist whether Covered Personnel is paid directly or whether compensation is routed through another legal entity, such as a limited liability company or non-profit organization.

Covered Personnel are required to report Financial Relationships at the time of any proposed activity covered under the terms of this Policy. Such arrangements may be subject to scrutiny under healthcare fraud and abuse regulations. Failure to disclose Financial Relationships as required under this Policy may result in disciplinary action up to and including dismissal, consistent with UNCHCS and University policies, as applicable.

The reporting requirements of this Policy are supplemental to and are required in addition to any reports required under the University's "Policy on Individual Conflicts of Interest and Commitment", "Institutional Conflicts of Interest", or "External Professional Activities for Pay" or applicable UNCHCS Policies. Financial information reported under this Policy is protected as confidential personnel information. Access to information disclosed under this Policy will be limited to those who need to know for business purposes, which includes the supervisors of Covered Personnel who must review proposed activities prior to initiation.

B. Purchasing Contracts with Vendors

Contracting with Vendors on behalf of the UNCHCS or SOM must be accomplished through the appropriate Purchasing Department. Covered Personnel are generally prohibited from participating in the procurement negotiations with any Vendor with whom such Covered Personnel have a personal interest, a Financial Relationship or other financial interest, or personal or family relationship. Covered Personnel may, however, provide professional advice to the persons reviewing specific goods and services, provided that they disclose any potential Financial Relationship(s) to those whom they are advising.

C. Educational Activities

Covered Personnel must adhere to the Accreditation Council for Continuing Medical Education ("ACCME") Standards for Commercial Support guidelines, the Accreditation Council for Graduate Medical Education ("ACGME") guidelines, and other University or UNCHCS Policies when organizing, holding or presenting and Educational Activity, whether or not credit is awarded. In no case may a vendor dictate or control the selection of speakers, topic, or educational material presented. Vendor representatives may not speak at Educational Activities or provide refreshments or gifts to attendees. Vendors may however make an unrestricted donation or educational grant to the SOM or UNCHCS that the relevant department or until may choose to use in support of an Educational Activity.

Other Learning Activities

Meals provided during webinars and other Educational Activities in which credits applicable to licensure maintenance (e.g. CME, CLE, CNE, CPE, etc.) that are provided in connection with such activities and are included as part of the event registration or as part of the relevant licensing board's membership dues are acceptable.

D. Educational Materials

Vendors are not permitted to distribute, post or leave any type of printed or handwritten material, advertisements, signs, or other such promotional materials anywhere at the UNCHCS or SOM unless specifically requested by faculty or staff. Vendors may leave educational materials regarding their goods or services that may be useful to patients with the applicable department administration, but Vendors may not distribute them directly to patients. All such educational information should be reviewed by and distributed by the appropriate department supervisor or designee. Educational materials, such as textbooks or medical journals which benefit patients, students or trainees may be provided by a Vendor to the UNCHCS or SOM, if such materials serve a genuine educational function. No promotional material or product information from the Vendor may be attached to any such item.

UNCHCS and SOM departments may sponsor educational events and solicit financial support from Vendors after advance approval is received from their supervisor and the UNCHCS Compliance Office and/or SOM Dean's Office. Once approved, the sponsoring department may charge fair market value to participating Vendors for tables to offset the cost of the event in addition to meeting the following conditions:

1. The support is unrestricted with respect to content, topic, and speaker;
2. The support is made at a divisional or departmental level for general educational purposes and not for the benefit of individual faculty members;
3. Support is in compliance with all applicable Accreditation Council for Graduate Medical Education (ACGME) and/or Accreditation Council for Continuing Medical Education (ACCME) standards; and
4. No trinkets, gifts, promotional material, free samples, or other marking materials are available at the educational event. Only educational materials may be distributed at an educational event.

The sponsoring department is responsible for ensuring that the Vendor(s) abide by all policies and restrictions during the event. The event information should note that the UNCHCS and/or University's acceptance of any such Vendor sponsorship does not constitute expressed or implied endorsement of any particular Vendor's product or service.

E. External Professional Activity

Through certain external professional activity opportunities, Covered Personnel may apply their specialized knowledge and clinical, teaching, research and administrative expertise, thereby contributing further to society. These activities are encouraged if they comply with the applicable policies of the UNCHCS and the University and do not create an unmanageable conflict of interest, as defined by each organization.

Submission of proposed External Professional Activities by the Covered Personnel are required whether Covered Personnel are compensated directly by the outside entity or paid through another legal entity, such as a limited liability company or a non-profit organization. Even if Covered Personnel direct any compensation to be donated or paid directly to UNCHCS or the University, review of the proposed activity is required. Such proposed activities will be reviewed by the UNCHCS and SOM under their respective processes and/or policies; they will also be reviewed for compliance with this Policy.

It is understood that there may be changes in External Professional Activities during a given academic/fiscal year. As applicable under the relevant UNCHCS or SOM process, Covered Personnel are responsible for submitting a new approval request that addresses any such changes, including changes in the amount of time or compensation involved, in advance where possible and not later than thirty (30) days after Covered Personnel learn of the changes related to the External Professional Activities. Failure to comply with these requirements may result in disciplinary action up to and including dismissal, consistent with applicable UNCHCS and University policies.

The UNCHCS and the SOM agree that the following conditions apply when any proposed External Professional Activity involves a Vendor and the Covered Personnel:

1. The proposed activity, including projected compensation, must not be excessive;
2. External Professional Activities must not interfere with the employment obligations of the Covered Personnel;
3. Any honoraria, travel reimbursement, meals or other hospitality associated with the external activity must be reasonable and consistent with the legitimate clinical, educational, administrative or scientific purpose of the activity;
4. Covered Personnel must retain discretion to provide objective commentary or advice based on their professional judgment when delivering the external activities;
5. Covered Personnel must articulate to Vendor and to any other audience that they are conducting such activities in their individual capability and their views do not necessarily reflect the views of the UNCHCS or University;
6. The external activity may not, in any manner, create an express or implied endorsement by UNCHCS or University of the Vendor's items, supplies, products or services;
7. Covered Personnel may not use UNCHCS or University resources for External Professional Activities. Such UNCHCS or University resources may include facilities, administrative offices, work product, results, materials, property, records, the institutional IRB, the assignment of work to students, residents or trainees, or the use of institutional support, except as otherwise reviewed and allowed under other related UNCHCS or University policies. Covered Personnel should seek guidance from their department manager for any clarification.

This Section does not apply to services provided under an authorized institutional contract between a Vendor and the UNCHCS or the University.

1. UNCHCS Specific Process:

Covered Personnel employed by the UNCHCS may engage in and be compensated for an External Professional Activities, including consulting and related travel arrangements, that are not part of their employment *only if*:

- a. The Covered Personnel has disclosed to their immediate supervisor the proposed activity, including the amount of compensation they expect to receive from the proposed External Professional Activity at least ten days prior to the activity;
- b. The supervisor determines that any External Professional Activity relationships, including projected compensation, are not excessive;
- c. The supervisor determines that such activities will not interfere with or inappropriately influence the employment obligations of the affected Covered Personnel;
- d. The supervisor otherwise approves of the activity; and
- e. The terms of the agreement for the External Professional Activity meet the standards of this Policy and this activity is not prohibited by another related policy.

2. University SOM Specific Process:

Covered Personnel at the SOM may be permitted to engage in an External Professional Activity provided the activity meets the standards and process of:

- a. The University Policy on External Professional Activities: Faculty and EHRA Non-Faculty;
- b. The University Policy on Individual Conflict Commitment;
- c. This Policy; and
- d. The activity is not otherwise prohibited by another related policy (e.g. in contravention of the moonlighting restrictions of the UNC Faculty Physicians Health Affairs Code)

Covered Personnel should start the disclosure process with submission of the External Professional Activity for Pay form. Once reviewed by the applicable individual within the department or unit under relevant policies, the form will be routed to the Dean's Office in the SOM for additional review. The Covered Personnel will receive an email stating the outcome of the reviews. The External Professional Activity for Pay may be subject to review under related policies, such as the University Policy on Individual Conflicts of Interest.

F. Ghostwriting, Speakers' Bureaus and Speaking Engagements

Covered Personnel are not allowed to engage in Ghostwriting or Speakers Bureaus under any circumstances.

Covered Personnel may be allowed to participate in "speaking engagements" compensated by a Vendor, whether as an External Professional Activity or an institutional activity, provided that:

1. The Covered Personnel are not supporting a Vendor product or service but merely participating as a subject matter expert within their field of expertise;
2. The Covered Personnel retains full editorial control and authority over the content of the presentation;
3. The content of the lecture is educational, free from commercial influence, and is not designed to recommend specific drugs, devices, or other commercial products or services;
4. The content of the lecture is based on best available evidence and reflects a balanced assessment of the current science and treatment options;
5. The Covered Personnel discloses at the beginning of the presentation all funding and editorial relationships with the Vendor(s), including disclosure of any Vendor sponsorship of the speaking engagement and receipt of honorarium and/or travel reimbursements for providing the presentation to the program attendees;
6. The slides do not contain any logos or names of the Vendor(s) that sponsored the speaking engagement, except as required for the foregoing disclosures; and
7. In the estimation of the supervisor authorized to approve the speaking activity, as applicable under UNCHCS or SOM policy, any honorarium and travel expenses paid for the speaker's participation are reasonable.

While prior review of the presentation by a Vendor is acceptable, Covered Personnel should not allow a Vendor to influence the content of the presentation, unless the edits requested by the Vendor are solely to protect its confidential or proprietary information (e.g. removal of content that disclose a non-yet-patented invention). Review of the presentation by the Covered Personnel's supervisor may be required, in the reasonable discretion of the supervisor prior to the Covered Personnel making any presentation at the request of a Vendor.

G. Gifts

Covered Personnel may not receive gifts of any nature or of any value from Vendors. Even items of a relatively trivial value that incorporate a product or company logo (such as pens, notepads, or desk items) may provide an inappropriate opportunity for the company to market to Covered Personnel, to patients, and to other members of the public. This prohibition includes any tangible enticement, whether in cash, extra goods, services, or gifts, which are offered by a Vendor to encourage the use or purchase of the Vendor's product. Covered Personnel may not accept payment, gifts, or other benefits in return for completing evaluations or surveys developed by a Vendor.

This prohibition includes gifts to the Family Members of Covered Personnel and to legal entities, such as limited liability companies, through which Covered Personnel might engage in consulting or other external professional activities.

H. Meals and Other Hospitality

Covered Personnel may generally not accept meals or other hospitality from Vendors. Under no circumstances may Covered Personnel accept complimentary tickets to sporting or other events from a Vendor. Covered Personnel must pay for their own meals if attending an educational meeting or journal club organized by a Vendor as an invitation-only event and held at a restaurant or resort.

Covered Personnel may accept meals or hospitality from Vendors only in the following circumstances:

- 1) Meals or receptions that are served as part of a general professional conference or meeting supported in whole or in part by Vendor(s) and included in the event registration (e.g., annual meetings of academic societies or professional association meetings and conferences where meals are served to all registered attendees);
- 2) Meals provided in conjunction with off-site activities as part of approved External Professional Activity (as provided in Section III.E above);
- 3) Materials provided by the organizers of a professional meeting that are available to all attendees at registration, provided the meeting is conducted under national continuing education accreditation body guidelines (e.g., a tote bag provided to conference attendees at check-in);
- 4) Notwithstanding Section G of this Policy, small gifts or opportunities for prize drawings on-site at UNC Hospitals, as approved by Employee Recreation and Wellness or Volunteer Services, may be permitted in the lobby of UNC Hospitals. Advance approval by the sponsoring office (i.e. Employee Recreation and Wellness or Volunteer Services) must be obtained if the Vendors would like to distribute small gifts (limited to items that have a relatively trivial or de minimis value) or offer a "drawing" for prizes. By the way of example, a local bank may set up an information table to provide employees information about banking services and offer a pen or other small token with the bank's logo and information. The office sponsoring the event is responsible for obtaining approval of any such gifts in advance of the activity and responsible for ensuring that the Vendor abide by all policies and restrictions during the time covering the Vendor's activities on the premises. Vendors may not offer food or health assessments of any kind in this settings.

I. Vendor Site Visits for Training, Possible Research or Evaluations

Covered Personnel may not directly accept reimbursement or sponsorship for travel and expenses for site visits for training or to evaluate a product or service.

Vendor sponsored visits by Covered Personnel to Vendor sites for training or potential research are acceptable if the cost of such visits is itemized in the quotation and included in a signed final contract with the UNCHCS or University, as applicable. Reimbursement should be requested through the appropriate UNCHCS or University office.

UNCHCS and University Covered Personnel may make site visits to evaluate a product or service, if necessary, at the Vendor's expense, provided that:

1. All arrangements related to site visits, including selection of participants, duration of the visit, selection of travel method and accommodations, are made by the applicable department.
2. Site visits at the expense of the Vendor may only include travel, housing, per diem payments, and food expenses specifically related to the evaluation of the product or service. Expenses may not include any extra expenses which are personal in nature or unrelated to the evaluation, including but not limited to first or business class travel.
3. All expenses will be determined and paid for by the applicable department with any reimbursement made to the Covered Personnel through the usual employee reimbursement process. The Department will send an invoice for appropriate expenses to the Vendor for reimbursement.

J. Research, including Sponsored Projects

All research activities, including but not limited to the use of investigational drugs must be conducted pursuant to University or UNCHCS policies and procedures concerning research. It is the obligation of the Covered Personnel to learn about the applicable policies and procedures before beginning any research projects, whether externally sponsored (funded) or supported by internal funds. UNCHCS Covered Personnel who participate in research are covered by the University's Policy on Conflict of Interest and Commitment for their research duties and activities when involved in University research projects (see Section II C: Applicability of Other UNCHCS, UNC Hospitals, and University Policies for a link to the complete Policy). Promotional activities by Vendors may not be performed under the guise of research.

K. Charitable Events

Invitations to local charitable or fundraising events (charity auctions, benefits dinners and golf outings) from non-pharma Vendors may be acceptable upon review and approval by the UNCHCS Compliance Office and/or SOM Dean's Office if all the following conditions are met:

1. Acceptance may not be used to influence decision-making, to induce referral of patients or the ordering of a service or supply, and cannot take into account the volume or value of referrals, purchases or business generated;
2. The event is solely for the benefit of the UNCHCS or the University or another bona fide charitable entity whose mission is related to, complementary to, or otherwise compatible with UNCHCS and/or the University;
3. Advance approval by one's supervisor is included in the request to the reviewing office;

4. Any additional gifts beyond the participation or attendance of charitable event must be declined; and
5. Limitations on the number of invitations may be made if such invitations become excessive.

L. Donations/Gifts from a Vendor

Beyond those unrestricted donations permitted under Section III.G, Vendors generally may provide unrestricted donations to a UNCHCS or SOM department. Those donations can be mailed to the Finance & Business Operations Office, Attention Vendor Relations Account 145 Medical Drive, CB 9515, Chapel Hill, NC 27599-9515, with reference the department name when making donations.

M. Policy Violations

Covered Personnel who are aware of potential violations of this Policy should report those allegations to the University or UNCHCS Compliance Office, University Counsel, or to University or UNCHCS Compliance Hotline. Alleged violations of this Policy shall be investigated by the UNCHCS or University Compliance offices. On finding a violation of this Policy, the supervisor of the Covered Personnel involved will be notified in writing of the facts and nature of the Policy violation. The applicable Compliance Office will work with Human Resources to recommend disciplinary action or other action provided under this Policy. All disciplinary action taken hereunder shall follow the established procedures of the University and/or the UNCHCS. In addition to any sanctions specifically provided herein, Covered Personnel found to have violated this Policy may be subject to disciplinary action up to and including dismissal.

N. Contacts

Please contact the UNCHCS Compliance Office or SOM Dean’s Office, as applicable, for any questions related to this Policy.

Approval Signatures

Step Description	Approver	Date
Policy Stat Administrator	Patricia Ness: Nurse Educator	10/2018
	Jerylyn Williams: VP Chief Audit & Comp Officer	10/2018
	Patrick Kennedy, HCS-Hospital Compliance Dir	10/2018

PolicyStat ID: 5574200		
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	New Review:	10/2021
	Owner:	Patrick Kennedy: HCS Dir Hospital Compliance
	Policy Area:	Compliance
	Policy Tag Groups:	
	Applicability:	UNC Medical Center

Vendor Relations. Retrieved 05/28/2019. Official copy at <http://unchealthcare-uncmc.policystat.com/policy/5574200/> Page 10 of 10
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Dermatology and Skin Cancer Centers

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Southern Village

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Fax: 984-974-3692

Dermatology at Hillsborough

460 Waterstone Drive
Hillsborough, NC 27278
Fax: 919-595-5943

Dermatology at Rex

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Dermatology at Burlington

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POLICY AND PROCEDURE

UNIVERSITY OF NORTH CAROLINA HOSPITALS GRADUATE MEDICAL EDUCATION POLCY ON CRITERIA FOR EXCEPTIONAL QUALIFICATIONS FOR SUBSPECIALTY RESIDENT CANDIDATES

Background:

ACGME requirements regarding eligibility for subspecialty residency (fellowship) training changed effective July 1, 2016. In general, in order for a resident to be eligible to participate in any UNC Hospitals' subspecialty residency (fellowship) program, the resident must have successfully completed core specialty training in: (1) an ACGME accredited program; or (2) an RCPSC accredited or CFPC-accredited residency program located in Canada. The ACGME allows limited exceptions to these eligibility requirements; however, each individual Residency Review Committee (RRC) determines whether it will recognize those exceptions within its program.

Scope:

This policy applies to all UNC subspecialty programs who are permitted by their individual RRC requirements to allow exceptions to the ACGME core specialty training requirements; and who desire to consider applicants under a permitted exception.

