Dermavant, Lilly, Novartis, Janssen, Regeneron, Sanofi, Pfizer, and Celgene. All other authors have no conflicts of interest to disclose.

Correspondence to: David Rosmarin, MD, Tufts Medical Center, 800 Washington St, no. 114, Boston, MA 02111

E-mail: drosmarin@tuftsmedicalcenter.org

REFERENCES

1. Schlapbach C, Hänni T, Yawalkar N, Hunger RE. Expression of the IL-23/Th17 pathway in lesions of hidradenitis suppurativa. *J Am Acad Dermatol*. 2011;65(4):790-798.
2. Gulliver WP, Jemec GBE, Baker KA. Experience with ustekinumab for the treatment of moderate to severe hidradenitis suppurativa. *J Eur Acad Dermatol Venereol*. 2012;26(7):911-914.
3. Kimball AB, Kerdel F, Adams D, et al. Adalimumab for the treatment of moderate to severe hidradenitis suppurativa. *Ann Intern Med*. 2012;157(12):846.

https://doi.org/10.1016/j.jaad.2018.12.017

Inpatient dermatology consultations and the July effect: A retrospective cohort study

To the Editor: The July effect refers to the proposed adverse effect on patient care when new interns begin their training in teaching hospitals.[1-5] We sought to examine whether a July effect exists with regards to inpatient dermatology consultations at a large tertiary referral medical center, as measured by the concordance or discordance of assessments between the primary and consulting teams.

The Institutional Review Board at University Hospitals Cleveland Medical Center approved this study. We retrospectively reviewed inpatient dermatology consultations from resident teaching services during the months April-September of January 1, 2012-December 31, 2017. We recorded the primary team, training level of charting resident, follow-up, concordance or discordance of assessment between the primary and consulting teams, and whether an inpatient biopsy was performed. After reviewing consulting notes and diagnoses, we categorized consultations as concordant or discordant on the basis of the qualitative assessment of diagnoses and whether the consulting team agreed with the primary team's initial assessment. Descriptive statistics were performed by using the χ^2 test and t test. P values $<.05$ were considered statistically significant.

There were 446 inpatient dermatology consultations during April-June and 523 during July-September (Table I). Most consultations were placed by internal medicine teaching teams, and most of charting physicians were interns. There were no differences in the number of consultations or types of primary services between April-June and July-September ($P > .05$ for all). Interns wrote most notes in April-June and July-September ($P = .003$).

There was no difference in the concordance of assessments between dermatologists and primary teams during April-June and July-September (odds ratio [OR] 0.94, 95% confidence interval [CI] 0.70-1.28; $P = .73$). We saw a significant difference in concordance and discordance only in pediatric consultants during April-June ($P = .005$). In addition, no differences in concordance and discordance was observed by training level or primary service (Table II). Consultations with discordant assessments were associated with significantly more inpatient biopsies (OR 1.51, 95% CI 1.08-1.45, $P = .02$), but this finding did not differ by time of year (OR 1.07, 95% CI 0.79-1.45, $P = .67$).

Limitations of this study include insufficient documentation of dermatologic assessment and lack of follow-up. About a quarter of assessments could not be evaluated for concordance because there was no documentation of the primary team's assessment of the cutaneous findings. Moreover, the team member proposing the consultation was not documented in the chart, which could explain the findings of no July effect. As such, some consultations might have been requested by attending physicians or senior residents, but we were only able to attribute placement of a consult to the charting physician, most often an intern.

In summary, we did not find evidence of a July effect related to inpatient dermatology consultations as evidenced by no significant trend for discordant assessments. Discordant assessments between primary and consulting teams resulted in a significantly higher rate of inpatient biopsies regardless of time of year, demonstrating a role for inpatient dermatology consultations in managing difficult dermatologic conditions. Future studies should examine methods to improve dermatology education among various specialties to increase awareness of dermatologic conditions.

Sheena Tsai, MD, MPH, Harib H. Ezaldein, MD, Rosalynn R. Z. Conic, MD, Miesha Merati, DO, and Jeffrey F. Scott, MD

From the Department of Dermatology, University Hospitals Cleveland Medical Center, Cleveland, Ohio; and Case Western Reserve University School of Medicine, Cleveland, Ohio

Funding sources: Supported by National Institutes of Health T32 grant (no. 5 T32 AR007569-23, to Dr Conic).

