

LETTERS TO THE EDITOR

Treatment of Minor and Benign Skin Lesions in the Spanish Public Health System: Experience in Health Area 19 of the Autonomous Community of Valencia

I. Betlloch-Mas

Servicio de Dermatología, Hospital General Universitario de Alicante, Spain

To the Editor

We read with great interest the article published recently by Dr J. M. Carrascosa,¹ in which he presents a problem experienced by most dermatologists working in the Spanish public health system and with which we identify completely.

For reasons that we will not go into, dermatologists, perhaps more so than other specialists, are forced to provide a response to the increasing demand for health care by the public, both in their need for a quick diagnosis and to satisfy their requests for treatment, regardless of the diagnosis. This huge demand has led to a saturation of dermatology outpatient clinics and long waiting lists that health care managers usually condemn by continually insisting that we reduce them. The standard solution does not generally involve an increase in the number of physicians, but rather a reduction in the time spent with each patient so as to serve a greater number.

In our health area—number 19 of the Autonomous Community of Valencia, which is served by Hospital General Universitario in Alicante—dermatology has been prioritized, thus enabling us to provide fairly wide coverage to outpatients in this specialty. Hierarchical organization has meant that area specialists performing multiple roles (now known as departmental specialists), in addition to covering the health care requirements that are typical of a tertiary hospital—with teaching, research programs, surgery facilities, specialist departments, and an emergency department—have been organized in such a way that they now offer appointments at different times

(morning and evening) and see an almost unmanageable number of patients.

The broad spectrum of outpatient clinics, the number of patients seen, the impossibility of increased staffing in the short term, and the pressure from management to reduce the growing outpatient waiting list led us to analyze the situation some months ago. Similar to previously reported findings,² we observed that more than 25% of our outpatient visits were for minor and benign skin lesions referred to us by primary care physicians, not so much for a diagnosis—but for treatment that had been requested by the patients themselves. Therefore, we decided to investigate whether we really had to treat this type of lesion and, to do so, we carefully examined the current Law on Health Care,³ in which article 2.3C states that “activities or services aimed at cosmetic or aesthetic improvements shall not be covered by the health system...” and Appendix IIIc states that “any cosmetic surgery not related to an accident, illness, or congenital malformation shall not be covered by the public health system or state funds allocated to health care.”

Consequently, we wrote to our departmental managers explaining our vision of dermatologic health care and we prepared a letter asking primary care physicians to put the following recommendations into practice: “not to refer benign tumors when a patient has consulted for aesthetic reasons, for example, seborrheic keratosis, cherry angioma, or acrochordons, or pigmented skin lesions caused by aging

of the skin such as senile lentigo ... and always to refer patients with symptoms or whose diagnosis raises doubts.”

This notice was sent to all the health centers covered by our department, with the following immediate reactions:

1. The publication in the local Sunday press of an article expressing the indignation of some primary care physicians who felt that our request was an attack on patients' rights.⁴
2. The demand by primary care physicians for operating rooms to perform minor surgery for the treatment of lesions that we had decided were not the responsibility of the public health system.
3. Complaints made to the patient services department by some patients who felt that our wish not to treat their aesthetic lesions was unfair.

Despite this clear rejection of our decision, we believe that it is justified. The terms in which we wrote our letter were sufficiently thought out and balanced for us not to be accused of refusing to provide a diagnosis or treat patients.

In our work as dermatologists, we dedicate a huge amount of energy to solving problems that are not within the remit of the state system, yet which take up time that could be devoted to more important and technically difficult problems. Legal recourse is available and we have the right to use it. No-one would expect the state system to cover dyeing gray hair or depilation of the legs. Similarly, certain conditions, as J. M. Carrascosa quite rightly points out, can be understood to be “part of ... the

normal development of the skin” and should not be treated within the state system. We do not believe that they should not be treated by the dermatologist so that they can be passed on to the primary care physician. What we do believe is that, in the state system, no-one should treat them, but that outside the state system, clearly the best person to treat them is a dermatologist.

A decision of this type means that there may always be a sector of the population whose poorer financial situation will discriminate against them in the sense that they cannot afford treatment for minor, yet unsightly, skin lesions. This altruistic argument could lead some dermatologists to try to please everyone so as not to create social injustice. It could also lead them to feel that the solution is not to cut health care provision but to provide it with more resources. It is true that we need much more staff and technical support, but for other ends. If a health care professional wishes to practice dermatologic charity with minor aesthetic lesions, then this must be done outside the state system, and not at its expense.

Following this line of action requires a change in culture, both among the general public and among primary care physicians, dermatologists, and the

managers of health care institutions. The investment is long-term, a long-distance race involving continuous information for patients and primary care physicians, a great deal of patience from dermatologists, and, of course, teamwork.

Some months after our deliberate change of approach, we are starting to observe that, since primary care physicians are regulating the patients they refer to us, patients are beginning to understand our position, and we have been able to reduce outpatient waiting lists and the number of patients per session to the extent that we are a little closer to the desired number—still a long way off—that will enable us to provide better quality health care.

Joint decision making by all health care professionals and the support of our institutions, such as the Spanish Society for Dermatology and Venereology and media such as this journal provide an exchange of viewpoints that will enable us to define the profile we want for our specialty.

We believe that this approach does not interfere with patients’ rights, nor with the ethical principles set out in the Law on Health Care,⁵ and we fully support the proposal of J. M. Carrascosa that dermatologists in the public health system should not treat minor and

benign skin lesions. Instead, we should direct our efforts towards developing other, more necessary, important, and complex areas of our specialty.

Acknowledgments

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Reply to: “Treatment of Minor and Benign Skin Lesions in the Spanish Public Health System: Experience in Health Area 19 of the Autonomous Community of Valencia”

J. M. Carrascosa

Associate Editor of *Actas Dermosifilográficas*, Servei de Dermatologia, Hospital Universitari Germans Trias i Pujol, Universitat Autònoma de Barcelona, Badalona, Spain

To the Editor

I thank Dr Betloch for her comments on my article.¹ These lead

me to believe that the conditions, circumstances, and conviction that led me to write it are echoed throughout

the Spanish public health system. From an absolutely legitimate and law-abiding standpoint, the approach adopted by