

OPINION ARTICLE

Dermatology and Primary Health Care: An Obligatory Relationship

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The relationship, or ideal relationship, between the dermatologist and the family physician differs, as in so many other areas of dermatology at present, according to whether we consider the public or private sector.^{1,2}

This dichotomy is driving an increasingly large wedge between dermatologists—both in terms of prices, salaries, range of services, career opportunities, and complexity of the activity and in terms of patient care. The process may eventually divide the profession into 2 ways of thinking, so I am obliged to concentrate on public health care, which is the only system that can be defined, evaluated, and compared today in Spain.³⁻⁶

Let us examine how primary and specialist care are related within the sphere of public health.

The dermatologist and the family physician attend the same patient and often treat the same condition. They belong to the same organization and have sufficient resources to carry out their work. They differ in that one is more specialized in certain techniques and can diagnose more complex dermatologic health problems, and the other can complement health care with a complete clinical history, an integral approach to the patient, and a relationship of trust. It is evident that the relationship between both professionals should be based on sincerity, mutual respect, and constant support so that the patient can benefit from uniform criteria and continuity in the health care provided and as perceived by the patient.⁷⁻⁹

It would be impossible to imagine an automobile factory without a close relationship between any 2 assembly line operatives. The consequent reduction in productivity would lead directly to their dismissal.

It is also true that, if there were no problems in this relationship, in other words, differences in criteria, this article would not have been written.

I propose to define the main players in this relationship, examine the current situation, and use examples to envisage a new type of relationship.

An analysis of current health problems¹⁰⁻¹⁵ treated in primary care and specialized care—dermatology in this case—will focus on the patient, management team (manager, medical director in both primary care and specialized care), and the pharmaceutical company, each with their own interests. Material resources, scientific evidence, and the disease should also be analyzed as should the physicians themselves (family and specialist), whose constant participation in decision-making makes their role pivotal. Their inter-relationship forms the basis of the system, the point of union between the levels.

Let us consider a typical health problem: acne.

1. The patient wants a quick and effective solution (no scarring, no effect on social life, no recurrence, and no treatment side effects).
2. In primary care management, the medical director's annual objectives might include a reduction in the number of referrals between primary and specialized care and an increase in the different types of problem treated, with a greater number of these in his or her centers. The manager will want to make savings in both human and material resources. These objectives must be reached without reducing the quality of health care.
3. The specialized care management team's objectives are to agree on the number of consultations per year, increase the number of visits from new patients relative to follow-up visits, ensure that the total number of consultations does not increase, classify procedures, and reduce expenditure on drugs. In addition, the manager wants to make savings in both human and material resources. These objectives must be reached without reducing the quality of health care.
4. The pharmaceutical company wants greater use of its products and greater profits, regardless of whether or not the scientific evidence is the best available. In fact, if the company can withdraw older products, even if they are still effective, it will do so, as they do not generate enough profits. In the case of acne, pressure will be applied to use isotretinoin earlier, for longer, at a higher dose, and more often. This has become all the more urgent since brand deregulation, the advent of generics, and the subsequent price drops.
5. Scientific evidence will make it possible to define which drug to use from among the range of currently available

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Accepted for publication February 9, 2007.

medications. This will be the drug with similar effectiveness at a lower cost and with fewer side effects and faster action, that is, the medication will be used rationally. However, this does not necessarily imply a reduction in the cost of treatment, as the best scientific evidence for each patient would mean having a complete range of services in all medical departments that would be freely available to the whole population. For example, a patient with scleroderma would be treated in the same way and using the best scientific evidence regardless of his or her place of residence (large city or small village some distance from a hospital).

6. As for material resources, in the case of acne, both primary and specialized care may have the available means, thus complicating matters. If the material resources were available only in the specialist center, then it would not be necessary to decide who should apply therapy.
7. The disease to be treated. Acne, for example, is peculiar in 2 ways: once the indication has been established, all patients to be treated with isotretinoin must be evaluated, treated, and followed up by the dermatologist; and women of childbearing potential must start using contraceptives—very often the health centers themselves manage family planning.
8. The family physician and dermatologist should form the link between the 2 levels of care. Thus, the family physician will refer patients with acne vulgaris to the dermatologist to start treatment with isotretinoin. Other standard treatments can be started at the health center. However, the lack of communication between the family physician and the dermatologist means that these patients arrive without the relevant laboratory analysis, without having started to use contraceptives (women of childbearing potential), and without sufficient information to sign a consent form. This usually generates a fruitless visit after a delay in health care provision. An analysis must be requested before the patient can be referred to another specialist so that contraceptives can be started, thus producing very unwelcome delays.

