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THE ART OF DERMATOLOGY*

BY

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Often, I suggest, it is more difficult in clinical medicine to practise an art than to pursue the principles of a science; for the practice of an art demands a quickness of perception, a rapid collection and sorting of a series of impressions, and the exercise of intuition, as well as the exploitation of such skill as one may possess in obtaining a history, in making a diagnosis, and in prescribing treatment. Admittedly in diagnosis and in treatment some element of science may be involved, but in the latter—in treatment—the art is at least as important as the science of the business. In dermatology, as in other branches of medicine, we use several highly scientific procedures: these include diagnosis by microscopy, the use of alpha particles derived from thorium *x*, the epilation of hair with *x* rays, the treatment of certain dermatoses with Grenz rays, and the destruction of basal- and squamous-cell carcinomata by *x* rays, gamma rays, and even by beta rays derived from radioactive isotopes.

In practice, therefore, the successful dermatologist must know how to utilize the gifts which the scientists have brought him; but it is the application of his art that I am concerned with here: I have been led to do this by the reflection that science is taught, but we learn our art by experience, refine it by practice, and seldom attempt to put our knowledge into words. We hope that our pupils learn something of what we have to teach in this matter by watching and hearing us as we work in our clinics, but we know that until they shoulder the responsibilities of taking their own clinics or of carrying their own practices they will not know much of the art of which I write.

A Twofold Purpose

The purpose of the art of dermatology is twofold. Firstly, to assist the clinician to an understanding of the aetiology of the patient's malady, and, secondly, to ensure the maximum efficiency in treatment. These two aspects are not only complementary; to some degree they overlap. It is widely recognized in dermatology, and is beginning to be recognized in other branches of medicine, that many maladies do not suddenly develop in apocalyptic fashion; some do (cutaneous anthrax, for example), but in many there are a long series of events which culminate in the eruption.

Modern research has indicated that even furunculosis and impetigo contagiosa are not likely to develop unless there is a preceding breakdown in the mechanism of self-disinfection of the skin; acne vulgaris may well be associated with some metabolic fault in relation to androgen and oestrogen metabolism, but diet and environmental factors play their part; nummular eczema, pompholyx, the sudden efflorescence of psoriasis, and perhaps also lichen planus may all have—as precipitating agents—factors of emotional stress. It thus becomes obvious that when one is confronted with a patient who exhibits a skin eruption one must very rapidly discover not only the simpler aetiological factors mentioned in all the textbooks but discover also as many of the more recondite factors as is possible; although these recondite factors are of importance in planning the first attack on the malady, their assessment is even more important when one looks to the future and endeavours to give the patient such advice as will prevent a recurrence of the disorder.

The treatment of chronic furunculosis in a patient who has no constitutional disease such as diabetes or nephritis may be taken as an example to illustrate what I mean. Most of us found in the early days of penicillin treatment how easy it was to rid the patient of a crop of boils. "There," we said, after he had sustained a few injections and the boils had subsided, "There—you're cured now!" But all too often that patient was back in our rooms a fortnight later with another crop of the lesions. We had removed the first crop with penicillin but had not taken any steps to rectify the lowered mechanisms of cutaneous self-disinfection whose failure was the primary cause of the furunculosis. A few words of advice concerning a reduction of his carbohydrate intake (particularly the intake of sugar in tea), a series of ultra-violet ray treatments, or a little sun-bathing and sea-bathing would have done much to prevent a relapse—but we failed to foresee the future and to give him that advice.

That is a very simple example of a failure to exploit the art of dermatology. The exploitation of this art may be much more complicated, as the following remarks may indicate.