Table I. Descriptive statistics

Category	April-June, N = 446	July-September, N = 523	OR (95% CI)	*P* value
Consulting team, n (%)				.733
Emergency medicine	27 (6.1)	29 (5.5)	0.90 (0.52-1.58)	
Internal medicine	228 (51.1)	271 (51.8)	Reference	
Neurology	14 (3.1)	21 (4.0)	1.26 (0.63-2.59)	
Obstetrics/Gynecology	11 (2.5)	14 (2.7)	1.07 (0.48-2.46)	
Pediatrics	126 (28.3)	154 (29.4)	1.03 (0.77-1.38)	
Surgery	40 (8.9)	34 (6.5)	0.73 (0.45-1.20)	
Specific type of team, n (%)				.837
Hematology/Oncology	20 (4.5)	29 (5.5)	1.31 (0.61-2.84)	
Infectious disease	28 (6.3)	31 (5.9)	Reference	
Medical intensive care unit	21 (4.7)	21 (4.0)	0.9 (0.41-2.00)	
Other	377 (84.5)	442 (84.5)	1.06 (0.62-1.8)	
Resident teaching teams, n (%)	386 (86.5)	472 (90.2)	0.86 (0.54-1.39)	.089
Training level of charting physician who wrote daily notes, n (%)				.003
Medical student	33 (7.4)	78 (14.9)	1.15 (0.62-2.14)	
Postgraduate year 1	168 (37.7)	204 (39.0)	1.08 (0.65-1.79)	
Postgraduate year 2	78 (17.5)	71 (13.6)	1.36 (0.74-2.51)	
Postgraduate year ≥3	82 (18.4)	100 (19.1)	1.20 (0.68-2.12)	
Resident of unknown training year	18 (4.0)	15 (2.9)	0.96 (0.39-2.39)	
Fellow physician	7 (1.6)	4 (0.8)	3.51 (0.54-6.80)	
Attending physician	60 (13.5)	51 (9.8)	Reference	
Day of admission consult was requested, n (%)				.299
0 (not admitted, seen in ED)	20 (4.5)	25 (4.8)	Reference	
1-7	363 (81.4)	419 (80.1)	0.92 (0.50-1.69)	
8-14	32 (7.2)	36 (6.9)	0.90 (0.42-1.92)	
15-21	10 (2.2)	18 (3.4)	1.44 (0.55-3.89)	
22-28	3 (0.7)	11 (2.1)	2.93 (0.79-14.3)	
≥29	18 (4.0)	14 (2.7)	0.62 (0.25-1.54)	
Consensus between dermatology and consulting team's assessment, n (%)				.678
Concordant	209 (46.9)	232 (44.4)	Reference	
Discordant	124 (27.8)	147 (28.1)	1.07 (0.79-1.45)	
Unknown	113 (25.3)	144 (27.5)	1.48 (0.84-1.57)	
Biopsy performed while patient was inpatient, n (%)				.460
Yes	120 (26.9)	153 (29.3)	1.51 (1.08-1.45)	
No	326 (73.1)	370 (70.7)	Reference	
Dermatology follow-up appointment scheduled at discharge, n (%)				.297
Yes	127 (28.5)	131 (25.1)	0.83 (0.63-1.11)	
No	319 (71.5)	392 (75.0)	Reference	
No. days after discharge follow-up was scheduled for, mean (SD)	9.10 (17.61)	7.47 (15.54)	NA	.126

CI, Confidence interval; *ED*, emergency department; *NA*, not applicable; *OR*, odds ratio; *SD*, standard deviation.

Conflicts of interest: None disclosed.

Previously presented as a poster at the Ohio Dermatological Association annual meeting in Columbus, Ohio, on September 8, 2018.

Reprints not available from the authors.

