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INTRODUCTION

Inpatient dermatology is emerging as a distinct dermatology subspecialty where dermatologists specialize in caring for patients hospitalized with skin disease. While the main focus of inpatient dermatology is the delivery of top-quality and timely dermatologic care to patients in the hospital setting, the practice of hospital-based dermatology has many additional components that are critical to its success. Factors that must be optimized in one's inpatient dermatology practice include integration of hospital consultations into one's current dermatologic practice, interactions with both colleagues of other specialties and allied health professionals, and education and training of medical students, residents, and non-dermatologists. Furthermore, as there is often little available data in the form of randomized controlled trials that can guide dermatologists in the care of the rare conditions encountered in the hospital setting, it is incumbent upon those who do care for these patients to generate the academic work that provides such guidance. Finally, the future of hospital dermatology demands that we train future inpatient dermatologists and provide the foundation for the subspecialty to evolve.

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Up until now, there has been no written guide on how to set up, manage, or optimize an inpatient dermatology practice. It is with this in mind that I decided to focus this issue of *Seminars in Cutaneous Medicine and Surgery: Hospital Dermatology* on the "how-to" of inpatient dermatology.

The series begins with a review by Dr Rosenbach on the logistical requirements to consider when starting an inpatient consultation practice. In this thoughtful piece, Dr Rosenbach addresses many practical and impactful components of hospital dermatology, including finances, organizational aspects, workflow and efficiency, data tracking, and measuring impact. This manuscript is a fine introduction to how one might implement a new or enhance an existing inpatient dermatology practice.

In the next article, Drs Ackerman and Kessler candidly discuss how to have an impactful and efficient inpatient dermatologic presence in the community hospital setting while still maintaining a primarily outpatient dermatology practice. Not only is this manuscript a practical guide but it also addresses what could be argued as one of the largest hurdles facing our specialty today, ie, increasing the presence of dermatologists in nonacademic hospitals throughout the country, thereby elevating the stature of dermatologists in the eyes of the house of medicine as a whole.

The application of teledermatology to inpatient dermatology has great potential. In the third article of the series, authors Tull and Wanat present teledermatology as a way to both effectively triage the acuity of hospital consultations and increase physician access to inpatient dermatologists in communities and centers where there is little-to-no hospital dermatology presence. The existing models of teledermatology, their benefits and limitations, and their application to inpatient dermatology are thoughtfully considered.

Authors Nguyen and Miller devote the fourth article to the role of inpatient dermatopathology in the practice of inpatient dermatology. Inpatient dermatopathology has its own challenges, which are reviewed in this paper. In addition, the authors make practical suggestions to optimize specimen handling and turnaround. A highlight is a summary of technical considerations, such as biopsy site based on morphology or differential diagnosis, specimen acquisition when infection is considered, and bedside diagnostic techniques.

The fifth and sixth articles in this series are introspective narratives on the roles that education and communication play in the hospital setting and how to enhance these experiences for both the educator and the learner. Authors Afifi and Shinkai appraise the literature on the best practices of education and communication in the workplace. In their first article, they also propose specific curricular objectives and education methods that could be applied to the inpatient setting; in their second, they detail the required components of effective communication as a hospital consultant.

As mentioned previously, inpatient dermatologists must work to produce evidence-based practice guidelines for the rare diseases that we manage, despite the barriers that exist. In the seventh article, Dr Micheletti discusses strategies to overcome said barriers so that we may ultimately provide the best possible care to our hospitalized patients.

As the subspecialty of hospital dermatology expands and the patients and diseases we manage become increasingly complex,

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we must consider how to best train future hospital dermatologists. One model to consider is an inpatient dermatology fellowship, the subject of which is explored by lead author Sun in the last article of the series. The challenges and successes of non-dermatology hospitalist fellowship models are examined and applied to hospital dermatology.

And so it gives me great pleasure to present to you this issue of *Seminars in Cutaneous Medicine and Surgery*, one that I hope provides a foundation for not only the development of future inpatient dermatology services but also the strengthening of those that already exist.

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