Inferential Knowledge of the Patient

One can know a good deal about one's patients before one sets eyes on them. Here is a letter from my friend Dr. Smith: he wants to refer Mr. A because of pruritus ani. Mr. A, he says, has seen a proctologist and has had his haemorrhoids cured and skin tags removed; *x*-ray treatment was given in the past; a ringworm infection was once suspected, but antifungal remedies failed to give relief; the pruritus continues, and Mr. A is getting quite desperate. Dr. Smith is a busy man, and he is writing to a skin specialist. As is proper, he has not prejudiced me in any way, and I may well find some skin condition that is responsible for the itching; but as I read his letter and dictate a suitable reply I think it is probable that this is but another case of idiopathic pruritus ani, and if I am correct in this supposition Mr. A is likely to be a hypochondriac in whom the pruritus is only one phase of a syndrome which has troubled him for a good many years, and will give a history of having in past years sought relief for such symptoms as indigestion,

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feelings of fullness after meals, various odd abdominal pains, constipation, a feeling of incomplete emptying of the lower bowel when at stool, and perhaps also some associated disturbance in regard to sexual function. The hypochondria is the real malady which demands treatment, and as it may shade into schizophrenia the treatment may well be difficult. The question of course is, Should he be submitted to dermatological treatment at all, and how best can he be transferred to the psychiatrist, in whose domain his case really lies?

Then there is a letter about Mr. B. I learn that he has had duodenal episodes in the past: recently he has developed a neurodermatitis, and the duodenal symptoms have been in abeyance. He is likely to present a problem. Evidently he has two organs of stress—his duodenum and his skin. If one cures his skin eruption and if his background of stress is not relieved, what chances are there of further duodenal symptoms developing: which will be the best thing for him—to let him suffer with his skin, or to run the risk, by curing his skin, of precipitating a much more dangerous condition, to wit, a recurrence of duodenitis?

One's secretary reports difficulties about Mr. C and Mrs. D. Mr. C is a very busy man; there has had to be a bit of juggling before the hour when he can come is adjusted to the vacant times the secretary has to offer. He did not telephone himself; his secretary fixed the appointment. At once one knows two things: Mr. C's malady is not yet incapacitating (it may in fact be trivial, for Mr. C may have learned the wisdom of getting advice as soon as he notices the least abnormality in his health); but, more important, Mr. C probably lives an ordered life in which time is a vital factor, and any such life—as we all know, for time is master of our own lives—is a life lived under stress. Mr. C will not want a doctor who vacillates: he prefers a general practitioner who has the courage to say, "I don't know about these symptoms: you had better see someone who does"; and Mr. C's prompt reply is *not*, "Whom do you suggest?" but, "Who's the best man?" When we are young men, not many of us see Mr. C as a patient: it is only when we are more established that Mr. C will bring his troubles to us. And when he comes he will require kindly but firm handling, and, the most difficult of all things, prognosis which is accurate in its estimate of the time involved for his cure. He greatly prefers a statement such as, "Wind up your engagements during the next week: then you will be in a nursing-home for two weeks and after that will require two weeks' convalescence"; a vacillating policy based on the "you try this and wait and see" type of procedure will not give him confidence. The easiest way of handling Mr. C is to remember that he is a mirror image of oneself: he is a busy man with many commitments; acts of God he will accept, but he is not going to stand either incompetence or an insufficient appreciation of the value of time. One has to be on one's mettle with Mr. C. His dermatological problem may be one of many things: the betting is slightly in favour of his malady being a nummular eczema, but it may well be some other disease—an early rodent ulcer, for example.

Mrs. D is an entirely different problem. She has a few spots on her face which keep coming and going; her beauty specialist has tried a lot of things without success; she cannot come on Friday or Monday, as she will be in the country, nor on Tuesday or Wednesday because of social engagements, but Thursday might be possible. Probably she has a variety of acne: she will carry out only such treatment as does not interfere with her cosmetic routine, her social engagements, or her dietetic preferences. Mrs. D as a patient is likely to be an unsatisfactory problem, and probably has a greater nuisance value to dermatologists than to specialists in other branches of medicine.

