UNDER MY SKIN

Discretionary Spending

Chad sat on the exam table with an elegant black bag from Amphora, a local purveyor of high-end skin care products.

"I need a prescription for Protopic," he said.

"I'll put in for Prior Authorization," I replied. "But your insurance may not cover it."

So he asked for samples. Then he asked for a prescription for Propecia. Then he asked about Botox and Restylane.

BY ALAN ROCKOFF, M.D.

People's attitudes toward spending money can be hard to figure. Take Eunice, for example, who came by later the same day for me to remove a lesion on her shin that biopsy had shown to be a basal cell carcinoma. She showed me another spot on her arm.

"Could be the same thing," I said.

"The last biopsy cost me $127 after insurance," she said. "Must you biopsy this one, too?"

I told her that I must.

While I curetted her leg and arm, Eunice reported on her recent trip. "The cruise was fabulous," she said. "We've tried different lines, but Royal Flushing is the best. There are thousands of passengers, but you always feel like you're getting personal service."

"Where did you go?" I asked.

"Athens, the Greek islands, Rome, Venice. You know what the best part was—Lido. It's a small island near Venice, away from the tourists, very quiet, really lovely."

And not covered by health insurance, presumably.

So it's okay to spend money on Propecia, Botox, and Lido, but not on Protopic or a biopsy.

But the paradox is only apparent, not real. In fact, people divide the world in two: things you're supposed to pay for and things somebody else is supposed to pay for. What matters is not the size of the expenditure, but the category. How things get classified is a matter for economic anthropologists to figure out. But get classified they do.

I mention Chad and Eunice not just because they're fresh in my mind but because they're middle class. The kind of paradoxical economic behavior I'm describing is more often blamed on "welfare queens." Money for frivolities while stinting the essentials.

Not that I exempt myself from such attitudes. I confess to irritation when Mrs. Will Medicaid Cover This? tells me about her recent jaunt to somewhere tropical. The phenomenon, however, is not limited to the poor, or to the bourgeoisie, petty or haute, which brings me to the wealthy.

Gilbert drops by twice a year. He tells me about his efforts to raise funds for his alma mater, a venerable and well-endowed southern institute of higher learning of which he is very proud.

"We set a goal of $1.3 billion for our capital campaign," he told me recently. "But we're already over a billion, so we've raised the goal to $1.7 billion."

I would have whistled if I knew how.

Gilbert went on to tell me about recruitment. "You might think we wouldn't do this with competitors," he said, "But we recruit with a consortium of other universities from our neck of the woods. It's more economical that way.

"Someone messed up when the recruiters went out to Denver last year and didn't book the hall we use every year. So they called one of the local private prep schools and asked about using an auditorium. They said sure, but it was going to cost $1,800. Can you imagine?

"So we said, hey, there's this consortium of well-known southern schools coming to your place. Our being there will do a lot for your prestige.

"They agreed that it would, and they'd be delighted to have us, but for $1,800."

"What did you do?" I asked him.

Gilbert smiled. "I have some contacts out there." He said. "One of them is a charter member of the Presbyopia Hunt Club. We used their facility, which worked out fine. It cost us $750."

Money for endowments? Check. Money for buildings and grounds? Check. Money for salaries? Nah, I know too many professors and postdoctorates to think that's the case.

Now if I were going on grandly about 10-figure sums, I would be, well, embarrassed to brag about how I saved a grand off somebody's standard fee which they didn't have the sense to discount for the honor of serving me. But that's just me.

The point is that no single class has a monopoly on inscrutable economic behavior. One should therefore be understanding and sympathetic to all. But the flesh is weak, and some people are, for me at least, a little harder to sympathize with. ■

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GUEST EDITORIAL

Dermatology Is Losing Ground as Medical Profession

The gap is widening between medical and appearance-based dermatology. The field is now at a crossroads: Should the focus be on disease with science-based skin medicine, or on wellness with "lifestyle dermatology" directed at beauty and skin rejuvenation?

Dermatology is an enormous field, comprising medical dermatology, dermatopathology, surgery, and other subspecialties aimed at prevention, diagnosis, and treatment. The field also includes cosmetic dermatology, which seeks to enhance the quality of life by improving appearance.

BY KLAUS WOLFF, M.D.

Skin is not an isolated tissue that can be taken off like a cloak, but an integral part of the whole organism, with multiple interactions and regulatory circuits that are common to the entire body. Basic dermatologic research has made significant contributions to cutaneous disease, wound healing, and skin rejuvenation, but also has provided insights into cancer treatment, inflammatory processes, autoimmune disorders, and connective tissue diseases.

Despite these advances, dermatology appears to be losing ground as a medical profession. Over the last few decades, we have slowly ceded more and more of our field of expertise to other medical professionals. For example, with the advent of broad-spectrum antifungal agents, fungal infections of the skin and nails are often treated by general practitioners without a definitive diagnosis.

Family physicians and pediatricians are treating bacterial skin diseases such as cellulitis, impetigo, and erysipelas, and viral skin diseases such as herpes zoster and herpes simplex. Should new biologics for autoimmune diseases of the skin be considered the domain of internists, clinical immunologists, and rheumatologists? We are being pressured to surrender diseases with systemic involvement to other medical specialties. If we cede, and thus surrender, we may as well surrender most of the dermatologic diseases because even atopic dermatitis is a disease that involves the entire immune system.

The change in dermatology's role has come about as we have added more "lifestyle services" in our practices. This is understandable since we are paid up front for lifestyle services, which means no rejected bills, no paperwork, and no reduced payments by managed care companies.

In the United States, many dermatologists are more likely to perform a Botox injection than to write an acne prescription. But what effect does the increased popularity of appearance-based dermatology have on the public's image of dermatology as a medical profession? Will dermatology survive as a respected medical specialty? There is the justified fear that lifestyle services will expand to our disadvantage.

As a medical profession, we must strike a balance between disease-oriented and lifestyle services. Too much focus on lifestyle services will lead to the perception of dermatologists as being superficial and as only a few steps away from being mere beauticians. The end result will be loss of reputation, loss of resources, and the trivialization of our specialty.

We must be more aggressive in defending our role in medicine and convincing the public of our professionalism.

Dermatology will not attract the best and brightest students if the field is marginalized. To underscore the fact that cosmetic dermatologists are medical doctors, the focus in cosmetic procedures should be shifted from an empirical basis to a scientific basis, from the correction of defects to the restoration of normal skin structure.

We must insist on having hospital beds, necessary not only for optimal teaching but also to maintain respect from other medical disciplines. Severe skin disease and skin disease with systemic involvement require hospital beds. If we are not needed for severe disease, we are not needed at all.

U.S. dermatologists have been cornered to the small field of primary tumor detection, with advanced melanoma being a disease reserved for oncologists.

In Austria, dermatologists successfully resisted attempts to cede treatment of advanced melanoma to oncologists. Screening, diagnosis, surgery, sentinel node biopsy, adjuvant therapy, and chemotherapy for advanced melanoma are performed by dermatologists at dermatology centers. Also in Austria, the clinical trials of new melanoma vaccines are directed by dermatologists, not oncologists.

We must continue to strive for excellence on the road to treatment and the road to wellness. Make dermatology the spearhead not of lifestyle, but of medicine that is based on science and focused on the cure and prevention of disease and the enhancement of quality of life. Increase the visibility of dermatology as the spearhead of such a movement, and pressure the public and the politicians to appreciate that life in health has a greater value than just being alive. ■

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