ACGME Policy – Directly from ACGME requirements:**III.A. Eligibility Requirements – Fellowship Programs**

All required clinical education for entry into ACGME-accredited fellowship programs must be completed in an ACGME-accredited residency program, or in an RCPSC accredited or CFPC-accredited residency program located in Canada. (Core)

III.A.1. Fellowship programs must receive verification of each entering fellow's level of competency in the required field using ACGME or CanMEDS Milestones assessments from the core residency program. (Core)

III.A.2. Fellow Eligibility Exception

A Review Committee may grant the following exception to the fellowship eligibility requirements: An ACGME-accredited fellowship program may accept an exceptionally qualified applicant**, who does not satisfy the eligibility requirements listed in Sections III.A and III.A.1., but who does meet all of the following additional qualifications and conditions: (Core)

III.A.2.a) Assessment by the program director and fellowship selection committee of the applicant's suitability to enter the program, based on prior training and review of the summative evaluations of training in the core specialty; and (Core)

III.A.2.b) Review and approval of the applicant's exceptional qualifications by the GMEC or a subcommittee of the GMEC; and

III.A.2.c) Satisfactory completion of the United States Medical Licensing Examination (USMLE) Steps 1, 2, and, if the applicant is eligible, 3, and; (Core)

III.A.2.d) For an international graduate, verification of Educational Commission for Foreign Medical Graduates (ECFMG) certification; and, (Core)

III.A.2.e) Applicants accepted by this exception must complete fellowship Milestones evaluation (for the purposes of establishment of baseline performance by the Clinical Competency Committee), conducted by the receiving fellowship program within six weeks of matriculation. This evaluation may be waived for an applicant who has completed an ACGME International-accredited residency bases on the applicant's Milestones evaluation conducted at the conclusion of the residency program. (Core)

III.A.2.e). (1) If the trainees does not meet the expected level of Milestones competency following entry into the fellowship program, the

trainee must undergo a period of remediation, overseen by the Clinical Competency Committee and monitored by the GMEC or a subcommittee of the GMEC. This period of remediation must not count toward time in fellowship training. (Core)

****An exceptionally qualified applicant has (1) completed a non-ACGME-accredited residency program in the core specialty, and (2) demonstrated clinical excellence, in comparison to peers, throughout training. Additional evidence of exceptional qualifications is required, which may include one of the following: (a) participation in additional clinical or research training in the specialty or subspecialty; (b) demonstrated scholarship in the specialty or subspecialty; (c) demonstrated leadership during or after residency training; (d) completion of an ACGME-International-accredited residency program.**

UNC Criteria for “Exceptionally Qualified”:

The following criteria must all be met, in addition to following all required elements of the ACGME policy as outlined above, to determine whether a candidate is Exceptionally Qualified.

1. Written Evaluation from the candidate’s core training Program Director confirming clinical excellence, in comparison to peers, throughout the entirety of training, and
2. **One** of the following additional criteria must be met, which shall be documented by the program director and submitted to the GME office:
 - Evidence of participation in scholarly activities during their core residency program, or
 - Additional research or training in the subspecialty to which they wish to enter, or
 - Evidence of demonstrated leadership activities during their core residency program, or
 - Completion of an ACGME-International-accredited core residency program

Procedure:

No offers of a training position may be made as an exception to the ACGME core specialty training requirements until the candidate’s applications is reviewed and approved by the UNC GME office, and until the candidate’s “Exceptional Qualifications” are reviewed and approved by the UNC Graduate Medical Education Committee (GMEC).

The GME office must receive the applicant’s fully completed application at least 2 weeks before the GMEC meeting date during which the candidate will be presented. The program director must be present at the GMEC meeting for the candidate to be reviewed.

All other applicable eligibility requirements as outlined in the UNC GME Policies on Eligibility, and on Visa Sponsorship, must be met. *Only after the GMEC has given final approval may a program offer the position to the candidate.*

Once an “Exceptional” candidate has matriculated in a UNC program, the Program Director must complete a Milestones assessment within 6 weeks of the start date (this requirement is waived if the candidate is a graduate of an ACGME international-accredited program). If the trainee does not meet expected Milestones performance for their level of training, then the Program Director must report this to the GMEC, and with the CCC, develop a remediate plan that includes a plan for GMEC monitoring of the progress of the trainee in their remediation plan. If the trainee does not meet expected Milestones progress during this remediation period, all applicable UNC GME policies pertaining to Academic and Performance issues will apply.

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	Owner:	Cynthia Trinidad Mitchell: Dir, Grad Medical Educ
	Policy Area:	GME and Other Training Programs
	Policy Tag Groups:	
	Applicability:	UNC Medical Center



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Dermatology and Skin Cancer Centers

Appointments
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Southern Village

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Dermatology at Hillsborough

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Dermatology at Burlington

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POLICY AND PROCEDURE

UNIVERSITY OF NORTH CAROLINA HOSPITALS GRADUATE MEDICAL EDUCATION POLCY ON DISRUPTIVE AND INAPPROPRIATE BEHAVIOR

I. Description

Describes disruptive and inappropriate behavior for all employees, staff and faculty (collectively, “health care team members”). For the University of North Carolina Health Care System (UNCHCS) Code of Conduct, see UNCHCS [Policy “Code of Conduct”](#).

II. Rationale

UNCHCS is committed to supporting a culture that values integrity, honesty and fair dealing among all health care team members, and promoting a caring environment for patients, visitors, and health care team members. Teamwork and good communication promote a culture of patient safety. Disruptive behavior that intimidates others and affects morale or staff turnover can be harmful to patient care and satisfaction as well as employee satisfaction and safety. All health care team members at every level of the organization will support the Disruptive and Inappropriate Behavior Policy through their interactions with patients, visitors, and each other.

Toward these goals, UNCHCS strives to maintain a workplace that is free from harassment and intimidation. This

includes behavior that could be perceived by a reasonable person as inappropriate or harassing, or that does not endeavor to meet the highest standards of professionalism. While this kind of conduct is not pervasive in our facilities, no hospital or clinic is immune. Awareness and cooperation at all levels of UNCHCS is necessary to implement this policy effectively and maintain a safe working environment.

III. Purpose of the Disruptive and Inappropriate Behavior Policy

The Purpose of the Disruptive and Inappropriate Behavior Policy is to:

- clarify that expectations of all health care team members during interactions with any individual at UNCHCS;
- encourage the prompt identification, investigation and resolution of alleged disruptive and inappropriate behavior;
- encourage identification of concerns about the well-being of a health care system member whose conduct is in question, including referral to the UNCHCS or UNC-CH Employees Assistance Program, as appropriate, or the North Carolina Physician's Health Program; and
- support this policy and appropriate interactions with patients, visitors, and health care team members on and off UNCHCS properties while engaging in UNCHCS business.

IV. Policy

A. We Care About and Are Committed To

1. Our Patients and Their Families – Delivering quality health care and outstanding service is fundamental to everything we do.
2. Our Team – Attracting and retaining the best team members is of paramount importance to UNCHCS. We will do this by becoming the health care employer of choice and by providing an environment that:
 - a. Pursues the highest level of safety and quality'
 - b. Focuses on treating patients and colleagues with courtesy, honesty, respect and dignity;
 - c. Recognizes people for their achievements and capabilities;
 - d. Is professionally satisfying;
 - e. Encourages the open exchange of views; and
 - f. Does not tolerate offensive and disruptive behavior.
3. Our Community – Dedication ourselves to finding ways to improve the health of all North Carolinians is central to our leading, teaching, and caring.

B. Acceptable Behavior

Acceptable behavior is behavior that is respectful, civil, reasonable, and appropriate in a professional context and that results in quality patient outcomes and a safe environment for patients, visitors and health care team members. Examples of acceptable behavior include, but are not limited to:

1. Engaging in clear, open, and honest communication that is positive and solution-oriented;
2. Promoting cooperation and the sharing of ideas and information to enhance team participation and success;
3. Actively listening to the perspectives of others and seeking to resolve conflicts promptly;
4. Offering constructive criticism in good faith to improve education, research, patient care, service and operations;

5. Demonstrating sensitivity to diverse backgrounds (e.g., race, ethnicity, religion, gender, sexual orientation, age, physical appearance or socioeconomic or educational status); and
6. Respecting and maintaining privacy and confidentiality of all individuals in accordance with law and policy.

C. Disruptive and Inappropriate Behavior

Disruptive and inappropriate behavior may be written, verbal or physical. Examples of disruptive and inappropriate behavior may include but are not limited to:

1. Disruptive and Inappropriate Written or Verbal Behavior
 - a. using profane, disrespectful, insulting, demeaning, condescending or abusive language;
 - b. shaming others for negative outcomes;
 - c. making demeaning comments or intimidating remarks, or speaking in a condescending tone;
 - d. having disruptive arguments with patients, family members, or health care team members;
 - e. having overly familiar conversations that violate professional boundaries with patients, family members, or health care team members;
 - f. making derogatory or insulting statements about health care team members(verbally or in chart notes), including making such statements in front of patients, visitors or other health care team members;
 - g. having outbursts of uncontrolled anger;
 - h. communicating or acting in a manner that others would describe as bullying;
 - i. making insensitive comments about a patient's, visitor's, or other health care team member's medical condition, appearance, or situation;
 - j. making threats;
 - k. making jokes or non-clinical comments about race, ethnicity, religion, gender, sexual orientation, age, physical appearance, socioeconomic status, or educational status;
 - l. ignoring potentially harmful situations or failing to report them appropriately;
 - m. creating rigid or inflexible barriers to requests for assistance/cooperation; and
 - n. refusing to answer questions or perform assigned tasks/insubordination.
2. Disruptive and Inappropriate Physical Behavior
 - a. throwing or breaking things;
 - b. refusing to comply with known and generally accepted practice standards such that the refusal inhibits staff or other care providers from delivering quality care;
 - c. using or threatening unwarranted physical force with patients, family members, or other health care team members;
 - d. repeated failure to respond to calls or requests for information or persistent lateness in responding to calls for assistance when on-call or expected to be available;
 - e. failing to work cooperatively with others;
 - f. making rude or lewd gestures; and
 - g. inappropriately touching a patient, visitor, or other health care team member.

D. Duty to Report, and Procedure for Reporting, Disruptive and Inappropriate Behavior

UNCHCS has zero tolerance for disruptive and inappropriate and/or intimidating behavior, especially in instances involving assault and other criminal acts. All instances of disruptive and inappropriate behavior should be reported as set forth below. Health care team members should, if possible and appropriate, first try to resolve situations involving disruptive and inappropriate behavior informally. Nevertheless, disruptive and inappropriate behavior should always be reported, even if resolved informally.

1. Threats, assaults, or other criminal behavior that require immediate attention by law enforcement must be reported first to Hospitals Police at 919-966-3686, or to 911 for an emergency response.
2. Every individual may file a report of disruptive and inappropriate behavior in good faith without fear of reprisal, retaliation, retribution or intimidation.
3. Anonymous reports of disruptive and inappropriate behavior will be considered to the extent possible, but the response to anonymous reports may be limited when there is insufficient information to support an investigation.
4. Reports of disruptive and inappropriate behavior should be made through the chain of command, e.g., immediate Supervisor, Department Director, or Vice President, in writing, verbally, or through UNCHCS's Compliance/Abusive Behavior Hotline. When a report is Office of Internal Audit, Privacy and Compliance for review. The Office of Internal Audit, Privacy and Compliance will work with or refer the concern to the appropriate support functions in the Hospital, UNC HCS, School of Medicine, and/or the UNC-CH to make certain the incident is investigated or reviewed consistent with the policy for the affected entity.
5. Health care team members who intentionally falsely accuse other health care team members of disruptive and inappropriate behavior will be appropriately disciplined in accordance with the medical staff bylaws and/or other applicable policies.
6. Individuals should report disruptive and inappropriate behavior where they were involved in the questionable behavior. In such cases the individual may receive some consideration for their cooperation in the investigation, but they remain responsible and there may be repercussions for their behavior.
7. Any reports that are not tied to UNC HCS by location or operational responsibility will be referred to the appropriate entity.

E. Screening, Investigation and Review of Reports of Disruptive and Inappropriate Behavior

1. Each report of disruptive and inappropriate behavior shall be screened, investigated and documented by staff trained to discern the severity of the violation, the presence of mitigating factors, and the existence of risk of harm to patients. Where appropriate, notification of incidents will be made to the Human Resources and Legal Affairs functions of the Hospital, UNC HCS, the School of Medicine, and/or UNC-CH, for their input and guidance in the investigation and evaluation process.
2. Upon receipt of a report of disruptive and inappropriate behavior, the following screening measures will be taken:
 - a. A member of Employee Relations, Human Resources, or the Office of Internal Audit, Privacy and Compliance will meet with the individual submitting the report to review the report and all available details, including names of others who may have knowledge of the incident.
 - b. A member of Employee Relations, Human Resources, or the Office of Internal Audit, Privacy and Compliance will meet with all who have knowledge of the event.

- c. A member of Employee Relations, Human Resources, or the Office of Internal Audit, Privacy and Compliance will review medical records or other documentation where relevant.

The Office of Internal Audit, Privacy and Compliance may work with or turn over the screening review to others as appropriate including, but not limited to, UNC HCS's Legal Department or UNC Hospital Police.

3. If the information obtained during the screening fails to demonstrate the incident complained of took place, or if the reported behavior was not, in fact, disruptive and inappropriate behavior, the Chief Audit & Compliance Officer will find that there is no basis for an investigation. In this event, the report shall be retained in the Office of Internal Audit, Privacy and Compliance file for five (5) years, with a clear indication that the allegations in the report were unfounded, together with the substantiating information.
4. If it is determined during the screening that disruptive and inappropriate behavior in violation of this policy may have taken place, the matter will be referred to the appropriate supervisor (i.e., the relevant UNC HCS VP, School of Medicine Department Chair or UNC Faculty Physicians' President, or the Chief Medical Officer if it involves the behavior of a member of the Medical Staff of UNC Hospitals) for investigation. Investigatory procedures that are utilized for other Compliance Helpline reports may be utilized for investigations and actions to occur, will document the investigation as set forth below, and will inform the Office of Internal Audit and Compliance of the results and any final action taken.
5. If the behavior complained of poses an immediate threat to patient care or the safety of others, or if the outcome of a prior complaint has indicated as much, the matter will be UNC-CH Legal Department, and the Chief Medical Officer for appropriate action. Appropriate actions may include, but are limited to:
 - a. Conversations directly addressing the problem;
 - b. Detailed action plans;
 - c. The use of mediators or conflict coaches;
 - d. Referral to the UNC HCS or UNC-CH Employee Assistance Programs, the North Carolina Physicians' Health Program, or other appropriate resources; and
 - e. Sanctions (discussed further below).

F. Confidentiality

The report investigation procedure and all related documents are intended to be confidential to the maximum extent possible. All parties to the process are expected to respect and maintain the confidentiality of the process and not divulge the details of the investigation unless required or permitted by law.

G. Documentation

Documentation of investigations into reports of disruptive and inappropriate behavior and their dispositions will be retained for five (5) years in the Office of Internal Audit, Privacy and Compliance, UNC HCS or UNC-CH Human Resources (as relevant), and UNC HCS or UNC-CH Legal Department (as relevant). Documentation of such investigations shall include:

1. The date and time of the disruptive and inappropriate behavior;
2. A statement of whether the disruptive and inappropriate behavior affected or involved a patient or patient safety in any way;
3. A description of the disruptive and inappropriate behavior;
4. The circumstances that precipitated the disruptive and inappropriate behavior;
5. The consequences, if any, of the disruptive and inappropriate behavior as it relates to patient care or operations; and
6. Actions taken in response to the disruptive and inappropriate behavior.

H. Education

1. All health care team members will receive annual education with documented competency on this policy.
2. The Office of Internal Audit and Compliance will report on observed trends in terms of violations of this policy to the UNC HCS Executive Council, UNC HCS Compliance Steering Committee, and UNC HCS Board Committee. A summary of the information will be reported to the Audit and Compliance Committee and to the Joint Conference Committee of the Board.
3. Progress of the implementation of this policy will be monitored through the use of a validated, reliable health care team members' survey tool on at least an annual basis. Results will be shared with all health care team members, Departmental Leadership, the Medical Staff Executive Committee, and the Board of Directors.

I. Sanctions

Disruptive conduct and inappropriate workplace behavior may be grounds for sanctions, including but not limited to suspension; termination of a contract; termination, revocation, suspension (summary or otherwise), restriction of non-renewal of medical staff membership and/or privileges; or corrective action, up to and including termination of employment, for health care team members. Sanctions will be imposed in accordance with the medical staff bylaws and/or other applicable policies, as appropriate.

J. Prohibition Against Retaliation

Retaliation against anyone who reports disruptive and inappropriate behavior, or who participates in an investigation as a witness or in any other capacity, is prohibited and will not be tolerated.

K. Patient Relations

The Patient Relations Department should be notified any time a patient or visitor is involved in or witnesses disruptive and inappropriate behavior by a health care team member. The Patient Relations Department will take appropriate action, including hearing and empathizing with their concerns, thanking them for sharing their concerns, and apologizing.

L. Related Policies

1. [Domestic Violence](#)
2. [Workplace Violence](#)
3. [Reporting Criminal Activity](#)
4. [Unlawful Harassment](#)
5. [Grievance Resolution](#)
6. [Corrective Actions](#)
7. [Social Media](#)
8. [Electronic Mail \(E-Mail\)](#)

VI. Contacts for Questions or Reporting

UNC HCS Compliance Office (984) 974-1027

Compliance Helpline (800) 362-2921 or <http://hotline.unchealthcare.org>

Compliance Email Compliance@unchealth.unc.edu

PolicyStat ID: 4824008		
	Origination:	03/2016
	Effective:	04/2018
	Last Approved:	04/2018
	Last Revised:	03/2016
	New Review:	03/2021
	Owner:	Jerylyn Williams: VP Chief Audit & Comp Officer
	Policy Area:	Compliance
	Policy Tag Groups:	
	Applicability:	UNC Medical Center



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Dermatology and Skin Cancer Centers

Appointments
984-974-3900

Southern Village

410 Market Street, Suite 400
Chapel Hill, N.C. 27516
Fax: 984-974-3692

Dermatology at Hillsborough

460 Waterstone Drive
Hillsborough, NC 27278
Fax: 919-595-5943

Dermatology at Rex

3921 Sunset Ridge Rd, Ste. 202
Raleigh, NC 27607
Fax: 984-974-0910

Dermatology at Burlington

1522 Vaughn Rd
Burlington NC 27217
Fax: 336-905-6191

POLICY AND PROCEDURE

UNIVERSITY OF NORTH CAROLINA HOSPITALS GRADUATE MEDICAL EDUCATION POLCY ON RECORDINGS OF PATIENTS, STAFF AND VISITORS

I. Description

Requirements for those wishing to photograph, film or record patients, staff or visitors. [Note: This policy does *not* apply to recordings authorized by UNC Health Care System for operational or treatment purposes, including, but not limited to, recordings for training purposes, quality improvement initiatives, surveillance, or telemedicine.]

