Barriers and Job Satisfaction Among Dermatology Hospitalists

Jake C. Robertson, BS; Maryam Safaee, MD; Fan Liu, MD; Michi M. Shinohara, MD

PRACTICE **POINTS**

- Dermatology hospitalists play a critical role in the specialized care of hospitalized patients with skin conditions.
- Dermatology hospitalists have high job satisfaction, with opportunities to teach trainees and practice complex medical dermatology.
- Most dermatology hospitalists do not generate sufficient revenue providing inpatient dermatology consultations to fully support their salary for the time spent as consultants; alternate payment models are needed to maintain dermatology's presence in the hospital.

Dermatology hospitalists (DHs) provide consultative care to inpatients with skin conditions. In this study, we surveyed current members of the Society for Dermatology Hospitalists (SDH) regarding barriers to care, current and ideal compensation models, and overall job satisfaction to evaluate the overall job satisfaction of DHs and further describe potential barriers to inpatient dermatology consultations.

Cutis. 2019;104:103-105, 113.

Consultative dermatologists, or dermatology hospitalists (DHs), perform a critical role in the care of inpatients with skin disease, providing efficient diagnosis and management of patients with complex skin conditions as well as education of patients and trainees in the hospital setting.[1] In 2013, 27% of the US population was seen by a physician for a skin disease.[2] In 2014, there were nearly 650,000 hospital admissions principally for skin disease.[3] Input by dermatologists facilitates accurate diagnosis and management of inpatients with skin disease,[4] including a substantial number of cutaneous malignancies diagnosed in the inpatient setting.[5] Several studies have highlighted the generally low level of diagnostic concordance between referring services and dermatology consultants,[4,6] with dermatology consultants frequently noting diagnoses not considered by referring services,[7] reinforcing the importance of having access to dermatologists in the hospital setting.

The care of skin disease in the inpatient setting has become increasingly complex. The Society for Dermatology Hospitalists (SDH) was created in 2009 to address this complexity, with the goal to "strive to develop the highest standards of clinical care of hospitalized patients with skin disease."[8] A recent survey found that 50% of DHs spend between 41 to 52 weeks per year on service.[9] Despite this degree of commitment, there are considerable barriers that prevent the majority of dermatologists from efficiently providing inpatient consultative care. The inpatient and outpatient provision of dermatology care varies greatly, including the variety of ethical situations encountered and the diversity of skin conditions treated.[10-12] Additionally, the transition between inpatient and outpatient care can be challenging for providers.[13]

The goal of this study was to evaluate the overall job satisfaction of DHs and further describe potential barriers to inpatient dermatology consultations.

Methods

An anonymous 31-question electronic survey was sent via email to all current members of the SDH from November 20 to December 10, 2018. The study was reviewed and determined to be exempt from federal human subjects regulations by the University of Washington Human Subjects Division (Seattle, Washington)(STUDY00005832).

Results

At the time of survey distribution, the SDH had 145 members, including attending-level dermatologists and resident members. Thirty-seven self-identified DHs (46% [17/37] women; 54% [20/37] men) completed the survey. The majority of respondents were junior faculty, with 46% (17/37) assistant professors, 5% (2/37)

From the University of Washington, Seattle. Mr. Robertson is from the School of Medicine. Drs. Safaee, Liu, and Shinohara are from the Division of Dermatology.

The authors report no conflict of interest.

Correspondence: Michi M. Shinohara, MD, University of Washington Dermatology and Dermatopathology, Box 356524 BB1332E, Seattle, WA 98195 (mshinoha@uw.edu).

acting instructors, 32% (12/37) associate professors, and 16% (6/37) professors. All regions of the United States were represented.

Time Dedicated to Providing Inpatient Dermatology Consultations—The majority of those surveyed were satisfied or very satisfied (68% [25/37]) with the amount of time allotted for inpatient dermatology consultations, while 14% (5/37) were unsatisfied or very unsatisfied. Of those surveyed, 46% (17/37) reported that 21% to 50% of their time is dedicated to inpatient dermatology consultations. The majority (57% [21/37]) reported that their outpatient clinic efforts are reduced when providing dermatology inpatient consultations.

Regarding travel to the inpatient practice site, 60% (22/37) rated their travel time/effort as very easy, with 38% (14/37) reporting that the sites at which they provide inpatient dermatology consultations and their main outpatient clinics are the same physical location; 38% (14/37) reported travel times of less than 15 minutes between clinical practice sites.

Eighty-nine percent (33/37) of respondents said they are able to spend more time teaching trainees when providing inpatient dermatology consultations compared to their time spent in clinic. Similarly, 70% (26/37) said they are able to spend more time learning about patients and their conditions when providing inpatient dermatology consultations. Respondents also reported additional time expenditures because of inpatient dermatology consultations, primarily additional teaching requirements (49% [18/37]), additional electronic medical record training (35% [13/37]), and credentialing requirements (24% [9/37]).

Infrastructure for Providing Inpatient Dermatology Consultations—For many respondents (30% [11/37]), only 2 faculty dermatologists regularly provide inpatient dermatology consultations at their institutions. Four respondents reported having at least 5 faculty dermatologists who regularly provide inpatient dermatology consultations; excluding these, the average number of DHs was 2.42 faculty per institution.

