

Editorial

Challenges to dermatology in Pakistan

Tariq Rashid, Ijaz Hussain

Department of Dermatology, Allama Iqbal Medical College/Jinnah Hospital, Lahore

* Department of Dermatology, King Edward Medical College/Mayo Hospital, Lahore

Dermatology, like other subspecialties, confronts many challenges. Nonetheless, the nature of these challenges is quite different in a country like Pakistan, where less than 1% of country's GNP is devoted to health. Dermatologists constitute an important part of tripartite system of health delivery comprising of patients, health providers and health managers. Patients expect the best possible diagnostic and therapeutic facilities whereas the health managers try to curtail the budget for dermatology care. So, the dermatologists have to fight on both fronts.

Dermatology workload comprises 20-30% of family physician practice and three group of dermatoses i.e. infestations, pyoderms and mycotic infections account for 80% of this. However, due to unavailability of dermatology services at the primary and secondary levels of health delivery system of the country, and the poor dermatological background of family physicians, the patients with skin diseases are largely mismanaged. In Punjab, out of 33 districts, 23 do not have any qualified dermatologist. Consequently, the tertiary level teaching hospitals are overburdened jeopardizing their teaching and research activities.

Further more, the dermatology departments in the teaching hospitals lack sophisticated diagnostic and therapeutic facilities. There are hardly one or two, fully staffed and equipped, state of the art departments in the whole country.

There are about 400 practicing dermatologists in the country i.e. one dermatologist for 375,000 persons, a ratio much higher than in the developed world (**Table 1**). The British Association of Dermatologists recommends a ratio of one consultant per 85-100,000 persons. It implies that still we do not have adequate number of dermatologists. The problem is further compounded by their uneven distribution. Like other developing countries, 70% of our population resides in rural areas; nonetheless, due to socioeconomic factors, 100% of dermatologists dwell in cities and 50% of these are concentrated in two metropolises i.e. Karachi and Lahore, even with a visible difference in urban-privileged and urban-unprivileged areas.

The root cause for the poor dermatological care at the primary level is the lack of customized undergraduate medical education. Although the Pakistan Medical and Dental Council has declared dermatology as an essential specialty in the MBBS curriculum, it is not an examination

Address for correspondence

Dr. Tariq Rashid,
Associate Professor of Dermatology
Allama Iqbal Medical College/Jinnah
Hospital, Lahore.

Table 1 Dermatologist-population ratio in different regions of the world [1]

USA	1:30,000
UK	1:200,000
Other European countries	1: 50,000
Pakistan	1:375,000
Asia	1:200,000 (urban) 1:780,000 (rural)
Sub-Sahara countries	1:1000,000 (urban) 1:5-50millions (rural)
Central/South America	1:76,000 (urban) 1:1-66 millions

subject. Dermatology is not given due importance in undergraduate teaching and examination schedule. Teaching hours are extremely limited and indoor and attachment is highly insufficient. No question pertaining to dermatology is compulsory in MBBS examination. Students are also not assessed clinically in dermatology. Hence, they exhibit a nonserious and casual attitude during lectures and ward attachments in dermatology. Furthermore, dermatology teaching programme is not uniform in different medical colleges. For example, in certain medical colleges lectures in dermatology are delivered in 3rd, 4th and final year whereas in others only in 4th year. Similarly, the clinical attachment varies from one week to 6 weeks in different colleges. All these factors contribute to dermatology-illiterate primary physicians with a consequent poor primary dermatological care to the community. At the same time postgraduate training needs to be uniform and customized. Dermatosurgery, cosmetology/esthetic dermatology, preventive dermatology, epidemiology and evidence-based medicine need to be emphasized during postgraduate training. Similarly, there does not exist any

system of continuous medical education in dermatology. A workable accreditation system, modes of implementation, reward and punishment, role of monitoring body and the use of teledermatology for CME need to be determined.

Another challenge to dermatology is autonomy of medical institutions, the real aftermath of which will surface a decade later. According to this new system the regular service structure for consultants and medical teachers and the role of Public Service Commission have been replaced by a contractual system. This has created an unrest and frustration amongst the younger consultants. Job insecurity and low salaries not only have led to poor job satisfaction and reduced work output but also promoted unethical medical practice and brain drain phenomenon. Now more and more doctors plan to proceed for overseas employment for better future prospects.

In the recent past, the College of Physicians and Surgeons Pakistan has changed the format for FCPS-II in dermatology. Increased requirement to five years and introduction of intermediate module, increased fee for mandatory workshops, dissertation fee and examination fee, all have indented the postgraduate training programmes in dermatology. Now less number of students is opting for FCPS-II dermatology.

Lack of motivation, poor guidance and scanty financial resources have adversely affected the quantity and quality of research in health sciences and dermatology is not an exemption. The popular slogan 'publish or perish' unfortunately could not flourish in

general. The majority writes under compulsion i.e. to get promotion and very few write for the advancement of knowledge.

The increasing popularity of cosmetology and the introduction of lasers and other money-spinning gadgets in dermatology have promoted the mushroom growths of dermatological quacks. These 'self-claimed' dermatologists have indulged in the laser business. Print and electronic media are being misused for commercial purposes. This trend is not only resulting in an unethical medical practice but also bringing a bad repute to dermatologists.

To add to the list, the unavailability of many dermatological drugs like pentavalent antimonials, dapsone, thalidomide, ivermectin etc. is another burning issue. Considering the scabies epidemic and leishmaniasis endemic, these drugs have assumed the status of essential drugs.

There may be still many more challenges; nonetheless, the present editorial aims to unfold the dermatology scenario in Pakistan today, to bring the confronting challenges in the limelight, and to provide a food for thought to the visionary members in general and the stakeholders of the Pakistan Association of Dermatologists (PAD), in particular. Government agencies and other non-governmental organizations can play an effective and vital role in devising strategies to meet these challenges. By setting realistic goals of what can be achieved within time and with limited resources and with a careful planning and implementation, there is no doubt that a visible difference can be made.

References

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