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AN EDITORIAL

On 1 April 1968, a "National Program for Dermatology" was submitted to Dr. James Shannon, Director of the National Institutes of Health. The text of 350 pages was prepared through the collaboration of more than sixty American dermatologists and is said to represent the first attempt of a specialty to evaluate itself: to review its own past, analyze its present performance, and project its future in an objective yet flexible manner. It was done without government or foundation support of any kind to help defray the considerable cost involved in time, effort and money.

The stimulus for the sudden and intense flare of activity that produced this document in the short period of 12 weeks was a formal request to several major dermatological organizations in the fall of 1967 from the National Institutes of Health. It was intended that the position of the specialty be established with relation to dermatological disease in the nation as a whole, giving particular consideration to disabling disorders. Thus dermatology became the first of a number of specialties to be charged with preparing an assessment of its own achievements, potential and needs. It was suggested that the evaluation might serve the government as a guide for future planning and support in consonance with its goals and overall health programs. The report, therefore, had to be written in language and concepts which were not only intelligible and meaningful to the knowledgeable layman sitting on the Bureau of the Budget or in the Congress, but also to the non-dermatologist physician and scientist.

To answer the challenge of the National Institutes of Health, the American Academy of Dermatology, the most comprehensive and representative organization of American dermatologists, appointed at its annual meeting in Chicago in December 1967 an *ad hoc* committee to prepare the report due in Washington by 1 April 1968. The name "Joint Committee on Planning for Dermatology" was chosen because it was anticipated that there would be approval and support from the other major dermatological organizations. In fact, the Committee has since received official endorsement from the American Board of Dermatology, the Association of Professors of Dermatology, the American Dermatologic Association, The Society for Investigative Dermatology, and the Dermatology Foundation, as well as financial support from the latter three organizations and the American Academy of Dermatology.

From the start the enormity of the task and press of time were apparent but there was no clear concept of the expected content and extent of the proposed report. There were no guides, no precedents. Each member of the Joint Committee was, nonetheless, fully aware of the significance of the challenge. In the United States today health and health care generally are no longer considered a blessing but a right. The quality of life is no longer reckoned by threat to existence but by freedom from physical limitation, by ready access to the fruits of medical research. It is a demand that should be met, but not by compromising the quality of care. It can best be answered through the careful planning and programming of those who understand the patient and his disease, who can direct the search for new information in dis-

ease areas of greatest morbidity, and who can select and utilize the most promising yield of related research.

It was quickly determined that the overall objectives of the program should establish the significance of skin diseases and identify measures in patient care, education and research that must be taken to make significant progress in overcoming disability. It was also fundamental to prove by historical documentation that dermatologists are the best qualified physicians to cope with problems of the skin. If such specialists are in fact in short supply, then educational programs at every level from instruction of the layman to the training of the general practitioner and the non-dermatological specialist would extend the effectiveness of the dermatologist's expertise. Special programs for nurses, aides, and paramedical personnel would magnify the talents of each physician. Hence through the dermatologist directly, or indirectly by trained personnel educated by him and working in collaboration with him, the best in dermatological health care could be extended to all.

Inevitably such an extension in care will involve new concepts in the delivery of health services. No arrangement for patient care can ignore the interlocking of the training center with the practicing dermatologist. In many centers the bulk of clinical teaching and the management of the clinic patient is provided by the practicing dermatologist, often without stipend. His time and talent are invaluable to the specialty. They are given in the best traditions of medicine and as an expression of the need to keep abreast of current thought and techniques.

But what of the practicing dermatologist who is far removed from a training center? What of the dermatological problems that are even farther removed from the specialist? In some way yet to be undertaken, lines of direct communication must be established with the dermatologist afield and from him to the problems demanding specialty care. This could be achieved through special educational programs provided for the distant specialist and by him to others. It may be facilitated by Dermatology units designed for specific diagnostic and therapeutic care, some with in-patient facilities, others not. It may be implemented through community hospitals, in special mobile units, by regional health programs, by special screening techniques, and more than likely by a host of techniques not yet imagined. The essential factor is the cooperation of the practicing dermatologist. Without him no effort to reduce dermatological disability through improved and extended patient service can ever succeed.

Obviously any program with a goal to conquer disease must place strong emphasis on research as well as on patient care and education. Pertinent investigative programs must include "disease-oriented" research with the study of fundamental general phenomena of cellular biology and chemistry which underlie pathogenic mechanisms. It might also extend to investigating phenomena of unrecognized, unknown, perhaps non-existent links with dermatological disease. It should emphasize the desirability, even the necessity, of following the current trend to channel research efforts toward problems that are significant in terms of suffering, disability, and increased prevalence. The Committee selected psoriasis, eczematous dermatoses, drug eruptions, cutaneous infections, acne and dermatoses due to environmental factors as

examples of disease-oriented research. Research on melanin, the epidermis and connective tissue were used as examples of basic approaches to the pathogenesis of skin diseases.