Most respondents (57% [21/37]) reported their institutions support inpatient dermatology services by providing salary support for residents to cover services. Other methods of support included dedicated office spaces (30% [11/37]), free hospital parking while providing inpatient consultations (24% [9/37]), and administrative support (11% [4/37]).

Consultation Composition—Respondents indicated that requests for DH consultations most often come from medical services, including medical intensive care, internal medicine, and family medicine (95% [35/37]); the emergency department (95% [35/37]); surgical services (92% [34/37]); and hematology/oncology (89% [33/37]). Fewer DHs reported receiving consultation requests from pediatrics (70% [26/37]).

Many respondents (49% [18/37]) reported consulting for patients with skin disorders that they considered to be life-threatening or potentially life-threatening either very frequently (daily) or frequently (several times weekly), with only 16% (6/37) responding that they see such patients about once per month.

Compensation for Inpatient Dermatology Consultation—The most commonly reported compensation models for DHs were fixed salary plus productivity or performance incentives and fixed salary only models (49% [18/37] and 32% [12/37], respectively), with relative value unit (RVU) models and other models less frequently reported (16% [6/37] and 3% [1/37], respectively). Only 46% (17/37) of respondents were satisfied or very satisfied with their institutions' compensation models; the remainder (54% [20/37]) were either neutral, unsatisfied, or very unsatisfied regarding their institutions' compensation models. Overall compensation satisfaction was higher, with 60% (22/37) of DHs reporting they were satisfied or very satisfied with their salaries and 41% (15/37) reporting they were either neutral or not satisfied. The majority (60% [2/37]) of respondents felt that fixed salary plus productivity or performance incentives models would be the ideal compensation model for DHs.

Of the DHs whose compensations models were RVU based (6/37 [16%]), 67% (4/6) said they receive incentive pay upon meeting their RVU targets. No respondents reported that they were expected to generate an equivalent number of RVUs when performing inpatient consultations as compared to an outpatient session. Only 32% (12/37) of respondents reported keeping the revenue/RVUs generated by inpatient dermatology consultations; most (57% [21/37]) noted that their dermatology divisions/departments keep the revenue/RVUs, followed by university hospitals (27% [10/37]), schools of medicine (11% [4/37]), and departments of medicine (3% [1/37]). The remainder of respondents (22% [8/37]) were unsure who keeps the revenue/RVUs generated by inpatient dermatology consultations.

Most respondents (70% [26/37]) reported that the revenue (or RVU equivalent) generated by inpatient dermatology consultations does not fully support their salary for the time spent as consultants. Rather, these DHs noted sources of additional financial support, primarily the DHs themselves (69% [18/26]), followed by dermatology divisions/departments (50% [13/26]), departments of medicine (23% [6/26]), university hospitals (23% [6/26]), and schools of medicine (12% [3/26]).

Job Fulfillment Among DHs—Most respondents said they choose to provide inpatient dermatology consultations due to their interest in complex medical dermatology and their desire to work with other medical teams and specialties (92% [34/37] and 76% [28/37], respectively). Seventy percent (26/37) said they choose to provide inpatient consultations to be able to teach medical students and residents as well as to take advantage of the added opportunities to practice in a variety of settings beyond their outpatient clinics (57% [21/37]). Only 3% (1/37) of respondents reported that they provide inpatient dermatology consultations because they are "required to do so."

Most DHs (84% [31/37]) said they feel their institutions as well as their dermatology divisions/departments value having access to inpatient dermatology services, though some did not feel this way (16% [6/37] neutral or strongly disagree). Nearly all respondents (97% [36/37]) felt they provide a critical service when performing inpatient dermatology consultations. All respondents (100%) said they found providing inpatient dermatology consultations fulfilling, and 65% (24/37) said they prefer providing inpatient dermatology consultations to spending time in clinic. Of the DHs who were surveyed, 68% (25/37) said they were satisfied with the balance of outpatient and inpatient services in their clinical practice and 30% (11/37) said they were not.

Comment

Factors such as patient care, hospital infrastructure, and procedural support have all been cited by DHs as crucial aspects of their contributions to the care of hospitalized patients.[14] Of those surveyed in the present study, 97% felt they provide a critical service within their division/department and 84% felt their divisions/departments value the services that they provide. Nearly half of DHs surveyed said they regularly consult for patients with life-threatening or potentially life-threatening skin disorders several times weekly, and most receive consultation requests from multiple departments, reinforcing the critical role that dermatologists still play in the hospital setting.

Dermatology is primarily an outpatient specialty, and our study highlighted several important challenges for providers performing inpatient dermatology consultations. A major issue is time expenditures, including additional teaching requirements, additional electronic medical record training, and credentialing requirements. Travel time to inpatient hospital sites does not appear to be one of these hindering factors; nearly 60% of respondents rated their travel time/effort as very easy, with approximately 75% of respondents' consultation locations being either at the same physical location as their main outpatient clinic or less than 15 minutes away. Maintaining easy travel between outpatient and inpatient settings is important to the success of the DH.

