Under My Skin

Times Change

The first boss I had after leaving my pediatric residency had trained at the Harriet Lane service at Johns Hopkins. One day he started reminiscing about how things had changed since his day. I had taken night call once every third night in my residency, and the residents at our UConn-affiliated program were currently on every fourth.

"At Hopkins they made a concession while I was there—they allowed us to get married. We were on every other night, but we couldn't leave the compound even on the off nights. That's why they called us interns—in case one of our own patients got sick."

BY ALAN ROCKOFF, M.D.

"Sure," I remember thinking at the time, "the Days of the Giants." I resented his clear subtext: "You whippersnappers don't work like we did."

I was young, though, and not yet acquainted with the wisdom of great philosophers like Mel Brooks' 2000-year-old man ("We mock the thing we are to be") and Pogo ("We have met the enemy and he is us").

The Romans used to say that times change, and we change with them. What triggered my thinking of changing times has been the doings not just of young folks but of colleagues my age or older.

My medical neighborhood has been infected with "conciergitis": All at once, several established internists joined the boutique bandwagon, slashed their panels from a few thousand patients to a few hundred, and asked those who signed on to pay annual fees of $1,500-$4,000 over and above what insurance pays.

And what do the patients get for these fees? The promise of being able to reach their doctors promptly, be seen fast, and have phone calls returned.

Funny, I thought that's what doctors were supposed to do anyway. How old-fashioned of me.

Doctors are "boutiquing" both because they feel they need to and because they can. My own internist of 25 years, Doug, ferociously opposed concierge medicine when it first appeared around here a few years ago, yet he has recently signed on with a national boutique firm.

"My only other choice was to retire," he told me. "My junior associate Karen is only 34, but she's burned out after only 4 years. She's taken a job as a hospitalist so she can have a personal life. My partner quit primary care and took a job doing just GI. With all the paperwork and staffing costs, the practice wasn't financially viable if I ran it myself."

Times change in many ways. Besides new circumstances like the burdens of paperwork and government regulations, there are also shifting attitudes and expectations.

Slowly, imperceptibly, people decide they're no longer willing to do what used to be taken for granted. They want personal lives. They find out that Peter, Paul, and Meg aren't putting up with things everyone used to accept, so the scales fall from their eyes and they don't see why they should either.

Times change whether we want them to or not, but changing with them gets harder as we age and our adaptive arteries harden.

Starting out, I built my practice on HMO referrals because many older colleagues decided that HMOs were just a fad and they weren't going along with the referral thing. Eventually, most came around because they had to. Those who didn't gave up and quit.

No need to enumerate all the changes since then: E/M codes, OSHA, CLIA, EMRs, etc. And the pace of change isn't slowing down.

As times change, one thing seems to stay the same: Older folks think that youngsters don't know what real work means, and the younger generation does not want to hear it.

When I took over the remains of a practice in 1981, the retiring gentleman showed me around his office, a converted garage, and said, "You newcomers can't get along without things we never needed. You insist on secretaries." I was too polite to respond, but I remember what I thought.

Like the man said, "We mock the thing we are to be."

Now, at the other end of my career, I face the prospect of hiring younger associates who will expect to earn guaranteed top dollar the first year out of training and, of course, to work no more than 4 days a week.

I could tell them my personal saga—the first office in the back room of a brownstone, the many part-time jobs while waiting for the phone to ring, and so forth—but nobody wants to hear that. Times change. This is now.

Either you have the flexibility to change with the times or you decide it's not worth the effort anymore. I'm trying to be flexible. Doug may have concierged off into the sunset, but I found another doctor who calls me back, even without a membership fee. He only has office hours on 4 days, but, hey, nobody's perfect. ■

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Guest Editorial

Communication Problems Hamper Diagnosis

When confronted with skin signs of internal disease, as dermatologists we have two jobs. The first is to establish the clinicopathologic character of each lesion type present. The second is to integrate those findings into the systemic disease.

In the diagnosis of cutaneous small-vessel vasculitis, however, this process can run askew because of miscommunication between medical specialists.

BY JOSEPH L. JORIZZO, M.D.

The diagnostic hallmarks of cutaneous small-vessel vasculitis are histopathologic leukocytoclastic vasculitis and clinical palpable purpura, but even among dermatologists, few physicians use the same nomenclature. Terms that are often used include necrotizing venulitis, hypersensitivity angiitis, and cutaneous leukocytoclastic vasculitis.

Histologic descriptions such as leukocytoclastic vasculitis are best not used to refer to clinical syndromes. Leukocytoclastic vasculitis is not a specific histopathologic finding, and it can occur in a variety of conditions—ranging from a bee sting to cold contact urticaria—that are completely unrelated to the clinical syndrome of cutaneous small-vessel vasculitis.

Although leukocytoclastic vasculitis is a characteristic histopathologic feature associated with cutaneous small-vessel vasculitis, these patients may or may not have histopathologic leukocytoclastic vasculitis at any given time. Their older lesions can be purely lymphocytic. Patients with Sweet's syndrome, on the other hand, might show full-blown leukocytoclastic vasculitis histopathologically.

The other clinical hallmark of cutaneous small-vessel vasculitis, palpable purpura, is also misunderstood. For nondermatologists, the term palpable purpura conveys the idea that the purpura is inflammatory. The impression of inflammation arises because the lesions are distributed on dependent sites and some of the lesions are palpable. However, many purpuras, such as solar purpura, are palpable but have nothing to do with vasculitis.

This is confusing to nondermatologists, and it requires patience on our part to educate our colleagues. We can have passionate battles with colleagues in nephrology or rheumatology over diagnostic criteria of cutaneous small-vessel vasculitis. In some situations, it might even be necessary to stop a patient's therapy until we make sure that we have a precise diagnosis that integrates the clinical finding of palpable purpura, or inflammatory purpura, with the histologic finding of leukocytoclastic vasculitis.

Another communication problem that affects diagnosis stems from changes in the way biopsy specimens are handled, due in large part to the rise of managed care.

Because physicians might be required to send skin biopsy specimens to selected pathologists who might not be dermatopathologists, it has become commonplace to receive pathology reports that consist of clinical interpretation rather than pure histopathologic description.

Clinical interpretation of a skin biopsy specimen, particularly from someone who is not a dermatopathologist, can be inappropriate and misleading.

A patient with pityriasis lichenoides et varioliformis acuta, for example, might be given a pathology report that simply states "lymphocytic vasculitis," prompting the dermatologist to perform a full clinical evaluation, including tests for hepatitis C. We should always insist on integrated clinical-pathologic correlation for each patient.

Classification of vasculitis is another area that can lead to confusion. Defining the morphology of a lesion is just the beginning of a patient's evaluation and treatment plan. For example, the morphology of the lesion might indicate cutaneous small-vessel vasculitis, but this finding can occur in the context of large-vessel vasculitis. Patients with large-vessel vasculitis, such as antineutrophil cytoplasmic antibody–associated vasculitis or systemic polyarteritis nodosa, can have spillover lesions of cutaneous small-vessel vasculitis. Disease classification should be based on the largest vessel involved.

Communication problems such as these also occur in the area of lupus erythematosus, with its disease subsets of chronic cutaneous lupus erythematosus, acute systemic lupus, and subacute cutaneous lupus. If we establish that a patient has a discoid lesion, we then have to determine if it indicates chronic cutaneous lupus, which is a benign, disfiguring skin disease, or systemic lupus, which sometimes presents as a discoid lesion. ■

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