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INTRODUCTION

# Why perform inpatient consultations?

Over the past 30 years, we have seen a declining number of inpatient dermatology units likely due to several factors that include the implementation of diagnosis-related groups, changes in reimbursement, and improved outpatient treatment options for some dermatologic diseases such as psoriasis (1). Given these changes, we have noted a shift to the dermatologist serving as a consultant in the hospital setting. Most academic centers have rotating attendings to cover inpatients, and a few have a dedicated "dermatology hospitalist" to cover the wards. However, some communities have no dermatologist willing to see patients in the hospital. Helms et al. explored this issue in Ohio by sending a survey to Ohio American Academy of Dermatology (AAD) members who reported that the rationale for not providing consults included reimbursement too low to cover travel time and time away from practice; 38% of responders felt that dermatology consults were not emergent and could be seen as an outpatient, and some had the fear of "opening the floodgates" if they are the only dermatologist in the area to do consults (2). On a national level, less than half of the dermatologists responding to the 2007 AAD Practice Profile Survey did any inpatient consultations. Of those who did see consults, only a small fraction spent more than 1 hour per week in the hospital (J. Resneck Jr, unpublished results). Therefore, we are observing that the care of some of our most complex dermatology cases is shifted to nondermatologists in the hospital setting. Relinquishing care of these complex, challenging hospital cases is detrimental to patient care as these nondermatologists often lack the skilled knowledge to recognize and treat these cutaneous diseases. I agree with Nahass et al. that skin findings are often "overlooked" by nondermatologists either due to the lack of a comprehensive skin exam, lack of training to know what to look for, or a lack of understanding of significance if they do find something on the skin (3). Nahass et al. found that 77% of skin findings were not identified by the primary team (4). Falanga et al. examined 591 inpatient dermatology consecutive consults and noted that dermatology consultation changed the diagnosis or treatment in over 60% of cases (5).

In addition, disappearing from the hospitals removes dermatologists from close contact with our administrative and political allies. If dermatologists are "out of sight", then it takes a special effort to participate in policy activities. The importance of this participation cannot be overemphasized so that dermatology does not lose our voice in decision-making processes which can have economic and quality-of-life impacts.

What do we personally gain from seeing patients in the hospital? I feel that dermatologists who see inpatient consults have several positive opportunities.

1. Opportunity to contribute substantially to patient care. Rapid diagnosis by a skilled dermatologist can improve patient care by tailoring correct treatment, thereby decreasing morbidity and mortality of patients. This is rewarding and it feels good.
2. Opportunity to save health care dollars. Rapid diagnosis can also decrease length of stay and readmissions, thereby saving health care dollars. How many of you have had the experience of an immediate discharge after a dermatology inpatient or ER consult for severe poison ivy, scabies, drug rash, urticaria, or stasis dermatitis?
3. Opportunity to raise the standing of dermatologists in the eyes of our peers and colleagues. We can build trust and build the reputation of dermatology by contributing thoughtful consults.

4. Opportunity to teach and opportunity to learn. One of the most stimulating aspects of seeing inpatient consultations is the interaction with our colleagues from other specialties. The exchange of ideas and information not only helps the patient but is educational for us as well. There exists a great opportunity to teach our colleagues about interesting dermatology diseases and physical examination clues on the wards. An interesting paper by Antic et al. in 2004 addressed this subject. They reviewed 1290 inpatient consults and compared diagnoses in 1998 (the first year of an established Dermatology Department) and several years later. They were interested to see if their colleagues were learning dermatology. They noted that consults for drug reactions decreased from 10% to 4.2%. Similarly, intertrigo accounted for 3.4% of consults in 1998 and only 1.2% in later years. They related the decrease in these common consults to their "teaching effect" (6). While caring for these challenging patients, we are also in a unique position to learn and gain insight about diseases from our peers in other specialties. This knowledge helps us to understand the complex interplay between cutaneous and systemic diseases and allows us to care for our future patients more effectively. There are dozens of examples where tips that I have learned from our transplant, renal, critical care, medicine, and infectious disease colleagues have enhanced my care of other patients.

In this issue, some of the most common consult issues are discussed by authors very familiar with inpatient dermatology. This issue of *Dermatologic Therapy* will provide you with practical approaches to these complex and challenging patients. I hope that you will find this issue interesting and helpful and that it might stimulate you to see inpatient consultations in your community. With the support of our fellow dermatologists, we have the opportunity to play a vital role on the hospital wards – truly impacting and improving patient care, saving health care dollars, and improving our standing in the eyes of our physician colleagues.

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The Society of Dermatology Hospitalists (SDH) is a group of dermatologists interested in inpatient dermatology. The SDH is recognized as an expert resource group by the American Academy of Dermatology. The mission statement of the group is "To strive to develop the highest standards of clinical care of hospitalized patients with skin disease by promoting clinical expertise, fostering research, and furthering education in the management of hospitalized patients with cutaneous disease." If you are interested in communicating with other dermatologists who enjoy seeing inpatient consults, feel free to contact us at dermhospitalists@gmail.com.

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