Getting under the skin of dermatology with Alex Anstey

Dr Alex Anstey has just published his memoir, *Under the Skin: A Dermatologist's Fight to Save the NHS*. A passionate, uplifting and personal look at the healthcare system, it also catalogues Alex's fight to improve patient care and outcomes, his passion for research, and his desire to put the patient experience at the centre of care. The book also reflects on some of Alex's inspirations and heroes in healthcare, which include the likes of nurse Betsi Cadwaladr and academic Archie Cochrane

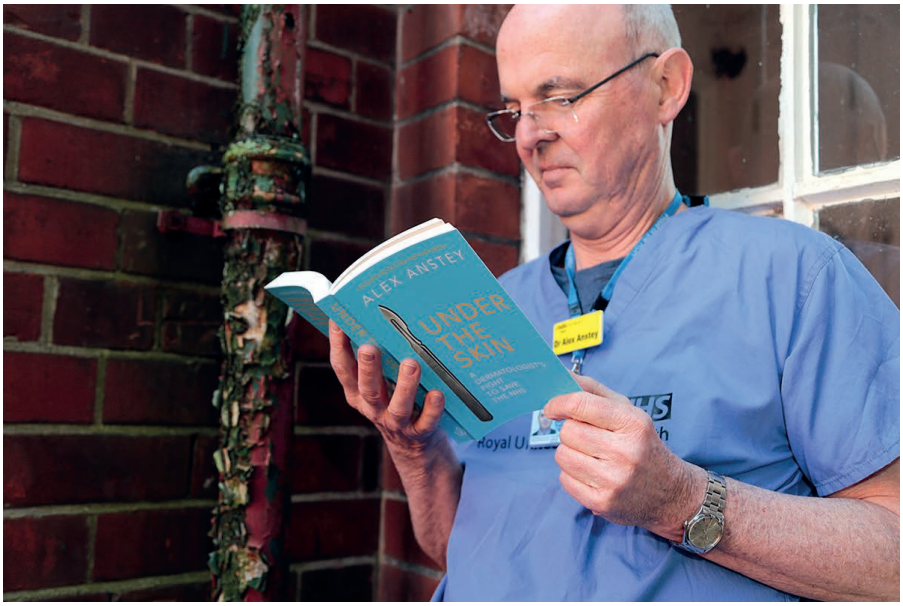
Dermatological Nursing (DN): One of the most appropriate places to start would be about the value of nursing. Throughout *Under the Skin* there's a focus on the strength of the team – of which nurses play a major role – and one of the heroes you write about is Betsi Cadwaladr, who was a nurse during the Crimean War.

Alex Anstey (AA): When we started to talk about publicising the book, nursing was one of the main discussion areas, because there's quite a lot about nursing in this book. Throughout my career I've been a strong advocate for nurses as part of the team.

In the book there's this extraordinary story of Betsi Cadwaladr, and I think she ends up being the heroine of the whole story. It was amazing – I was in the Betsi Cadwaladr University Health Board, and no-one really knew who she was. So, I did some digging and discovered what an incredibly inspiring individual she was; her story really complimented the book. For me, it's one of the best bits of the book and was totally unexpected.

DN: Chapters on these heroes and heroines are intersperse throughout the more personal parts of the book. And there are a real range of characters. You have a background and interest in medical research, but how was it doing this sort of historical research?

AA: I've known about most of these people for a long time, and there are some whom I revere. I became interested in medical history when I was teaching medical students. I ended up creating an intercalated degree in Medical Education; one of the key parts of medical education is understanding where we've come from. So, I'm really interested in the key people who have influenced the development of medicine.



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One of the interesting things about the research for this book, though, is how interlinked it can be. For example, Dr William Osler, I think everyone knows about him in medicine. It was only after I set up the intercalated degree that I learned more about Osler; his name just kept coming up. I realised he was a key character and that I should highlight this to the students.

