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Psychodermatology fellowship: is it time?

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Abstract

The fields of dermatology and psychiatry have overlap in the patient populations and diseases they treat. However, there are not currently fellowship opportunities for dermatologists or psychiatrists specifically interested in gaining expertise in psychodermatology. We discuss the logistics of a one-year psychodermatology fellowship, open to residents after completing either dermatology or psychiatry residencies, and the potential benefits that it could bring to both dermatology and psychiatry training programs across the county.

Keywords: psychiatry, dermatology, psychodermatology, graduate medical education, residency, fellowship

Introduction

Following completion of dermatology residency, current graduates have the option of pursuing fellowships in a wide array dermatology subspecialties. The American Board of Dermatology (ABD) currently recognizes three Accreditation Council for Graduate Medical Education (ACGME) subspecialty fellowships in dermatology: pediatric dermatology, dermatopathology, and micrographic surgery and dermatologic oncology. The ABD currently offers board certification examinations in pediatric dermatology and dermatopathology and plans a future certification examination for micrographic dermatologic surgery in October 2021. Dermatopathology fellowships are unique to dermatology because they are also open to residents who have completed pathology training.

In addition to the three currently ACGME-accredited dermatology fellowships, other fellowship opportunities offered by academic dermatology departments abound and include clinical research fellowships, cosmetics, psoriasis, phototherapy, contact dermatitis, complex medical dermatology, clinician-teacher, cutaneous oncology, cutaneous lymphoma, occupational dermatology, wound healing, pruritus, cutaneous immunology, laser medicine, connective tissue disease, dermatology-rheumatology, and teledermatology. Surprisingly, there are currently no established fellowships for dermatologists interested in subspecializing in psychodermatology. However, psychodermatology is an area of longstanding historic interest to dermatologists and psychiatrists. There is ongoing research in both specialties, and a dual pathway for subspecialty training in this area would be an asset to patients suffering from both skin and psychiatric illness. Comorbid depression and anxiety disorders are found to be associated with common chronic skin diseases such as acne, atopic dermatitis, psoriasis, and others that may not be identified and treated if not recognized by dermatologists. Patients who may benefit from psychiatric evaluation and intervention may decline recommended evaluation. Fellowship training in psychodermatology by dermatologists has the potential for increasing clinical expertise and expanding patient access for the diagnosis and management of these disorders, as well as generating new knowledge through additional research and educational focus.

Discussion

Psychodermatology is an important topic to be covered in dermatology residency education at U.S. training programs. It is included in a general dermatology textbook [1], multiple specialized books on the topic are currently available, and scholarly articles on this topic are regularly published in peer-reviewed dermatology journals that are

discussed in dermatology residency journal clubs. Several international professional organizations such as the Association of Psychocutaneous Medicine of North America and the European Society for Dermatology and Psychiatry hold annual meetings. Despite the known relevance of psychodermatology, the amount of time and training dedicated to psychodermatology tends to be minimal and may not adequately prepare dermatologists to feel fully comfortable in this important area of dermatology.

Senior dermatology residents with career interest in psychodermatology have the possibility of dual training in both dermatology and psychiatry by taking consecutive residencies in both specialties, but owing to restrictions in Medicare institutional payment for physicians taking more than one residency, many institutions are unable to provide additional postgraduate education for second residencies. Educational loan burden of physicians and professional opportunity costs are also higher for the two-residency route (8 years for dermatology and general psychiatry sequential residencies) compared to one year of specialized fellowship training in psychodermatology (4 years of residency and one additional year of fellowship training for both dermatologists and psychiatrists). The consecutive residency approach also suffers from a four-year period in which the physician does not routinely practice or maintain the clinical skills acquired from the first residency as he/she completes training in the second residency.

What could additional psychodermatology training for dermatologists entail? In 1986 Van Moffaert suggested that psychodermatology training programs for dermatologists should be initially based on biweekly case discussions of skin disease with "overt psychiatric problems" and reactive depression secondary to chronic skin conditions [2]. This training would later progress to case management with psychiatric supervision. She cautioned that a potential risk for psychiatric training of dermatologists could result in overconfidence that could delay psychiatric referral when needed. A one-year fellowship in psychodermatology at medical schools with dermatology and psychiatry residency programs would provide trainees with more focused exposure to this patient population. With supervised 12-month rotations for dermatologists on the psychiatry service, fellows would become familiar with the criteria for psychiatric diagnosis, the use of psychotrophic medications, and the integration of nonpharmacologic psychiatric interventions. This type of structured clinical training in psychiatry should allay the fears that dermatologists might not recognize psychiatric disease that requires immediate referral. After 12-month rotations for psychiatrists on the dermatology service, psychiatrists would become more familiar with dermatologic diagnosis and management of skin diseases. Both specialists would gain invaluable exposure related to these diverse patient populations that are not possible through current residency training curriculum in either specialty alone. Dermatologists and psychiatrists would become more familiar with the complexity of disease management and alternative approaches. Stronger interspecialty ties will be created that will benefit patient care. This model is like the educational plan currently employed in dermatopathology fellowship; dermatologists rotate on pathology services during fellowship and pathologists rotate with dermatologists in the clinic to gain clinical exposure. Trainees would also participate in multidisciplinary clinics in which patients with comorbid dermatology and psychiatric conditions would be evaluated and managed, and best practices could be implemented [3].

It is unlikely that the ABD and the American Board of Psychiatry and Neurology (ABPN) will quickly establish board certification in psychodermatology because, like other nonaccredited subspecialty dermatology fellowships, these innovative training programs will probably be limited in number at first. However, as the value of these dual specialty training programs is recognized, it is possible that dermatology and psychiatry departments will add psychodermatology subspecialists to their faculty. If this occurs, it will have a beneficial impact on their patients, residents, faculty, and medical students because subspecialty expertise would permeate throughout the department. The impact of successful psychodermatology fellowship programs may encourage additional residency training

programs to develop them at their own institutions. Increasing numbers of psychodermatology subspecialists could eventually lead to interest for subspecialty certification in psychodermatology by the ABD and ABPN with oversight by the ACGME; the evolution would be similar to the development of fellowships in dermatopathology. Funding of psychodermatology fellowships will need to be addressed, with institutional, foundation, grant, or other outside funding sources. Since graduating dermatologists and psychiatrists may be eligible for faculty appointment in their respective departments at many institutions during fellowship, institutional fellowship training costs may also be mitigated by scheduling them with a limited number of faculty clinics in their primary specialty to maintain the clinical specialty skills so recently mastered, a strategy currently used successfully in other types of dermatology fellowship programs.

Conclusion

Very few dermatology programs in the U.S. have an expert in psychodermatology, creating the problem of limited exposure throughout dermatology training and making it difficult to recruit faculty with an expertise in this area. These problems could be mitigated through the creation of a one-year psychodermatology fellowship open to graduates of both psychiatry and dermatology residencies. Although logistical barriers exist in setting up such a fellowship, the potential benefits from such a program would likely have a positive impact on patients, residents, and faculty as expertise in psychodermatology becomes more widespread.

Potential conflicts of interest

The authors declare no conflicts of interest.

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