II. Rationale

For patient safety and to protect the rights of staff, the University of North Carolina Health Care System (UNCHCS) maintains policies related to the photographing, filming or recording of patients and staff. In addition, it is the policy of UNCHCS to assist the media in obtaining photographs, motion pictures, or recordings of UNCHCS facilities, procedures and/or patients when UNCHCS staff, attending physicians have agreed to such photography, filming or recording or as otherwise permitted by law.

III. Definitions

Recordings: This policy and procedure applies to all recordings, films, or other images involving patients or staff,

as the case may be, including photographic, video, electronic, or audio media, or any real-time or broadcast representations of the same, such as Skype (collectively referred to herein as “Recordings” or being “Recorded”).

Personally Identifiable Information (“PII”): Any information that could be used to identify, contact, or locate an individual, such as name, home address, email address, IP address, telephone number, SSN, MRN/FIN, driver’s license number, vehicle registration number, credit card number, biometrics (finger print or voice print), facial photos or images, or a unique characteristic (such as unusual tattoos).

IV. Policy

- A. **Recordings of Patients:** Recordings of patients may be made in accordance with the Procedures set forth in Section V below. In all circumstances, it is the policy of UNCHCS to protect the rights and confidentiality of its patients by following the procedures outlined below. Recordings may also be disallowed or discontinued at any time at the discretion of the responsible health care provider or manager when it may interfere with patient care and/or is the interest of patient safety, privacy, treatment, and/or health care operations.
- B. **Recordings of Staff:** UNCHCS staff members (including employees, health care providers, faculty, students, and volunteers) should only be Recorded with the permission of the staff member being Recorded. All UNCHCS staff members have the right to refuse to be Recorded, regardless of whether the Recording is being done by a patient, a patient representative, media, UNCHCS representatives, or other individuality.
- C. **Recordings of Visitors:** Visitors to UNCHCS facilities have the right to refuse to be Recorded, regardless of whether the Recording is being done by a patient, a patient representative, media, UNCHCS representatives, or other individual/entity.

V. Procedure

A. Procedures for Recordings of Patients, Visitors or Staff Made by UNCHCS Representatives

- 1. **Treatment:** Recordings of patients made by UNCHCS representatives for diagnostic or treatment purposes are made as determined by the provider and authorized by the patient as part of his/her General Consent to Treatment. Recordings of patients may not be made using personal devices (such as cell phones, smartphones and tablets) except through the use of the Haiku, Canto or Rover applications for Epic and if the personal device complies with the requirements of “Information Security” and [“Mobile Communication Devices \(MCD\) – Mobile Phones and Smartphones”](#).
- 2. **Health Care Operations and Research:** Requests by UNCHCS representatives to make a Recording of a patient for health care operations (including but not limited to quality assessment, education and training) or research purposes should be approved by the patient’s attending physician. They are authorized by the patient as part of his/her General Consent to Treatment or other authorization, as required by applicable law.
- 3. **Marketing/News:** Recordings of patients, visitors or staff made by UNCHCS representatives for public relations or marketing purposes must be authorized by the UNC Medical Center News Office and require the consent of the patients, visitors or staff being Recorded. If the Recording involves a patient, the consent is documented in writing on a release form available from the UNC Medical Center News Office or at: <http://uncmedicalcenter.intranet.unchealthcare.org/Documents/Administrative%20Forms/PatientPhoto-VideoInfoRelease-PR-MedPurposes.pdf>.

The release form must be signed by the patient, provided he or she is at least 18 years of age and competent to sign, or by an authorized representative. The release form for a patient is submitted to and filed by the Health Information Management Department in the patient’s medical record.

The Marketing/News representative responsible for the Recording will inform the consenting patient, visitor or staff member in general how the Recording might be used, but need not specify publication date or context in which such Recording will be used.

4. **Recruiting:** Recordings of staff members by UNCHCS representatives for recruiting purposes (e.g., videos used by Talent Acquisition) require the consent of the staff members being Recorded, but written documentation is not required.
5. **Crime Victims:** Recordings of potential crime victims may be made by UNCHCS representatives for the purpose of collecting forensic evidence for possible use in a legal or judicial proceeding. Recordings taken for forensic purposes are not considered part of the medical record and should not be placed in the medical record. See also UNCHCS [“Management of Victims of Alleged Rape or Sexual Offense”](#).

B. Procedures for Recordings Made By Patients, Patient Representatives or Visitors

Patients, patient representatives or visitors may only record UNCHCS staff members (including employees, health care providers, faculty, students, and volunteers) with the explicit permission of the staff member being Recorded, and a staff member is entitled to refuse for any or no reason.

Under no circumstances may a patient, patient representative or visitor take a Recording of another patient, patient representative or visitor without explicit permission.

Requests to make a Recording of a patient for the purposes of legal documentation should be referred to the UNCHCS Legal Department.

Due to patient safety concerns, whether a patient procedure may be photographed, filmed or videotaped will be determined on a case-by-case basis by the attending physician or surgeon, as applicable, in concert with the patient. Appropriate consent forms are available from the UNC Medical Center News Office, or the UNCHCS Legal Department. The release form is submitted to and filed by the Health Information Management Department in the patient’s medical record.

C. Procedure for Recordings by External Media

Media representatives must work through the UNC Medical Center News Office to arrange for permission from appropriate parties and must be escorted by a representative or designee of the UNC Medical Center News Office. As set forth below, no Recording in which a patient is identifiable may be made by a media representative without the prior written authorization of the patient or the patient’s authorized representative and with UNCHCS permission.

1. Media representatives wishing to make a Recording inside a UNCHCS facility may do so only with the consent of a representative of UNC Medical Center News Office.
2. When patients appear in a Recording, a representative of the UNC Medical Center News Office will make sure that the patient(s) appearing in the Recording consented to the Recording. The UNC Medical Center News Office will obtain appropriate prior written consent.
3. Consent is granted on a release form available from the UNC Medical Center News Office or at:
<http://uncmedicalcenter.intranet.unchealthcare.org/documents/administrative%20Forms/PatientPhoto-VideoInfoRelease-PR-MedPurposes.pdf>.

The release form must be signed by the patient, provided he or she is at least 18 years of age and has decisional capacity to sign, or by the patient’s authorized

representative. The release form is submitted to and filed by the Health Information Management Department in the patient’s medical record.

4. A representative of the UNC Medical Center News Office will confer with the patient’s attending physician to ensure that the Recording of the patient will not be harmful to the patient or interfere with patient-care activities.
5. If the patient is an inpatient at UNC Hospitals, the UNC Medical Center News Office representative will notify the patient’s head nurse or charge nurse on the floor where the patient is staying prior to any media representative making any Recording. The representative also will notify UNC Hospitals Police, the UNC Hospitals Information Desk, Valet Parking, Ambulatory Care Center, or Family Practice staff, as applicable, and any other affected area if multiple media outlets are involved.
6. **Under no circumstances may photographs, films or videotapes be made by media representatives of patients or visitors at a UNCHCS facility if such patients or visitors are unaware, unwilling or reluctant. The UNC Medical Center news Office should be notified immediately if any unescorted photographer or camera crew appears at a UNCHCS facility.**

D. Procedure for Recordings by External Law Enforcement

Recordings may be made by external law enforcement agencies in accordance with UNCHCS Policy [“Police and Investigative Activities in the Hospital”](#).

VI. Related Policies

- [Police and Investigative Activities in the Hospital](#)
- [Management of Victims of Alleged Rape or Sexual Offense](#)
- Information Security
- [Mobile Communication Devices \(MCD\) – Mobile Phones and Smartphones](#)

Approval Signatures

Step Description	Approver	Date
Policy Stat Administrator	Patricia Ness: Nurse Educator	03/2019
	Betty George: Chief Legal Counsel	03/2019
	Jennifer Markham: HCS-Sr Attorney	03/2019

PolicyStat ID: 6089143		
	Origination:	01/2018
	Effective:	03/2019
	Last Approved:	03/2019
	Last Revised:	03/2019
	New Review:	12/2020
	Owner:	Jennifer Markham: HCS-Sr Attorney
	Policy Area:	Administrative
	Policy Tag Groups:	
	Applicability:	UNC Medical Center

Recordings of Patients, Staff and Visitors. Retrieved 05/28/2019. Official copy at <http://unchealthcare-uncmc.policystat.com/policy/6089143/>. Copyright © 2019 UNC Medical Center

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

UNC Department of Dermatology Residency – ACGME Core Competency Curriculum 2019-20

1) Patient Care

Domain	Competency Objectives	Opportunities and Methods For Learning	Expected Behavioral Outcomes	Method of Evaluation
Doctor-patient relationship	<ul style="list-style-type: none"> ▪ Demonstrate caring and respectful Behavioral Outcomes through effective communication ▪ Incorporate patient education, counseling, and informed decision-making throughout practice 	<ul style="list-style-type: none"> ▪ Didactic sessions ▪ Clinical Experiences ▪ Modeling ▪ Conferences 	<ul style="list-style-type: none"> ▪ Open-ended questions ▪ Waiting for pt response ▪ Clarification ▪ Eye contact ▪ Open body language ▪ Asking for patient input ▪ Explanations that are understood ▪ Provides patient handouts or other written instructions 	<ul style="list-style-type: none"> ▪ ABD ▪ BASIC/Core exams ▪ Procedure log ▪ Portfolio ▪ Sept Clinical skills assessment ▪ Faculty personal feedback card ▪ Milestones
Gathering information and synthesis into action	<ul style="list-style-type: none"> ▪ Gather essential and accurate biopsychosocial information ▪ Develop and carry out patient management plans (diagnostic and therapeutic) based on patient information and preferences, up-to-date scientific evidence, and clinical judgment ▪ Use information technology to support patient care decisions and patient education 	<ul style="list-style-type: none"> ▪ Clinic presentations/performance ▪ UNC/Duke Conferences ▪ Conferences 	<ul style="list-style-type: none"> ▪ Obtains complete history or appropriately focused/problem-based history ▪ Follows information transfer with cogent assessment and plan ▪ Provides reference for action plan ▪ Conducts literature reviews 	<ul style="list-style-type: none"> ▪ ABD ▪ BASIC/Core exams ▪ Procedure log ▪ Portfolio ▪ Sept Clinical skills assessment ▪ Faculty personal feedback card ▪ Milestones
Comprehensive care	<ul style="list-style-type: none"> ▪ Incorporate prevention and health maintenance throughout practice ▪ Coordinate patient-focused care with all other healthcare disciplines 	<ul style="list-style-type: none"> ▪ Presentations to preceptor ▪ Referral experiences ▪ Conferences 	<ul style="list-style-type: none"> ▪ Specific referral question(s) and reasons for referral stated ▪ Uses ancillary healthcare services ▪ Follows up on referral recommendations 	<ul style="list-style-type: none"> ▪ ABD ▪ BASIC/Core exams ▪ Procedure log ▪ Portfolio ▪ Milestones
Psychomotor skills	<ul style="list-style-type: none"> ▪ Perform competently physical exams and all procedures appropriate to Dermatology 	<ul style="list-style-type: none"> ▪ Modeling by faculty preceptors and attendings ▪ Direct clinical teaching 	<ul style="list-style-type: none"> ▪ Can perform physical exams and procedures correctly under supervision 	<ul style="list-style-type: none"> ▪ ABD ▪ Sept Clinical skills assessment ▪ Faculty personal feedback card ▪ Milestones

2) Medical Knowledge

Domain	Competency Objectives	Opportunities and Methods for Learning	Expected Behavioral Outcomes	Method of Evaluation
Gathering information and synthesis into action	<ul style="list-style-type: none"> ▪ Demonstrate a “critical thinking” approach to clinical situations ▪ Demonstrate sound scientific and clinical knowledge base appropriate to Dermatology 	<ul style="list-style-type: none"> ▪ Hideaway Conference ▪ Didactic Conferences ▪ UNC/Duke Conferences ▪ Independent reading/study 	<ul style="list-style-type: none"> ▪ 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 	<ul style="list-style-type: none"> ▪ ABD ▪ BASIC/Core exams ▪ Faculty personal feedback card ▪ Milestones

3) Practice Based Learning

Domain	Competency Objectives	Opportunities and Methods for Learning	Expected Behavioral Outcomes	Method of Evaluation
Gathering information and synthesis into action	<ul style="list-style-type: none"> ▪ Obtain and use population and community-based information ▪ Demonstrate evidence-based approach to practice ▪ Apply critical principles to investigate diagnostic and therapeutic options 	<ul style="list-style-type: none"> ▪ UNC/Duke Conferences ▪ Didactic conference presentations ▪ Independent Study 	Completes required projects and presentations	<ul style="list-style-type: none"> ▪ ABD ▪ Portfolio ▪ BASIC/Core exams ▪ Portfolio ▪ Faculty personal feedback card ▪ Milestones
Maintaining Quality	<ul style="list-style-type: none"> ▪ Demonstrate practice-based learning ▪ Apply principles of quality care to outpatient and inpatient practice 	<ul style="list-style-type: none"> ▪ Quality Assurance Conference participation ▪ Conferences 	Quality Assurance Conference participation	<ul style="list-style-type: none"> ▪ ABD ▪ BASIC/Core exams ▪ Portfolio ▪ Milestones
Teaching and Learning	<ul style="list-style-type: none"> ▪ Facilitate the learning of others ▪ Use information technology effectively in all aspects of practice and continuing education 	<ul style="list-style-type: none"> ▪ Preceptor Modeling ▪ Clinical experiences ▪ Computing resources ▪ Presentations ▪ Conferences 	<ul style="list-style-type: none"> ▪ Active participation in conferences ▪ Progressive leadership and teaching skills development ▪ Medical student teaching ▪ Uses computing resources 	<ul style="list-style-type: none"> ▪ ABD ▪ BASIC/Core exams ▪ Portfolio ▪ Speaker score ▪ Milestones

4) Interpersonal Skills

Domain	Competency Objectives	Opportunities and Methods for Learning	Expected Behavioral Outcomes	Method of Evaluation
Doctor-Patient Relationship	<ul style="list-style-type: none"> ▪ Create and sustain a therapeutic and ethically sound relationship with patients ▪ Use effective listening skills and elicit and provide information using effective nonverbal, explanatory, questioning, and writing skills 	<ul style="list-style-type: none"> ▪ Preceptor Modeling ▪ Clinical experiences ▪ Conferences 	<ul style="list-style-type: none"> ▪ Open-ended questions ▪ Waiting for pt response ▪ Clarification ▪ Eye contact ▪ Open body language ▪ Asking for patient input ▪ Explanations that are understood ▪ Provides written instructions when appropriate 	<ul style="list-style-type: none"> ▪ ABD ▪ BASIC/Core exams ▪ Speaker score ▪ Sept Clinical skills assessment ▪ Faculty personal feedback card ▪ Milestones
Professional Relationships	<ul style="list-style-type: none"> ▪ Demonstrate effective teamwork 	<ul style="list-style-type: none"> ▪ Advancing roles as leaders to conferences and clinics ▪ Faculty modeling ▪ Conferences 	<ul style="list-style-type: none"> ▪ Satisfactory evaluations from nurses, other staff, and peers ▪ Progressive leadership skills as advances through each year level ▪ Active participation in departmental meetings, and partnerships 	<ul style="list-style-type: none"> ▪ ABD ▪ BASIC/Core exams ▪ Speaker score ▪ Sept Clinical skills assessment ▪ Faculty personal feedback card ▪ Milestones

5) Professionalism

Domain	Competency Objectives	Opportunities and Methods for Learning	Expected Behavioral Outcomes	Method of Evaluation
Values	<ul style="list-style-type: none"> ▪ Demonstrate respect, compassion, and integrity ▪ Demonstrate a responsiveness to the needs of patients and society that supercedes self-interest ▪ Demonstrate accountability to patients, society, and the profession ▪ Demonstrate a commitment to excellence and ongoing professional development ▪ Demonstrate sensitivity and responsiveness to patients’ culture, age, gender, and disabilities 	<ul style="list-style-type: none"> ▪ Faculty modeling ▪ Lectures ▪ Conferences 	<ul style="list-style-type: none"> ▪ Professional attire ▪ Active listening ▪ Assesses patient understanding ▪ Explains issues in non-condescending fashion ▪ Works effectively with nurses/staff ▪ Gives bad news effectively ▪ 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 	<ul style="list-style-type: none"> ▪ ABD ▪ BASIC/Core exams ▪ Sept Clinical skills assessment ▪ Faculty personal feedback card ▪ Milestones

Ethics	<ul style="list-style-type: none"> ▪ Demonstrate a commitment to ethical principles pertaining to provision or withholding of clinical care, confidentiality of patient information, informed consent, and business practices 	<ul style="list-style-type: none"> ▪ Lectures ▪ Case discussions ▪ Quality assurance meetings ▪ Conferences 	<ul style="list-style-type: none"> ▪ Defines the principles of beneficence, autonomy, justice, and nonmalficence ▪ Displays ethically defensible approaches to dealing with cases involving withholding care, confidentiality, informed consent, and competing principles of the business model of care 	<ul style="list-style-type: none"> ▪ ABD ▪ BASIC/Core exams ▪ Faculty personal feedback card ▪ Milestones