By total coincidence, it turned out that William Osler's house in Oxford is curated by Terence Ryan, who is a very eminent and famous retired dermatologist from my training. So, it was as though all these pieces just fell into place. So I set up this visit to Oxford, we went to Osler's House and it was an amazing experience. But it was this bizarre twist of fate that Terence Ryan was curating the house. It was though the stories stumbled into one another.

DN: When these same characters keep popping up, I guess you start to build a relationship with them, even though they might be 100 or 200 years old?

AA: It's quite remarkable. Another example is Nye Bevan. We all know about Nye Bevan, but by fate, I ended up as the dermatologist for his area of South Wales – his constituency was bang in the middle of the area that I served as a dermatologist. It was his experience of healthcare in Tredegar and Ebbw Vale in local community hospitals that helped him to create this concept of an NHS, and to have that link was great for the story.

DN: Prior to getting into dermatology, you had quite a varied career as a junior doctor and as a GP. But what attracted you to dermatology?

AA: I'm probably like a lot of dermatologists, and I didn't have much experience of dermatology before I went into it. I had this vague notion in my mind, that it might be a good thing to do. I'd experienced a lot of dermatology by being a GP, because most dermatology is done in primary care. Actually, what this made me realise is that GPs are a huge resource for improving dermatology services within an area. So, I did a lot of dermatology as a GP, but like most GPs, I had almost no guidance in how to do it, the local dermatologists being distant and remote – they were just there if you eventually ran out of ideas.

But also, I could see the need. Lots of people needed help, but there wasn't really a lot of resource. The local dermatology services were under-resourced and hard to access. So, ultimately, it seemed like a good idea.

Actually, I was really in two minds at the time, because I was also thinking about rheumatology, which was another discipline I'd found very interesting – for very similar reason to dermatology, actually. There was a lot of it in primary care and the local rheumatology service was just as remote and inaccessible as dermatology.

DN: You mention this in the book, but having just two weeks to get trained in dermatology as a student isn't very long…

AA: I have to say, Cardiff University is good; their medical students get two weeks of dermatology. My son Ben has recently graduated from Manchester, and he was meant to get only one week, but the week included a Bank Holiday on the Monday and the Consultant was off sick on the Friday, so they only got three days of dermatology.

Of course, you can learn dermatology from books and read up about it, but one of the great opportunities as a medical student is to really see what the discipline is like. If you only spend three days in it, you won't have much of an opportunity to see whether it's the right thing for you.

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DN: And also, the discipline of dermatology is changing. In the book, you mention teledermatology quite a bit, and when combined with the work you've done in Wales, it's really changed the service. In the book you start with a case study in Wales where someone had to travel 30 miles to see a specialist, and that had an impact on her two daughters because they had to travel with her. Teledermatology has the potential to change that, doesn't it?

AA: It's been absolutely transformational for dermatology. Initially, I was a little bit of a sceptic about teledermatology, as there were a whole load of technological issues that were barriers. But the game changer has been the steady progress in mobile phone technology; now, most people have access to fantastic cameras, and most GPs can take very good quality photographs with their mobile phone.

Even five or 10 years ago, the quality of the photos we received for teledermatology was sometimes pretty poor. Some dermatologists tried to solve this by getting professional photographers involved, and by having access to a photography studio, so the patients got referred and had to go to the studio. But this built in a whole level of complexity and cost. You would end up with fabulous quality photographs, but a whole load of inconvenience for all concerned, as well as a massive cost to set up the photographic studios and to pay the photographer.

Now with teledermatology, the cost is basically the platform. In Bath we deal with about 50 to 60 cases a day, and more than half of those don't need to come to the hospital. I'd say about 60% of those cases are managed via teledermatology.

The GP sends the referral in with a whole load of photographs, and we send a response with recommendations, and the GPs get on with it. It's fantastic. And all of that happens within a day or two. We usually manage to clear the cases every day, instead of having an extra 30 to 40 patients added to the waiting list. At that volume, our conventional pre-teledermatology service was just unsustainable.

