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European dermatology: great past—no future?

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The title of this article is not my own creation. It was suggested by the editor of the journal, but I eagerly agreed to use it because I strongly disagree with it. Not all the past of European dermatology was great (I am focusing mainly on central Europe). There were our giants: founding fathers who established the foundation of our discipline, established schools and created an aura of *excellence nonpareil* around themselves. But there were also mediocre epigones during whose times the progress of dermatology froze or came to a standstill. We recently overcame a lengthy period of stagnation one generation ago. And why no future? Dermatology has probably never experienced a better time than it has had in the past years, and the luster of our specialty shows no sign of fading; there are still many research problems to explore, many interesting diagnoses to be made, there is a constant influx of new highly effective therapies, and most dermatologists both in hospital and private practice are doing well economically.

I believe that the future of dermatology may be bright. We cannot afford to sit back and expect this to simply happen; it will take considerable efforts on the part of all of us to insure this rosy future.

Besides its greatness, the history of dermatology also shows some degree of faintheartedness and a staunch and slightly paranoid preparedness to keep intruders from its premises. We never have given up territory voluntarily, even if we felt that our overstretched forces could not hold it any longer. One of my first impressions in dermatology, around 1966 on the occasion of a meeting of the Austrian Dermatological Society, was of a universal sense of Cassandra-like doom, which broke out because the "Lupus-Station" of a large peripheral hospital in Vienna was closed down by the hospital authorities. The Lupus-Station was a ward of several dozen beds exclusively allotted (at least theoretically) to patients with skin tuberculosis—most beds being empty, of course, because the incidence of tuberculosis had dropped dramatically after World War II.

Skin doctors may suffer somewhat from a Freudian trauma: however smart they may be in research or in clinical performance, they feel that the fellow physicians and the general public hold them in mild disregard because dermatology is not perceived as "real" medicine. This attitude is not so much sensed in large cities with a long tradition in dermatology, but more clearly in small towns. This is probably one of the reasons why the dermatology department is usually among the first victims in hospitals when it comes to the reduction of beds or the cutting of funds. It is not surprising that in the 1930s in Vienna, two-thirds of dermatologists were Jewish—they were simply not welcome in "real" medicine, like internal medicine or surgery.

We still bear some of this basic mistrust, and we bare our teeth when we see our dominance over melanoma, lymphoma, autoimmune diseases and many other disorders threatened. Interestingly, the rise of dermatology began when the skin was finally perceived as an organ of its own; now, when it is clear that this organ obeys the same rules as most others, alarmists fear that competition from other specialties may lead to its fall. But there is a counter-trend. In our part of the world, dermatology has swallowed a large

number of "subspecialties" like allergy, histopathology, phlebology, and (in some places) proctology and andrology, not to mention cosmetic dermatology. This umbrella approach has functioned well for some decades, but now we are at a crossroads; we do not have the manpower to handle all these ample fields properly, nor to provide adequate teaching for our juniors. An experienced university dermatologist specializing in allergy has calculated that all the dermatology centers in Austria together could not possibly handle the testing of drug allergy patients, even if freed from all other clinical work, if the guidelines for drug testing were strictly followed. Equally disquieting is the threat to dermatohistopathology. Due to the rigid training rules imposed by regulatory authorities, it will be very difficult to maintain continuing education in the field of dermatopathology. Its disappearance from smaller dermatology departments in Austria is a realistic possibility.

Medicine in Austria, and probably in most of Europe, is threatened by the current financial crisis. In Austria, the problem began a number of years ago with the ever-increasing savings plans, which impoverished the *Wissenschaftsfonds* (the central Austrian agency for funding research) and bled the universities and hospitals financially, which then led to a shortage of personnel and funds. In dermatology, the problem is compounded by a vicious circle of hyperactivity: still too many beds, too many wards, too many outpatients, and too many subspecialties—all making it hard to provide adequate care and still nurture an intellectual discipline. There is no easy way out. We have to reconsider our overall position in the medical system: we will probably have to jettison some of our pet clinical and laboratory activities, adjust and focus on our patient care, downsize our facilities and try to cooperate (as difficult as it may be) with the hospital authorities. Most crucially, we must then redirect our energies into rewarding research and clinical activities.

This is not easy and may provoke resistance from politicians and patients. There is also a serious flaw in the idea of trying to get rid of "simple" cases in order to get leeway for more important things; routine cases are the indispensable training ground for excellent clinical performance. I have seen quite a number of outstanding academic dermatologists who have had difficulties in making simple diagnoses.

In the present time of shortage of personnel and funds, we have to reject the outdated tenet that the dermatologist must master the laboratory work himself. When I was a resident, it was the residents who worked in histochemistry, electron microscopy, cell culture and other fields. This was appropriate many years ago and served a good purpose, but now the doctors are needed in clinical work, and laboratory work has become much too difficult to be mastered by non-professionals. Today, we must cooperate with PhDs, but the goal and direction of research must be defined by the physician. In the old times, the research questions were directly generated from clinical problems. I remember when my teacher, Klaus Wolff, told us during a laboratory meeting: "Sitting in the refrigerator is a piece of pemphigus skin in which we will hopefully find intercellular immunoglobulin deposits at the ultrastructural level." And so it was. Today, research questions sometimes seem to be derived from an alternative universe. Dermatologists should not forget that their research should primarily serve dermatological purposes.

When I was a resident, we did not really feel that the function of Langerhans cells would ever be unraveled, that melanoma could ever be defeated, and that the cause of genodermatoses would ever be pinpointed. Today, we are very close to all these answers and many other goals. I am very curious as to what dermatology has in store for us in future. Until then, we must try to adapt to the economic, organizational and structural conditions of today. This is a Darwinian process like several others before which dermatology has successfully mastered.