6) System-Based Care

Domain	Competency Objectives	Opportunities and Methods for Learning	Expected Behavioral Outcomes	Method of Evaluation
Models of Care	<ul style="list-style-type: none"> ▪ Understand the integration of individual practice with the medical system at-large ▪ Know how types of medical practice and delivery systems differ from one another, including methods of controlling health care costs and allocating resources ▪ Use multidisciplinary approach to coordinate care for individuals and families 	<ul style="list-style-type: none"> ▪ Faculty modeling ▪ Clinical experiences ▪ Conferences 	<ul style="list-style-type: none"> ▪ Appropriate referral pattern ▪ Integration with community services, home health agencies ▪ Appropriate response to referral request 	<ul style="list-style-type: none"> ▪ ABD ▪ BASIC/Core exams ▪ Portfolio ▪ Sept Clinical skills assessment ▪ Faculty personal feedback card ▪ Milestones
Cost Consciousness	<ul style="list-style-type: none"> ▪ Practice cost-effective, high quality health care and resource allocation 	<ul style="list-style-type: none"> ▪ Modeling by faculty ▪ Coding seminars ▪ Conferences 	<ul style="list-style-type: none"> ▪ Articulates choices based on cost awareness ▪ Appropriate coding 	<ul style="list-style-type: none"> ▪ ABD ▪ BASIC/Core exams ▪ Portfolio ▪ Milestones
Patient-Centered	<ul style="list-style-type: none"> ▪ Advocate for, and assist patients in achieving quality care in larger system 	<ul style="list-style-type: none"> ▪ UNC/Duke Conferences ▪ Faculty modeling ▪ Conferences 	<ul style="list-style-type: none"> ▪ Articulates strategies when confronted with care barriers 	<ul style="list-style-type: none"> ▪ ABD ▪ BASIC/Core exams ▪ Portfolio ▪ Sept Clinical skills assessment ▪ Faculty personal feedback card ▪ Milestones

APPENDIX B

Evaluation Forms



DEPARTMENT OF DERMATOLOGY

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Heather Holahan, MD
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Ning Li, PhD
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Dermatology and Skin Cancer Centers

Appointments
984-974-3900

Southern Village

410 Market Street, Suite 400
Chapel Hill, N.C. 27516
Fax: 984-974-3692

Dermatology at Hillsborough

460 Waterstone Drive
Hillsborough, NC 27278
Fax: 919-595-5943

Dermatology at Rex

3921 Sunset Ridge Rd, Ste. 202
Raleigh, NC 27607
Fax: 984-974-0910

Dermatology at Burlington

1522 Vaughn Rd
Burlington NC 27217
Fax: 336-905-6191

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 Nancy Thomas, MD, PhD, Professor and Chair of Dermatology, Puneet Jolly, MD, PhD, Associate 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.

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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

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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

ICS2. Having Difficult Conversations					
Has not Achieved Level 1	Level 1	Level 2	Level 3	Level 4	Level 5
	Describes the general approach to difficult conversations with patients and families, but usually needs guidance to recognize these situations and to respond appropriately	Recognizes the circumstances related to having difficult conversations with patients and families Begins to effectively communicate in routine clinical situations, but requires guidance in complex or unusual circumstances	Usually communicates effectively in difficult conversations with patients and families, including some complex or unusual circumstances	Consistently communicates effectively in difficult conversations with patients and families in routine and complex circumstances Customizes communication of emotionally difficult information with patients and families	Role models an effective and sensitive approach to difficult conversations with patients and families 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
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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).

**DERMATOLOGY MILESTONES
ACGME Report Worksheet**

PC1. History, Examination, and Presentation									
Has not Achieved Level 1	Level 1	Level 2	Level 3	Level 4	Level 5				
	<p>With guidance, consistently able to identify key historical or physical examination findings and recognize their significance</p> <p>Consistently demonstrates use of basic dermatologic terminology, but often needs guidance with precise description of skin disease morphology</p> <p>Presentations are often unfocused</p>	<p>Consistently obtains accurate, targeted history and examination for routine conditions efficiently; needs guidance with subtle or complex findings</p> <p>Usually gives a targeted presentation using appropriate terminology and providing pertinent negatives</p>	<p>Consistently able to extract difficult-to-elicited but pertinent information and clinical findings; occasionally needs guidance with subtle or complex findings</p> <p>Consistently gives targeted and precise presentation with pertinent negatives</p>	<p>Consistently identifies information and subtle clinical patterns to diagnose complex disorders</p>	<p>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</p> <p>Teaches presentation techniques and demonstrates mastery of descriptive language</p>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Comments:									

PC2. Diagnostic Tests					
Has not Achieved Level 1	Level 1	Level 2	Level 3	Level 4	Level 5
	Occasionally able to perform and interpret in-office tests, such as KOH preparations and scrapings for ectoparasites	Usually performs in-office tests proficiently Consistently selects clinically-appropriate laboratory and imaging tests	Consistently performs in-office tests proficiently and interprets results correctly Consistently accurately interprets laboratory and imaging test results	Teaches junior learners to accurately interpret laboratory and imaging test results, including the selection of tests that are evidence-based and cost-effective	Is a role model for the performance and interpretation of in-office tests Ensures that appropriate regulatory processes are in place for performing in-office tests
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Comments:					

PC3. Dermatopathology Application					
Has not Achieved Level 1	Level 1	Level 2	Level 3	Level 4	Level 5
	<p>Seeks clinicopathologic correlation</p> <p>Ensures accurate completion of pathology requisition forms</p>	<p>Usually interprets and applies findings to clinical care accurately for common neoplasms</p> <p>Reviews own biopsy slides</p>	<p>Usually interprets and applies findings to clinical care accurately, including for uncommon neoplasms and common inflammatory dermatoses</p> <p>Usually interprets the results of special stains</p>	<p>Consistently interprets and correlates specimens accurately</p> <p>Articulates the limitations and challenges of dermatopathologic interpretation</p>	<p>Performs at the level of someone with advanced education in dermatopathology and teaches clinicopathologic correlation</p>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Comments:					

PC4. Medical Treatment					
Has not Achieved Level 1	Level 1	Level 2	Level 3	Level 4	Level 5
	<p>Consistently able to prescribe medications, but usually requires guidance for indications, contraindications, dosing, and monitoring</p>	<p>Usually selects appropriate medications for common dermatologic disorders</p> <p>Consistently selects correct vehicle and quantity for topical medications</p> <p>Consistently prescribes and manages systemic medications for common dermatologic disease</p> <p>Usually recognizes common and serious side effects, but needs direction in ordering monitoring tests</p>	<p>Consistently selects appropriate medication and changes to medical therapy and usually selects appropriate systemic medication for management of complex diseases</p> <p>Consistently monitors for side effects, including ordering appropriate tests</p>	<p>Usually able to select alternative medications for patients with recalcitrant disease or significant side effects from therapy</p>	<p>Role models appropriate medical management</p>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Comments:					

PC5. Pediatric Treatment					
Has not Achieved Level 1	Level 1	Level 2	Level 3	Level 4	Level 5
	Seeks to integrate age and developmental status when managing or evaluating children	<p>Occasionally integrates age, development status, and psychosocial factors into care</p> <p>Consistently uses weight-based dosing with guidance when prescribing medications for children</p> <p>Consistently performs simple procedures on children with guidance</p> <p>Seeks input on medicolegal issues (e.g, prescribing to unaccompanied minors, child abuse, etc.)</p>	<p>Usually integrates age, development status, and psychosocial factors into care of common disorders</p> <p>Consistently uses weight-based dosing when prescribing medications for children</p> <p>Consistently performs simple procedures on children independently</p>	<p>Consistently integrates age, development status, and psychosocial factors into care of common, uncommon, and complex patients</p> <p>Consistently counsels patients and families with certain disorders, such as birthmarks and genodermatoses</p>	Performs at the level of someone with advanced education in pediatric dermatology and serves as a role model
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Comments:					

PC6. Surgical Treatment					
Has not Achieved Level 1	Level 1	Level 2	Level 3	Level 4	Level 5
	<p>Consistently Implements universal precautions; obtains informed consent for biopsy; performs antisepsis; and administers local anesthesia for common procedures</p> <p>Consistently demonstrates proficiency in basic procedures such as cryotherapy and biopsy</p> <p>Consistently completes documentation for basic surgical procedures</p>	<p>Consistently able to assess and counsel patients for basic procedures</p> <p>Usually able to perform a pre-operative assessment and to set up surgical instrumentation</p> <p>Consistently able to perform skin preparation and to administer local anesthesia for more complex procedures</p> <p>Usually performs basic procedures, such as malignant destruction and excision sutured by layered closure, with guidance</p> <p>Consistently able to manage post-operative care and minor complications</p>	<p>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</p> <p>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)</p> <p>Consistently performs basic procedures, such as malignant destruction and excision sutured by layered closure</p>	<p>Usually able to assess patients for invasive cosmetic procedures, such as laser resurfacing, hair transplantation, and liposuction</p> <p>Consistently able to surgically treat most skin cancers by demonstrating a knowledge of relevant anatomy to guide intra-operative surgical decision-making</p>	<p>Serves as a role model in performing basic and advanced procedures with consistent high quality outcomes with low complication rates</p> <p>Performs at the level of someone with advanced education in procedural dermatology</p>

			<p>Usually performs complex reconstruction, such as flaps and grafts, with guidance</p> <p>Observes or assists in Mohs micrographic surgery and non- invasive cosmetic procedures, such as soft tissue augmentation, botulinum toxin injections, and laser</p> <p>Consistently able to manage most complications related to surgery</p>		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Comments:					

PC7. Diagnosis, Management Decisions and Patient Education					
Has not Achieved Level 1	Level 1	Level 2	Level 3	Level 4	Level 5
	<p>Consistently formulates a limited differential diagnosis, but usually needs guidance in prioritizing diagnoses</p> <p>Occasionally able to formulate an appropriate management plan for common disorders, but usually needs guidance</p>	<p>Consistently develops a differential diagnosis that includes common disorders and some more complex conditions and only occasionally needs guidance for prioritization</p> <p>Occasionally counsels patients about prevention, disease expectations, treatment, and longitudinal care</p> <p>Usually able to formulate appropriate management plans for patients with common disorders, including longitudinal continuity care</p> <p>Usually suggests appropriate specialist consultations</p>	<p>Consistently develops a comprehensive and weighted differential diagnosis</p> <p>Usually educates patients with common and complex disorders with guidance</p> <p>Consistently 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</p> <p>Consistently seeks appropriate specialist consultations</p>	<p>Consistently and independently educates patients</p> <p>Consistently makes independent management decisions, including customizing care in the context of patient preferences, overall health, and ability to comply</p>	<p>Models and teaches development of a comprehensive and weighted differential diagnosis</p> <p>Role models patient education, including ensuring that current, high-quality patient education is available in the practice setting; is a public patient advocate</p> <p>Models management decision-making and actively seeks to improve (for example, using Maintenance Of Certification, Component 4)</p> <p>Actively seeks new opportunities for utilization of external resources</p>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Comments:					

MK1. Medical Dermatology					
Has not Achieved Level 1	Level 1	Level 2	Level 3	Level 4	Level 5
	Demonstrates rudimentary knowledge of common skin disorders	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 Demonstrates rudimentary knowledge of the value of preventive care and socio-behavioral aspects of medical dermatologic disorders (for example, health care economics and medical ethics)	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 Usually demonstrates knowledge of preventive care and the socio-behavioral aspects of common and complex medical dermatologic disorders	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 Consistently recognizes the value of preventive care and demonstrates sophisticated understanding of the socio-behavioral aspects of medical dermatologic disorders	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
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Comments:					

MK2. Pediatric Dermatology					
Has not Achieved Level 1	Level 1	Level 2	Level 3	Level 4	Level 5
	Demonstrates rudimentary knowledge of common skin disorders in pediatric patients	Demonstrates knowledge of the clinical and laboratory manifestations, expected course, and management options of common pediatric dermatologic disorders Demonstrates rudimentary knowledge about socio-behavioral aspects (for example, child development) and the value of preventive care in pediatric dermatology	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 Usually demonstrates knowledge about socio-behavioral aspects and the value of preventive care in pediatric dermatology	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 Consistently demonstrates knowledge about socio-behavioral aspects and the value of preventive care in pediatric dermatology	Demonstrates mastery of and teaches the 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
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Comments:					

MK3. Dermatologic Surgery					
Has not Achieved Level 1	Level 1	Level 2	Level 3	Level 4	Level 5
	<p>Demonstrates knowledge of the basic concepts of antisepsis, pharmacokinetics of local anesthesia, and wound healing, including management of clean wounds and signs of infection</p> <p>Recognizes the reasons for protocol-driven procedural safety, including universal precautions and informed consent</p>	<p>Demonstrates knowledge of suture material used in the skin and complex concepts of wound healing, including chronic ulcers and other complex wounds</p> <p>Demonstrates knowledge of topical anatomy and relevant underlying structures</p> <p>Recognizes potential relevant drug reactions and interactions related to dermatologic surgery</p> <p>Demonstrates knowledge of relevant oral sedatives or analgesics, including narcotics</p> <p>Recognizes the pathology of skin cancer and how it impacts surgical decision making</p>	<p>Demonstrates knowledge of tissue biomechanics and optimal wound closure, including the design of flaps and grafts</p> <p>Demonstrates mastery in identifying topical anatomy and relevant underlying structures</p> <p>Demonstrates knowledge of the science of device-tissue interaction for commonly used tools in dermatologic surgery, including liquid nitrogen, electrosurgical devices, and laser physics</p> <p>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</p>	<p>Demonstrates knowledge of the methodology of procedures such as Mohs micrographic surgery, soft tissue augmentation, botulinum toxin injections, and laser</p> <p>Demonstrates knowledge of the methodology and science associated with invasive cosmetic dermatologic procedures, such as laser resurfacing, hair transplantation, and liposuction</p>	<p>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</p> <p>Demonstrates mastery of and teaches the indications and cost-effectiveness of Mohs micrographic surgery, and performs this procedure at the level of someone with advanced training in procedural dermatology</p> <p>Demonstrates mastery of and teaches the</p>

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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				
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Comments:									

MK4. Dermatopathology					
Has not Achieved Level 1	Level 1	Level 2	Level 3	Level 4	Level 5
	Identifies basic histology of the skin and inflammatory cells	Recognizes histologic patterns of inflammatory disease and common neoplastic conditions Occasionally identifies histopathologic findings of common skin disorders correctly Formulates a limited differential diagnosis of pathologic findings Demonstrates knowledge of direct and indirect immunofluorescence tests and correct locations for biopsies Demonstrates knowledge of relevant special stains	Usually identifies histopathologic findings of common skin disorders correctly; occasionally identifies less common disorders correctly Formulates an expanded differential diagnosis for inflammatory and non-inflammatory disorders Recognizes histologic features of most benign and malignant cutaneous tumors Demonstrates knowledge of the indications and cost of special stains, immunofluorescence, and immunohistochemistry	Consistently identifies histopathologic findings of uncommon skin disorders correctly Formulates an exhaustive differential diagnosis for inflammatory and non-inflammatory disorders Correctly identifies histologic features of benign and malignant cutaneous tumors	For dermatologists interpreting their own biopsy specimens: consistently uses histology correctly to diagnose most cutaneous tumors and inflammatory disorders; fulfills and maintains CLIA requirements and regulations Discriminates when to obtain special stains, immunofluorescence, and immunohistochemistry, and/or expert consultation for less common or difficult disorders 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
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Comments:					

MK5. Application of Basic Science Knowledge to Clinical Care									
Has not Achieved Level 1	Level 1	Level 2	Level 3	Level 4	Level 5				
	Demonstrates rudimentary knowledge of basic science relevant to dermatologic conditions Needs frequent guidance in applying basic science knowledge to dermatologic disorders	Occasionally applies basic science knowledge to dermatologic disorders	Usually applies basic science knowledge to dermatologic disorders, and relates advances in basic science to clinical practice Occasionally formulates clinical questions raised by new basic science information	Consistently demonstrates ability to organize, present, and apply relevant basic science knowledge to the care of dermatology patients Usually formulates clinical questions raised by new basic science information	Organizes, teaches, and models application of relevant and recent basic science knowledge in the care of dermatology patients Formulates clinical questions and considers management options raised by new basic science information	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Comments:									

SBP1. Adapts easily and works effectively in various health care delivery settings and systems					
Has not Achieved Level 1	Level 1	Level 2	Level 3	Level 4	Level 5
	<p>Completes all required tasks for residency and first rotation site orientation</p> <p>Articulates health care missions at participating sites</p>	<p>Utilizes electronic medical record (EMR) efficiently and independently</p> <p>Adapts to clinical work in different sites and health care systems (for example, VA, university medical center, etc.)</p> <p>Maintains access to all needed systems</p> <p>Identifies target patient populations, and the differences in demographics and needs of these populations at each participating site</p> <p>Accesses support services appropriately at different practice sites</p>	<p>Effectively navigates systems to overcome obstacles to optimal patient care (for example, facilitating access to care)</p> <p>Identifies target patient populations, differences in demographics, and can utilize the appropriate agencies/resources to address specific needs of these populations</p>	<p>Recognizes the differences between a system change and a work-around (a bypass of a recognized system fault that attempts to improve efficiency)</p> <p>Identifies at least one work-around, explores opportunities for change, and when possible, takes steps to improve the system fault that incited it</p>	<p>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</p>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Comments:					