Technique of Consultation

From all this you will appreciate that one's service to the individuals concerned has commenced before one sets eyes on them. When they do arrive there is much in the technique of the consultation—be that consultation either in the office or in hospital—which could be discussed, but time does not permit. In my opinion many patients, wholly or partially undressed, lying on a couch, dealing with a man whom they do not know, feel defenceless and very much at a disadvantage. You may have experienced this defencelessness yourself; I am sure that the correct thing to do is to keep the patient on the couch only for as short a time as possible, and that, whilst he is there, questions should be kept to a minimum; anything that does not require an immediate answer should be left until later. There is one exception to this. In some cases one is confronted with a patient whose aggression is all too obvious: he hates the world in general, and probably—poor devil—himself too. For the time being the dermatologist is the focal point of his hostility. If courtesy, obvious interest in his case, and similar manœuvres have little effect and he remains unco-operative, get him unclothed and on the couch as soon as possible; the alternative is to get him out of the room as soon as you can, in which case you will have skimped attention to the details of his case and you will have succeeded only in confirming his belief that doctors are inattentive, slapdash, uncooperative, and interested only in getting the maximum fee for the minimum of work. He cannot maintain this belief if he is slowly examined from top to toe, on a couch, showered with questions when there, and, while still there, slowly instructed in the details of his treatment.

Difficulties in Examination

Of the difficulties which may confront you when you examine the patient I shall give only two examples. The first may be presented in the form of a question: What do you do when confronted with an eruption which you believe is self-inflicted? Oddly enough, for these patients deserve sympathy, some clinicians become angry when faced with a flat denial by the patient that she (for it is often a woman) has been applying an escharotic to her skin. That method not only does not help, it may do a great deal of harm. One must remember that in most cases the patient's relatives will be most unwilling to accept a diagnosis of self-inflicted eruption, and any carelessly made revelation of your diagnosis is likely to be met with a degree of hostility which will surprise you. It is worth remembering that, whilst hysterics may do themselves a good deal of damage on anaesthetic areas, neurotic individuals dislike pain and do not indulge in the more dramatic self-inflicted rashes; as I. Macalpine (1955, personal communication) has pointed out, severe trauma points more to insanity than to neurosis or hysteria.

My view is that the first thing to do, before disclosing the diagnosis to relations, is to obtain a confession from the patient; the best approach for this is to get her alone and to say, "You must have been, and you must be, very unhappy." That simple approach may lead to tears, and slowly to a confession. If the patient says, "I'm not unhappy—why should you think I am?" the answer is, "I have never known this rash occur in people who were not unhappy or who did not have grave anxieties." If you reach an impasse—and you may well do so—what is important is that when the patient leaves she should realize very clearly, firstly, that you have met a good many cases of this type before, and, secondly, that you know the cause of the trouble, although you have not actually accused her. Both points are important: she has hoaxed her family, and it is quite a severe shock to find that you are not so easily misled. The very fear that you may "call her bluff" may make her desist, particularly if she is only a victim of a mild degree of neurosis or hysteria. One has not got to say much: "I think you know about this trouble," one says, "and I know about it too"; then you give her a face-saving chance. "Here," you say, "is a prescription for a lotion: I think this will do the trick." Do not say, "I think this will cure you": that statement would put her on her mettle to defeat you; "do the trick" is much more enigmatic, and is calculated to reinforce what has gone before.

Lastly, in many of these cases—if the patients are young and much at the mercy of the parents—it is often better not to give them away to their relations. The latter will never forget, and for years may persecute their child for a minor lapse for which, in truth, they may be responsible. In many cases, if the patient does well after one or two consultations, nothing is to be gained by giving her away, and your reticence may well add to the happiness of all concerned.

The second difficulty to which I wish briefly to refer is the litigiously minded patient. Such an individual will not disclose that he is weighing your lightest word in the hope that you will say something which will give grist to his solicitor. The mere use of the word "dermatitis" instead of "eczema" may involve you in telephone conversations (all carefuly recorded on a tape machine) or in correspondence which you may find unwelcome. For to many the word "dermatitis" means something preventable for which someone else—employer, hairdresser, or clothing salesman—is responsible. I am often quite disturbed by the scanty evidence on which, according to the patient, her practitioner has reached the conclusion that some eruption is due to detergents, cosmetics, or other factors. If one feels that the patient has just grounds for believing that he or she has a legal case, then I suppose it is ethically one's duty either to give one's support or else to say from the outset, "I am not prepared to undertake medico-legal work: if you want support in this matter you must see someone else."

