Protecting the Psychodermatology Health Care Professional

4

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There are some challenges for health care professionals who work in psychodermatology. These include:

Complaints: Dermatologists who treat psychodermatology patients are at high risk of complaints, abuse and being threatened or stalked, as are other specialties, such as psychiatrists or cosmetic and plastic surgeons. Complaints are very common as well as threats of defamation through the internet and social media platforms.

Trust: Psychodermatology patients struggle to trust their treating physician, leading often to 'doctor shopping', a need for a second opinion and poor adherence to the treatment plan.

Burnout: Burnout in dermatology and specifically in psychodermatology is a reality and needs to be addressed.

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Recommendations:
(a) Development of networks in Psychodermatology.
(b) Regular 'burnout' sessions at national and international meetings.
(c) Regular, sympathetic, confidential assessment for depression, anxiety and burnout for all dermatologists who treat psychodermatology patients.
(d) General Medical Council and other national regulatory bodies need to recognise the challenges of working in this emerging subspecialty of dermatology.
(e) Further training in psychodermatology is required.
(f) Development of regional dedicated psychodermatology clinics.

Introduction

Psychodermatology is an emerging subspecialty of dermatology dealing with the complex interaction between the skin and the mind. Psychodermatology or psychocutaneous medicine deals with two large categories of patients: (a) patients with primary psychiatric disease that develop secondary skin lesions or symptoms and (b) patients with primary dermatological disease that develop significant psychiatric or psychosocial comorbidities due to their skin problem. Both of these categories can be quite challenging in terms of management. In particular, patients with psychiatric disease may refuse a referral to a psychiatrist and frequently seek help from a dermatologist, considering their condition to be of cutaneous origin.

Complaints

Psychiatrists and related healthcare staff are at risk of complaints, abuse and being threatened or stalked, as are other specialties, such as plastic surgeons, especially those performing cosmetic procedures. In a study conducted in Australasia, 20% of cosmetic and plastic surgeons reported having been harassed by patients, especially those with body dysmorphic disorder or other underlying psychopathology. According to Gkini et al. 2019, in a survey performed in psychodermatology, 75% of dermatologists admitted feeling stressed, when dealing with this challenging category of psychodermatology patients. Also, 36% of psychodermatologists had received complaints about misdiagnosis and/or wrong diagnostic tests, which is a much higher percentage of complaints when compared to those generated from routine general dermatology referrals. Complaints were either escalated to local clinical governance teams/chief executives or/and National Regulatory bodies and physicians had to respond formally. Some colleagues were verbally abused by their patients and/or threatened with defamation. All of them reported that Internet abuse (trolling) has been used to threaten and/or defame them, using social media platforms, such as YouTube or Facebook.

Patients with delusional beliefs may be more demanding than other general dermatology and psychodermatology patients. In particular, managing patients with delusional infestation (DI) may invoke risks to dermatologists' personal and professional well-being. Dermatologists, who manage patients with DI, need to be aware of the specific personal risks, including complaints, referral to regulatory body, threatening behaviour, stalking and (very rarely) the risk of a violent attack. Regulatory and defence bodies appear to at least partly recognise the risks and offer guidance for doctors who are stalked. Due to the risks implicated, dermatologists may choose to refer psychodermatology patients to other healthcare professionals to obviate the risk to themselves and to achieve the best care for patients who represent a higher risk of complaints/abuse.

Burnout

Burnout is a major issue among physicians. Burnout has been defined as long-term, unresolvable job stress that leads to exhaustion and feeling overwhelmed, cynical detachment from the job, and a diminished sense of personal accomplishment, according to Maslach et al. In Medscape's 2019 report, 44% of physicians reported feeling burnt out; 11% were colloquially depressed and 4% were clinically depressed. In 2019, critical care (48%), neurology (48%), family medicine (47%), obstetrics/gynaecology (46%) and internal medicine (46%) were among the most burnt out specialties. Among the least burned out were plastic surgeons (23%), pathologists (32%) and dermatologists (32%).

Physician burnout affects both the patient and the physician. It has been demonstrated that physician burnout leads to lower patient satisfaction and care as well as a higher risk of medical errors. Direct effects on the physician may include higher employment turnover and an increased risk of addiction and suicide. Other more downstream effects of burnout may involve physicians' families and societal effects when fully trained physicians leave their clinical practice to pursue other careers.

Burnout in Dermatology and Psychodermatology

Working as a dermatologist often entails challenges and frustration. Compared with other specialties, dermatologists are in the middle of the pack, as the percentage of dermatologists who are burned out is less than that of physicians overall (44%) .

Only 34% of dermatologists in Medscape's survey responded that they were very or extremely happy. Dermatologists' rates of reported colloquial and clinical depression are about the same as those of physicians overall (11 and 4% overall). There are many contributing factors to burn out but the most significant include too many administrative tasks and bureaucracy, complying with policies and regulations, and less time for clinical work. The majority of dermatologists do not seek help. Many physicians have rationalised their exhaustion and discontent, noting that other physicians feel it too. Others say that their degree of unhappiness is bad enough to require outside help.