SBP2. Works effectively within an interprofessional team					
Has not Achieved Level 1	Level 1	Level 2	Level 3	Level 4	Level 5
	<p>Identifies members of the team who coordinate patient care</p> <p>Describes own role as member of the health care team</p>	<p>Utilizes and consults with other health care providers in coordination of patient care</p> <p>Appropriately communicates and coordinates care with the primary care and/or referral provider(s)</p> <p>Describes unique contributions (knowledge, skills, and attitudes) of other health care professionals, and seeks their input for appropriate issues</p> <p>Describes the use of checklists and briefings to prevent adverse events in health care; recognizes the roles of team members and participates in briefings</p>	<p>Delegates tasks appropriately to members of the health care team</p> <p>Attends and contributes to academic department/division retreats (or similar organizational venue), as well as to clinic team/staff meetings at participating sites</p> <p>Facilitates checklist-guided briefings (for example pre-procedure timeouts) in health care activities</p>	<p>Demonstrates how to manage, utilize, and coordinate the inter-professional team</p> <p>Participates in an interdisciplinary team meeting for clinic or program improvement</p>	<p>Leads an interdisciplinary team</p>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Comments:					

SBP3. Improves health care delivery by identifying system errors and implementing potential systems solutions					
Advocates for quality patient care and optimal patient care systems					
Has not Achieved Level 1	Level 1	Level 2	Level 3	Level 4	Level 5
	<p>Articulates understanding of the limitations of the health care system and potential for systems errors</p>	<p>Participates in discussion during conferences that highlight systems errors</p> <p>Articulates understanding of institutional risk-management resources available</p> <p>Begins to identify the social/governmental services necessary for vulnerable populations, including determination of eligibility for services and delivery of some aspects of care</p> <p>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)</p>	<p>Leads discussion during conferences that highlight systems errors</p> <p>Articulates understanding of the intersection of the legal system and health care system in the context of medical errors</p> <p>Consistently identifies the social/governmental services necessary for vulnerable populations, including determination of eligibility for services and delivery of some aspects of care</p> <p>Consistently advocates for optimal patient care in the setting of interdisciplinary interactions</p>	<p>Consistently encourages open and safe discussion of error, and begins to identify and analyze error events</p>	<p>Consistently encourages open and safe discussion of errors, and characteristically identifies and analyzes error events, habitually approaching medical errors with a system solution methodology</p> <p>Actively and routinely engages with teams and processes through which systems are modified to prevent medical errors</p> <p>Advocates to improve patient care provided by health care, social, community, and governmental systems, including for vulnerable populations</p>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Comments:					

SBP4. Practices cost-conscious care (for patients and populations)					
Has not Achieved Level 1	Level 1	Level 2	Level 3	Level 4	Level 5
	Articulates awareness of health care costs	<p>Demonstrates knowledge of how a patient's health care is paid for, and how this affects the patient's care</p> <p>Articulates awareness of costs for common diagnostic or therapeutic tests, including the cost of performing and interpreting skin biopsies</p> <p>Considers cost of medical and surgical therapies, and incorporates this into therapy decisions and discussions with the patient</p> <p>Demonstrates awareness of minimizing unnecessary care, including tests, procedures, therapies, and ambulatory or hospital encounters</p> <p>Usually applies principles</p>	<p>Articulates awareness of common socio-economic barriers that impact patient care</p> <p>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)</p> <p>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</p> <p>Consistently applies principles of coding (ICD-9/10) and reimbursement</p>	<p>Articulates an awareness of current debates/issues of health care financing and how it will affect patients, providers, third party payers, and other stakeholders</p> <p>Identifies inherent biases of interactions with pharmaceutical and medical device industries</p> <p>Demonstrates the incorporation of cost-awareness principles into standard clinical judgments and decision-making</p>	Demonstrates the incorporation of cost-awareness principles into complex clinical scenarios

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		of coding (ICD-9/10) and reimbursement (E&M levels/procedures) appropriate to medical record documentation	(E&M levels/procedures) appropriate to medical record documentation Identifies and minimizes unnecessary care, including tests, procedures, therapies, and ambulatory or hospital encounters		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Comments:					

PBL1. Appraise and assimilate scientific evidence					
Has not Achieved Level 1	Level 1	Level 2	Level 3	Level 4	Level 5
	<p>When directed, accesses appropriate print or electronic resources to find dermatology information requested or assigned</p> <p>Navigates electronic databases of indexed citations and abstracts to medical sciences journal articles</p> <p>Describes basic concepts in clinical epidemiology, biostatistics, and clinical reasoning, and can categorize the study design of a research study</p> <p>Provides appropriate reference lists for prepared hand-outs or other program-specific assignments</p>	<p>Without being directed, accesses appropriate print or electronic resources to find dermatology information requested or assigned</p> <p>Identifies critical threats to study validity and generalizability when reading a research paper or study synopsis</p> <p>Identifies well conducted research that impacts patient care</p> <p>Actively participates by leading article review discussion and by asking appropriate questions during journal club/journal review activities</p>	<p>Actively seeks appropriate resources to find dermatology information to answer clinical questions without being requested or assigned this task</p> <p>Applies a set of critical appraisal criteria to different types of research, including synopses of original research findings, systematic reviews, meta-analyses, and clinical practice guidelines</p> <p>Critically evaluates information from others, including colleagues, experts, industry representatives, and patients</p> <p>Summarizes complex medical topics through effective information</p>	<p>Incorporates principles and basic practices of evidence-based practice and information mastery into clinical practice</p> <p>Identifies alternative resources to answer clinical questions (for example, microbiology lab director, E&M coding guidelines, Medicare policies, CDC reporting requirements)</p>	<p>Independently teaches and assesses evidence-based medicine and information mastery techniques</p> <p>Cites evidence supporting several common practices in his or her practice</p>

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				synthesis and presentation of material within time allotted						
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Comments:										

PBLI2. Continuously improve through self-assessment of competence					
Has not Achieved Level 1	Level 1	Level 2	Level 3	Level 4	Level 5
	<p>Usually asks for feedback</p> <p>Relies on teachers and colleagues for immediate information needs</p>	<p>Consistently asks for feedback</p> <p>Reviews feedback, acknowledges gaps in personal knowledge and expertise, and uses feedback/assessments to develop learning plans with some assistance</p> <p>Remains open to criticism of performance, avoids defensiveness or denial of constructive criticisms received</p> <p>Participates in the collection and analysis of program-specific resident competency data (for example, patient logs, procedure logs, and treatment logs)</p> <p>Identifies the process for incident and error reporting in the institution</p>	<p>Self-assessment or learning plan demonstrates a balanced and accurate assessment of competence and areas for continued improvement</p> <p>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.)</p>	<p>Performs mostly self-directed learning, integrating multiple feedback and assessment sources, with little external guidance</p> <p>Demonstrates an effective method, system, or process for staying current with relevant changes in clinical dermatology and dermatology medical knowledge</p> <p>Identifies personal gaps in achieving necessary or desired aspects of residency education and communicates these with program director</p>	<p>Regularly seeks to determine and maintain knowledge of best evidence supporting common practices, demonstrating consistent behavior of regularly reviewing evidence in common practice areas</p> <p>Demonstrates an effective method, system, or process for staying current with relevant changes in dermatology health policy and practice management</p> <p>Regularly completes self-assessments of medical knowledge gaps relevant to practice and patient population</p>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Comments:					

PBLI3. Integrate quality improvement concepts and activities in practice					
Has not Achieved Level 1	Level 1	Level 2	Level 3	Level 4	Level 5
	Identifies problems in health care delivery and sees the quality gap in care	<p>Identifies the basic processes involved in quality improvement</p> <p>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)</p> <p>Identifies some stakeholders involved in quality gaps</p>	<p>Reviews local gaps in quality, and identifies systems and human errors that contribute to gaps in quality</p> <p>Critically appraises current or proposed quality improvement interventions</p> <p>Participates in quality improvement activities</p> <p>Defines and constructs process and outcome measures</p>	Assesses outcomes of quality improvement efforts, and applies these towards continuous quality improvement	Continues to engage in innovative quality improvement activities appropriate to practice venue, including activities that prepare the resident for Maintenance Of Certification, Component 4
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Comments:					

PBLI4. Teach others					
Has not Achieved Level 1	Level 1	Level 2	Level 3	Level 4	Level 5
	<p>Provides education on a few basic dermatology topics to patients and other learners</p> <p>Actively participates in conferences</p>	<p>Creates presentations that incorporate digital images</p> <p>Able to synthesize medical topics, with some help, for presentations</p>	<p>Summarizes complex medical topics through effective information synthesis and presentation of material</p> <p>Actively participates in activities designed to develop and improve teaching skills</p> <p>Seizes the teachable moment with others in the clinical setting</p>	<p>Assumes a significant role in clinically teaching learners</p> <p>Presents information in a well-rehearsed, confident manner within the allotted time</p> <p>Seeks and receives feedback on clinical teaching and assesses this information to determine areas for teaching improvement</p>	<p>Continues to teach others, including non-dermatology providers, about dermatology</p> <p>Seeks feedback on teaching others, and incorporates plan to address areas for teaching improvement</p>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Comments:					

PROF1. Practices medicine ethically					
Has not Achieved Level 1	Level 1	Level 2	Level 3	Level 4	Level 5
	<p>Truthfully documents and reports clinical information</p> <p>Reads and abides by formal policies and procedures (for example, program, departmental, GME, HIPAA, use of clinical images, social media)</p> <p>Completes institutional confidentiality training and maintains confidentiality of protected health information</p> <p>Understands a physician's fiduciary obligation to patients, and consistently places patient care needs above self-interest</p>	<p>Treats all patients with respect and dignity, regardless of socio-economic, racial, or ethnic background or sexual orientation</p> <p>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</p> <p>Displays academic honesty and avoids plagiarism in talks, presentations, and publications</p> <p>Performs all human subjects research in accordance with federal, state, and institutional regulations and guidelines</p> <p>Understands the actions and relationships that constitute potential boundary crossings and violations, and actively avoids these</p> <p>Recognizes, manages, and</p>	<p>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</p> <p>Adheres to state, institutional, and professional guidelines regarding physician relationships with industry</p>	<p>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</p> <p>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</p>	<p>Adheres to federal and state regulations regarding digital privacy, HIV privacy, access to medical records, and records storage</p> <p>Avoids inappropriate or problematic relationships with patients, staff members, other residents, and students</p> <p>Does not engage in misleading statements or puffery or use false testimonials when promoting his or her practice</p> <p>Bills honestly, avoiding dishonest upcoding or inflated documentation</p>

		<p>discloses obvious conflicts of interest in publications and presentations</p> <p>Aware of pitfalls of self-care and care of family members and associates, and under what circumstances these are either inappropriate or illegal</p> <p>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</p>			
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<p>Comments:</p>					

PROF2. Committed to lifelong learning and improvement					
Has not Achieved Level 1	Level 1	Level 2	Level 3	Level 4	Level 5
	<p>Aware of personal errors</p> <p>Usually elicits feedback from faculty members</p> <p>Explains how team work benefits patient care</p> <p>Requires direction in determining what is important in learning goals</p>	<p>Admits to limitations and personal errors, and knows when and whom to ask for help</p> <p>Accepts constructive feedback and strives to improve</p> <p>Explains the concept of leading by example</p> <p>Lists and organizes the topics and subtopics that must be learned for patient care and to pass the ABD certifying examination</p>	<p>Develops self-improvement plan to address limitations and personal errors</p> <p>Provides feedback to junior residents and medical students</p> <p>Assumes leadership role among the resident group (for example, as chief resident, project manager); serves as a role model for junior residents</p> <p>Lists gaps of knowledge and devises plan for improvement</p>	<p>Assists junior residents in recognizing their own limitations</p> <p>Describes key elements in how to provide effective feedback</p> <p>Describes the fundamental skill set for effective leadership</p> <p>Capable of passing the ABD certifying examination</p>	<p>Mentors residents/new graduates on how to recognize limitations and develop self-improvement plans</p> <p>Effectively provides feedback to peers, office staff, and other learners</p> <p>Takes a leadership role within the practice/department or in regional, state, or national organizations</p> <p>Understands the ABD Maintenance Of Certification program, and fulfills state licensure requirements</p>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Comments:					

PROF3. Patient care is the first priority					
Has not Achieved Level 1	Level 1	Level 2	Level 3	Level 4	Level 5
	<p>Recognizes the challenges of balancing professional and personal life</p> <p>Demonstrates empathy and compassion to patients; respects patient dignity and autonomy</p> <p>Describes common opportunities for patient advocacy in the outpatient setting</p> <p>Treats patients with dignity, civility and respect, regardless of race, culture, gender, ethnicity, age, sexual orientation, or socioeconomic status</p>	<p>May need assistance with time management and setting priorities, but all patient care activities are completed in a timely fashion</p> <p>Consistently demonstrates empathy and compassion to patients of all ages</p> <p>Seeks appropriate resources to advocate for individual patient needs with assistance</p> <p>Recognizes when patient values differ from his or her own values and how this might affect the physician-patient interaction</p> <p>Recognizes disparities in health care among the local or referral-based population and how these may impact care of specific dermatologic diagnoses</p>	<p>Establishes list of priorities and effective time management that enables successful pursuit of professional and personal goals</p> <p>Consistently demonstrates empathy and compassion to patients of all ages, including difficult or challenging patients</p> <p>Demonstrates effective strategies to manage conflict when patient values differ from his or her own values</p> <p>Discusses ideas and strategies to offset disparities in health care for specific dermatologic diagnoses</p>	<p>Adjusts priorities in response to changing demands</p> <p>Anticipates the needs of patients, and works to meet those needs in daily practice</p> <p>Effectively advocates for individual patient needs</p>	<p>Provides advice and assistance for peers or other learners experiencing major changes affecting professional or personal life</p> <p>Is a proactive advocate for individual patients and their families</p> <p>Embraces the physician's role in understanding and addressing causes of disparity in disease and suffering</p>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Comments:					

ICS1. Communication and Rapport with Patients and Families					
Has not Achieved Level 1	Level 1	Level 2	Level 3	Level 4	Level 5
	<p>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</p> <p>Begins to demonstrate sensitivity to socio-cultural practices</p>	<p>Usually communicates effectively and builds rapport with patients and families in routine encounters, but requires guidance in stressful encounters</p> <p>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</p> <p>Speaks in easily understandable language and avoids technical jargon</p> <p>Actively seeks the patient's and family's perspective; uses patient hand-outs and/or diagrams to explain diseases and treatments when appropriate</p> <p>Counsels and provides clear and specific verbal and/or</p>	<p>Consistently communicates effectively and builds rapport with patients and families in routine encounters, occasionally requiring guidance in stressful encounters</p> <p>Usually recognizes non-verbal cues from patients, and uses non-verbal skills to convey empathy</p> <p>Usually paces clinical interviews appropriately, spending extra time when indicated</p> <p>Consistently maintains composure in difficult patient and family encounters</p> <p>Considers patient beliefs in shaping the patient-physician relationship and therapeutic plan</p>	<p>Consistently communicates effectively and builds rapport with patients and families in routine and stressful encounters</p> <p>Consistently recognizes and effectively uses non-verbal communication skills in relating to patients and families</p> <p>Consistently paces clinical interviews appropriately</p>	<p>Role models the communication skills necessary to build rapport with patients and families; uses a wide range of communication skills to optimize care in stressful or contentious situations</p> <p>Coaches others to improve communication skills and to work effectively with vulnerable populations</p> <p>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</p>

		<p>written instructions to patients related to diagnostic tests, risk/benefits of treatment, treatment alternatives, and therapeutic plans (including prescriptions), and assesses patient comprehension</p> <p>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</p> <p>Demonstrates appropriate face-to-face interaction while using the electronic medical record or completing the patient health record</p>	<p>Adapts patient/family-related information gathering to social and cultural context</p>		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<p>Comments:</p>					

ICS2. Having Difficult Conversations					
Has not Achieved Level 1	Level 1	Level 2	Level 3	Level 4	Level 5
	Describes the general approach to difficult conversations with patients and families, but usually needs guidance to recognize these situations and respond appropriately	Recognizes the circumstances related to having difficult conversations with patients and families Begins to effectively communicate in routine clinical situations, but requires guidance in complex or unusual circumstances	Usually communicates effectively in difficult conversations with patients and families, including some complex or unusual circumstances	Consistently communicates effectively in difficult conversations with patients and families in routine and complex circumstances Customizes communication of emotionally difficult information for patients and families	Role models an effective and sensitive approach to difficult conversations with patients and families Is regularly sought out 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
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Comments:					

ICS3. Team Member Respect and Care Coordination					
Has not Achieved Level 1	Level 1	Level 2	Level 3	Level 4	Level 5
	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	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	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	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	Role models communication that shows appreciation for all members of the health care team, including in difficult or contentious situations 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
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Comments:					

ICS4. Communication and Consultation with Other Physicians					
Has not Achieved Level 1	Level 1	Level 2	Level 3	Level 4	Level 5
	Begins to recognize situations where consultation is needed, and the importance of effective communication with supervisors, consultants, and referring health care providers	Obtains and provides consultation and communicates effectively with supervisors, consultants, and referring providers in routine patient care situations, but needs guidance in complex or nuanced circumstances Demonstrates receptiveness to requests for consultations from other specialties and communicates promptly with referring providers	Consistently obtains and provides consultation and communicates effectively and efficiently with supervisors, consultants, and referring providers in routine patient care situations, occasionally needing guidance in complex or nuanced situations Communicates effectively with medical students, peers, and faculty members in a variety of formal and informal educational settings Provides both positive and negative feedback, as appropriate, when mentoring other physicians Consistently respectful of the opinions of colleagues, and works to resolve conflicts through proper channels and communication	Consistently obtains and provides consultation independently , and communicates effectively and efficiently with supervisors, consultants, and referring providers in routine and complex or nuanced patient care situations Promotes care coordination and ongoing communication with other providers	Role models coordination and ongoing communication with supervisors, consultants, and referring providers Is regularly sought out by junior learners, peers, and other members of the health care team for his or her skill in functioning effectively both as consulter and consultant
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Comments:					

IC5. Medical Documentation					
Has not Achieved Level 1	Level 1	Level 2	Level 3	Level 4	Level 5
	<p>Recognizes the importance of accuracy in documenting information in the patient record, as well as of the use of medical records in patient care</p> <p>Recognizes that accurate and prompt completion of patient records contributes to patient safety and reduces the risk of medical error</p>	<p>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</p> <p>Ensures that patient records and orders are accurate, comprehensive, timely, and legible with attention to preventing confusion and error</p>	<p>Consistently ensures that patient records, including outpatient and inpatient consultations and transitions of care, are promptly and accurately documented for routine and complex situations</p>	<p>Provides some examples of the medicolegal repercussions of inappropriate medical record documentation</p>	<p>Serves as role model for, and consultant to, junior learners, peers, and other members of the health care team in patient record documentation</p>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Comments:					

UNC DERMATOLOGY RESIDENCY

END OF YEAR EVALUATION SUMMARY 2019-20

Resident name _____ PGY _____ Date _____

1. BASIC/Core Examinations:

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)

Raw score	Your Class average:
-----------	---------------------

Percentile	Your Class average:
------------	---------------------

Strengths:	Weaknesses:
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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:
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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: _____

Your Class average:

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)

Reviewed

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 _____

**Department of Dermatology
University of North Carolina at Chapel Hill
Elective Faculty of Resident**

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Elective Faculty of Resident

 Insufficient contact to evaluate (delete evaluation)

The following evaluation needs to be completed, and will become part of the resident's file. Thank you for allowing the the resident to spend time at your clinic.

