

Editorial

Dermatology: we need to look beyond the borders

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In medical practice, specialization has improved the delivery of medical care in many ways, but much like the rest of life, it also has resulted in compartmentalization. Compartments create borders, and all of us, at one time or another, have trouble seeing beyond them and thus prevent us from visualizing certain things. There are important things happening in other disciplines that we can't see. There may be bias in what we see coming from another compartments, so this also makes some of our own observations untrustworthy and we can't always trust even what we do see. Furthermore, this approach also affects the context in which we interpret our observations. These limitations on perception impact the physician-patient relationship and outcomes of care, as well as inter-specialty relationships. The implications of borders are so profound that we may consider that some of our current thinking or past beliefs were erroneously based on an effect of compartmentalization. Compartments exert significant influences over our views of the world. We should be better integrated with our colleagues in other compartments of medicine. This would reduce the mistrust that compartmentalization engenders. Though it

may appear otherwise to us at times, we shouldn't forget that all medical specialties have one thing in common; that is, holding patients' interests at heart.

Being dermatologists, we often become so tubular in our approach that we hardly think of other compartments of medicine. When we become compartmentalized, we can't see many things and for those things that we do see, we may not be looking at their full perspective. Remember there are things that we don't see. We must be on the lookout for them. For those things that we do see, we should start looking at a representative sample and in full perspective. Compartmentalization have dramatic effect on our interpretations of observations in our professional lives and this also makes us to think that miscommunication and differences in interpretation of observations are the root cause of even some of the most horrific conflicts in the world today.

Let's now see the impacts of compartmentalization in view of our own specialty.

We start with things that we can't see. In dermatology when we attend the patients in our clinics, we give prescriptions to them. If a patient returns not doing well, we perceive that our medications did not work. But we can't see whether that patient followed the instructions and used the medications

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properly as we prescribed. It has been known in a clinical trial¹ that patients do follow the prescription in the beginning but compliance reduces gradually in following days and weeks and it becomes almost zero in about six months in case of some chronic dermatological illnesses like psoriasis. We may contribute this non-responsiveness as tachyphylaxis² (the more you use the steroids, the less it works) but in fact this is a result of non-compliance (the less you use the steroids, the less it works). Sometimes patients adhere to the prescription but at the same time they also use some other alternate/homeopath medicines or spiritual therapies that can aggravate or improve the disease.

Things that we can't see are, indeed, very important. But what about the things we do see? We rely on our own observations for our judgments. Because of compartmentalization, there are certain things we can see that should not be trusted. Intralesional steroid in appropriate dilution is a very effective treatment of alopecia areata. Let's assume for a moment that weekly intralesional steroid injections for four weeks clear 90 percent of patients with alopecia areata. If we treat ten patients in our office, nine of these patients will clear. House remedies like application of garlic or garlic extract at affected area is another form of treatment, but many dermatologists don't think that application of garlic extract treats the patches of alopecia affectively. Let's just assume for a moment that application of garlic extract is as effective as intralesional steroid treatment, that it would clear nine out of ten patients (this is just hypothetical). Let's say a dermatologist sees ten patients who came in after trying application of

garlic extract twice daily for 4 weeks for alopecia areata. How many of them would be clear? At face value, the answer appears to be nine; but, this will not be the case in actuality. Patients whose patches cleared with application of garlic would not come in to see a dermatologist. The dermatologist would only see patients whose disease did not respond. Relying on these observations, dermatologist would get a very wrong sense of the actual efficacy of garlic in treating the patches of alopecia.

Similarly many of the skin disorders are effectively treated by general duty medical officers (GDMOs) or general practitioners (GPs) at primary care level. How many of us have ever seen a patient for a skin disease that had been effectively managed by the GDMOs or GPs? None. Only treatment failures are referred to a dermatologist. This simple fact makes it too easy for us to believe that doctors at primary care level do not effectively manage their skin disease patients.

We do our best in treating patients; we take care of hundreds and thousands of them, and majority of our patients do acknowledge our efforts. Few odd patients who are not satisfied with our treatment or who develop some serious problem would give warped impression and the news media, however, would only report that odd patient (may it be 1 in 10,000), and the public would receive a wrong impression about medical practice. If someone wants to understand the quality of medical care in the country, he or she shouldn't judge it solely on the events that newspapers report. He/she needs to get in there and assess a more representative sample.

Departmental bias has dramatic impact for inter-specialty relationships. We need to look beyond the borders of our specialty and integrate dermatology with other specialties. Although all doctors go to medical colleges, they eventually opt for different specialty group compartments. And the impact of this compartmentalization reflects how different specialties view each other. This kind of bias also affects the perception between different specialties. We dermatologists effectively treat many benign, premalignant and malignant cutaneous tumours. When surgeons see occasional patients with cutaneous tumours referred by dermatologists that had not been managed well with cryosurgery or Mohs' surgery, etc. they would get a warped view of the care that dermatologists provide. Similarly there are certain skin disorders that overlap between different disciplines of medicine and compartmental approach in managing these may create misperceptions. Perception that we make in our mind about something is always based on the context. The vast majority of what is seen as "good" or "evil" is affected by context. For example, pharmaceutical companies are considered evil in the public eye. Yet these companies

create, discover and develop the drugs that actually improve our patients' lives. As Livingood³ stated, that it was very important that dermatologists need not be insular and that we look beyond the borders of our own specialties. Dermatology is a small specialty and that we need to look beyond and integrate with the rest of medicine. Similarly, we should also look beyond the borders in our lives.

References

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