Hong Kong J. Dermatol. Venereol. (2015) **23**, 51-52

Editorial

My reflection on the public dermatology service

Having worked in the public dermatology service for over two decades, I experienced the joys and sadness of it. On the one hand, I have seen many young doctors joining our Service with a passion for dermatology; on the other hand, I have realised that a number of disappointed colleagues have left because of dissatisfaction with the Service.

Twenty odd years ago, when I first joined the public skin service, the expertise in dermatology was rather basic. However, with advances in technology, new ways of diagnosing and treating skin diseases have been discovered. Examples of these include the use of ELISA test for detecting anti-skin antibodies (instead of monkey oesophagus), autologous melanocyte transplant for patients with vitiligo; the use of topical immunotherapy for alopecia totalis and the application of photodynamic therapy for skin cancers. These new techniques have never been looked into in the public skin service. Besides, the psychosocial aspects of skin diseases have received minimal attention.

It has been slowly realised that patients with chronic skin diseases encounter a lot of problems in their psychosocial life. Experts have found that the quality of life of patients with psoriasis is no better than that of chronic pulmonary disease or diabetes. Depression is common and non-adherence to treatment is prevalent. In the public dermatology service, no attempts have been made to incorporate these important aspects into the care of patients. Seeing dissatisfied patients leave the consultation room can impart a sense of helplessness among empathetic staff who are under yet greater pressure from the incessant workload. Often, they can only spend five minutes for each patient. This is hardly sufficient to build a good rapport nor for a comprehensive assessment of the patient's problems. No wonder the morale of the staff has slowly dwindled over the years.

I think there are many reasons to account for the current suboptimal situations in the public service, such as low staffing levels; lack of incentive for change; increasing demand and high expectation from patients. On a wider scope, the lack of academicians in dermatology; the ineffective gate-keeping of the General Outpatient Service also contributes to the current situation. Nevertheless, one important reason that everyone would agree on is the lack of resources.

Public dermatology service is currently provided by the Social Hygiene Service which is also responsible for treating patients with sexually transmitted infections. The Service is under the supervision of the Centre for Health Protection which emphasises disease prevention and control. In other words, its focus is on infectious diseases. The non-contagious nature of most skin diseases makes it a lower priority for resource allocation. Compared with other subspecialties under the Hospital Authority, such as cardiology, gastroenterology, neurology etc. the advancement in dermatology in the past two decades has been next to minimal. Of course, as dermatological diseases are mostly non-life threatening, it would not be a top priority in

any medical development. However, it is equally unjustified to completely neglect it.

Looking ahead, I would suggest that the public dermatology service should pay more attention to the following areas:

i) Public education
Some skin diseases could be preventable. These include asteatotic dermatitis due to an excessive use of soap in bathing and irritant contact dermatitis due to a lack of awareness of hand protection at work. Furthermore, skin diseases like psoriasis and vitiligo are stigmatising. People unfamiliar with these may worry about infectivity and shun these patients. It is not uncommon that patients with these skin diseases are turned away from public facilities like swimming pools. Patients may become socially withdrawn as a result. All these require persistent long-term public education.

ii) Innovation
It has been estimated that in the year 2020, more than 20% of our population will have reached the age of 65. With the increasing longevity of our elderly patients, more and more will be living in elderly homes. Dry skin, bullous pemphigoid, stasis dermatitis, incontinence leading to contact dermatitis and drug eruptions are common in this age group. Many elderly patients come to our clinics on wheelchairs accompanied by the part-time helpers. It is not known how many are not referred to dermatologists due to the lack of caretakers, immobility and financial unaffordability. The use of tele-dermatology and the collaboration with the outreach geriatricians might help to alleviate this imminent problem.

iii) Leadership
As the largest public dermatology service provider, the Service should actively play the leading role in the field. This could be in the form of testing out advanced treatment modalities for skin problems; organising patient groups in order to find out more about the psychosocial impact of their skin diseases as well as their needs in the public service; and liaising with other specialists e.g. psychiatrists to implement multidisciplinary clinics etc.

All in all, public dermatology service in Hong Kong still has a long way to go. If we take a look at our specialty in our neighbouring areas like Taiwan and Singapore, it is not difficult to see the backwardness of our Service. However it is never too late to initiate changes. I think the first step is to arouse the awareness of the importance of skin diseases in the authority.

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