BJD
British Journal of Dermatology

# A very peculiar practice: dermatology in the era of COVID-19

DOI: 10.1111/bjd.19414

'Aren't you one of the dermatology consultants?' – the staff nurse was looking at me with slightly narrowed eyes, and an expression that wavered between curiosity, confusion and amusement ... and then settled on fear and blind panic. It was Saturday morning, and I had just stepped on to a 30-bedded acute coronavirus disease (COVID) ward in the hospital for the start of my shift. I was wearing a hopelessly oversized set of theatre scrubs, with a stethoscope draped unconvincingly around my neck.

In the middle of March 2020 the UK government declared its strategic response to the crisis posed by COVID-19, an announcement that set in motion a series of profound changes in the provision of services, in both primary and secondary care, and a complete upheaval in the way all doctors practice medicine. It quickly became apparent that the numbers of extremely ill patients with COVID-19 would swamp the existing acute services. Thus, physicians from a variety of nonacute clinical specialties at our South London hospital were asked to redeploy to COVID wards to bolster the staffing.

There was little time to process this alarming directive – alarming because acute medicine was for many in the dim and distant past, and alarming because in our new clinical roles we would be exposed to high levels of active infection. The days before were spent furiously reading about a host of acute medical problems: how to manage type 1 respiratory failure, how to insert a venous cannula, how to prescribe heparin. These and similar clinical competencies were to be our primary skill set over the next few weeks while clinical dermatology was temporarily put to one side.

It was not only the worry of contact with coronavirus that caused anxiety, it was the fear of incompetence that made the palms sweat. It would be erroneous to claim that the mantle of relevant knowledge was effortlessly assumed, but equally it is true that generic clinical competencies, such as history taking and careful clinical examination, honed in dermatology practice, stood us in excellent stead. Physicianly skills of compassion, careful listening, clear communication and leadership proved equally readily transferrable to our new environment. Encountering death was an aspect of our redeployment that was more unfamiliar; dermatology being a nonacute speciality, we are usually sheltered from end-of-life care. This proved emotionally challenging to many of those redeployed.

Almost inevitably, in the aftermath of the COVID experience, our minds have turned to the oft-debated question of whether a dermatologist is exclusively 'a doctor of the skin', or, to borrow the terminology preferred by an eminent South London colleague, Professor Peter Mortimer, 'a physician with an interest in the skin'. Fresh from our exposure to the acute wards, there is a certain attraction to a professional life combining both skin and internal medicine. The holistic approach we bring to dermatology patients lends itself well to multisystem disease; surgical training affords us a manual agility transferrable to medical procedures; and our communication skills, honed in many hours of outpatient consultations, would be an asset in the practice of general internal medicine (GIM). The increasing recognition that inflammatory skin diseases such as psoriasis have important systemic comorbidities, and the advent of immunomodulatory treatment in the management of these diseases, will likely demand more internal medicine competencies of dermatologists in years to come. From an organizational perspective, the position of dermatology within acute hospital trusts would be assured if we were to share in the burden of managing hospital inpatients.

This is not to suggest that such a career path would suit all. However, one is prompted to consider anew the concept of the 'dermatology hospitalist'. This model, well established on the continent and in the USA, would allow motivated individuals to pursue GIM training in tandem with dermatology training, with a view to specializing in the care of dermatology inpatients as well as contributing to acute medical services. Achieving dual accreditation in dermatology and GIM would necessarily take longer than existing specialist training; nonetheless, development of the 'dermatology hospitalist' would follow in the footsteps of other specialties: for example, a proportion of rheumatologists acquire registration in both rheumatology and GIM.

We found our redeployment experience to be invigorating, and returned to dermatology with renewed enthusiasm for our specialty and its role in the acute hospital context. The pandemic has been an opportunity for what is sometimes referred to in the world of management consultancy as 'disruptive innovation'. There is no doubting the disruptive effect of COVID-19. We must grasp this opportunity for innovation, and allow it to stimulate potentially exciting developments in the practice of dermatology.

Acknowledgments: The authors would like to thank Professor Peter Mortimer for his review of this manuscript and for his helpful comments.

*A Very Peculiar Practice* was a surreal comedy drama, written by Andrew Davies, set in the health centre of a British university. It was broadcast on the BBC between 1986 and 1988.

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Conflicts of interest: The authors declare they have no conflicts of interest.

Funding: none.