Certain of these research areas may adapt to a coordinated scheme, the multi-disciplined approach of the Institute, but others will not. The important point is that "investigative" dermatologists insure an effective challenge to the diseases of greatest insult. Through such a concerted effort it is hoped to reduce significantly their physical, psychic and economic burden.

The Committee strove to present hard facts, not opinions, and to furnish critical paths which included time and costs for the development of research and educational programs, and proposals for improved patient care. The preliminary report is replete with tables and charts of systems analysis that programs various undertakings from start to finish. With few exceptions the clinical data available were "numerator" type, reflecting the selection and interest of the clinic or hospital rather than actual prevalence of a problem in a community as a whole. As we sought to establish the "denominator" it became apparent that a substantial portion of skin disease—probably more than 70%—is not being treated by dermatologists. No doubt, many factors are contributory, including the degree of sophistication and selection on the part of the patient and his non-dermatologist physician. It is also in some measure a reflection of the limited total number of dermatologists and their uneven distribution about the country.

Perhaps the most painful realization of our study was to discover how lacking we are in hard facts of any kind about many of the very fundamentals of our specialty. To estimate the prevalence of skin problems, for example, we had to rely on insurance claims made against large carriers, on the workmen's compensation awards of various states, on loss of time from active duty by the military and on out-patient statistics for dermatology services of municipal hospitals. Prevalence rates for dermatological diagnoses among insurance claims (6.4%), among discharge diagnoses of hospitalized patients (3.6%) and of ambulatory patients to clinic facilities in civilian life (5%) and in the military (all 6.6%—Viet Nam 10.5%) were surprisingly consistent in demonstrating the magnitude of the problem. Yet these data are obviously limited.

Nor were we in a better position to arrive at a true figure for costs due to skin disease. We were forced to underestimate in order to base our calculations on firm figures. For hospital and professional medical costs as well as the dollar translation of man hours lost because of skin disease, we accepted the data of the most recent Public Health Service Publication that was pertinent, 1963. Not only are these data five years old but in large measure they are based on National Health Survey Information where estimates of problems of the skin are derived from questions concerning the seeking of a dermatologist's care, not specifically whether or not there has been a skin problem.

To these Public Health Service data, understated as they are, we have added the national expenditures for proprietary and ethical topical preparations. We ignored completely such costly oral medications as antibiotics and steroids which are often prescribed by dermatologists, but not by them exclusively

and not in any recognized proportion. We also excluded from consideration cosmetics, sunburn preventives and toiletries such as soaps. Despite these omissions, our estimate of the yearly cost of skin disease in the United States exceeds 1.5 billion dollars.

The order of magnitude of the economic burden and the significant prevalence manifested by an affected group of more than 10 million people, established beyond reasonable challenge that diseases of the skin constitute a national problem that cannot be dismissed. The consequences of dermatological disorders such as suffering and disfigurement would lend urgency to the problem but because they are almost impossible to measure have been ignored.

To implement our proposed solutions which involve education and research as well as patient service it becomes quite obvious that some coordinating administrative plan is essential for efficient function. For this a National Center for Dermatology has been proposed, not as a superimposed central authority, but rather as a central servicing-unit subordinate to the three major facets of the program and advised by a Council representing the major dermatological organizations and the National Institutes of Health. The chief functions envisioned for the center include data processing, the provision of educational materials, perhaps eventually courses and faculty, and the establishment of a reference laboratory of standards for test procedures, for antigens and such chemical and cultural media that are needed in special dermatological tests. There would also be a section for coordinating cooperative clinical studies, providing guidance for statistical sampling. In the future new roles will undoubtedly become apparent.

The National Program for Dermatology bears on its cover the imprint "preliminary report" to remind the reader that it represents a first attempt to collect and collate available data, to generate and develop solutions to problems. A revised version is due in Washington in April, 1969. Despite the preliminary status of the present report it has been well received and may well become a prototype of self evaluation for other specialties.

In the preparation of present and future "Programs" there is the continued stimulus to view our specialty holistically. The most gratifying aspect is to recognize its potential, to realize we can be instrumental in shaping its future. We have proven that we are organized, cooperative, interested, that we can act in unison with speed, state our goals, and chart with precision our progress towards them.

The preliminary Program must be honed and improved, perhaps completely changed. This can only be done effectively through a feed back of ideas and constructive criticisms. The next version of the National Program for Dermatology will be merely another phase in a continuing effort to program a future for dermatology which will provide the best in medical care for all afflicted with skin diseases while maintaining standards of education and research second to none.

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