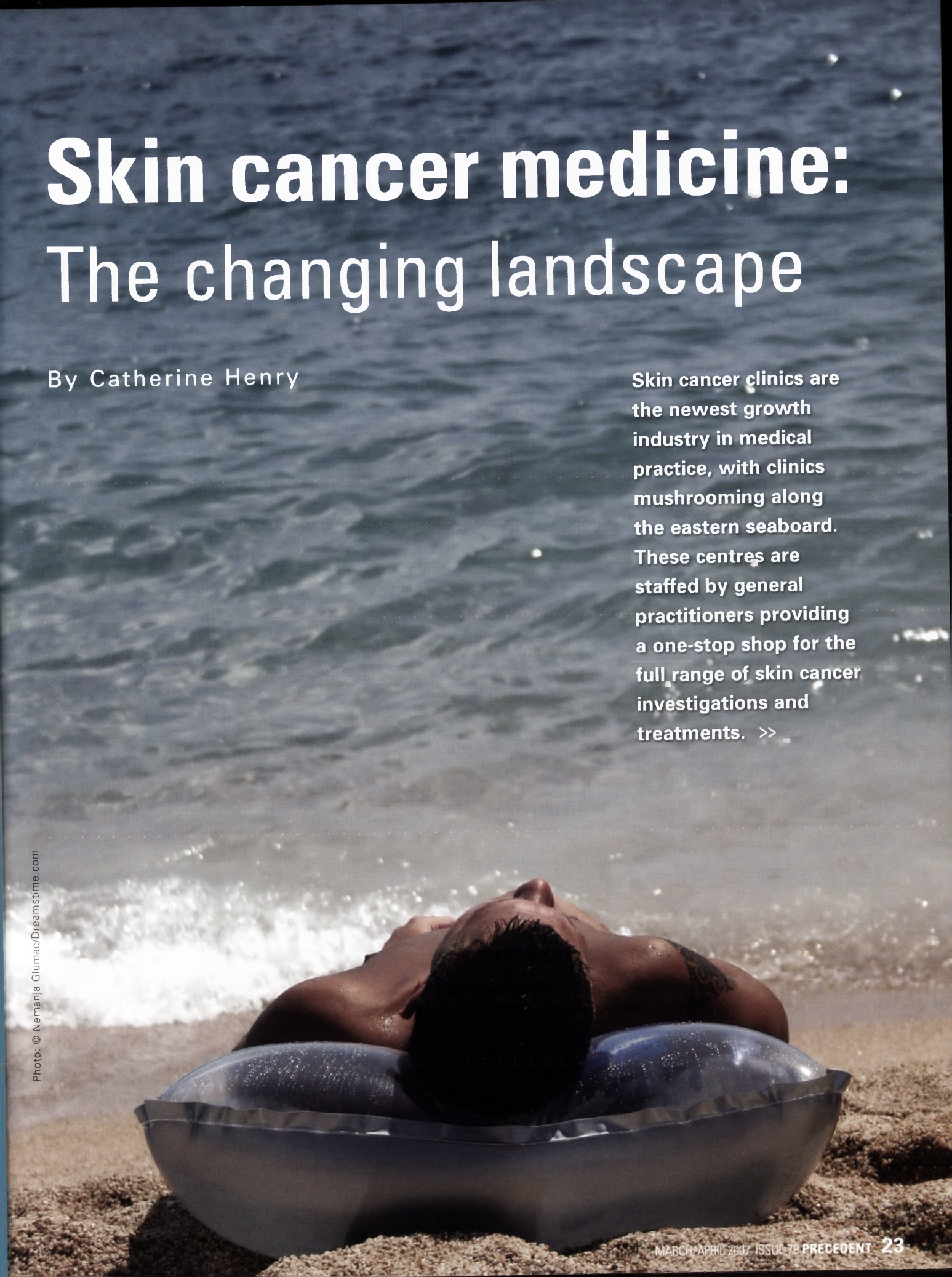
Skin cancer medicine:
The changing landscape

By Catherine Henry

Skin cancer clinics are the newest growth industry in medical practice, with clinics mushrooming along the eastern seaboard. These centres are staffed by general practitioners providing a one-stop shop for the full range of skin cancer investigations and treatments. >>



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Skin cancer surgeons and dermatologists, whose patients are flocking to the clinics for speedier treatment at reduced cost, say that patients will receive a significantly reduced standard of care. They, and others, argue that better training, improved standards and a system of accreditation are needed to ensure optimal health outcomes for patients.