Our data suggest that compensation of DHs is a potential limitation to providing inpatient dermatology care. Our survey reinforced that providers who do inpatient dermatology consultations generally do not generate the revenue necessary to cover these efforts. More than 40% of DH respondents said they either feel neutral about or unsatisfied with their overall salary, and more than half said they feel similarly regarding their institutions' compensation models. Most respondents said that a fixed salary model plus productivity or performance incentives is the ideal compensation model for those providing inpatient dermatology consultations, though only half said they actually are compensated according to this model. This discrepancy highlights the disconnect between the current accepted compensation models and the DH's ideal model and provides direction for dermatology chairs and division heads as to what compensation model is preferable to support the success of DHs at their institutions.

Despite the barriers and compensation constraints we identified, DHs report high job satisfaction, which we hypothesize could combat burnout. In our study, all DHs surveyed say they find providing inpatient dermatology consultations fulfilling, and most were satisfied with the amount of time allotted for consultations. Some of the possible reasons why DHs may find their work fulfilling include increased time for teaching trainees and learning about patients and their conditions while consulting, as well as a preference for providing inpatient dermatology consultations to spending time in clinic. Most DHs said they choose to provide inpatient dermatology consultation rather than do so as a requirement, primarily due to their interest in complex medical dermatology and their desire to work with other medical teams/specialties; thankfully, only a small percentage said they provide these consultations because they are required to do so.

This study was conducted to analyze job satisfaction among DHs who provided inpatient dermatology consultations and determine common barriers and obstacles to their job satisfaction. Limitations to our study included the small sample size and the possibly limited representation of the intended population, as only the members of the SDH were surveyed, potentially excluding providers who regularly perform inpatient dermatology consultations but are not members of the SDH. Further limitations included recall bias and the qualitative nature of the survey instrument.

Final Thoughts

There was near-unanimous agreement among the DHs we surveyed regarding the importance of the role they play in their divisions/departments, but there are clear barriers to provision of inpatient dermatology consultation, specifically relating to extraneous time expenditures and compensation. Despite these barriers, the majority of respondents said they are very satisfied with the role they play in the inpatient setting and feel that their contributions are valued by the institutions where they work. Protecting these benefits of providing dermatology hospital consultations will be critical for maintaining this high job satisfaction and balancing out the barriers to providing these consultations. Protecting the time required to provide consultations is paramount so DHs continue to gain fulfillment from teaching trainees, caring for complex patients, and maintaining their place as valuable colleagues in the hospital setting.

Acknowledgment—The authors thank the members of the SDH for their participation in this survey.

REFERENCES

1. Biesbroeck LK, Shinohara MM. Inpatient consultative dermatology. *Med Clin North Am.* 2015;99:1349-1364.
2. Lim HW, Collins SAB, Resneck JS Jr, et al. The burden of skin disease in the United States. *J Am Acad Dermatol.* 2017;76:958-972.e2.

CONTINUED ON PAGE 113

CONTINUED FROM PAGE 105

3. Arnold JD, Yoon SJ, Kirkorian AY. The national burden of inpatient dermatology in adults. *J Am Acad Dermatol*. 2018;80:425-432.
4. Mancusi S, Festa Neto C. Inpatient dermatological consultations in a university hospital. *Clinics (Sao Paulo)*. 2010;65:851-855.
5. Tsai S, Scott JF, Keller JJ, et al. Cutaneous malignancies identified in an inpatient dermatology consultation service. *Br J Dermatol*. 2017;177:e116-e118.
6. Pereira AR, Porro AM, Seque CA, et al. Inpatient dermatology consultations in renal transplant recipients. *Actas Dermosifiliogr*. 2018;109:900-907.
7. Tracey EH, Forrestel A, Rosenbach M, et al. Inpatient dermatology consultation in patients with hematologic malignancies. *J Am Acad Dermatol*. 2016;75:835-836.
8. Fox LP, Cotliar J, Hughey L, et al. Hospitalist dermatology. *J Am Acad Dermatol*. 2009;61:153-154.
9. Ko LN, Kroshinsky D. Dermatology hospitalists: a multicenter survey study characterizing the infrastructure of consultative dermatology in select American hospitals. *Int J Dermatol*. 2018;57:553-558.
10. Hansra NK, Shinkai K, Fox LP. Ethical issues in inpatient consultative dermatology. *Clin Dermatol*. 2012;30:496-500.
11. El-Azhary R, Weenig RH, Gibson LE. The dermatology hospitalist: creating value by rapid clinical pathologic correlation in a patient-centered care model. *Int J Dermatol*. 2012;51:1461-1466.
12. Ahronowitz I, Fox LP. Herpes zoster in hospitalized adults: practice gaps, new evidence, and remaining questions. *J Am Acad Dermatol*. 2018;78:223-230.e3.
13. Rosenbach M. The logistics of an inpatient dermatology service. *Semin Cutan Med Surg*. 2017;36:3-8.
14. Ackerman L, Kessler M. The efficient, effective community hospital inpatient dermatology consult. *Semin Cutan Med Surg*. 2017;36:9-11.