	N/A	Poor	Fair	Good	Very Good	Excellent
	0	1	2	3	4	5
1. Medical Knowledge*	<input type="radio"/>					
2. Professionalism*	<input type="radio"/>					
3. Patient Care*	<input type="radio"/>					
4. Improvement of patient care through life-long learning*	<input type="radio"/>					
5. Interpersonal Communication Skills*	<input type="radio"/>					
6. Teamwork (Systems-Based Care)*	<input type="radio"/>					

Comments:

* Required fields  Option description (place mouse over field to view)

Reset Form

Submit completed evaluation

Submit

**Department of Dermatology
University of North Carolina at Chapel Hill
Example of Patient Evaluation (Through PressGaney)**

#	Category	Top-Box	Average Peer Top-Box	Score	Average Peer Score	Score 95% Confidence Interval Lower Bound	Score 95% Confidence Interval Upper Bound	# of Responses
1	My doctor explained what procedures were being performed.	0.0	81.0	4.22	4.79	2.97	5.00	1

Patient Safety

Avg. Peer Score: 4.67, Avg. Top-Box: 71.9

Score: 4.00

#	Category	Top-Box	Average Peer Top-Box	Score	Average Peer Score	Score 95% Confidence Interval Lower Bound	Score 95% Confidence Interval Upper Bound	# of Responses
1	My doctor reviewed possible side effects of any procedure before starting.	0.0	68.2	4.00	4.61	2.76	5.00	1

Patient Comments

Total Comments	Positive Comments	Negative Comments	Neutral Comments	Unscored Comments
0	0	0	0	0

Avg. Peer Score: 4.70, Avg. Top-Box: 73.4

Score: 4.74

#	Category	Top-Box	Average Peer Top-Box	Score	Average Peer Score	Score 95% Confidence Interval Lower Bound	Score 95% Confidence Interval Upper Bound	# of Responses
1	My doctor explained things in a way I could understand.	100.0	76.2	4.65	4.75	3.37	5.00	1
2	My doctor informed me of my treatment options.	100.0	82.0	4.83	4.77	3.97	5.00	2

Patient Centered Care

Avg. Peer Score: 4.65, Avg. Top-Box: 66.7

Score: 4.37

#	Category	Top-Box	Average Peer Top-Box	Score	Average Peer Score	Score 95% Confidence Interval Lower Bound	Score 95% Confidence Interval Upper Bound	# of Responses
1	My doctor included me in decisions about my care.	0.0	57.2	4.37	4.55	3.10	5.00	1

Patient Safety

Avg. Peer Score: 4.59, Avg. Top-Box: 66.6

Score: 4.70

#	Category	Top-Box	Average Peer Top-Box	Score	Average Peer Score	Score 95% Confidence Interval Lower Bound	Score 95% Confidence Interval Upper Bound	# of Responses
---	----------	---------	----------------------	-------	--------------------	---	---	----------------

1	My doctor alerted me to things I should have checked immediately should they occur after surgery.	100.0	74.3	4.70	4.70	3.44	5.00	1
---	---	-------	------	------	------	------	------	---

Provider Expertise and Interpersonal Skills

Avg. Peer Score: 4.82, Avg. Top-Box: 81.7

Score: 4.55

#	Category	Top-Box	Average Peer Top-Box	Score	Average Peer Score	Score 95% Confidence Interval Lower Bound	Score 95% Confidence Interval Upper Bound	# of Responses
---	----------	---------	----------------------	-------	--------------------	---	---	----------------

1	My doctor's overall appearance was professional.	0.0	79.5	4.55	4.83	3.24	5.00	1
---	--	-----	------	------	------	------	------	---

Patient Comments

Total Comments	Positive Comments	Negative Comments	Neutral Comments	Unscored Comments
4	2	2	0	0

**Department of Dermatology
University of North Carolina at Chapel Hill
Patient Feedback of Resident**

Patient Feedback of Physician: _____

	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	N/A
1. My doctor explained things in a way I could understand.	<input type="checkbox"/>					
2. My doctor informed me of my treatment options.	<input type="checkbox"/>					
3. My doctor included me in decisions about my care.	<input type="checkbox"/>					
4. My doctor listened to me.	<input type="checkbox"/>					
5. My doctor made me feel comfortable about asking questions.	<input type="checkbox"/>					
6. My doctor reviewed possible side effects of any procedure before starting.	<input type="checkbox"/>					
7. Prior to starting, my doctor made it clear I was having a procedure.	<input type="checkbox"/>					
8. I would trust this doctor to care for my friends/family.	<input type="checkbox"/>					
9. My doctor was kind and caring.	<input type="checkbox"/>					
10. Overall, my doctor was professional.	<input type="checkbox"/>					

Return to Front Desk

**Department of Dermatology
University of North Carolina at Chapel Hill
Graduate Medical Education Committee - Resident of Faculty**

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Resident of Faculty

[Insufficient contact to evaluate](#) (delete evaluation)

Unable to Evaluate	Poor	Fair	Very Good	Excellent
0	1	2	3	4

1. Availability*	<input type="radio"/>				
2. Effective Role Model*	<input type="radio"/>				
3. Case Related Teaching*	<input type="radio"/>				
4. Didactic Teaching (conferences, lectures)*	<input type="radio"/>				
5. Communication*	<input type="radio"/>				
6. Helpfulness*	<input type="radio"/>				

Strengths:

Areas to Improve:

Other Comments:

UNC DEPARTMENT OF DERMATOLOGY PROGRAM EVALUATION BY FORMER RESIDENTS

Preview Form
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Alumni

[Insufficient contact to evaluate](#) (delete evaluation)

Alumni, on their one-year anniversary graduating from the program, have the opportunity to evaluate the Dermatology Program. This evaluation will become part of the agenda for the PEC in formulating changes in the program. The alumni may rate the different areas as Excellent (5), Very Good (4), Good (3), Fair (2), Poor (1), and Not Applicable [N/A] (0).

Program Director						
	N/A	Poor	Fair	Good	Very Good	Excellent
	0	1	2	3	4	5
1. Effectiveness of Program Director leadership*	<input type="radio"/>					
2. Program Director availability to residents*	<input type="radio"/>					
3. Clarity of expectations of residents, from Program Director*	<input type="radio"/>					
4. Fairness and evaluation of the residents strengths and weaknesses by Program Director*	<input type="radio"/>					
5. Quality of guidance in what the residents need to do to improve, from Program Director*	<input type="radio"/>					
Department Chair						
	N/A	Poor	Fair	Good	Very Good	Excellent
	0	1	2	3	4	5
6. Effectiveness of leadership of Chair*	<input type="radio"/>					
7. Chair support of education*	<input type="radio"/>					
Resident Support						
	N/A	Poor	Fair	Good	Very Good	Excellent
	0	1	2	3	4	5
8. Departmental staff effectiveness in dealing with resident issues*	<input type="radio"/>					

Faculty						
	N/A	Poor	Fair	Good	Very Good	Excellent
	0	1	2	3	4	5
9. Medical knowledge of faculty*	<input type="radio"/>					
10. Clinical skills of faculty*	<input type="radio"/>					
11. Treatment of residents*	<input type="radio"/>					
12. Teaching skills of faculty*	<input type="radio"/>					
13. Accessibility*	<input type="radio"/>					
14. Feedback from faculty*	<input type="radio"/>					
Resident Input						
	N/A	Poor	Fair	Good	Very Good	Excellent
	0	1	2	3	4	5
15. Input on faculty evaluations*	<input type="radio"/>					
16. Input on patient care activities*	<input type="radio"/>					
17. Resident ability to express concerns without fear of retaliation*	<input type="radio"/>					
Resident Quality of Life						
	N/A	Poor	Fair	Good	Very Good	Excellent
	0	1	2	3	4	5
18. Ability to balance residency demands and personal commitments*	<input type="radio"/>					
19. Ability to participate in family and/or community activities*	<input type="radio"/>					
20. Compliance with duty hours*	<input type="radio"/>					
Satisfaction with Program						
	N/A	Poor	Fair	Good	Very Good	Excellent

0	1	2	3	4	5
---	---	---	---	---	---

21. Extent to which education prepares residents for career objectives*

<input type="radio"/>					
-----------------------	-----------------------	-----------------------	-----------------------	-----------------------	-----------------------

Program Overall

N/A	Poor	Fair	Good	Very Good	Excellent
0	1	2	3	4	5

22. Program Director*

<input type="radio"/>					
-----------------------	-----------------------	-----------------------	-----------------------	-----------------------	-----------------------

23. Department Chair*

<input type="radio"/>					
-----------------------	-----------------------	-----------------------	-----------------------	-----------------------	-----------------------

24. Resident Support*

<input type="radio"/>					
-----------------------	-----------------------	-----------------------	-----------------------	-----------------------	-----------------------

25. Faculty*

<input type="radio"/>					
-----------------------	-----------------------	-----------------------	-----------------------	-----------------------	-----------------------

26. Resident Input*

<input type="radio"/>					
-----------------------	-----------------------	-----------------------	-----------------------	-----------------------	-----------------------

27. Resident Quality of Life*

<input type="radio"/>					
-----------------------	-----------------------	-----------------------	-----------------------	-----------------------	-----------------------

28. Satisfaction with Program*

<input type="radio"/>					
-----------------------	-----------------------	-----------------------	-----------------------	-----------------------	-----------------------

Comments:

* Required fields ◀ Option description (place mouse over field to view)

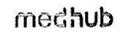
Reset Form

Submit completed evaluation

Submit

UNC DEPARTMENT OF DERMATOLOGY PROGRAM EVALUATION BY RESIDENTS

Preview Form
Printed on Jun 13, 2017



Program by Residents

[Insufficient contact to evaluate](#) (delete evaluation)

Program Director						
	N/A	Poor	Fair	Good	Very Good	Excellent
	0	1	2	3	4	5
1. Effectiveness of Program Director leadership*	<input type="radio"/>					
2. Program Director availability to residents*	<input type="radio"/>					
3. Clarity of expectations of residents, from Program Director*	<input type="radio"/>					
4. Fairness and evaluation of your strengths and weaknesses*	<input type="radio"/>					
5. Quality of guidance in what you need to do to improve*	<input type="radio"/>					
Resident Support						
	N/A	Poor	Fair	Good	Very Good	Excellent
	0	1	2	3	4	5
6. Departmental staff helpfulness to residents*	<input type="radio"/>					
7. Program Coordinator effectiveness in dealing with resident issues*	<input type="radio"/>					
Faculty						
	N/A	Poor	Fair	Good	Very Good	Excellent
	0	1	2	3	4	5
8. Medical knowledge of faculty*	<input type="radio"/>					
9. Clinical skills of faculty*	<input type="radio"/>					

10. Teaching skills of faculty*

11. Accessibility*

12. Feedback from faculty*

Resident Input

N/A	Poor	Fair	Good	Very Good	Excellent
0	1	2	3	4	5

13. Extent of feedback from faculty evaluations*

14. Resident input on patient care activities*

15. Resident ability to express concerns without fear of retaliation*

Resident Quality of Life

N/A	Poor	Fair	Good	Very Good	Excellent
0	1	2	3	4	5

16. Ability to balance residency demands and personal commitments*

Satisfaction of Program

N/A	Poor	Fair	Good	Very Good	Excellent
0	1	2	3	4	5

17. Extent to which educational experience prepares residents for career objectives*

18. Match of educational experience with program stated goals*

19. Resident role as a member of the team*

Program Overall

N/A	Poor	Fair	Good	Very Good	Excellent
0	1	2	3	4	5

20. Program Director*	<input type="radio"/>					
21. Faculty*	<input type="radio"/>					
22. Resident Quality of Life*	<input type="radio"/>					
23. Satisfaction of Program*	<input type="radio"/>					

Comments:

* Required fields 4 Option description (place mouse over field to view)

Reset Form

Submit completed evaluation

Submit

UNC DEPARTMENT OF DERMATOLOGY PROGRAM EVALUATION BY FACULTY

Preview Form
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Program by Faculty

[Insufficient contact to evaluate](#) (delete evaluation)

Program Director						
	N/A	Poor	Fair	Good	Very Good	Excellent
	0	1	2	3	4	5
1. Effectiveness of Program Director leadership*	<input type="radio"/>					
2. Program Director availability to residents*	<input type="radio"/>					
3. Clarity of expectations of residents, from Program Director*	<input type="radio"/>					
4. Fairness and evaluation of the residents strengths and weaknesses, by Program Director*	<input type="radio"/>					
5. Quality of guidance in what the residents need to do to improve, from Program Director*	<input type="radio"/>					
Department Chair						
	N/A	Poor	Fair	Good	Very Good	Excellent
	0	1	2	3	4	5
6. Effectiveness of leadership of Chair*	<input type="radio"/>					
7. Chair support of education*	<input type="radio"/>					
Resident Support						
	N/A	Poor	Fair	Good	Very Good	Excellent
	0	1	2	3	4	5
8. Departmental staff helpfulness to residents*	<input type="radio"/>					
9. Program Coordinator effectiveness in dealing with resident issues*	<input type="radio"/>					

Faculty						
	N/A	Poor	Fair	Good	Very Good	Excellent
	0	1	2	3	4	5
10. Medical knowledge of faculty*	<input type="radio"/>					
11. Clinical skills of faculty*	<input type="radio"/>					
12. Treatment of residents*	<input type="radio"/>					
13. Teaching skills of faculty*	<input type="radio"/>					
14. Accessibility*	<input type="radio"/>					
15. Feedback from faculty*	<input type="radio"/>					
Resident						
	N/A	Poor	Fair	Good	Very Good	Excellent
	0	1	2	3	4	5
16. Extent of input on faculty evaluations*	<input type="radio"/>					
17. Resident input on patient care activities*	<input type="radio"/>					
18. Resident ability to express concerns without fear of retaliation*	<input type="radio"/>					
Quality of Life						
	N/A	Poor	Fair	Good	Very Good	Excellent
	0	1	2	3	4	5
19. Ability to balance residency demands and personal commitments*	<input type="radio"/>					
20. Ability to participate in family and/or community activities*	<input type="radio"/>					
Satisfaction with Program						
	N/A	Poor	Fair	Good	Very Good	Excellent
	0	1	2	3	4	5

21. Extent to which educational experience prepares residents for career objectives*	<input type="radio"/>					
22. Match of educational experience with program stated goals*	<input type="radio"/>					
23. Resident opportunity to participate in research*	<input type="radio"/>					
24. Resident role as a member of the team*	<input type="radio"/>					

Program Overall

N/A	Poor	Fair	Good	Very Good	Excellent
0	1	2	3	4	5

25. Program Director*	<input type="radio"/>					
26. Department Chair*	<input type="radio"/>					
27. Resident Support*	<input type="radio"/>					
28. Faculty*	<input type="radio"/>					
29. Resident Input*	<input type="radio"/>					
30. Resident Quality of Life*	<input type="radio"/>					
31. Satisfaction with Program*	<input type="radio"/>					

Comments:

* Required fields ◀ Option description (place mouse over field to view)

Reset Form

Submit completed evaluation

Submit

Staff of Resident

Evaluation Form

Printed on May 10, 2018



Staff of Resident

Evaluator: _____

Evaluation of: _____

Date: _____

	N/A	Never	Seldom	Sometimes	Usually	Always
1. Resident listens attentively to you during interactions/conversations especially regarding patients*	<input type="checkbox"/>					
2. Resident interrupts you during conversation*	<input type="checkbox"/>					
3. Resident is courteous and polite*	<input type="checkbox"/>					
4. Resident shows respect to you as a "team member"*	<input type="checkbox"/>					
5. Resident apologizes to you for inappropriate behavior on his/her part*	<input type="checkbox"/>					

Comments: _____

Rotations by Resident

Preview Form
Printed on Jun 13, 2017

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Rotation - Aesthetic Solutions

Insufficient contact to evaluate (delete evaluation)

Not applicable	Poor	Fair	Good	Very Good	Excellent
N/A	1	2	3	4	5

1. Quality of patient care experience*

2. Sensitivity to residents' cultural differences*

3. Supervision*

4. Treatment of residents*

5. Rotation overall*

Overall:

* Required fields  Option description (place mouse over field to view)

Reset Form

Submit completed evaluation

Submit

Rotation - Alopecia/Hair Disorders Clinic

Insufficient contact to evaluate (delete evaluation)

Not applicable	Poor	Fair	Good	Very Good	Excellent
N/A	1	2	3	4	5

1. Quality of patient care experience*

2. Ability to get assistance from faculty with a patient when needed*

3. Frequency of service work rather than educational experience*

4. Frequency of Informal evaluation*

5. Constructiveness of feedback received from informal evaluations*

6. Sensitivity to residents' cultural differences*

7. Supervision*

8. Treatment of residents*

9. Rotation Overall*

Comments:

* Required fields ▲ Option description (place mouse over field to view)

