Who Decides How Doctors Treat Patients and what Patients can Demand from Doctors?

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Treatment of patients has improved in recent years, especially for skin diseases. At the same time, the number of inpatient beds has decreased considerably. Much of this is due to scientific progress, new treatments and new drugs.

Psoriasis treatment is a typical example, with the use of new biological drugs. In addition, psoriasis is much more of a systemic disease than previously thought, with joint involvement, increased risk of myocardial infarction, etc. There has been an explosion of scientific knowledge in recent years. This is all good news for patients, but for improvements to take effect, it is necessary that doctors prescribe proper treatment.

The situation is complicated by the fact that there are several players in the field; the Swedish Medical Products Agency, the National Board of Health and Welfare, national dermatological associations, the Nordic Dermatological Association, the European Academy of Dermatology and Venereology (EADV), the European Dermatology Forum (EDF), guidelines and tradition at the local clinic, etc. Furthermore, if something goes wrong and the doctor is accused of malpractice, legal considerations are taken into account. Consequently, everyday life for the dermatologist is complicated, as different guidelines are sometimes contradictory.

In addition, patients have access to the same data as doctors, and are sometimes better than doctors at searching out information. However, interpretation is important and, in general, doctors are better placed to interpret medical information. Nevertheless, "iPad patients" have become more common the last 5 years. I find it stimulating to have more educated patients, and consider that it improves the quality of my work; however, it can also be a challenge to doctors.

Education and scientific meetings are important in order to keep up with the latest scientific developments. In Sweden, we have a very troublesome situation, as there is no compulsory post-specialist education. This is very different from other countries, which have board certification, re-certification and continuous medical education (CME) credits. Most dermatologists are, of course, serious and take care of their own post-specialist education. However, I find it very odd that Sweden, with all its regulations in other areas, neglects this important issue. I consider that it is necessary to have the same rules as in other developed countries; otherwise there is a risk that Swedish doctors will be less well suited to use new treatments than doctors from other countries, such as the USA, Germany, etc.

Dermatologists have many important places to meet and exchange knowledge, such as at local, national and international conferences. EADV meetings are, of course, extremely important, but Nordic meetings are also necessary to discuss specifically Nordic issues. We share common values in healthcare and are often considered to be in the forefront of international dermatology.

Basic medical studies are also important. In Sweden, in contrast to almost every other country, we have no graded degrees in medical education. At present we are happy to welcome foreign doctors, who almost always have graded degrees in their basic education. As the first medical faculty in Sweden, the Sahlgrenska Academy in Gothenburg, has decided to re-introduce graded degreew to basic medical education. We are convinced that this will improve quality, but also be fairer to students as they seek their first jobs. This may sounds like a sharpening of demands for clinical practice, but it is merely an adaption to international rules.