Dermatology and ethics: some case studies

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The field of dermatology is seen by many in the medical fraternity as a "hassle-free" subject. However, it has its role to play from a public health viewpoint. People's skin is the focus of much debate in India. Most public health issues relating to dermatology in India stem from poverty. At the same time, the focus of dermatology has been drawn to issues of excess: cosmetology, beauty awareness, obesity and expensive new modalities of treatment. Dermatology also encompasses three distinct areas: skin, sexually transmitted diseases and leprosy. I shall highlight for discussion some encounters which have raised ethical questions relating to public health.

A 26-year-old woman with a limited income visited a dermatologist complaining of a nevus of Ota (hyper-pigmented patch over the region of the eye and surrounding areas) from birth. She was swarthy in complexion and the nevus did not impair her vision in any way. The only issue in question was its cosmetic unacceptability.

One may question the importance of this lesion from a public heath point of view but given the media hype on beauty, this is an area to which dermatologists should devote their attention seriously. There are too many so-called beauticians, herbal specialists and other self-proclaimed 'specialists' airing their views in leading magazines, who are only too happy to prescribe scheduled medicaments in their columns.

This patient was referred to a senior dermatologist who promptly recommended laser therapy besides charging a hefty fee for his consultation. The patient was explained only the bare essentials of the procedure with minimum discussion of the side effects or complications. She underwent the surgery recommended as she was of 'marriageable' age and her parents were desperate given Indian men's desire for 'fair' skin. For the first two sittings, there was considerable lightening of the skin and they were pleased. After a while, post-inflammatory hyper-pigmentation set in and over the next two sittings, the skin colour returned to its black and blue hue with an overall improvement of just about 20 per cent. At this point, the patient decided to discontinue. By now, she was set back by approximately Rs.40,000.

A 32-year-old man from a low socio-economic group presented to the skin outpatient department. The huge growths on his face with dimpling at their centres were diagnosed to be a pox virus infection named molluscum contagiosum. Given the clinical presentation and his occupation (truck driver), an ELISA for HIV was asked for though the patient initially denied a history of extramarital sex.

At this point, his wife said he had tested HIV positive in Mumbai. She knew of her husband's premarital sex but had not been unduly concerned as he was apparently faithful to her after marriage. They had a five-year-old son who had been repeatedly falling ill. Both mother and child were not aware of their HIV status. The family was unaware of the implications of HIV. The man had been running from pillar to post in Mumbai trying all sorts of remedies guaranteed to 'cure' him and was at the end of his rope both financially and emotionally. His only concern was to know if his condition was terminal and what he could do for his family that he loved. He was not aware of the seriousness of his condition.

The mother and son were tested after extensive pre-test counselling, and it was found that they too were HIV positive. Further ethical questions arise: was it right to do a HIV test on the man without first educating him? Given the cost of anti-retroviral drugs, what could we offer the patient after a diagnosis? How many dermatologists or even doctors in other fields can honestly say that we recommend HIV testing only after adequate pre-test counselling and how many can claim to have played a role in imparting public health education on HIV? Are we not ethically obliged to do so given that prevention is our only option at this point?

A 25-year-old woman came to the outpatient department with a single, well-defined hypo-aesthetic patch over her right forearm, of two months' duration. There was no associated nerve deficit or any other patches on examination. A detailed examination of the peripheral nerves showed a mild enlargement of the right ulnar nerve; no nerve to patch or any other nerves were present. A provisional diagnosis of indeterminate/ tuberculoid leprosy was made. A skin biopsy was performed and the result was suggestive of leprosy at the tuberculoid end of the spectrum.

The WHO six-month MDT regime for paucibacillary leprosy calls for Rifampicin in a monthly dose of 600 mg and Dapsone in a daily dose of 100 mg. Here we faced a dilemma. There have been reports on other regimes, citing the inadequacy of MDT. One of them is a single dose of three drugs — Rifampicin 600 mg, Ofloxacin 400 mg and Minocycline 100 mg. Compliance would be better with a one-time regime, and side effects fewer but there are questions about its efficacy. Data on MDT go back more than a decade and initially showed good results with a later plateau. The studies on the new regimen are in their infancy. Given this background are we justified in opting for a one-time regime or should we stick to the tried and tested six-month one? After much debate we decided to put the pros and cons of each to the patient and let her select. She chose the latter.

These are some of the many dilemmas we come across as dermatologists. I believe that most such situations can be resolved only if we reflect on the pros and cons at each step, and disseminate accurate information to the patient in the interest of public health. A well-informed public and a conscientious doctor can only result in a healthier doctor-patient relationship.

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