

# Skin cancer: changing paradigms of practice and medical education

Christopher A Commens

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Over the past two decades, preventive health programs about the need for sun protection have alerted patients to the significance of increased rates of skin cancer in white Australians. Skin checks of both affected people and the “worried well” have become daily medical practice. This public demand has resulted in changes to medical practice and an increase in associated health costs, as touched on in two other articles in this issue.<sup>1,2</sup> In this editorial, I argue that, as practice continues to evolve, there will be a need for concurrent changes in undergraduate and postgraduate medical education on skin cancer.

Each year over 300 000 Australians are diagnosed with melanoma or non-melanoma skin cancer.<sup>3</sup> However, on clinical examination, it is not always easy to tell the difference between benign lesions and skin cancer, even with specialist training. Both patients and medical practitioners feel the pressure to excise lesions if there is doubt about their malignancy. In this issue of the Journal, Youl et al (*page 215*) report that a quarter of the number of lesions removed were as a result of patient insistence.<sup>1</sup> For every melanoma excised, about 20–25 benign pigmented lesions are excised,<sup>1,4</sup> amplifying surgical and pathology costs — nearly 300 000 benign naevi were excised over the period July 2005 to June 2006.<sup>5</sup> Further, Askew et al (*page 210*) demonstrate that skin cancer excisions are increasingly associated with com-

plex and expensive surgical repairs.<sup>2</sup> Medicare Australia statistics show that procedural cryotherapy for 10 or more solar keratoses was performed 595 568 times between July 2005 and June 2006.<sup>5</sup> Skin cancer has been reported as the costliest of all cancers to treat.<sup>6</sup>

Traditionally, actinic lesions were initially managed by general practitioners, with appropriate referral to dermatologists, surgeons and radiotherapists. If GPs were uncertain about skin cancer diagnoses, they would refer patients to specialist dermatologists, who often had long waiting lists, were variably accessible, and charged higher fees.

The Australasian College of Dermatologists (ACD) has long recognised the skin cancer “epidemic” in Australia, but has had difficulty meeting patient demand for dermatologists’ services, even with a trebling of the number of trainees from 20 in 1976 to 65 in 2006 (ACD, unpublished data). With a minimum 4-year training scheme, the number of practising Australian dermatologists has only risen from 136 in 1976 to about 350 in 2006 (ACD, unpublished data). Most people in metropolitan areas will have to wait for weeks or months to see a dermatologist, while access to dermatologists in rural and regional Australia is variable. The College’s state facilities have created regional

outreach clinics with rostered dermatologists, but services still need to be improved.

The two-tier relationship between GPs and specialists has been challenged recently by the rapid growth of skin cancer clinics that bulk-bill patients and are staffed by non-specialist medical practitioners.<sup>7</sup> There are no regulations about who can set up these clinics — some are part of large commercial corporations. Nor are there any particular requirements for training of the clinicians who work there. Thus, an under-regulated three-tiered system of skin cancer management has developed. From the patient's point of view, the convenience, accessibility and billing arrangement of these clinics may be appreciated. But, patients may also be incorrectly assuming that the attending medical practitioners have had "specialist training" and be unaware that their usual GP may be just as competent.<sup>1</sup> From a professional perspective, some skin cancer clinicians, realising that they may have a "credibility" issue with their colleagues, have started to form liaisons with universities to establish accreditation courses. These clinicians are the "standard bearers", but we need to know the competence of all clinicians in all skin cancer clinics, which should be open to examination by the public and professional peers.

In my view, the rise of skin cancer clinics and the partial "sidelining" of GPs in skin cancer management is due not only to the relative shortage of specialist dermatologists but also to a failure in undergraduate and postgraduate education on skin cancer. In the 1980s and 1990s, I believe there was a profound, long-term underinvestment in the number of Australian medical schools, accompanied by variability in the breadth and quality of teaching on skin cancer. Over the next few years, owing to the development of new medical schools, the number of medical students graduating each year will almost double.<sup>8</sup> Ensuring that skin cancer education is adequate will be an enormous challenge. Given the high prevalence of skin cancer in Australia, the Australian Medical Council should ensure that universities can sign off their graduates as competent in clinical recognition of skin cancers, as all interns will need this skill. This education needs to be significantly patient-based, to ensure that medical students have the chance to develop an appreciation of subtle clinical features. Available resources, including teachers as well as patients, are limited. New paradigms, educational technologies and collaborations will need to be established quickly.<sup>9,10</sup>

Going beyond basic recognition of lesions, skin cancer management is a complex issue, involving both procedural and pharmaceutical interventions. This requires supervised training, which should be undertaken by postgraduate clinicians who want to manage skin cancer. At the moment, further training for non-dermatologists who wish to increase their skills in this area is extremely ad hoc. Some universities have recently capitalised on the interest in skin cancer management by establishing skin cancer courses for medical postgraduates.<sup>7</sup> These vary from weekend diagnostic certificate courses to year-long masters degrees, but, critically, may lack a significant component of face-to-face clinical contact with patients. While such courses may form an important part of future postgraduate skin cancer

education, I believe the first priority of universities must remain the provision of undergraduate education.

A different approach would be to look at more "hands-on" clinical training to achieve clinical competence in skin cancer management. The Royal Australian College of General Practitioners, the Australian College of Rural and Remote Medicine, and the ACD are working on a unique training and education scheme that will provide supervised clinical attachments and assess competence, but this program will take years to provide enough certified GPs. In the meantime, other GPs are establishing and publishing their credentials to manage skin cancer.<sup>2,3</sup> There may be little difference in outcomes between competent experienced GPs and skin cancer clinicians.<sup>1</sup>

Public health studies have ensured that we are now aware that skin cancers are five times more common than all other cancers combined.<sup>6</sup> Now the public needs to be assured that new medical graduates are able to recognise skin cancers and that postgraduate education institutes will ensure that clinicians who choose to treat skin cancer are appropriately trained and competent.

### Competing interests

Christopher Commens is a dermatologist and Chair of the Ethics Committee of the ACD. He was formerly Chief Censor of the ACD.

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