Analysis of another health problem such as actinic keratosis, which can be treated by the family physician using an economical and effective resource such as Efludix, shows us that the family physician will eventually prescribe a more expensive and, at best, equally effective treatment due to pressure from the specialist and the pharmaceutical company.¹⁶ The company will attempt to have very cheap drugs withdrawn from the usual sales channels. The specialist, who is influenced by the pharmaceutical industry for different, easily imaginable reasons, will use more expensive procedures or drugs.

Other techniques could be used to treat actinic keratosis, such as cryotherapy, electrosurgery, or photodynamic therapy, but these are usually the domain of specialists, and thus

always involve a referral. This leads the primary care physician to try to convince management that in-house cryotherapy would reduce the number of referrals, with the result that many health centers now have cryotherapy equipment.

Therefore, a decision influenced by a pharmaceutical company finishes with the implementation of cryotherapy in a primary care health center. Decisions should be considered carefully, since they can affect matters of policy.

But that is not the end of the story. Once cryotherapy, electrosurgery, or minor surgery has been installed in primary care, a new problem arises, namely, physician training and know-how. As they feel isolated and in a separate area from the dermatologists, family physicians form training groups, and, in order to maximize their financial resources, they begin to attend courses in minor surgery and cryotherapy. That is, these procedures are set up in primary care and, instead of receiving appropriate training from dermatologists, the family physicians themselves carry out the training. In some cases, the quality of training is obviously unacceptable and can lead to the transmission of errors stemming from a lack of experience or knowledge.

Therefore, a decision based on lack of communication and financial pressure from pharmaceutical companies substantially impairs the management and treatment of dermatology patients.

This generates a lack of trust between family physicians and dermatologists. Family physicians see dermatologists as colleagues who will not allow them to reach their objectives, who will force them to prescribe treatments that are not in their guidelines, and who turn the patients into an enemy by telling them that the treatment they have been prescribed is obsolete or that the referral has been made late.^{17,18}

By contrast, dermatologists think that family physicians have referred the patient incorrectly, are carrying out techniques that are going to take away their jobs, and are keeping patients that should be referred.

Therefore, what is the ideal relationship between the family physician and the dermatologist?

Some dermatologists feel that family physicians should not be the gatekeepers to specialized care and that the patient should have the choice. In our and in other European health services, this is not possible as it would be unfeasible. If we did not have family physicians to control referrals, we would be continuously caring for patients with no dermatological condition, a completely untenable situation from the point of view of a publicly funded health service. In such a case, the relationship between the dermatologist and the family physician would be neither real nor important.

However, the gatekeepers to health service dermatologists are the family physicians, and there is ample evidence that

patients prefer referral by the family physician to not being referred from primary health care.¹⁹ This referral must be based on agreed principles and supported with structured ongoing training.

In 2006, the Ministry of Education, in association with the Ministry of Health, approved a project aimed at enhancing this relationship, given its importance for the public health service. Thus, medical residents from different specialties that have a close relationship with primary care would have to rotate for a specific period in a health center. Dermatology is one of these specialties.

Also in 2006, the general management of the Madrid Health Board encouraged strengthening of the relationship between both levels of care in the belief that this increased collaboration would improve the system and lead to shorter waiting lists. The consultant specialist was considered as a regulator, and one of the most requested specialties to initiate that relationship was dermatology.

Once again, old and out-of-date methods—sessions, joint consultations, reference specialist as patient contact—were used to try to make the relationship work. However, with the exception of the creation of “parallel hospital services” to attend patients faster, as if they were preferential patients, these initiatives did not take shape.²⁰⁻²² Undoubtedly, this latest initiative requires greater human and material resources, quite the opposite of what was originally intended.

In my opinion, the only way to make this relationship last, to improve the efficiency of the system, and to enhance the quality of the health care offered and how it is perceived by the patient is through protocols and training.

Protocols

Protocols for both diagnostic and therapeutic action will serve to establish a relationship based on respect and unified criteria.

However, here we are faced with a new problem. Protocols have been developed for several diseases and in different specialties, yet they have not been effective at maintaining a relationship between both levels and have been filed away without their recommendations being followed.

This situation has arisen because joint protocols need to be founded on basic principles before they can be put into action. Their reason for being is to meet a common need and lead to agreement between all the parties involved, rather than in the imposition of a specific area of work.

1. No protocol (eg, a protocol for the treatment of actinic keratosis) can be drawn up by a pharmaceutical company and distributed to all health areas. It would not receive government approval and, even if it was based on scientific evidence, there would be an intrinsic conflict of interest.

2. A protocol drawn up and implemented by family physicians would not be accepted by dermatologists and vice versa.
3. A protocol promoted by management and aimed at the primary health care teams would not receive the support of a large number of physicians, as they would feel that some as yet undefined conditions might lead to an increased workload and poorer quality of life.
4. No protocol can be drawn up in scheduled meetings by middle managers who neglect their health care work and thus increase the workload of their colleagues.