Reset Form

Submit completed evaluation

Submit

Rotation - Consultation Service

Insufficient contact to evaluate (delete evaluation)

	Not applicable	Poor	Fair	Good	Very Good	Excellent
	N/A	1	2	3	4	5
1. Quality of patient care experience*	<input type="radio"/>					
2. Ability to get assistance from faculty with a patient when needed*	<input type="radio"/>					
3. Frequency of service work rather than educational experience*	<input type="radio"/>					
4. Frequency of informal evaluation*	<input type="radio"/>					
5. Constructiveness of feedback received from informal evaluations*	<input type="radio"/>					
6. Sensitivity to residents' cultural differences*	<input type="radio"/>					
7. Supervision*	<input type="radio"/>					
8. Treatment of residents*	<input type="radio"/>					
9. Rotation overall*	<input type="radio"/>					
Comments:						

* Required fields  Option description (place mouse over field to view)

Rotation - Contact Dermatitis

Insufficient contact to evaluate (delete evaluation)

	Not applicable	Poor	Fair	Good	Very Good	Excellent
	N/A	1	2	3	4	5
1. Quality of patient care experience*	<input type="radio"/>					
2. Ability to get assistance from faculty with a patient when needed*	<input type="radio"/>					
3. Frequency of service work rather than educational experience*	<input type="radio"/>					
4. Frequency of informal evaluation*	<input type="radio"/>					
5. Constructiveness of feedback received from informal evaluations*	<input type="radio"/>					
6. Sensitivity to residents' cultural differences*	<input type="radio"/>					
7. Supervision*	<input type="radio"/>					
8. Treatment of residents*	<input type="radio"/>					
9. Rotation overall*	<input type="radio"/>					

Comments:

* Required fields ↗ Option description (place mouse over field to view)

Rotation - Cosmetic Dermatology

Insufficient contact to evaluate (delete evaluation)

	Not applicable	Poor	Fair	Good	Very Good	Excellent
	N/A	1	2	3	4	5
1. Quality of patient care experience*	<input type="radio"/>					
2. Ability to get assistance from faculty with a patient when needed*	<input type="radio"/>					
3. Frequency of service work rather educational experience*	<input type="radio"/>					
4. Frequency of informal evaluation*	<input type="radio"/>					
5. Constructiveness of feedback received from Informal evaluations*	<input type="radio"/>					
6. Sensitivity to residents' cultural differences*	<input type="radio"/>					
7. Supervision*	<input type="radio"/>					
8. Treatment of residents*	<input type="radio"/>					
9. Rotation overall*	<input type="radio"/>					

Comments:

* Required fields ◀ Option description (place mouse over field to view)

Rotation - Cutaneous Lymphoma

Insufficient contact to evaluate (delete evaluation)

	Not applicable	Poor	Fair	Good	Very Good	Excellent
	N/A	1	2	3	4	5
1. Quality of patient care experience*	<input type="radio"/>					
2. Ability to get assistance from faculty with a patient when needed*	<input type="radio"/>					
3. Frequency of service work rather than educational experience*	<input type="radio"/>					
4. Frequency of informal evaluation*	<input type="radio"/>					
5. Constructiveness of feedback received from informal evaluations*	<input type="radio"/>					
6. Sensitivity to residents' cultural differences*	<input type="radio"/>					
7. Supervision*	<input type="radio"/>					
8. Treatment of residents*	<input type="radio"/>					
9. Rotation overall*	<input type="radio"/>					
Comments:						

* Required fields ◀ Option description (place mouse over field to view)

Rotation - Dermatologic Surgery (Non-Mohs)

Insufficient contact to evaluate (delete evaluation)

Not applicable	Poor	Fair	Good	Very Good	Excellent
N/A	1	2	3	4	5

1. Quality of patient care experience*	<input type="radio"/>					
2. Ability to get assistance from faculty with a patient when needed*	<input type="radio"/>					
3. Frequency of service work rather than educational experience*	<input type="radio"/>					
4. Frequency of informal evaluation*	<input type="radio"/>					
5. Constructiveness of feedback received from Informal evaluations*	<input type="radio"/>					
6. Sensitivity to residents' cultural differences*	<input type="radio"/>					
7. Supervision*	<input type="radio"/>					
8. Treatment of residents*	<input type="radio"/>					
9. Rotation overall*	<input type="radio"/>					
10. Comments:	<input type="radio"/>					

* Required fields  Option description (place mouse over field to view)

Reset Form

Submit completed evaluation

Submit

Rotation - Dermatopathology Read-Out Sessions

Insufficient contact to evaluate (delete evaluation)

Not applicable	Poor	Fair	Good	Very Good	Excellent
N/A	1	2	3	4	5

1. Quality of patient care experience*

2. Ability to get assistance from faculty with a patient when needed*

3. Frequency of service work rather than educational experience*

4. Frequency of informal evaluation*

5. Constructiveness of feedback received from informal evaluations*

6. Sensitivity to residents' cultural differences*

7. Supervision*

8. Treatment of residents*

9. Rotation overall*

Comments:

* Required fields # Option description (place mouse over field to view)

Reset Form

Submit completed evaluation

Submit

Rotation - General Dermatology

Insufficient contact to evaluate (delete evaluation)

	Not applicable	Poor	Fair	Good	Very Good	Excellent
	N/A	1	2	3	4	5
1. Quality of patient care experience*	<input type="radio"/>					
2. Ability to get assistance from faculty with a patient when needed*	<input type="radio"/>					
3. Frequency of service work rather than educational experience*	<input type="radio"/>					
4. Frequency of Informal evaluation*	<input type="radio"/>					
5. Constructiveness of feedback received from informal evaluations*	<input type="radio"/>					
6. Sensitivity to residents' cultural differences*	<input type="radio"/>					
7. Supervision*	<input type="radio"/>					
8. Treatment of residents*	<input type="radio"/>					
9. Rotation overall*	<input type="radio"/>					

Comments:

* Required fields ⚡ Option description (place mouse over field to view)

Reset Form

Submit completed evaluation

Submit

Rotation - Hidradenitis Suppurativa

Insufficient contact to evaluate (delete evaluation)

	Not applicable	Poor	Fair	Good	Very Good	Excellent
	N/A	1	2	3	4	5
1. Quality of patient care experience*	<input type="radio"/>					
2. Ability to get assistance from faculty with a patient when needed*	<input type="radio"/>					
3. Frequency of service work rather than educational experience*	<input type="radio"/>					
4. Frequency of Informal evaluation*	<input type="radio"/>					
5. Constructiveness of feedback received from informal evaluations*	<input type="radio"/>					
6. Sensitivity to residents' cultural differences*	<input type="radio"/>					
7. Supervision*	<input type="radio"/>					
8. Treatment of residents*	<input type="radio"/>					
9. Rotation overall*	<input type="radio"/>					

Comments:

* Required fields ⚡ Option description (place mouse over field to view)

Reset Form

Submit completed evaluation

Submit

Rotation - High Risk Skin Cancer Clinic

Insufficient contact to evaluate (delete evaluation)

	Not applicable	Poor	Fair	Good	Very Good	Excellent
	N/A	1	2	3	4	5
1. Quality of patient care experience*	<input type="radio"/>					
2. Ability to get assistance from faculty with a patient when needed*	<input type="radio"/>					
3. Frequency of service work rather than educational experience*	<input type="radio"/>					
4. Frequency of informal evaluation*	<input type="radio"/>					
5. Constructiveness of feedback received from informal evaluations*	<input type="radio"/>					
6. Sensitivity to residents' cultural differences*	<input type="radio"/>					
7. Supervision*	<input type="radio"/>					
8. Treatment of residents*	<input type="radio"/>					
9. Rotation overall*	<input type="radio"/>					

Comments:

* Required fields ▲ Option description (place mouse over field to view)

Reset Form

Submit completed evaluation

Submit

Rotation - Immunodermatology

Insufficient contact to evaluate (delete evaluation)

	Not applicable	Poor	Fair	Good	Very Good	Excellent
	N/A	1	2	3	4	5
1. Quality of patient care experience*	<input type="radio"/>					
2. Ability to get assistance from faculty with a patient when needed*	<input type="radio"/>					
3. Frequency of service work rather than educational experience*	<input type="radio"/>					
4. Frequency of informal evaluation*	<input type="radio"/>					
5. Constructiveness of feedback received from informal evaluations*	<input type="radio"/>					
6. Sensitivity to residents' cultural differences*	<input type="radio"/>					
7. Supervision*	<input type="radio"/>					
8. Treatment of residents*	<input type="radio"/>					
9. Rotation overall*	<input type="radio"/>					

Comments:

* Required fields * Option description (place mouse over field to view)

Reset Form

Submit completed evaluation

Submit

Rotation - Lasers

Insufficient contact to evaluate (delete evaluation)

	Not applicable	Poor	Fair	Good	Very Good	Excellent
	N/A	1	2	3	4	5
1. Quality of patient care experience*	<input type="radio"/>					
2. Ability to get assistance from faculty with a patient when needed*	<input type="radio"/>					
3. Frequency of service work rather than educational experience*	<input type="radio"/>					
4. Frequency of Informal evaluation*	<input type="radio"/>					
5. Constructiveness of feedback received from Informal evaluations*	<input type="radio"/>					
6. Sensitivity to residents' cultural differences*	<input type="radio"/>					
7. Supervision*	<input type="radio"/>					
8. Treatment of residents*	<input type="radio"/>					
9. Rotation overall*	<input type="radio"/>					
Comments:						

* Required fields ◀ Option description (place mouse over field to view)

Rotation - Mohs

Insufficient contact to evaluate (delete evaluation)

	Not applicable	Poor	Fair	Good	Very Good	Excellent
	N/A	1	2	3	4	5
1. Quality of patient care experience*	<input type="radio"/>					
2. Ability to get assistance from faculty with a patient when needed*	<input type="radio"/>					
3. Frequency of service work rather than educational experience*	<input type="radio"/>					
4. Frequency of Informal evaluations*	<input type="radio"/>					
5. Constructiveness of feedback received from Informal evaluations*	<input type="radio"/>					
6. Sensitivity to residents' cultural differences*	<input type="radio"/>					
7. Supervision*	<input type="radio"/>					
8. Treatment of residents*	<input type="radio"/>					
9. Rotation overall*	<input type="radio"/>					

Comments:

* Required fields  Option description (place mouse over field to view)

Reset Form

Submit completed evaluation

Submit

Rotation - Pediatric Dermatology

Insufficient contact to evaluate (delete evaluation)

	Not applicable	Poor	Fair	Good	Very Good	Excellent
	N/A	1	2	3	4	5
1. Quality of patient care experience*	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2. Ability to get assistance from faculty with a patient when needed*	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3. Frequency of service work rather than educational experience*	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4. Frequency of informal evaluation*	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5. Constructiveness of feedback received from informal evaluations*	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
6. Sensitivity to residents' cultural differences*	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
7. Supervision*	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
8. Treatment of residents*	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
9. Rotation overall*	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Comments:	<div style="border: 1px solid black; height: 60px;"></div>					

* Required fields # Option description (place mouse over field to view)

Rotation - Piedmont Health Services

Insufficient contact to evaluate (delete evaluation)

Not applicable	Poor	Fair	Good	Very Good	Excellent
N/A	1	2	3	4	5

1. Quality of patient care experience*

<input type="radio"/>					
-----------------------	-----------------------	-----------------------	-----------------------	-----------------------	-----------------------

2. Ability to get assistance from faculty with a patient when needed*

<input type="radio"/>					
-----------------------	-----------------------	-----------------------	-----------------------	-----------------------	-----------------------

3. Frequency of service work rather than educational experience*

<input type="radio"/>					
-----------------------	-----------------------	-----------------------	-----------------------	-----------------------	-----------------------

4. Frequency of informal evaluation*

<input type="radio"/>					
-----------------------	-----------------------	-----------------------	-----------------------	-----------------------	-----------------------

5. Constructiveness of feedback received from informal evaluations*

<input type="radio"/>					
-----------------------	-----------------------	-----------------------	-----------------------	-----------------------	-----------------------

6. Sensitivity to residents' cultural differences*

<input type="radio"/>					
-----------------------	-----------------------	-----------------------	-----------------------	-----------------------	-----------------------

7. Supervision*

<input type="radio"/>					
-----------------------	-----------------------	-----------------------	-----------------------	-----------------------	-----------------------

8. Treatment of residents*

<input type="radio"/>					
-----------------------	-----------------------	-----------------------	-----------------------	-----------------------	-----------------------

9. Rotation overall*

<input type="radio"/>					
-----------------------	-----------------------	-----------------------	-----------------------	-----------------------	-----------------------

Comments:

* Required fields  Option description (place mouse over field to view)

Reset Form

Submit completed evaluation

Submit

Rotation - Pigmented Lesion

Insufficient contact to evaluate (delete evaluation)

	Not applicable	Poor	Fair	Good	Very Good	Excellent
	N/A	1	2	3	4	5
1. Quality of patient care experience*	<input type="radio"/>					
2. Ability to get assistance from faculty with a patient when needed*	<input type="radio"/>					
3. Frequency of service work rather than educational experience*	<input type="radio"/>					
4. Frequency of informal evaluation*	<input type="radio"/>					
5. Constructiveness of feedback received from informal evaluations*	<input type="radio"/>					
6. Sensitivity to residents' cultural differences*	<input type="radio"/>					
7. Supervision*	<input type="radio"/>					
8. Treatment of residents*	<input type="radio"/>					
9. Rotation overall*	<input type="radio"/>					

Comments:

* Required fields  Option description (place mouse over field to view)

Reset Form

Submit completed evaluation

Submit

Rotation - Resident Continuity Clinic

Insufficient contact to evaluate (delete evaluation)

	Not applicable	Poor	Fair	Good	Very Good	Excellent
	N/A	1	2	3	4	5
1. Quality of patient care experience*	<input type="radio"/>					
2. Ability to get assistance from faculty with a patient when needed*	<input type="radio"/>					
3. Frequency of service work rather than educational experience*	<input type="radio"/>					
4. Frequency of informal evaluation*	<input type="radio"/>					
5. Constructiveness of feedback received from informal evaluations*	<input type="radio"/>					
6. Sensitivity to residents' cultural differences*	<input type="radio"/>					
7. Supervision*	<input type="radio"/>					
8. Treatment of residents*	<input type="radio"/>					
9. Rotation overall*	<input type="radio"/>					

Comments:

* Required fields  Option description (place mouse over field to view)

Reset Form

Submit completed evaluation

Submit

Educational Activities by Residents

Preview Form
Printed on Jun 02, 2017

medhub

Educational Activities by Residents						
<input checked="" type="radio"/> Insufficient contact to evaluate (delete evaluation)						
Hideaway Conference						
	Not Applicable	Needs Improvement	Adequate	Good	Great	Excellent
1. Overall value*	<input type="radio"/>					
2. Patient quality*	<input type="radio"/>					
Comments:						
Didactic Lectures						
	Not Applicable	Needs Improvement	Adequate	Good	Great	Excellent
3. Overall value*	<input type="radio"/>					
Comments:						
Kodachromes						
	Not Applicable	Needs Improvement	Adequate	Good	Great	Excellent
4. Overall value*	<input type="radio"/>					
5. Image quality*	<input type="radio"/>					
Comments:						

UNC/Duke Conferences

	Not Applicable	Needs Improvement	Adequate	Good	Great	Excellent
6. Overall value*	<input type="radio"/>					
7. Patient quality*	<input type="radio"/>					

Comments:

Journal Club

	Not Applicable	Needs Improvement	Adequate	Good	Great	Excellent
8. Overall value*	<input type="radio"/>					

Comments:

Evaluation Process

	Not Applicable	Needs Improvement	Adequate	Good	Great	Excellent
9. Overall value*	<input type="radio"/>					

Comments:

QA

	Not Applicable	Needs Improvement	Adequate	Good	Great	Excellent
10. Overall value*	<input type="radio"/>					

Comments:

Overall Residency Training

	Not Applicable	Needs Improvement	Adequate	Good	Great	Excellent
11. Overall value*	<input type="radio"/>					

Comments:

* Required fields ↗ Option description (place mouse over field to view)

Reset Form

Submit completed evaluation

Submit

Educational Activities by Faculty

Preview Form
Printed on Jun 13, 2017

medhub

Educational Activities by Faculty

[Insufficient contact to evaluate](#) (delete evaluation)

Hideaway Conference

Not Applicable

Needs Improvement

Adequate

Good

Great

Excellent

1. Overall Value*

Comments:

Didactic Lectures

Not Applicable

Needs Improvement

Adequate

Good

Great

Excellent

2. Overall value*

Comments:

Kodachromes

Not Applicable

Needs Improvement

Adequate

Good

Great

Excellent

3. Overall value*

Comments:

UNC/Duke Conference

	Not Applicable	Needs Improvement	Adequate	Good	Great	Excellent
--	----------------	-------------------	----------	------	-------	-----------

4. Overall value*

5. Patient quality*

Comments:

Journal Club

	Not Applicable	Needs Improvement	Adequate	Good	Great	Excellent
--	----------------	-------------------	----------	------	-------	-----------

6. Overall value*

Comments:

Evaluation Process

	Not Applicable	Needs Improvement	Adequate	Good	Great	Excellent
--	----------------	-------------------	----------	------	-------	-----------

7. Overall value*

Comments:

Overall Residency Training

	Not Applicable	Needs Improvement	Adequate	Good	Great	Excellent
--	----------------	-------------------	----------	------	-------	-----------

8. Overall value*

Comments:

^ Required fields ▲ Option description (place mouse over field to view)

Reset Form

Submit completed evaluation

Submit

Speaker Evaluation

Insufficient contact to evaluate (delete evaluation)

Return to Cherie

	Poor	Fair	Good	Excellent	Outstanding
	1	2	3	4	5
1. Topic Quality*	<input type="radio"/>				
2. Presentation Quality*	<input type="radio"/>				

Areas of Weakness/Improvement:

* Required fields ▲ Option description (place mouse over field to view)

