

# Digging for the Deeper Diagnoses in Dermatology

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## ABSTRACT

In a small private dermatology practice, I became aware that knowledge of some patients' adverse childhood experiences, traumatic experiences, and social determinants of health was essential to establish a successful therapeutic relationship. I discuss how these factors play important and lifelong roles in the disorders that dermatologists see, but these factors have not been addressed in the dermatology literature.

*More humanism and less science,  
that's what medicine needs, but  
humanism is hard work, and  
so much of science is just Tinkertoy.*

— Robertson Davies<sup>1</sup>

## INTRODUCTION

On March 3, 2018, *The New York Times* published an in-depth profile of Nakesha Williams, a 47-year-old homeless woman who died on the streets of New York City.<sup>2</sup> Born in poverty to an unwed teenage mother, Williams was an honors graduate of the prestigious Williams College in Williamstown, MA. Although her parents eventually wed, they divorced a few years later, according to the article. Her mother's next partner was reportedly an abusive drug addict who repeatedly molested Williams when she was just a child. Her mother died at age 37 years when Williams was in college. Within a few years of graduation Williams became paranoid and eventually homeless. Living on the streets, she gave birth to 2 children, who were taken away by child protective services. When Williams died, the 1.5-m (5-ft) tall, former college dancer weighed 114.8 kg (255 lb).<sup>2</sup> This article made an impact on me, as I later discuss.

In the 40 years since I completed my dermatology residency, my entire career has been as a solo dermatology practitioner. Before residency, I spent 3 years as a general practitioner in an idyllic rural town on the Hawaiian island of Kauai. Seeing 60 patients a day was too much for an inexperienced physician, so I bailed out and specialized in dermatology. However, my practice mindset has always been that of a generalist who tries to focus on upstream thinking: Trying to see each

patient as a unique collection of experiences that have led that individual to his/her current state of health. Therefore, the quote from Robertson Davies<sup>1</sup> character, Jonathan Hullah, in his novel, *The Cunning Man*, resonates with me.

Freezing innocuous actinic keratoses, identifying melanoma in situ, treating low-grade skin cancers, and doing largely unnecessary skin examinations to allay patients' anxiety without educating them may be somewhat important and are lucrative activities, but we do them at the expense of our patients. These remunerative office visits are completed in 10 to 15 minutes, but they are mostly just business transactions.

In 1899, William Osler,<sup>3</sup> in an address to medical students, said:

*There is a strong feeling abroad among people—you see it in the newspapers—that we doctors are given over nowadays to science; that we care much more for the disease and its scientific aspects than for the individual. I don't believe it, but at any rate, whether the tendency exists or not, I would urge upon you in your own practice to care more particularly ... for the individual patient than for the special features of the disease. ... Dealing as we do with poor suffering humanity, we see the man unmasked, exposed to all the frailties and weaknesses, and you have to keep your heart soft and tender lest you have too great a contempt for your fellow creatures. The best way is to keep a looking-glass in your own heart, and the more carefully you scan your own frailties the more tender you are for those of your fellow creatures.*

Somewhere along the way, it became obvious to me that many of my colleagues were excluding certain groups of patients from their private offices. I have

always felt it important to see the “poor suffering humanity” in our communities. Six dermatologists serve my geographic area. I had my secretary call each office to see who accepted Medicaid patients. Unsurprisingly, I was the only one who welcomed these patients, at least in a timely manner. Only one other specialist in my area participated with Massachusetts Medicaid, and that office gave a Medicaid patient an appointment no less than 6 months in the future. This amounts to “structural violence.”<sup>4</sup>

## IMPORTANCE OF PATIENTS' TRAUMATIC LIFE EVENTS

After a close reading of Balint's<sup>5</sup> iconic book, *The Doctor, His Patient and the Illness*, it became clear to me that many of my patients had traumatic life events that were important to know about and that had direct bearing on their medical and psychiatric illnesses. Balint called this “the deeper diagnosis.” The childhood history is rarely inquired after when patients present for skin problems because the standard dermatology appointment does not allow one time to discover these important antecedents.

The history of a patient's adverse childhood experiences (ACEs) is important to know about when one is presented with difficult diagnostic or therapeutic challenges. ACEs have not been covered in the dermatologic literature, yet we ignore them at our patients' peril. An accessible article by Felitti and Anda<sup>6</sup> on ACEs should be required reading for all physicians. They have demonstrated how ACEs play a major and lifelong role in the difficulty, effectiveness, and cost of adult medical

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practice, and are the major origin of numerous important public health, medical, and social problems.<sup>6</sup>

In addition, we need to factor in the social determinants of health (SDH) that our patients have when we establish a therapeutic relationship. Marmot's<sup>7</sup> book, *The Health Gap*, is also essential reading for all physicians. The need to consider ACEs, traumatic experiences, and SDH has not been covered by any major dermatology journal, to my knowledge. In my specialty, we pay exclusive attention to the downstream pathologies and ignore important social and historical causes of the pathologies that we encounter. By the time we see the patient, it may, sadly, be too late to moderate the effects of ACEs, traumatic experiences, or SDH, but it does not seem right to ignore them, and it is important to acknowledge their clinical significance. Felitti and Anda<sup>6</sup> tell us, "The clinical practice of asking, listening, and accepting is doing."