In dealing with this type of individual, however rushed you are, see that your notes are impeccable (you may have to produce them), and at the outset take the line: "I can give you only an opinion now. If you are taking this matter further we may need chemical analyses of the suspected agent, patch-tests and similar investigations, and when I am noting your history you must be extremely accurate in regard to your past medical history and the dates of the events which you consider led to the present attack."

When dealing with a patient whose veracity is a little suspect, and who is likely to omit from his history details which he thinks might make you waver in your support, it is sometimes useful to give a little jerk to the reins in the following way. One of your first questions will have been, "Have you ever had a rash before?" To which the answer is usually a firm, "No, doctor." "No impetigo or acne when you were a boy?" you ask—not that these points are very relevant to the present case, but they indicate that you are alert. "No, doctor," he replies. Later, if matters are getting out of hand, you can fairly safely go back to this question. "Look," you say, "you said you never had a rash before—have you never had measles or chicken-pox?" When, as usually happens, he admits he has, and protests vigorously that this is not relevant, you can nevertheless more easily, and without provoking him too much, check the points in his later history which you think are suspect.

The Art of Treatment

There is, of course, a very great art in prescribing treatment: the obvious point is that everything must be explained clearly and satisfactorily, and in terms comprehensible to the patient. Sometimes one is caught out by a well-dressed, carefully mannered woman who appears to be self-assured and of average ability: in actual fact she may have a surprisingly low intelligence and, instead of being addressed as an adult, requires the type of explanation one reserves usually for a child of 12. Often it is surprisingly difficult to recognize this type of individual, whose intellectual deficiencies are covered by the poise acquired by years of careful schooling.

In dermatology, more than in any other branch of medicine, the success or failure of treatment—and the success or failure of the dermatologist—is in the hands of the patient; one is to a surprising degree at the mercy of his incompetence. It seems so easy to apply an ointment, a lotion, a cream, or a paste that one takes it for granted that any patient can do it; a single dressing done by the physician or by a trained nurse to show the patient how to do the job may make all the difference between a rapid or a protracted cure. Every year, in every country, because we do not realize this, gallons of lotion and hundredweights of ointment and paste are wasted.

Now, before prescribing treatment one should attempt to assess, firstly, the intelligence of the patient, and, secondly, whether he is a markedly obsessional or an averagely conscientious or a slapdash type of individual. The markedly obsessional individual is the one who produces a pencil and a notebook as soon as we reach this stage of the consultation. He jots down a précis of everything one says, and even makes notes on the prescription slip when he takes it from you. In telling him what to do one has to remember that he will overdo everything, and probably keep his eruption going by his endeavours. If one says, "Clean off the last application of ointment with oil before applying the next layer of ointment," you can be sure that he will traumatize his skin vigorously each time he changes the dressing, by conscientiously scrubbing away with a swab soaked in oil to remove every particle of zinc before he gets on to the new application of ointment. If you say, "Soak the hand for a short time in the solution of potassium permanganate," he will soak it for a minimum of ten minutes on each occasion. With him, directions must cover in detail every aspect of the treatment. The worst time I experienced with one of these individuals was when I discovered that, owing to my inexperience in giving directions, he was dabbing calamine lotion on to his eczema, letting it dry, then rubbing the resulting powder into his skin. The slapdash individual requires some overemphasis in the details of treatment, but make it as easy for him as you can: remember that he will not co-operate fully if the treatment prescribed is too onerous.

