EDITORIAL

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THE ART AND STYLE OF DERMATOLOGIC PRACTICE

When I was approached to write an editorial I enquired about the editor's preference of a subject between "*Dermatologic Practice*" and "*Clinical Research in Dermatology*", two of my major pursuits as a dermatologist. As anticipated, the response was for the latter! I have always marvelled at the hypnotic fascination of all the literates (which includes us) with the word "research"! I remember to have read many articles on methods of research but not a single one on how to practise dermatology although for almost 99% of us more than 90% of our professional time is going to be in practice. Hence I decided to look back on my evolution as a practitioner in dermato-venereology and see what sort of picture emerges. I beg of the reader's pardon in advance for essentially an ego-centric account, but hope that this venture may profit at least some of them who may be in the beginning of their career.

Let me first define what I mean by the art and style of practice. The art of practice, like all artistic endeavours, requires a "logical approach" to different facets of the presenting subject, so as to gain aesthetically satisfying picture to oneself. Hence I do not claim universal appeal. The facets of dermatologic practice requiring logical approach are:

a) to define the problem of the patient in the short time of the first consultation leading to rational diagnosis, prognosis, and therapy and a working hypothesis on the possible approaches to all the three.

b) to brief the patient in his own language the total problem as above, so that he knows the routes we shall follow in arriving at a diagnosis and therapy, as he happens to be the second party in our deal.

c) to give quickly as much relief as one can in the meantime.

The style of practice refers to developing a framework for application of new knowledge on the etiopathogenesis, diagnosis, and therapy. Let us look closer now at the above items.

The Art:

(a) To define the problem quickly at the first consultation one requires to assign priorities to common diseases which form almost 80% of our daily practice. One should study intensively their clinical and diagnostic facets, their natural history without treatment, and possible treatment procedures.

For this purpose I have catalogued 20 common problems of skin and V. D. practice in India, based on my experiences on their ecology[1], and frequency in practice[2].

TABLE I

Twenty common problems of skin & V. D. Practice in India

1. **Infectious and communicable Dermatoses :—**
   Scabies, Pyoderma, Dermato-mycoses, Leprosy, Viral Dermatoses
2. **Dyschromias**
   (a) Hypo or Depigmentations.
   (b) Chemical Melanosis.
3. **Allergy-Eczema-Dermatitis Group**
   Urticaria, Parasitic Eczema, Drug eruptions and iatrogenic dermatitis.
4. **Adnexal disorders**
   Acneform eruptions, Hair disorders.
5. **Venereal diseases**
   Varieties of Balanitis, Urethritis, and genital sores.
6. **Diseases of unknown origin**
   Lichen Planus, Psoriasis, Pityriasis Rosea, Seborrhoeic Dermatitis

More than 1400 other dermatologic problems will form about 20% of the practice over a number of years. One gets sufficient opportunity to read up on these when faced with a problem thus building our experience of the total speciality. Further I catalogue review articles and new informations on 40–50 diseases which form the remaining 20% of practice in such diverse groups of diseases such as common papulo-squamous disorders of unknown etiology, collagen disorders, vasculitis, hair problems, common neoplasms, bullous and genodermatoses and other still rarer uncommon problems. I believe that this approach could help to arrive at a "quick" working acquaintance which could deliver results for a new entrant to our specialities. Just count the number of articles published on rarities and one may soon realise the oddity of our fascination for the "difficult case" — Sherlockian instinct. On the above grounds I advocated 16–20 lectures cum clinics for under-graduate teaching of our specialities in India[3], which could help a general practitioner to look after more than 60% of his dispensary problems of dermato-venereology. Next one must learn quick working - method. Most dermatologic texts give details of methods of examination from which one could design one's own method. I have summed up mine and named it as the "Panchsheel" (five principles) of dermatologic diagnosis[4]. Important thing is not the superiority of one or the other method, but "remembering" to apply it to all patients and get "relevant and practical" information. The clinical diagnosis is either arrived at within first 5 minutes for most common problems in dermatology or it is going to take time. About 20% of patients require diagnostic aids such as curettage, magnifying lens, testing the sensations or skin function, diascopy or Wood's Lamp.