Therefore, I believe that protocols should be drawn up through necessity and agreement. First, the need should be felt by both parties; an example might be treatment of actinic keratosis. Second, a protocol must be based on the range of services offered by both specialists and family physicians, bearing in mind that this may vary according to the hospital or health center and thus would require a personalized approach.

A working team must be chosen. This team will not be selected by management or heads of service, but by the general agreement of the team's members in the knowledge that they will sometimes have to work outside office hours, or that if this work takes place during office hours, then the team will have to take on part of the care workload or hire a replacement, with all that this entails.

Once the protocol has been drawn up according to the best scientific evidence available and with agreement on the form and duration of follow-up, the condition to be treated should be considered preferential and there must be no restrictions or waiting lists. Management would then endorse this, as it would form part of the range of services covered by the protocol and no referrals outside the protocol could be accepted.^{23,24}

A worthy example can be found in the protocol drawn up for acne. When family physicians refer a patient with acne to the dermatologist to start isotretinoin, the patient has the relevant laboratory workup carried out the same week, the appropriate contraceptive method, a negative pregnancy test, and the informed consent document that the dermatologist will ask the patient to sign. This means that after the first visit to the specialist the patient leaves the clinic with prescriptions and the obligatory report for the inspector. Patient perception of quality increases considerably. In order to complete the protocol, the dermatologist agrees to attend the patient quickly so that the results of the workup are valid to start treatment. In addition, such quick attention reinforces the relationship with the family physician.

The protocol obliges both parties to hold joint meetings with the aim of improving the quality of care.

Both physicians treat the patient and any breaches of the protocol are sanctioned.²⁵

A further step in this relationship involves defining the condition to be covered by the protocol. Almost all conditions can be covered by a protocol, but we must always be clear about the range of services provided by family physicians for a dermatological condition in terms of diagnosis, treatment, and applicable techniques. The relationship should be friendly, based on scientific evidence, and free from fear.

Another example might involve the treatment and follow-up of a tumor. If it is decided which aspects of the condition are to be followed up in primary care, then agreement would have to be reached that a biopsy could not be performed at this level, and family physicians would not be able to decide whether a tumor was malignant. Patients would have to be referred in cases of doubtful diagnosis. Furthermore, dermatologists must make family physicians aware that their range of services covers all skin tumors including ungual tumors, and that, if referral is necessary, this should be directly to the dermatologist and not to another specialist. Once the patient has been treated by a dermatologist and recurrence has been ruled out within a suitable timeframe, for example, in basal cell carcinoma, the stipulated periodic checkups could be with the family physician; moreover, this physician attends the patient for other health problems and will know earlier if the patient has had a recurrence. If a recurrence is observed, the dermatologist would treat the patient without delay.

Training

The relationship discussed here must be complemented by training,²⁶ which should involve not only chats in health centres, but also open access to hospitals so that physicians can visit their patients and keep up to date. Such a relationship nurtures trust between both parties, and the family physician can resolve any doubts in his or her daily practice through direct contact with the dermatologist. This type of training with a family physician rotating in a hospital is likely to meet with the reticence of primary care managers—for reasons of cost—because a replacement physician will have to be contracted. Covering the clinic using colleagues is not a valid option. The relationship forged by these rotations is long lasting, as it generates trust. Timescales for rotations and objectives would have to be defined.

Training programs must lack conflicts of interest. In other words, family physicians and their managers will not accept any training financed by or involving the pharmaceutical industry. This is of the utmost importance, since funding by the pharmaceutical industry can only be secondary and should come from more than 1 company. The rules of the game must be clearly defined and transmitted to all the relevant parties.

Where does teledermatology fit in all this? Is it more than just another tool to bring both physicians together? Some physicians claim that it would only be profitable for isolated patients or for patients who live far from a hospital. To provide an acceptable teledermatology service, the demands on the time of dermatologists, family physicians, and the patients themselves makes it of little practical use when both levels of care are physically close to one another, unless the patient suffers some physical impediment. Some managers initially thought that teledermatology would reduce the need to hire dermatologists, since problems could be solved without physically needing to see the patient. However, they did not factor in the time necessary to perform the technique and, even though agreement can be greater than 80% in planned studies, the reality is that the same number of biopsies are performed and the burden on human resources is not reduced.^{27,28}

Clearly, these proposals will not be shared by all; in fact, many may consider them somewhat utopian and, therefore, unattainable. Some may think that strengthening or improving the relationship between family physicians and dermatologists could negatively affect the number of patients attended, especially in private medicine. However, I believe in the advantages provided by the Spanish public health system, its high level of quality, and its accessibility. It is also true that changes such as those proposed here can generate an excess of consultations, but this can be mitigated by an organized and continuous relationship between both levels. In conclusion, it is necessary to point out that, for the dermatologist, the family physician is a direct client who must be attended professionally and competently, since it is the family physician who decides how and to whom patients can be referred.

Conflict of Interests

The author declares no conflict of interests.

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