Acne Vulgaris

It is a common mistake, when dealing with adolescents suffering from acne vulgaris, to overburden them with too much advice. Put yourself in the place of a boy or girl of 16 suffering from this malady. At that age it is sufficiently devastating to find that chocolate, cocoa, and ice-cream are forbidden, without also having to carry away a long diet sheet which will take half an hour to memorize and which seems to cut out half the pleasures of life, such as bacon, ham, cheese, anything really tasty that can be concocted in a frying-pan, and all the "grub" which fills you up when you are hungry, such as waffles and maple syrup, suet pudding, and steak-and-kidney pie. Then, as though this is not enough, there are all sorts of directions about shampooing the hair and rubbing in a pomade; a series of different lotions and pastes to apply to different areas; and injunctions about squeezing out blackheads—a process which, says our teenager, always hurts like hell, although the old geezer (that's you, doctor) actually said it does not if it is done properly. It is probable, in a case dealt with in this fashion, that the unfortunate patient's co-operation, which is vital, has been lost and treatment is likely to be a failure. It is much better, I suggest, to remember that very many quite severe cases of acne vulgaris can be cured by a minimum of carbohydrate restriction, a complete removal of chocolate, cocoa, and cocoa-like drinks from the diet, and the use each night of a paste containing resorcin 6%, sulphur 6%, and zinc oxide 35%, in an emulgent base. Every morning the paste can be washed off, and no treatment need be applied during the day. In addition, once every five days such blackheads as can be squeezed out easily should be neatly removed.

Acne vulgaris is so often badly handled that it may be worth while emphasizing the art of its handling. The malady is essentially one in which the free flow of oil from the sebaceous glands is prevented by the formation of blackheads. Primarily, treatment is a matter of promoting the normal drainage of these glands on to the surface of the skin; a carrying out of a normal surgical principle. Yet

there are practitioners who tell their patients: "Don't squeeze out blackheads: don't prick pustules." The rule should be, "Don't squeeze blackheads too often—once every five days is enough; don't bruise the skin when doing it. Prick pustules with a clean needle as soon as a yellow head is seen, and when you use the needle insert it transversely into the yellow mass, holding the needle parallel with the skin so that you can't prick deeply. Then swab away the pus with a swab soaked in spirit and don't smear the pus over the adjacent skin." (In parenthesis—if the patient has cysts, these should be left to the dermatologist.)

Now, the paste is going to dry the skin and make it uncomfortable. In fact, when dealing with blond types it is as well to reduce the amount of sulphur and resorcin by 2% in each case. The patient should be told that when the skin gets a little sore he can use cold cream for a night or two instead of the paste until he is is comfortable, and then continue with the paste.

That is all he need be told to do at the first consultation; when you see him in two to three weeks' time you can assess his progress and intensify treatment as necessary. By then there should be sufficient improvement to encourage the patient to pay attention to what you have to say. But if there isn't any improvement, and you find the patient has not co-operated in your treatment, remember it is as much your fault as his: you have failed to win his co-operation.

Psoriasis

Psoriasis is another malady that often is badly handled. There is nowadays a popular medical heresy to the effect that there is no need to go to bed unless one has a temperature; consequently, in psoriasis, and also in eczema, the amount of ointment which is wasted and the amount of clothing which is spoiled is appalling. In both these maladies the precipitating factor is often emotional, and often if one is certain that emotional stress is the precipitating factor the efflorescence of the eruption can be checked and the lesions made to recede by an enforced rest in bed under fairly heavy sedation—for example, sodium amytal, 3 gr. (0.2 g.) six-hourly. Similarly in already well-developed psoriasis, the exploitation of the Goeckerman regime, either in a full or in a modified form, offers to the majority of cases the hope of a rapid relief of symptoms. This regime may be carried out in general practice without too much difficulty, yet I know of few general practices in which it is used as a routine measure. There is one old belief in regard to psoriasis which is now largely forgotten, yet it probably is correct in many cases: this is that one should urge the patient to persevere with treatment until he is spotless, because relapses may occur more readily if a few lesions in areas difficult of approach—for example, in the scalp—remain.