BACKGROUND

Australians have a one-in-two chance of exposure to skin cancer in their lifetime. Non-melanoma skin cancer, such as basal cell and squamous cell carcinoma, is the most commonly diagnosed cancer in this country. It is also the most expensive to treat.[1] The most insidious of the skin cancers is malignant melanoma ('melanoma'), which develop from melanocytes, or the cells that produce pigment. They are the most common cancer among the age group 15-44, and the second most common cause of cancer death in that age group.[2] Statistics like these certainly justify aggressive public health campaigns to encourage safe behaviour in the sun, and vigilance in checking sunspots and changing skin lesions.

A surge in awareness of the dangers of sun exposure has created the perfect environment for the development of skin cancer clinics, typically staffed by general practitioners and concentrated along the coast of NSW and Queensland. Some clinics are part of large corporate chains; others are run by smaller independent operators.[3] The clinics trade on their relative accessibility: no lengthy waiting periods, no need for referral, and bulk-billing is the norm. Given the threefold increase in the proportion of patients opting for treatment at skin cancer clinics rather than traditional GP surgeries,[4] they have been described as 'the new medical growth industry'.[5]

ENTREPRENEURIALISM

The rise of skin cancer clinics has not been met with enthusiasm from all quarters. Those who treat the same clientele, such as dermatologists and plastic and reconstructive surgeons, have concerns on a number of different levels. Perceived entrepreneurialism is one issue. An aggressive advertising style seems to have been adopted across the board, both by the clinic chains and the independent operators. Many working in the skin cancer area believe that the clinics have developed in response to an ' entrepreneurial opportunity … put together by non-medical people who have simply advertised for doctors to work for them'.[6] They are seen as 'entrepreneurial touting computerised systems for diagnosing melanomas … most of the[m] bulk bill[ing]'.[7]

Related to this are concerns about inappropriate and unnecessary procedures. The growth of skin cancer clinics has coincided with a marked increase in the use of Medicare item numbers dealing with skin cancer procedures. In the case of skin lesion biopsies, Medicare statistics record a 128% increase over a five-year period.[8] Typical examples of over-servicing by certain clinics include removing large numbers of benign lesions.[9] The recent report (January 2007) of the body that oversees the operation of Medicare, the *Professional Services Review*, noted the very large number of excisions and unnecessary pathology testing by skin cancer clinics.[10]

CLINICAL CONCERNS

Another problem is the way in which skin cancer clinics market their services. The doctors practising at these clinics are general practitioners, not specialists, and the most that can be said for their level of expertise is that they 'have a *special interest* in skin cancer work'.[11] Despite this limitation, patients are in many instances led to believe that they are dealing with practitioners with special expertise in skin cancer medicine, and there is anecdotal evidence of some doctors telling patients that they *are* skin cancer specialists,[12] when in reality they have no more training than the average general practitioner.

By way of example, consider the terms of the following advertisement for a Newcastle skin cancer clinic, which appeared in a free Cumberland-style publication in the Hunter Valley:[13]

Get your skin checked

The Skin Cancer Clinic in Newcastle has now been open for seven years.

There are 11 doctors who specialise in the detection of skin cancer operating from the clinic.

The clinic is very popular as it bulk-bills and even though appointments are necessary, patients can usually be seen without too much delay.

Two Australians aged 55 plus die every day from melanoma and 6 out of 10 melanomas occur in people aged over 55.

More than five sunburns in a lifetime can double your risk.

The clinic encourages people with fair skin, freckles, history of severe sunburn, changing moles, fair or red hair, blue or green eyes, or family history of melanoma to arrange an appointment.

An additional clinic has recently been opened at Cardiff to accommodate increasing demand.

The Star – 26 January 2005

Lack of surgical expertise has not deterred a number of skin cancer doctors from taking on complicated and aggressive surgical procedures, such as skin flap procedures for scar revision. The 2007 report of the Professional Services Review cited a case of a Sydney GP performing skin cancer work who was required to repay $80,000 after being found to have carried out the highest number of skin flap repairs in Australia – 6,300 services to 1,826 patients claiming more than $300,000 in Medicare benefits in a year.[14] In another case, the review body found that the lesions excised by a doctor who had claimed for skin flap repairs were too small to have required this procedure. 'The size of the skin excised was so small and shallow that single stage local skin flap surgery would not have been possible without further skin being excised', the report claimed.[15] Such cases, the report observed, supported the view that treatment at skin clinics in

many instances 'appear[ed] to have been aimed at increasing profit for practitioners rather than what medical peers would regard as being in the best interest of patients'.[16]

DIAGNOSIS ISSUES

Significant concerns have been raised not only about the type of work done by some doctors in some clinics but also about the *quality* of the work done. The medical press is full of complaints from alarmed plastic surgeons and dermatologists about patients treated at skin cancer clinics whose genuine melanomas have been missed, or who have had moles removed from their faces, leaving unsightly scars.[17] Federal Secretary of the Australasian College of Dermatologists, Dr Stephen Schumack, observes that while 'anyone can miss a skin cancer, and we're not saying dermatologists or surgeons are immune from that, it's obviously less likely if you've had six to eight years of advanced training on top of a medical degree, as opposed to no extra training'.[18]