DN: With regards to the work you did in Wales, you really transformed the system and put GPs at the heart of dermatology care. Your new model was really patient-focused and cut down on waiting and travel, but you still needed to get that buy-in from local GPs. And I imagine some of those were entrenched in traditional ways of working. So how do you pull people into your way of thinking when you propose service transformation like that?

AA: It was easier to sell the concept because I'd trained as a GP. I was up there in North Wales for six years, but we only really started doing this two or three years into the that six year period.

When I was sounding out the GPs to see what they thought of the concept, I was quick to point out that I had trained

in general practice. I really tried to frame it around improving patient care, rather drawing a veil over who was going to be doing the work. I know GPs can be paranoid about getting dumped on by the hospital, so I really wanted to make sure it wasn't framed in that way. So, the focus of the pitch was always around improving patient care, which is something that all of us could and would sign up to.

But also, part of it was about practicing what you preach, and trying to get over the concept of an integrated team. What you'll find is that the most dysfunctional services throughout healthcare are those where there's a wide separation between primary and secondary care. I think back to my GP days and my time spent in York; the overall quality of health care was very good in York; part of the reason for this was that we GPs worked closely with the specialists in the hospital.

I loved the idea of just seeing if we could get create an integrated service where we actually worked together side-by-side, shoulder-to-shoulder as a team. And to do that, I had to do a lot of out-reach, going into the GP surgeries. They were amazed that I did, because they weren't used to a hospital doctor giving up half a day to come to their surgery. I wouldn't go for 10 minutes or half an hour, I'd be there for two hours.

And those meetings were about me listening to them as much as selling the concept of integrated care. I didn't want to go all preachy, and spend 90% of the time speaking. I wanted it to be a genuine exchange and to hear what they have to say too.

I'd ask the GPs to bring along three or four of their patients; we could then see them together as a group – it was all straightforward stuff, but the GPs really liked it. They could say to selected patients 'we've got the specialist coming to the practice next Wednesday, why don't you come along'. And the patients loved it because it shows we wanted to listen to them and understand their experiences.

It's a very powerful thing, for groups and teams to learn together, and if you want to create a really strong integrated team, it can lead to a really wonderful, constructive day.

DN: And a further interesting development from this project is that you were able to save a considerable amount of money – £125,000 – just through better and more appropriate prescriptions and interventions. That's a compelling argument for your bosses, as not only have you transformed patient care, you're also saving money…

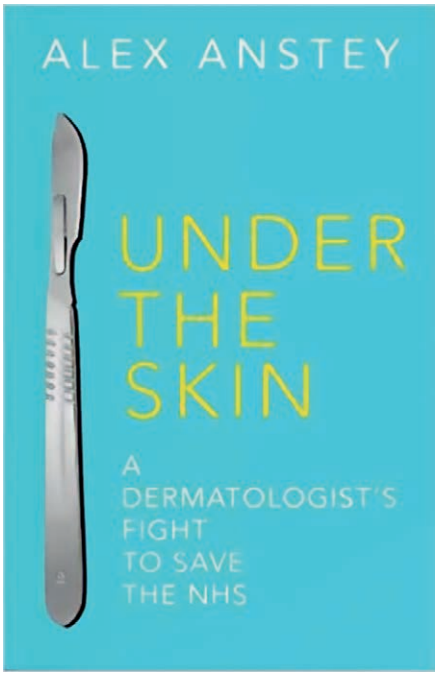
AA: Absolutely. If you've got a model where all the all the focus is on the hospital, everyone comes to the hospital.

One of the things that gets overlooked is the value of community services. One thing that should be in the community, but which often isn't, is ultraviolet light therapy. Phototherapy has got to be accessible, and it has got to be convenient; it needs to be near to patient homes.

I became a bit obsessive about it, all the time thinking about the next paper and preparing grant applications

But around the UK many dermatology departments have their phototherapy unit in their department in the in the hospital. In this post-Covid era, the last thing hospitals want is loads of patients attending who don't really need to be coming to the hospital.

