BY ALAN ROCKOFF, M.D.

Under My Skin

Let's Get Physical

My first exposure to clinical dermatology consisted of a month of Friday morning skin clinics during my second year of pediatric residency. Then, as now, skin disease was judged too unimportant to be taught to medical students.

Three volunteer dermatologists slumming from Manhattan supervised—two men and a woman. Their stylish dress clashed with the dingy decor of a Bronx city hospital OPD. Between patients, they spoke of cars.

My first patient sat on a gurney at the back of an alcove separated from the corridor by a curtain. Because I had no idea what she had, my presentation must have been brief. The three dermatologists followed me back in and took a casual look. Turning to leave, one of the men said, "Pityriasis rubra pilaris." The others nodded, exiting the alcove.

I was astonished. How could they just look at something and know what it was? Much later, I learned their twin secrets:

- Knowing from experience.
- Making up what you don't know.

What prompted this small reminiscence was a recent essay in the New England Journal of Medicine, "The Demise of the Physical Exam" (2006;354:548-51). In the essay, Dr. Sandeep Jauhar recounts a medical school incident in which he missed an aortic dissection by failing to note that the patient's blood pressure was higher on one side than the other. The way he remembers physical diagnosis instruction sounded familiar: "The preceptor was an intense but likable oncology fellow who was clearly ambivalent about the value of the skills he was teaching. …Even as he went through the motions of teaching physical diagnosis, he appeared to be dismissing it."

When I ask my medical students what their impression is of a rash, their eyes widen in a silent plea: You mean I should know *just by looking*?

Dr. Jauhar notes several reasons for this dismissal, including lack of time to do a proper physical and the noisy distractions of a hospital milieu. The most important reason, however, is the fact that diagnostic tests just do a better job at making diagnoses. This is true even in comparing chest x-rays with auscultation, and new diagnostic technology of mind-bending sophistication only makes the disparity more glaring. Compared with an MRI, a physical exam seems like something from grandma's attic.

One field of medicine remains, however, where physical examination is alive and well: ours. Most dermatologists with any experience do every day what my long-ago preceptors so amazed me with: walk in, look, diagnose. We don't do a lot of tests. We don't have a lot of tests to do.

Last week, I recorded patients' diagnoses and lab tests on a random day. Of 46 patients, 23 had rashes (acne, psoriasis, and so forth); 5 had bacterial or fungal skin infections; 5 had warts; 11 had lesions of some sort; and 2 had cosmetic-related questions.

The lab test tally for that day was one bacterial skin culture, one fungus culture, one KOH prep, blood tests for a patient taking isotretinoin, and three biopsies.

This seems typical of one of our days. Most of the time, we glance and know at once what we're dealing with. (Managing it is another story.)

For every lesion we biopsy, people show us 20 we diagnose by inspection (visual or dermoscopic). Rashes are mostly clear cut. When they aren't, we biopsy. (And how often does the biopsy of a rash give us a decisive answer?) For many infections, cultures are confirmatory, if not redundant. Drug rashes? Viral exanthems? Clinical diagnoses.

Medical students find all this as weird as I did when first exposed to it. They're so used to watching people order tests—to diagnose, placate senior staff, or ward off phantom attorneys—that their clinical skills atrophy before they develop; they lose it even before they use it. When I ask my students what their impression is of a rash, their eyes widen in a silent plea: You mean I should know *just by looking*?

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Letters

AAD Initiative 'Was Severely Flawed'

Since we were instrumental in convincing the American Academy of Dermatology's Board of Directors to terminate the Dermatology Workforce Initiative following its initial 3 years, we would like to respond to Dr. David Pariser's guest editorial "Stand Together to Tackle Workforce Issues" (May 2006, p. 12).

Dr. Pariser called it "a pocketbook issue" without referring to the initiative by name, but the program was never perceived that way. Our objections, which were shared by hundreds of our colleagues, had nothing to do with the potential for increased competition. In fact, we would welcome such competition. We were opposed to the establishment of this program because AAD members were never given the opportunity to vote on this fundamental issue. The Board of Directors' original vote on the workforce initiative was not unanimous, indicating underlying controversy.

The board based its decisions to develop this initiative on the 2002 Dermatology Practice Profile Survey, which revealed that 51% of those who were surveyed believed that the supply of dermatologists was either adequate or excessive. Only 49% of those surveyed felt that there was a shortage.

Between 1995 and 2004, the number of first-year dermatology residents rose from 283 to 342 (American Medical Association data), a dramatic 21% increase. In other words, even without the AAD's initiative, the number of dermatology residents in training has been significantly increasing.

The Dermatology Workforce Initiative created serious ethical and conflict of interest issues. In the July 18, 2005, issue of American Medical News, Dr. Jerome Kassirer, former editor of the New England Journal of Medicine, called the initiative a "disgrace" and said that "it's hard to imagine the drug companies are interested only in the education of dermatologists." In the same article, Arthur Caplan, Ph.D., a University of Pennsylvania bioethicist, asked "if they [the public] want their doctors' education paid for by companies who have a direct interest in medical products?"

Finally, the initiative's design was severely flawed. The program aimed to increase the number of medical dermatologists, especially those in underserved areas. However, in an effort to conceal which residents were funded by the initiative, no individual residents were designated as recipients. This left evaluators of the program's effectiveness without knowledge of which residents received funding, making it impossible to link the support to the outcome.

We were glad to see the AAD Board change its mind about this initiative. We hope they have learned to rely on a membership vote when they face a fundamental and controversial issue.

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Well, yes. As is true of any skill, you can develop it, with instruction and practice.

Without a dermatology elective in school, many physicians carry this primal fear of skin disease indefinitely. "Skin makes me nervous," they tell patients. "See the dermatologist." They think our skills are a little occult.

We dermatologists shouldn't take too much credit for our archaic clinical virtuosity, such as it is. To a large extent, we don't rely on tests because we don't have tests to rely on. If we had more crutches, we would lean on them as much as anyone else does. Our patients would insist.

Meantime, however, we practice in a manner that is alarmingly similar to the way our remote clinical ancestors did.

We walk in, look, and know from experience what's going on. And what we don't know, we make up, assigning a provisional label in the hope that time will clarify things and bail us out—which it often does.

For our small corner of the medical universe, therefore, reports of the demise of the physical exam have been greatly exaggerated. ■

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Correction

The April 2006 issue featured several articles from the annual Hawaii Dermatology Seminar sponsored by Skin Disease Education Foundation. The dateline should have indicated that the meeting was held in Koloa, Hawaii.