While some might see the criticisms of the specialists as just part of the age-old 'GPs versus specialists' debate, or perhaps even 'skin cancer clinic doctors versus the rest',[19] the fact that there is no barrier to any GP taking on a position in a skin cancer clinic and that there is no formal assessment of competency in an environment where presenting symptoms can be life-threatening should be a cause for significant concern. Both dermatologists and plastic surgeons maintain that they are best placed to diagnose and manage patients with skin cancer; certainly the academic literature supports a strong connection between diagnostic accuracy and length of training, particularly in the specialist area of dermatology.[20] The point has been made, however, that there are hardly enough dermatologists to cope with current demand for their general services, let alone enough to manage the majority of skin cancers in Australia. Resources and 'turf war' issues aside, there is no doubt that in the area of skin cancer, as with all forms of cancer, diagnosis is critically linked to prognosis. A patient diagnosed with melanoma has the best prognosis when detection has been made early. Significantly, melanoma is among the group of cancers with the highest relative survival rate.[21]

CAPONE v COLLIS[22]

A negligence case against a GP practising in a Newcastle skin cancer clinic, the Hunter Skin Cancer Clinic, highlights the clinical challenges of screening for and diagnosing skin cancer. The case achieved a significant degree of notoriety in both the legal and medical press in NSW,[23] and has led to renewed calls for introducing some form of accreditation framework for skin cancer clinics.

The late Mr Loreto Capone had a lesion on his back for about 15 years before it was first assessed by a doctor in September 2002. He was concerned that the lesion was growing. The GP referred Mr Capone to a local dermatologist, noting that the lesion appeared hyperpigmented. The dermatologist was not able to see Mr Capone for a three-month period and, hoping to put his concerns about the possibility of a melanoma to rest, Mr Capone sought an earlier appointment in the interim with one of the GPs practising at a nearby skin cancer clinic. The plaintiff's case was that he and his partner believed the skin cancer clinic doctors to be specialists in melanoma.

The plaintiff gave evidence on commission that the doctor seen at the clinic, a Dr Collis, had reassured Mr Capone that the lesion was benign and not a melanoma. It was alleged that Dr Collis had said, 'I know a melanoma when I see one.' Mr Capone was told to return to the clinic in 12 months' time. Relying upon the reassurance of Dr Collis, he cancelled the appointment with the dermatologist. Over time, however, Mr Capone noticed that the lesion was getting worse and, 14 months after the last appointment, he again saw Dr Collis, who agreed that the lesion did appear to be worse.

The results of a punch biopsy taken during that consultation confirmed the presence of a malignant melanoma level 4, with a depth of 2.6mm. The evidence as to causation showed that had an excision been done at the time of Mr Capone's first appointment at the skin cancer clinic, he would have had an 85% chance of five-year survival: in effect, a normal life expectancy. Further, had a biopsy been done on or soon after that time, it would have shown a thickness of 1-1.2mm. As it was, the cancer metastasised shortly after diagnosis and, following an 18-month period of illness including multiple surgical procedures, Mr Capone died.

The matter settled during the trial and before the close of the plaintiff's case. The case had classic 'failure to diagnose' >>

features: a lesion that had changed in appearance and which had hyperpigmented features.[24] The plaintiff's expert (a GP) described the defendant GP's assertion that '[he] knew a melanoma when [he saw] one' as both foolhardy and 'diminish[ing] the patient's realistic concern ... regarding changes in a pigmented lesion and the reasonable plan of management of [the GP first consulted]'.[25] Notwithstanding this evidence, reports in the medical press sought to characterise the case as a failure (on the part of the plaintiff) to follow through with the specialist referral:[26] Dr Collis was reported as saying, 'I thought I had a reasonable defence ... [A]rrangements [for the patient to see a specialist] had already been made, and he cancelled those arrangements.'[27]

As is common in cancer litigation, the defence pleaded contributory negligence on the basis that Mr Capone had been advised by Dr Collis to have a biopsy and had rejected that advice. Interestingly, there was no record of any such advice in the defendant's patient notes. The plaintiff's lawyers argued that such a finding was inconsistent with a review in 12 months.