General Principles

There are many other matters which could come within my purview, and I can deal with only a few of them.

As a generalization I would say that I am not unduly enamoured of emulgent bases for ointments and pastes. They are useful for acne, and for providing vehicles which can be easily washed out of the hair, but their injudicious use may complicate treatment. Soft paraffin and lanolin bases are more predictable in their effects. Similarly for many cases, particularly eczema, vegetable oils, liquid paraffin, and even well-boiled milk are preferable to quaternary ammonium compounds for cleaning the skin. There are very few patients who react adversely to these, whereas the injudicious use of quaternary ammonium compounds for the cleansing of an area of eczema may merely induce another sensitization.

One should make the treatment of exposed areas, particularly the face, as pleasant as possible: skin patients are often depressed, and to give them something which is disfiguring, such as crystal violet solutions, to paint on their faces only adds to their burden.

The old golden rule in prescribing "lotions for acute conditions, creams and pastes for subacute ones, and ointments only for chronic maladies" still holds good as a generalization, although there are more exceptions to the rule nowadays (the use of chlortetracycline ointment in acute impetigo contagiosa, for example) than there used to be.

Finally, I am reminded by my last remark that one should always consider carefully whether it is not better to use old remedies than to fly to the antibiotics. So far as can be foreseen, in another fifteen years' time, when all staphylococci are resistant to all antibiotics, we will return to potassium permanganate, perchloride of mercury, and the old antiseptics. I hope that we will not have forgotten that sulphur (which is an unusual drug, its reactions on the skin being very different from its actions *in vitro*) has been used for generations for the cure of staphylococcal skin infections, and staphylococci have not yet acquired an immunity to it.

I will say no more about this matter of the art of dermatology, for I have said enough to indicate that it embraces a very wide field. Essentially it is a personal matter, and many—with great cleverness—have absorbed all the knowledge in the books and yet know little of the art! To know a little of it is to know a little of medical wisdom—and wisdom, I need scarcely remind you, is quite different from cleverness.

Conclusions

I would like to end my remarks with a paradox. You have, I hope, accepted the differentiation I have used between the science and the art of dermatology as though they were entirely different factors of our practical work. Nevertheless semantically they should not be divided: the art of medicine is but one aspect of the science of medicine; for the word science is derived from the Latin *scire*, to learn or to know, and in its proper sense is synonymous with learning and knowledge in all their aspects; but throughout this present century, in general usage, a more restricted meaning has been adopted which differentiates "science" from other branches of accurate knowledge. This observation was made by W. C. D. Whetham (1911) forty-four years ago, and his use of the phrase "accurate knowledge" is worth emphasizing; for it is only a modern heresy whereby some men believe that what is not scientific cannot be accurate; and that, I hope, is a comforting thought to leave with you—a group of men and women, many of whom spend their lives away from laboratories and remote from teaching hospitals, but who strive through many difficulties to prosecute in all its aspects the science of many branches of medicine.

REFERENCE

Whetham, W. C. D. (1911). *Encyclopaedia Britannica*, 11th ed., 24, 396. Cambridge Univ. Press.

The Ophthalmic Hospital of the Order of St. John, Jerusalem, had a difficult year in 1954. The recently published report of the hospital committee records that both the warden and the matron were ill, and a nursing sister had to return to England because of an injury. Nevertheless, 31,238 new patients attended during the year, an increase of over a thousand above the total for 1953. 2,567 operations were performed, with no loss of sight from sepsis. Mr. Frank Law, who visited the hospital during the year, operated on several patients, gave guidance on clinical problems, and inspected prospective sites for a new hospital. The long hot summer resulted in a high incidence of acute inflammatory disease, and work in the out-patient department was made heavy by epidemic acute ophthalmia of infancy and childhood. The condition of most of the cataract patients continued to be distressing, and nearly every eye operated on at the hospital was infected with trachoma. The United Nations Welfare and Relief Agency, for whom the hospital trained twelve orderlies, has continued to supply drugs and dressings.