So, I think this is another opportunity. If you neglect phototherapy and if you make it inconvenient, and inaccessible, patients will reject it. They'll say 'Oh, I live too far away, I can't possibly do this'. And then they end up on the next rung on the therapeutic ladder. Once you're at that step, you're talking about more expensive treatments for psoriasis and eczema. If you're not careful you end up creating a huge drug bill, simply because your service model for phototherapy is based around the hospital and excludes too many patients.



The other thing that made us save money was having a pharmacist on board. We had a Band Seven pharmacist, and she was very switched on. We had her for two days a week, so she was a constant team member. We were systematic about identifying the most expensive drugs, and trying to understand why they were being prescribed and how they were being prescribed.

DN: Another thing that comes through in the book is your love for research, and in particular writing papers and editing the British Journal of Dermatology (BJD). What sort of value do you place on research, and what took you down that route?

AA: I had several inspiring and intimidating bosses! I didn't really have much experience of research, but when I arrived at High Wycombe for my first dermatology job, both of my bosses were charismatic and obsessed with research and writing papers. Their academic output was quite extraordinary.

I joined this team, and it was really a case of joining in with what everyone else was doing. It was expected of you, but because I hadn't really done anything like this, I didn't have experience in this area. So I cut my teeth, and before you knew it, I started to write academic stuff and participate in research studies; I actually quite enjoyed it. Then I became a bit obsessive about it, all the time thinking about the next paper and preparing grant applications.

At the end of my six-year term, the journal was in a much stronger position, and I'm really proud of that

DN: And, I guess this led you, ultimately to the *BJD*. In the book you mention how, much like the services you worked in, it needed to be restructured. Part of this was extending the term of editorship, so when it came to that, was it simply about applying what you'd learnt in practice and applying it to this new role in publishing?

AA: I think it was the first time the *BJD* ever had a proper strategy. I went into it at a time when the journal was in crisis. I had some strong support from Professor Irene Leigh the BAD Academic Vice-President. Irene really understood the importance of creating a decent long-term strategy. She helped me shape this strategy, and she helped me deal with the politics.

At the end of my six-year term, the journal was in a much stronger position, and I'm really proud of that. What I would say, though, is that it has really powered on since I've left, which is even better, because it's terrible to do something and then find it slump when you go, because ultimately that's also a failure of your own leadership. To see the BJD doing so well is fantastic. Ultimately, what the journal is trying to do is improve patient care around the world, and that's exactly why I went into medicine.

DN: Finally, I really want to bring it back to nursing. You've mentioned the importance that comes with working as a team, but how important have nurses been to you throughout your career?

AA: Nurses have been incredibly important throughout my career. In Bangor we flipped the model and ended up with primary and secondary care coming together in an integrated way. But at one level, when you look at what we did and the size of the population we were working with, you think, 'how on earth did they do this with a single consultant?'

The short answer is that I wasn't alone. I had a team that included a couple of younger staff doctors, and they were important. We also decided to invest in our nurses. To start with we had one clinical nurse specialist, who was a nurse prescriber. She was very effective and hard-working. She was working alongside the consultants in the front-line, seeing patients and sorting them out.

After that, our plan was to appoint another nurse-prescriber. We advertised and shortlisted. When we interviewed, two of the nurses were so good we couldn't make up our mind between them – so we appointed them both.

So, we ended up with three clinical nurse specialists, all nurse prescribers. And you can achieve a lot with a team of six experienced members of staff if we all pull together and we're clear about what you're trying to do: three doctors and three nurses all working in harmony.

It's actually quite a contrast from my current unit in Bath. We've got a fantastic team of six consultants. We have got some clinical nurse specialists, but none of them are nurse prescribers. I think our team in North Wales was high-functioning, and there were many reasons for that, but one was that our nurses were outstanding.

The other thing I want to mention is that the star of my book was also a nurse. Much of what Betsi Cadwaladr did was dermatology nursing when she was out in the Crimea. She was on the frontline helping soldiers recover from shrapnel wounds and injuries, as well as doing more general nursing. She's an outstanding inspiration, and I think we can adopt her as one of our own. DN

SPACE to fill
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