In regard to the amount of damages, the plaintiff's case on causation was that diagnosis at the time of initial presentation to the clinic would have resulted in a complete cure. It was not therefore a 'loss of a chance' case as per *Tran v Lam*.[28]

CONCLUSION

Common-law negligence cases such as *Capone v Collis* highlight the issues of quality and safety in skin cancer clinics in Australia and, as such, should be seen as another vehicle for formulating public health policy in the area of skin cancer medicine. They add to the weight of evidence that supports the establishment of an accreditation framework in the interests of maximising patient safety. ■

Notes: **1** These were the findings of a series of reports on relative survival after being diagnosed with cancer during the period 1982-1997. See, generally, Australian Institute of Health and Welfare, *Cancer in Australia 2001*, Canberra, AIHW and Australian Association of Cancer Registries, 2004, as cited in E Wilkinson, P Bourne, A Dixon and S Kitchener, 'Skin Cancer Medicine in Primary Care: Towards An Agenda for Quality Health Outcomes' (2006) *Medical Journal of Australia* 184(1), pp11-12. **2** *Ibid.* **3** *Ibid.* **4** According to an investigation conducted by the Queensland Cancer Fund. The results of the study showed that between 2000 and 2001, 70% of patients visited their GP for detailed skin examination, with 10% opting for skin cancer clinics. But between 2002 and 2004, 54% of patients visited GP surgeries and 31% visited skin cancer clinics: see 'Leap in Skin Cancer Clinic Use' *Australian Doctor*, 24 November 2005. **5** Kerry O'Brien on ABC TV, *7.30 Report*: program 'Patients at Risk in Skin Clinic Boom'; broadcast 23 August 2005. **6** This is the view of Professor William McCarthy of the Sydney Melanoma Unit, *Newcastle Herald*, 2 July 2005. **7** Such is the view of Dr Norman Swan, Presenter of ABC Radio National The Health Report, 8 August 2005. **8** 'Skin Cancer Clinics under the Microscope', *Sydney Morning Herald*, 16 September 2005. **9** This is the view of Professor Robin Marks, Professor of Dermatology at the University of Melbourne: see 'Warning Advised on "Specialist" Skin Cancer Clinics', *Australian Doctor*, 7 March 2006. **10** 'Some Skin Cancer Doctors "Rort" Medicare', *Sydney Morning Herald*, 15 January 2007. **11** See press advertisements for a NSW chain of skin cancer clinics, 'The Skin Cancer Clinics', with clinics in Hornsby, Ryde, Orange and Windsor. Emphasis added. **12** According to reports by members of the Australian Society of Plastic Surgeons: see 'Surgeons Warn over Skin Cancer Clinics', *Health News*, 26 July 2005. **13** An advertisement published in *The Star*, 26 January 2005. **14** 'Skin Cancer Clinics Caught Rorting Medicare', *Sydney Morning Herald*, 15 January 2007. **15** *Ibid.* **16** *Ibid.* **17** 'Surgeons Warn over Skin Cancer Clinics', see Note 12; 'Skin Cancer Clinics under Microscope', *The Age*, 3 January 2006; 'Skin Cancer Clinics Should Be Accredited', *Sydney Morning Herald*, 1 January 2006. **18** This is certainly the view of Dr David Wilkinson, School of Medicine, University of Queensland, who also works one day a week in a Skin Alert skin cancer clinic. See Wilkinson, Bourne et al, *Op Cit* (see Note 1), 11. **19** See, for example, CA Morton and RM Mackie, 'Clinical Accuracy of the Diagnosis of Cutaneous Malignant Melanoma', *British Journal of Dermatology* 138, 1998, pp283-7; RF Wagner, D Wagner, JM Tomich, KD Wagner and DJ Grande, 'Diagnoses of Skin Disease: Dermatologists vs Non-dermatologists', *Journal of Dermatological Surgical Oncology*, 11(5), 1985, pp476-9. **20** 'Cancer Survival in Australia', Australian Institute of Health and Welfare, 2001, as quoted in 'New Reports Show Cancer Deaths Falling', 23 November 2001, http://www.mydr.com.au. **21** Helen Signy, 'Cancer Case Prompts Follow-up Warning', *Medical Observer*, 15 July 2005; Wilkinson, Bourne et al, *Op. Cit* (Note 1). **22** *Capone v Collis* District Court of NSW, No. 258 of 2005. **23** Helen Signy, Loc.Cit; Wilkinson, Bourne et al, *Op.Cit* (Note 1). **24** See risk management strategies identified in the case of clinical diagnosis of melanoma in Sara Bird, 'Failure to Diagnose: Melanoma', *Australian Family Physician*, 2007, 33 (9), pp673-768. **25** Evidence given by Dr James Lynch GP at T 4.6. **26** Helen Signy, *Loc. Cit.* **27** *Ibid.* **28** (Unreported, NSWSC, 20 June 1997, per Badjery-Parker J), and *Rufo v Hosking* [2002] NSWSC 1041.

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