Procedural dermatology evaluation for residents: A system in progress

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Introduction

Dermatology practice has revolutionised in the past half-century. Procedural dermatology has now become an integral part of dermatology practice. Whether performing skin biopsies, minor procedures, minimally invasive procedures including botulinum toxin injections and fillers, lasers, or even complex excisions and reconstructions, a trained dermatologist is expected to perform all of them satisfactorily.

Need for procedural dermatology evaluation

Currently, the end-of-residency examination does not evaluate skills in procedural dermatology in most Indian institutions. Procedural dermatology should become an important component of not only postgraduate training, with clearly defined goals, but should also receive some weightage in the final practical examination similar to the evaluation of medical therapeutics. Such an evaluation is not possible without adequate procedural training. This evaluation, in turn, would ensure better training in procedural dermatology.

Novel ideas are often faced with scepticism and criticism. It could be considered an additional burden for residents who do not want to practice procedural dermatology after their residency and as experimenting on unsuspecting patients with the additional risk of litigation. Though the above concerns are valid, there are many reasons why this integration is necessary. We must take solace in the words of Gautam Buddha—“change is never painful, only the resistance to change is painful”. Residents are the ones who perform minor procedures routinely for patients, and they should be rigorously trained and assessed to evaluate their competence in these procedures.

Integration with procedural dermatology training

There is requirement of a significant overhaul of dermatology services, including the resident training curriculum. Policymakers can take a cue from dermatology residency programs in the West, as well as residency programs for surgical disciplines at major teaching institutes in India. Such an examination is a common practice during final residency assessment in surgical disciplines at many centres. An integral part of the evaluation for competency in procedures is the requirement to maintain a logbook throughout the residency period. Such a logbook must have information verified by a tutor on the number and types of procedures a resident has observed, assisted in, and/or performed independently, with a minimum number required for the latter. The procedures included in the logbook could be divided into those that are basic and essential to know and those that are optional. It must be ensured that there is sufficient exposure to basic procedures. Tertiary centres may offer training in more complex procedures.

The onus for this change lies on the tertiary centres, which regularly perform basic as well as advanced dermatological procedures, and in due course of time, this must be adapted and included in all centres offering postgraduate training in dermatology as well as in the recommendations of licencing institutions, such as the National Medical Commission.

Model evaluation

Our department at All India Institute of Medical Sciences, Delhi, India has been performing procedural dermatology examinations as a part of the final residency assessment for the last two batches, with particularly good feedback from

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the examinee residents as well as external examiners. We describe a tested model approach for such an examination.

The procedural dermatology exam is usually performed 2–3 weeks prior to the theory examination, allowing candidates the least inconvenience close to their examination date. Up to four students can be accommodated on one day at our centre, determined on the basis of number of available operating theatres, staff, and average time per procedure. Each candidate is assigned a single minor dermatological procedure. Three examiners specialised in procedures, including external examiners, assess every candidate. The marks constitute 10% of the total practical marks.

To ensure patient safety, the procedures are done under the supervision of at least one of the examiners and are recorded for viewing by the external examiners, with patient consent [Figure 1]. Videography enabled us to schedule the examinations in advance when external examiners were not available and was useful to limit the number of people in the operating theatre during coronavirus disease 2019 pandemic. Such videos may also form a part of department archives for training.

The students are asked to perform either a simple surgical excision with suturing in two layers or a radiofrequency-assisted excision. Representative cases for the above include, but are not limited to, simple epidermoid cysts, melanocytic nevi, benign appendageal and connective tissue tumours (up to 2 cm in diameter). These are situated preferably over cosmetically less-sensitive areas such as trunk or proximal limbs. Only those procedures are selected which are commonly performed in the department and which the resident has performed independently sufficient times during training. Only patients consenting to photography and videography of their procedure for examination/teaching purposes are selected.

The examinees are tested on the following skill subsets against an objective marking scheme (Table 1).

Consent and explanation of the procedure

This includes the introduction of self, pre-operative evaluation (including comorbidities and contraindications), explanation of steps of the procedure and likely outcome, taking informed consent and addressing any queries or possible apprehensions of the patient.

The procedure

The examinees are expected to plan and execute the procedure independently, with the help of one nursing assistant. A rotating operating theatre assistant is present for sourcing materials, adjusting lights and other miscellaneous work. The steps of the procedure itself are evaluated in different domains, including aseptic technique (glove donning, cleaning and draping), marking of site, safe injection of local anaesthetic, followed by evaluation of the surgical procedure itself, including incision/excision, undermining, wound edge approximation with suturing in two layers and dressing.

Figure 1: Procedural dermatology examination of a resident, with videography

Table 1: Example of marking scheme for one examiner

Candidate	Preoperative counselling including consent (5)	Procedure (30)					Postprocedure explanation (5)	Total (40)
		Cleaning/draping	Local/regional anaesthesia	Marking incision, incision placement	Dissection and closing	Dressing		
Candidate 1								
Candidate 2								
Candidate 3								

Post-operative instructions and counselling

The patient should be instructed about the care of the dressing, when to remove it, how to clean the wound and apply fresh dressings, oral medications (if any) and follow-up date. The patient's doubts should be addressed, if any.

Conclusion

Dermatology has undergone a revolution in terms of procedural dermatology, but dermatologists in teaching hospitals lag behind their peers in many other countries in terms of their procedural skills. It is time for a similar revolution in dermatology residents' training curriculum and introducing it as a separate evaluation to encourage better training.

Declaration of patient consent

Patient's consent not required as there are no patients in this study.

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Conflict of interest

There is no conflict of interest.