Correspondence to: Sheena Tsai, MD, MPH, Department of Dermatology, University Hospitals Cleveland Medical Center, Lakeside 3500 11100 Euclid Ave, Cleveland, OH 44106

E-mail: sxt278@case.edu

REFERENCES

1. Mims LD, Porter M, Simpson KN, Carek PJ. The "July effect": a look at July medical admissions in teaching hospitals. *J Am Board Fam Med*. 2017;30(2):189-195.
2. McDonald JS, Clarke MJ, Helm GA, Kallmes DF. The effect of July admission on inpatient outcomes following spinal surgery. *J Neurosurg Spine*. 2013;18:280-288.
3. Shuhaiber JH, Goldsmith K, Nashef SAM. Impact of cardiothoracic resident turnover on mortality after cardiac

Table II. Quality of consults stratified by primary team and physician training level

Category	April-June			July-September			
	Discordant, N = 124	Concordant, N = 209	*P* value, concordance vs discordance	Discordant, N = 147	Concordant, N = 232	*P* value, concordance vs discordance	*P* value, both time periods
Primary team, n (%)			.005			.52	.009
Emergency medicine	8 (22.2)	8 (22.2)		6 (16.7)	14 (38.9)		
Internal medicine	74 (19.6)	106 (28.1)		84 (22.3)	113 (30.0)		
Neurology	9 (45.0)	3 (15.0)		4 (20.0)	4 (20.0)		
Obstetrics/Gynecology	3 (18.75)	4 (25.0)		3 (18.75)	6 (37.5)		
Pediatrics	24 (10.6)	74 (32.6)		43 (18.9)	86 (37.9)		
Surgery	6 (16.7)	14 (38.9)		7 (19.4)	9 (25.0)		
Specific type of team, n (%)			.79			.42	.59
Hematology/Oncology	3 (8.8)	9 (26.5)		6 (17.6)	16 (47.1)		
Infectious disease	8 (16.7)	16 (33.3)		12 (25.0)	12 (25.0)		
Medical intensive care unit	7 (22.6)	11 (35.5)		6 (19.3)	7 (22.6)		
Other	106 (17.7)	173 (28.9)		123 (20.5)	197 (32.9)		
Training level of consulting physician who wrote daily notes, n (%)			.58			.64	.065
Medical student	8 (9.1)	19 (21.6)		26 (29.5)	35 (39.8)		
Postgraduate year 1	50 (17.8)	77 (27.3)		61 (21.6)	94 (33.3)		
Postgraduate year 2	21 (21.0)	35 (35.0)		13 (13.0)	31 (31.0)		
Postgraduate year ≥3	21 (16.0)	38 (29.0)		27 (20.6)	45 (34.4)		
Resident of unknown training year	5 (19.2)	9 (34.6)		6 (23.1)	6 (23.1)		
Fellow physician	0 (0)	5 (83.3)		1 (16.7)	0 (0)		
Attending physician	20 (25.0)	26 (32.5)		13 (16.3)	21 (26.2)		

surgery: a dynamic human factor. *Ann Thorac Cardiovasc Surg*. 2008;86(1):123-131.

4. Nicolas K, Raroque S, Rowland D, Chaiban J. Is there a "July effect" for inpatient glycemic control? *Endocr Pract*. 2014;20(9):919-924.
5. Nicholson WK, Witter F, Powe NR. Effect of hospital setting and volume on clinical outcomes in women with gestational and type 2 diabetes mellitus. *J Womens Health (Larchmt)*. 2009; 18(10):1567-1576.

https://doi.org/10.1016/j.jaad.2019.02.030

The most common causes of burnout among US academic dermatologists based on a survey study

To the Editor: According to the 2018 Medscape National Physician Burnout and Depression report, 32% of dermatologists are burned out.[1] This represents a large decrease in dermatology burnout from 46% in 2017; however, the threat of burnout in dermatology has not disappeared.[2] For the first time in 4 years, dermatologists were not ranked as the happiest physicians and the percentage of dermatologists reporting extreme happiness decreased from 43% in 2017 to 33% in 2018.[1-4] The best way to understand and combat burnout in dermatology is to identify which factors cause dermatologists to feel burned out. Sources of burnout may be different for academic dermatologists and private dermatologists given their separate settings and responsibilities. This study aimed to assess the most common causes of burnout among practicing academic dermatologists in the United States.

An anonymous Research Electronic Data Capture survey approved by the human research subjects committee at Wake Forest School of Medicine was sent to 518 academic dermatologists through an Association of Professors of Dermatology listserv e-mail. An optional question on this survey asked dermatologists to describe the factors that contribute to burnout in dermatology. Free text was collected. The dermatologists' comments were grouped into categories and are reported in this study.

Of the 518 e-mail recipients, 91 attending dermatologists (18%) participated in the survey, and of the 91 survey participants, 58 (64%) commented on causes of burnout in the field (Table I). The most common cause, reported by 19 dermatologists (22%), was excessive documentation and time spent on the electronic