Studying the works of Balint, Marmot, Felitti and Anda, and other authors led me to witness many patients whose ACEs, traumatic experiences, and SDH were important precursors to the cutaneous disorders they presented with. In my experience, a large number of these individuals were receiving Medicaid or were poor and uninsured. They would not have gained access to other dermatology practices in my community, so to my colleagues they would have been invisible. In large cities, these patients are cared for by trainee physicians, who likely focus their dermatoscopes on the disease and not on the patient with the disease. The persons with the disease are largely unknown at these teaching centers, and they rarely receive continuity of care.

Marginalized patients have shorter lifespans and poorer outcomes than do more affluent patients, especially when they are black or Hispanic, according to a large body of research. Like Nakesha Williams, they often have health care gaps and "death gaps."<sup>8</sup>

My desultory readings on these topics, informed by PubMed searches, led me to the work of Kirkengen,<sup>9</sup> and Tomasdottir and colleagues<sup>10</sup> on how abused children

become unhealthy adults. Dr Kirkengen has been generous with her time to respond to my emails regarding some patients, and at her suggestion, I started to collect a few of my patients' stories. Whereas Felitti's San Diego Kaiser Permanente group used a 10-point questionnaire, Kirkengen with Tomasdottir and colleagues<sup>10</sup> have simplified this to 1 question: "When you think about your childhood, would you describe it as: 'Very good-good-average-difficult-very difficult'?" It is not always appropriate to pry into a patient's private life, and some patients may be reluctant to disclose embarrassing or shameful experiences. Therefore, this single question may have the advantage of identifying more at-risk patients.

### LISTENING AS A THERAPEUTIC ACT

Twenty patient vignettes to which I have been privy appear in the Appendix (available at: [www.thepermanentjournal.org/files/2020/19-090-appendix.pdf](http://www.thepermanentjournal.org/files/2020/19-090-appendix.pdf)). I have found that it can take me many visits before a patient is comfortable disclosing painful or sensitive personal material. However, the longer I am in practice the more I am convinced that most patients welcome my concern. The vignettes in the Appendix were collected during a 2-month period in early 2019. This is a work in progress, and I am learning important patient-related material every day. Initially, I thought this knowledge might help me to treat these patients more effectively, but I have come to believe that many, like Humpty Dumpty, are too broken to be fixed. Perhaps, all one can do is allow one's office to be a sanctuary where their problems can be acknowledged and where they are welcomed, caringly listened to, and not discriminated against. Listening can be a therapeutic act.

Excluding poor and marginalized patients from our offices is unfair to the most damaged and vulnerable members of our communities. By concentrating on the affluent and privately insured, we leave many others in the shadows. The result is that these people are invisible. Our abandonment of them has forced them to endure more physical and mental

illnesses and to die earlier than do more advantaged individuals.

Sadly, in many US communities, the resources to help these people are sorely lacking. Most of these people often wind up seeing psychopharmacologists; being placed on drug cocktails of 2, 3, or more drugs; and visiting a psychologist every month or so if their insurance plan allows it. They do not receive the in-depth care they require. The root problem is often not known and is rarely addressed.

The study populations of Felitti and Anda and Tomasdottir et al<sup>6,10</sup> are more uniform socially and economically than the people I see in my community regarding access to care and basic resources. It is not unusual for some of my patients to have a net worth of less than \$100. They cannot get the same level of care as the more affluent people seen at Kaiser Permanente Medical Centers<sup>6</sup> or those who make up most of the patients surveyed in Nord-Trøndelag County, Norway.<sup>10</sup> Yet the tools used in those settings are directly applicable to my clinic patients.

Although there is an enormous body of literature on the importance of ACEs from many academic disciplines (medical anthropology, medical sociology, psychology, public health, the economics of health care, social geography, and others), there has been an inexplicable silence on this topic in most journals that clinicians read. This report from a rural dermatology practice sheds light on the importance of such anamnesis to practicing physicians.

### CONCLUSION

Nakesha Williams had the advantage of the best education one can obtain in the US, yet her ACEs eventually claimed her. She had friends, and social services were available, yet the trauma had been done. The abuse she sustained caused permanent scars, and she was a casualty, decades later, of childhood trauma. When I read her obituary in *The New York Times*, I didn't understand this. During the past year, however, studying about ACEs and SDH has opened my eyes. Our medical model does not serve

these people. There must be a better way. A start may be just sitting with these people and listening.

A poem by the 19th century American poet, Emily Dickinson,<sup>11</sup> instructs us on a model for patient care and is applicable to what our patients with ACEs need from us, their caregivers.

If I can stop one Heart from breaking  
I shall not live in vain  
If I can ease one Life the Aching,  
Or cool one Pain

Or help one fainting Robin  
Unto his Nest again,  
I shall not live in Vain.



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