Dermatologists practicing psychodermatology are at a higher risk of burnout compared to general dermatologists. There have been no available data until recently. We recently conducted a European Survey in an attempt to quantify our hypothesis and assess the levels of burnout among psychodermatologists and evaluate potential contributing factors to it (Gkini et al. 2019). Despite the fact that the majority of physicians were working part-time with a mean number of working hours of 32, the mean score for burnout amongst psychodermatologists was high/very high, using the Oldenburg Burnout Inventory. The mean scores for disengagement and exhaustion were also high/very high. In conclusion, treating psychodermatology patients seems to be associated with an increased risk for burnout, disengagement and exhaustion.

Contributing Factors to Burnout and Mental Illness

Work-related factors that can contribute to mental illness in medical staff, including dermatologists include:

(a) Poor quality and/or risky working environments.
(b) Dissatisfaction with the achievable quality of patient care.
(c) Lack of support, e.g. from managers, or socially within the workplace.
(d) Employers' failure to address workplace stressors, e.g. time pressures, excessive workload and absence of support.
(e) Feelings of not being valued as an HCP.

(a) Poor Quality and/or Risky Working Environments
From our survey of European dermatologists who treat patients with DI, most were specialists in psychodermatology who had been trained in larger specialist centres. Further training in risk management for psychodermatology trainees and consultants may be necessary, perhaps with the development of support networks for dermatologists who manage patients with DI Dermatologists, who manage patients with psychocutaneous disease, may need appropriate support themselves. Regulatory bodies should become sufficiently briefed to assess and manage the complaints received from patients with DI. A multidisciplinary approach through a psychodermatology clinic is preferred when treating this challenging category of patients, as it builds a trust relationship between patient and clinician. Further studies with larger sample size and higher response rate are needed to provide objective data about complaints and stalking in psychodermatology, but also in dermatology in general.

(b) Dissatisfaction with Achievable Quality of Care
Another key point is the dissatisfaction with the achievable quality of care. It has become increasingly recognised that the best outcomes for patients with the psychodermatological disease are via a multidisciplinary psychodermatology team. The

exact configuration of the multidisciplinary team is, to some extent, determined by local expertise. Primary and secondary care need to work together consistently because patients with psychocutaneous disease may be 'doctor-shoppers'. Patients may seek repeated consultations in primary care because their disease, they believe, is not being acknowledged, or they may seek repeated referrals to dermatologists and other specialists for the same reasons. It is important for primary and secondary care to have the same agenda in treating patients with psychocutaneous disease, as any difference between approaches will be recognised by patients and will lead to dissatisfaction with the service and disengagement from clinicians. In addition, there is a growing body of evidence that it is much more cost-effective to manage patients with psychodermatological disease in dedicated psychodermatology clinics. Nevertheless, despite this evidence, and the demand from patients (and patient advocacy groups) for the delivery and establishment of psychodermatology services, it is very sporadic globally. Clinical and academic expertise in psychodermatology is emerging in dermatology and other (often peer-reviewed) literature. Healthcare professionals need to be aware of the steps necessary to establish and maintain psychodermatology services (see below). Furthermore, organisations such as the European Society for Dermatology and Psychiatry champion clinical and academic advances in psychodermatology, whilst also enabling training of health care professionals in psychodermatology, which should be mandatory for dermatology training curriculum.

- Psychodermatology Useful references in Clinical Practice: Main Principles.

Marshall C, Taylor R, Bewley A. Acta Derm Venereol. 2016 Aug 23;96(217):30–4

- How to set up a psychodermatology clinic.

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There are other factors contributing to poor quality of services. Psychodermatology patients are often angry, desperate or fed up, expressing explicitly their bitterness, when they reach the specialist psychodermatology clinic. It is much harder to build a patient-physician trust relationship, especially when the patients lack the capacity to engage in the proposed management plan. Therefore, the consultation time with patients should be much longer than that of general dermatology consultations, with a mean time of almost 40 min (Marshall and Aguilar above). We often find that adherence to treatment is very poor due to the fact that patients are not happy to start on psychotropic medication, as they consider it to be irrelevant or they are scared of the potential adverse events. In a short survey (Pathmarajah Br J Dermatol, Jan 2019), patients seemed to be pleased with the information provided by their treating physician/prescriber, but there was

insufficient or even contradictory counselling by the pharmacy. Pharmacy departments should receive appropriate education to ensure that expectations are met, and a lack of education may in fact explain the ineffectiveness of the counselling as perceived by the patients. A tighter cross-collaboration between physicians, pharmacists and the patient could help to improve adherence behaviour.