DERMATOLOGY RESIDENT PERSONAL CLINICAL EVALUATION
University of North Carolina, Department of Dermatology
 Resident Performance Rating Form

Resident Name: _____

Attending: _____

Clinic: _____

Date: _____

	Needs Improvement	Competent Performance	Exemplary
Patient Care	1	2	3
Medical Knowledge	1	2	3
Documentation	1	2	3
Communication and Interpersonal Skills	1	2	3
Professionalism	1	2	3
Practice Based Learning Receptive to feedback	1	2	3
Systems Based Practice Uses system resources well	1	2	3

Please list one specific way in which this resident could improve, or one thing to work on this week:

Additional Comments:

Supervisor Signature: _____

APPENDIX C

Program Evaluation Committee



DEPARTMENT OF DERMATOLOGY

Faculty

Nancy E. Thomas, MD, PhD,
The Irene & Robert Alan
Briggaman Distinguished
Professor & Chair

Edith Bowers, MD, PhD
Craig N. Burkhart, MD
Sarah Corley, MD
Donna Culton, MD, PhD
Luis A. Diaz, MD, *The C.E. Wheeler
Distinguished Professor*
Megan Evans, MD
Amy W. Fox, MD
Lowell A. Goldsmith, MD, MPH, *Emeritus*
Paul Googe, MD
Heather Holahan, 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
Julie Mervak, MD
Jayson Miedema, MD
Dean S. Morrell, MD
Michelle Pearlstein, MD
Ye Qian, PhD
David S. Rubenstein, MD, PhD
Christopher J. Sayed, MD
Rajat Varma, MD
Carolyn Ziemer, MD

Administration

Emma Beckham
Associate Chair
For Administration

2352 Genome Science Bldg
250 Bell Tower Drive CB 7287
University of North Carolina
Chapel Hill, N.C. 27599-7287
Phone: 919-966-0785
Fax: 919-966-3898
<http://med.unc.edu/derm>

Research

Laboratories
2nd Floor Green and Blue Pod
Genome Science Building
250 Bell Tower Drive
Phone: 919-843-6756

Immunodermatology

Luis A. Diaz, MD
Donna Culton, MD, PhD
Phone: 919-843-5401
Fax: 919-843-5766

Dermatopathology

Paul Googe, MD
Jayson Miedema, MD
2144 Genome Science Bldg
University of North Carolina
Chapel Hill, NC 27599-7287
Phone: 919-966-0786
Fax: 919-843-2530

Dermatology and Skin Cancer Centers

Appointments
984-974-3900

Southern Village

410 Market Street, Suite 400
Chapel Hill, N.C. 27516
Fax: 984-974-3692

Dermatology at Hillsborough

460 Waterstone Drive
Hillsborough, NC 27278
Fax: 919-595-5943

Dermatology at Rex

3921 Sunset Ridge Rd, Ste. 202
Raleigh, NC 27607
Fax: 984-974-0910

Dermatology at Burlington

1522 Vaughn Rd
Burlington NC 27217
Fax: 336-905-6191

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;
11. Generates written new 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

Reviewed June 2015

Reviewed June 2016

Reviewed June 2017

Reviewed June 2018

Reviewed June 2019

UNC Dermatology Program Evaluation Committee 2019

06/17/2019

In attendance: Morrell, Fox, Lugo-Somolinos, Kenyon, Ezuka

Purpose of Committee: Evaluate program's goals, progress toward goals, needed program improvement, and operating environment to identify strengths, challenges, opportunities, threats

1. Action Plan
 - a. Improve resident academic performance and ensure faculty MOC
 - b. Improve faculty and resident wellness and decrease burnout
 - c. Increase faculty and resident diversity
 - d. Improve clinical quality and safety metrics
 - e. Improve program evaluation
2. Curriculum
 - a. Clinical activities
 - b. Didactics
3. Outcomes of prior Annual Program Evaluation
4. ACGME communications
5. Quality and safety of patient care
6. Aggregate resident and faculty
 - a. Well-being
 - b. Recruitment and retention
 - c. Diversity
 - d. QI and patient safety
 - e. Scholarly activity
 - f. ACGME surveys
 - g. Evaluations of program
7. Aggregate resident
 - a. Milestone achievement
 - b. ITE performance
 - c. Board pass rate and certification
 - d. Graduate performance
8. Aggregate faculty
 - a. Evaluation
 - b. Professional development
9. Mission and aims
10. Strengths
11. Areas of improvement
12. Threats

UNC DERMATOLOGY PROGRAM EVALUATION COMMITTEE

June 17, 2019

Bold = action plan for 2019-20

1. Action Plan
 - a. Improve resident academic performance and ensure faculty MOC (Morrell, Lugo, Chiefs)
 - i. Reconstructure didactic lectures
 1. Bologna chapters
 2. Assigned faculty-resident dyad
 - ii. Improve visual recognition
 1. Return to AAD Kodachrome set
 - iii. Board review question reviews
 1. Recruit interested faculty to review MOC questions
 - b. Improve faculty and resident wellness and decrease burnout (Morrell, Fox, Chiefs)
 - i. Offload some faculty and resident administrative activities
 1. Flowchart creation for repeated admin tasks
 2. Leadership Committee, Clinical Operations Committee
 - c. Increase faculty and resident diversity (Morrell, Lugo, Others)
 - i. Identification of departmental Diversity Officer
 - ii. Over-represent qualified URMs in residency interview invites
 - iii. Interaction with 'pipelines'
 1. Project Uplift
 2. Summer MED Program
 3. SNMA conferences
 4. Carolina First Look
 - d. Improve clinical quality and safety metrics (Fox)
 - i. Identify and track measures
 - ii. Participate in 2 institutional M&M conferences
 - e. Improve program evaluation (Morrell)
 - i. Create graduate post-training performance evaluation
2. Curriculum
 - a. Clinical activities
 - i. General derm
 - ii. Peds derm
 - iii. Dermatosurgery
 - iv. Cosmetic derm
 - v. Contact dermatitis
 - vi. Immunodermatology
 - vii. Pigmented lesion
 - viii. Dermatopathology
 - ix. Consultation service
 - x. Resident continuity clinic
 - xi. Laser clinic
 - xii. High risk skin cancer
 - xiii. Cutaneous Lymphoma
 - xiv. Alopecia
 - xv. Hidradenitis
 - xvi. Consult cases
 - b. Didactics
 - i. Quality Assurance
 - ii. Hideaway
 - iii. Journal Club
 - iv. Faculty/resident chapter review
 - v. Faculty mini lecture
 - vi. Resident lecture
 - vii. Cosmetic sessions
 - viii. Kodachromes
 - ix. UNC/Duke
 - x. AAD

- xi. DEC
- xii. Melanoma
- xiii. Dermpath: Mock boards, Unknowns, Lectures
- 3. Outcomes of prior Annual Program Evaluation
 - a. All completed
 - i. Short of goals on
 - 1. 1st year Dermpath score
 - 2. Faculty ACGME survey: seek guidance score
 - 3. Basic science on cert exam lower
- 4. ACGME communications
 - a. Full accreditation with no citations
- 5. Quality and safety of patient care
 - a. Need for next year (Fox)
- 6. Aggregate resident and faculty
 - a. Well-being
 - i. Well-being index
 - ii. Lactation room completed
 - b. Recruitment and retention
 - i. 2 new faculty joining (Vedak, Holahan)
 - ii. 2.2 applicants ranked per resident position to totally fill
 - iii. No departures of faculty or residents
 - c. Diversity
 - i. Faculty: Lugo-Somolinos, Pearlstein (on paper); Residents: Flores (on paper)
 - ii. Resident applicants %

	2010 CENSUS	APPLICANTS TOTAL	FINAL 80	INVITED 30
WHITE	72	56	56	67
AA	13	6	11	10
LATINO	6	7	11	20
NATIVE	1	1	0	0
URM	20	14	22	30

- 1. Recruitment efforts
 - a. Carolina 1st and 2nd look heavily advertised to URM applicants
 - b. Frequent emails and texts to our top 2 URM resident applicants (ranked to match)
 - c. One asked to be connected to alumni (6 alumni interacted)
- d. QI and patient safety
 - i. Monthly QA meetings for staff, faculty and residents
 - 1. New PORS system with structured discussion
 - ii. All residents participate in institutional CQI course during their training
 - iii. No participation in institutional multidisciplinary M&M series this year
- e. Scholarly activity
 - i. Pending end of year resident portfolios
 - ii. Pending end of year faculty WebADS listing
- f. ACGME surveys
 - i. Resident 14 below national average
 - ii. Faculty 1 below
- g. Evaluations of program
 - i. Resident of program
 - ii. Faculty of program
 - iii. Annual report card
 - iv. Resident assessment/ideas for admin duties
 - v. Alumni summative evaluation
- 7. Aggregate resident
 - a. Milestone achievement (Goals Yr 1: 2.0; Yr 2: 3.0; Yr 3: 4.0)
 End of year milestones overall team average 3.4 (3.51)
 Yr1: 2.4 (2.5, 2.6, 2.6, 2.8)
 Yr2: 3.4 (3.7, 3.6, 3.5, 3.6)
 Yr3: 4.5 (4.4, 4.2, 4.2, 4.3)

b. ITE performance

	09	10	11	12	13	14	15	16	17	18	19
Overall	54.2	52.2	50.7	55	73	57	68	51	58	59	48
Basic Science	48.6	52.8	54	50	64	69	62	45	65	55	36
Gen Derm	61	46	56.2	49	72	50	62	47	53	54	47
Procedural	47.5	51	44.6	58	78	64	72	52	48	65	50
Path	35.8	47	33	52	59	57	59	55	61	60	55
Peds Derm	47.9	54	47.8	72	78	68	60	66	65	74	47
Visual	50.6	52	64	53	84	64	56	51	65	--	--
Level 1/Applied	53	50	53	35	84	--	74	40	72	69	56
% Correct	75.2	74	76	76	77	73	83	73	76	80	78

Basic examination (average national %ile)

	2018	2019
Overall	49	51
Basic Science	50	40
Gen Derm	50	44
Procedural	51	36
Path	48	47
Peds Derm	49	67
Visual	50	33
% Correct	86	81

c. Board pass rate and certification

Certifying Exam (national %ile)

1997-1999	50
1999-2001	81
2002-2004	62
2003-2005	60
2006	66
2007	31
2008	19
2009	20 (1 failed)
2010	62
2011	39
2012	81
2013	48
2014	22
2015	88
2016	30
2017	58
2018	38

ABD graduates average deciles (10th is best)

	2014	2015	2016	2017	2018	2019
Clinical	3.75	7	4	6.2	4.7	
Path	2.5	6	5.25	5	4.3	
Procedural	5	7	4.5	5.2	4.5	
Basic science	5.25	6	3.75	4.6	4.2	
Applied	X	X	X	X	6	

d. Graduate performance

i. Need to create evaluation

8. Aggregate faculty

a. Evaluation

Faculty evaluations by residents 3.64 (3.82, 3.71, 3.71, 3.77, 3.68, 3.72)
(Excellent = 4, Poor = 1)

	19	18	17	16	15	14	13
Availability	3.67	3.78	3.63	3.6	3.72	3.66	3.77
Effective Role Model	3.73	3.87	3.73	3.72	3.77	3.69	3.72
Case Related Teaching (clinic, OR rounds)	3.74	3.8	3.75	3.69	3.74	3.69	3.71
Didactic Teaching (conferences, lectures)	3.73	3.82	3.75	3.74	3.77	3.66	3.66
Communication	3.71	3.83	3.69	3.68	3.75	3.65	3.69
Helpfulness	3.69	3.82	3.68	3.74	3.76	3.67	3.74

b. Professional development

i. Pending end of year

9. Mission and aims

- a. Excellent patient care
- b. Recruit excellent and diverse residents
- c. Report card includes program goals
- d. Testing outcomes greater than 75th percentile
- e. Procedural exposure greater than 50th percentile
- f. Successful placement in post-training positions

10. Strengths

- a. Diversity of patients: cultural, racial, economic
- b. UNC Health Care
- c. Faculty and their subspecialties
- d. Location and facilities

11. Areas of improvement

- a. Academic: Testing outcomes (new chapter reviews)
- b. Wellness: Offload administrative work (leadership)
- c. Diversity: lack of among faculty and residents
- d. Quality and safety activities
 - i. Institutional M&M conference (we will participate in 2 online)
 - ii. Quality care and patient safety outcomes measures (Fox)

12. Threats

- a. Administrative workload
- b. Burnout

APPENDIX D

Action Plan for Upcoming Year

UNC Dermatology Residency Action Plan 2019-20

TOPIC	ISSUE	PLAN	RESPONSIBLE PARTY	OUTCOME
Resident academic performance	Less than desired score on ITE	Bologna chapter reviews	Morrell, Chief Residents	
Resident academic performance	Less than desired score on visual recognition	Return to AAD Kodachrome sets	Morrell, Chief Residents	
Resident academic performance	Less than desired score on resident certifying exam	Faculty lunch hour MOC review questions	Morrell	
Faculty and resident wellness	Less than desired score on ACGME wellness questions	Offload admin activities	Leadership Committee	
Faculty and resident diversity	Less than desired faculty and resident URM's	Identify Diversity Liaison team	Thomas, Morrell	
Quality and safety measures	New ACGME metric	QA sessions to include metrics at end of academic year	Fox	Done
Program evaluation	New ACGME requirement	Create post-training performance evaluation	Morrell, Ezuka	

APPENDIX E

Department of Dermatology “Report Card”

ANNUAL PROGRAM REPORT CARD 2018-19

June 30, 2019

2019: Goals met: 19; Goals not met: 2; pending: (X%)

1. Curriculum

Instrument	Definition	Mean	Standard	Met/not met
Rotation evaluations by residents	9 5 option	4.6 (4.65, 4.6, 4.55, 4.64, 4.43, 4.63, 4.46, 4.24, 4.0, 3.4, 4.3)	≥ 3	Met
In-training exam	Standardized test score	2/3: 48 (59)%ile 1 st : 51 (49)%ile	Aggregate >50%ile	Not met Met
Conference evaluations by residents (Hideaway, Lectures, UNC/Duke)	5 option	3.81 (4.28)	≥ 3	Met
Conference evaluations by faculty (Hideaway, Lectures, UNC/Duke)	5 option	4.6 (4.5)	≥ 3	Met

2. Faculty

Instrument	Definition	Mean	Standard	Met/not met
Evaluations by residents	7 4 option	3.64 (3.82, 3.71, 3.67, 3.77, 3.68, 3.72, 3.69, 3.6, 3.4, 3.2, 3.6, 3.8)	≥ 2	Met
Attendance at conferences	Percent attended	Lectures 55 (55.7, 63, 45, 63.5/22.3, 63/28, 79/33, 70/26, 78/33, 73/17, 80/15)	Clinicians >25%	Met
		UNC/Duke 74 (78.2, 70, 75, 77, 71.1, 73, 73, 81, 80, 74, 68%)	>50%	Met
		Hideaway 68 (69, 73, 49, 70, 74.4, 79/59, 89/60, 81/75, 87/55, 81/53%)	>50%	Met
Speaker Eval	4 14 option	13.8 (13.9, 13.9, 13.7, 13.7, 13.7, 13.6, 13.3, 13.6, 13.65, 12.57, 13)	≥ 10	Met

3. Residents

Instrument	Definition	Mean/Score	Standard	Met/not met
Senior ABD evaluations	Multiple option	All achieved	Achieved all competencies	Met
360 degree evaluations WINTER	Composite Milestones score 0-5	3.1 (3.23, 3.36, 2.99, 3.24)	>2.5	Met
360 degree evaluations SUMMER	Composite Milestones score 0-5	3.4 (3.51, 3.51, 3.36, 3.67)	>3	Met
Procedures logs updated	ABD requirement	All (All, All, All, All, All, All, All, All, All except 1, All, All) submitted	All updated	Met

Portfolio review	Entries with reflection and learning plan	P (All, All, All, All, All, All, All, lack 3, all) submitted	All residents with > 5 entries with reflection/plan	Pending
Attendance at conferences	Percent attended	98.1 (98.1, 98.5, 96, 96.7, 98, 98.6, 99.59, 97, 93, 93.8)%	Aggregate >90%ile	Met
Speaker Eval	4 14 option	13.9 (13.8, 13.5, 13.6, 13.1, 13.5, 12.2, 13.6, 13.65, 12.8)	≥ 10	Met

4. Overall program resources

Instrument	Definition	Mean/Score	Standard	Met/not met
ABD board scores	National percentile	(39, 58, 30, 88, 22, 46, 81, 39, 62, 20, 19, 25)%ile	Aggregate >50%ile	Pending
ABD board failures	Failure to pass on first attempt	(0, 0, 0, 0, 0, 0, 0, 0, 0, 0, 1, 0, 0)	<10%	Pending
Resident recruitment	Ranks per spot to fill	2.2 (2, 3.2, 2.8, 1.3, 3, 2, 2.5, 3.2, 2.3)	Spots filled within 3 ranks per spot	Met
Resident retention	Residents departing	None left	No departures	Met
Alumni survey	34 5 option	4.15 (4.94, 5.0, 4.7, 3.9, 4.69, 4.53, 4.3, 4.75, 4.38, 4.7, 4.5, 4.7)	≥ 3	Met
Program evaluation by residents	34 5 option	4.05 (4.77, 4.67, 4.72, 4.64, 4.36, 4.7, 4.67, 4.07, 3.93, 4.5, 4.5, 4.5)	≥ 3	Met
Program evaluation by faculty	32 5 option	4.77 (4.82, 4.79, 4.5, 4.73, 4.8, 4.9, 4.67, 4.36, 4.5, 4.7, 4.7, 4.8)	≥ 3	Met
ACGME Resident/Faculty Surveys	Multiple option	2Fm 1F, 1R, (1F, 1R; 3 F, 4 R) non-compliance above national average	None above national average	Not met
Graduates ACGME procedure log	National minimums per ACGME 2014	All achieved	All exceed on the 8 criteria	Met