Another 10% may require simple laboratory aids viz. KOH examination, Giemsa Stain for cytodiagnosis (excellent presentation on its applicability is given by Graham, Johnson and Helwig)[5]. and Grams and acid fast stains for common microbial infections in India and routine urine and blood examinations. Less than 1% of patients will require histopathologic confirmation. These methods are simple but must be learnt by practice and

checked on the spot. I wonder how many of us possess a small one table laboratory not only for quick confirmation but also to give a scientific image to our practice.

b) To brief the patient in his own language about the causative factors, possible life history of the disease, and anticipated therapeutic approaches is the most important and difficult art to learn by practice. Moreover the information has to be tailored to his understanding. It is necessary to educate the patient with judicious knowledge on the disease which he is suffering from, so that he is not misled by the market and family "rumours" as well as "remedies" including from the so called other "systems" of medicines. For this pupose, after explaining to the patient, I give a printed brief of current knowledge on common problems in my practice such as vitiligo, skin infections, methods of disinfection, Acne, Hansen's Disease, Psoriasis, and hair problems. This also helps in erasing the patient's "false knowledge" on his disease, and our "false assumptions" on the practicality of our advice to him.

Since the patient-doctor relationship involves financial transaction (in private practice) the patient should be made to assess his economic liability for chronic diseases, otherwise the patients are likely to blame us for the "high" costs which they did not anticipate. In the absence of health insurance this is one of the most difficult problems: as there are limited ways of paying for illness, viz., either one pays when one is healthy (i.e. insurance) or one pays when one is sick, or the state pays — but someone has to pay! Thus one can help a needy patient to tailor his costs by adjustment of fees, as well as economy in choice of diagnostic and therapeutic methods when available.

At this point I shall refrain from commenting on the polar attitudes to patients of "a caring idealist" (a full time employed specialist believes to be) and "a rank materialist" (a private practitioner). These are eternal subjects of debate.

(c) To give relief: The patient is impatient for quick relief and is not interested in a "brilliant" diagnosis of a "rare" disease. Hence one needs to learn about quick relief procedures to bridge the time required for full revelation of the disease or for investigative procedures. Severe pruritus, acute oozing, acute inflammations and ulcers, widespread bullous eruptions are some of the dermatologic symptoms requiring quick relief in the same fashion as fever, headache or diarrhoea. Judicious combination of symptomatic and specific remedies may have to be used. Reasons for delay in getting adequate relief for chronic conditions such as Psoriasis, Lichen Planus, vitiligo, Hansen's Disease and Pigmentary problems should be explained at the first interview because patients generally expect quick results from allopathy while they are "conditioned" to await years if not months of doubtful treatments "when their bad blood is being improved" "heat is being removed" or "the disease is being cured radically" and "constitution changed" by other systems of practice! Judicious hope should always be given by pointing out positive areas of help one can offer. Patients of psoriasis, or acne or vitiligo should be taught to look after their prolonged problems and their limits of proficiency shown, after which medical help may be required. I give them a target of 3 months to learn. This allows us to sort out individual responses and to assess their capacities for self-help.

Style of Rational Practice :—

This requires continuous development of framework for application of

modern knowledge in daily practice. This item is of first importance in the making of a successful specialist, unfortunately also the first casualty in our set-up because of lack of perception of the necessity and ability to imbibe new facts, as well as absence of a stage for learning and assessing new methods.

Several times, we have tried to organize a seminar on modern therapeutic practices in India as the most important part of our conference, but somehow, we have succeeded only on rare occasions. It is a well known fact that 50% of knowledge every five years and 70% every 10 years is redundant and is replaced by new findings in almost every field of science. This situation requires systematic investment of 20% of work time and reasonable amount of money in books, journals and attending "worthwhile" conferences. Without this, "learning by experience" is a delusion of making the same mistakes with increasing confidence of age and success. Intelligent choice of reading material from many books and journals is required. Besides the well known text books of our speciality journals from India and abroad, atleast one journal giving a background of medical practice in other specialities is required (I prefer British Medical Journal) to give an idea about progress in the related fields. Additionally the year book of Dermatology, Recent Advance volumes, a current book on dermal pathology and Martindale[6] (an excellent reference on all the current drugs, their actions, reactions, and usage with trade names). This gives a perspective of the usage of many common drugs e. g. tranquilizers, immuno suppressive drugs, antibiotics, hormones and drug interactions as well as common medical problems we may face in our practice. To imbibe new knowledge one requires to catalogue what we read from above. I make a card index or a "ready reckoner" of drugs, dosages, and diseases in daily practice. After a few years in the beginning I gave up binding journals which voluminously sit on our book case gathering dust, and consume space and money out of propotion to the return one gets from preserving them. I cut out articles of three categories viz. diagnostic procedures, therapeutic procedures, basic sciences and new knowledge on medicine, and catalogue them. I also make cards containing short summary of references on uncommon diseases in practice, and on new treatments or diagnostic methods for ready availability of information. This style helps to avoid reflex "oozing out" of "therapeutic inflictions" from our pen!

Proper "medicare" requires continuing "research" of the literature which one may have read but forgotten to organize in a retrieval system as indicated above.

Hence let each of us determine how far we can deliver the social demands on scientific medicine by adding the dimensions of the art and the style in daily practice.

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