Another important component of service quality is the patient's satisfaction with their treating physician. In psychodermatology clinics, patients may struggle to trust their dermatologists. In our research (Stavrou, Br J Dermatol, Oct 2020), 25 and 45% of patients thought that their doctors do not really care or are inconsiderate of their needs respectively; 25% reported limited trust levels towards their physician, and 33% reported a wish for a second medical opinion. These data highlight the challenging levels of distrust towards dermatologists in psychodermatology. Further research is required to improve patient access to comprehensive multidisciplinary psychodermatology services.

(c) Lack of Support

Another key factor affecting health care physicians who practise psychodermatology is the support from managers, clinical governance teams as well as regulatory bodies. In 2013 in the UK, a leading psychodermatologist, addressed a letter to the UK's General Medical Council to discuss whether avoiding sharing the diagnosis of delusional infestation with a patient would be permitted as patients with delusional infestation may lack capacity to make a shared management decision with their treating physician. The reply from the GMC indicated that conveying the diagnosis to the patient follows Good Medical Practice, as stated but the GMC, but that it was very difficult to give guidance about this category of patients.

Clinical governance teams may need to be trained about managing complaints from psychodermatology patients, and to escalate only non-abusive complaints and those where the patient has the capacity to complain. Medical Defence organisations have recently published guidance for physicians who may be the target of stalking, such as General Practitioners and Psychiatrists, but not dermatologists. Further official guidance is required for subjects such as complaints, threats of any origin, verbal/ physical abuse and stalking.

(d) Failure to Address Workplace Stressors

Consultation time is much longer during a psychodermatology clinic, and lack of administrative time can be a crucial factor for burnout. Psychodermatology patients can be very complex and adequate time is required in order to offer an effective holistic approach with satisfactory results. Therefore, employers and commissioners must facilitate the setting up of dedicated comprehensive psychodermatology clinics (www.appgs.co.uk/mental-health-and-skin-disease-report-2020/).

(e) Overlooking Dermatologists' Role

Finally, in large medical centres and hospitals, the dermatologists' role may be overlooked, due to the relatively few emergencies and often modest on-call work hours. Nevertheless, the reality is contradictory, as dermatologists see a significant number of patients, with complicated skin and systemic diseases that cause significant

impairment in the quality of life of patients. It is vital to inform other colleagues, managers and the public about the importance of that work.

Current Situation

The impact and the extent of the psychosocial burden amongst dermatologists who practise psychodermatology have not been researched sufficiently. Pilot studies with a small number of participants have shown that burnout exists in psychodermatology, with levels being high to very high. Contributing factors include working environment, lack of administrative time, absence of available comprehensive psychodermatology clinics, complaints and abuse (verbal, online trolling, physical) by patients as well as lack of support by managers, clinical governance teams and regulatory bodies. Further studies are required from various countries, in order to support psychodermatology working practices. Issues with mental health and the well-being of psychodermatology staff need to be addressed and further investigated and managed. Stigmatisation of physicians with psychosocial comorbidities exists and this is a contributing factor for dermatologists not requesting help and support and needs to be challenged. Treating psychodermatology patients can be challenging and constitutes a risk for personal and professional well-being. Currently, insufficient priority is being given to improving the health and well-being of psychodermatologists within the duty of care that all employers have for their staff. The need for set up of dedicated psychodermatology clinics could contribute positively towards both physicians and patients.

Recommendations

Our recommendations include the development of networks in Psychodermatology. International societies, such as ESDAP (European Society for Dermatology and Psychiatry) and APMNA (Association for Psychoneurocutaneous Medicine of North America), as well as national societies, such as Psychodermatology UK, can serve as a domain for the exchange of views, clinical and academic, in the subspecialty of psychodermatology, leading to the championing of clinical and academic excellence in psychocutaneous medicine.

Regular burn out sessions should be organised at the national and international dermatology meetings as well as in the local work environment, in an attempt to address the relevant issues and offer support to physicians.

Regular, sympathetic and confidential assessments for depression, anxiety and burnout could be offered to all dermatologists who treat psychodermatology patients. Activities and social gatherings within the workplace should be offered so as to improve physicians well-being at work. If there is clinical depression, anxiety or /and suicidal ideation, professional psychiatric and psychological help should be offered in a non-judgmental way, without stigmatisation.

The General Medical Council and other national regulatory bodies need to update about the emerging subspecialty of psychodermatology and familiarise themselves with the challenges faced.

In the workplace, clinical governance teams need to become aware of psychodermatologists' potential personal and professional risks and offer support.

There is increasing demand for formal regional and national clinical networks to identify the training needs of staff. Further training is required for both resident and specialist dermatologists and should be part of the dermatology training curriculum.

Commissioners should encourage employers to prioritise the support of dermatology staff who practice psychodermatology, regarding their mental health and wellbeing through engagement with local initiatives and organisational improvements.

There should be a close collaboration with national dermatology societies for the promotion of dedicated comprehensive psychodermatology services.

Finally, the development of at least regional dedicated psychodermatology services with a trained specialist psychodermatologists and clinical psychologist support should be encouraged.

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