PHYSICIAN-PATIENT RELATIONSHIP IN DERMATOLOGY: SPECIFICITY OF ETHICAL ISSUES

Dvornikov AS, Minkina OV, Grebenshchikova EG ✉, Vvedenskaya EV, Mylnikova IS

Pirogov Russian National Research Medical University, Moscow, Russia

The article deals with ethical aspects of physician-patient relationship in dermatology, and demonstrates their influence on success of diagnostic and treatment activities and level of satisfaction with quality of medical services. Special attention is paid to the specific nature of bioethical issues in dermatology, associated with visuality and peculiarities of the course of disease, emotional and physiological background and coexisting disorders. Special priority is given to effective strategies of physician-patient communication, respect for patient autonomy and protection of confidentiality both in clinical practice, and on the Internet. It is shown that linking personal and strategic social media accounts raises a number of ethical and legal issues, associated with obtaining voluntary informed consent, compliance with standards of corporate ethics, and perception of medical information by non-professional audience. In conclusion, compliance with principles and rules of biomedical ethics is important to set constructive relations in clinical dermatological practice, ensure social trust in medicine and prepare future specialists. It is also important to discuss ethical issues in a professional community, slowly forming an interdisciplinary space of communication between physicians, health officials, specialists in bioethics, medical law, psychology and sociology of medicine.

Key words: dermatology, bioethics, physician-patient relationship, intimate space of the patient, social networks

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✉ **Correspondence should be addressed:** Elena G. Grebenshchikova
ul. Ostrovityanova, 1, Moscow, 117997, Russia; aika45@ya.ru

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ВЗАИМООТНОШЕНИЯ ВРАЧ-ПАЦИЕНТ В ДЕРМАТОЛОГИИ: СПЕЦИФИКА ЭТИЧЕСКИХ ПРОБЛЕМ

А. С. Дворников, О. В. Минкина, Е. Г. Гребенщикова ✉, Е. В. Введенская, И. С. Мыльникова

Российский национальный исследовательский медицинский университет имени Н. И. Пирогова, Москва, Россия

В статье рассматриваются этические аспекты взаимоотношений врач-пациент в дерматологии, показано их влияние на успех лечебно-диагностических мероприятий и степень удовлетворенности качеством медицинских услуг. Акцентируется внимание на специфике биоэтических проблем дерматологии, обусловленных визуальностью и особенностями течения заболеваний, эмоционально-психологическим фоном и сопутствующими заболеваниями пациента. Особое внимание также уделено эффективным коммуникативным стратегиям во взаимодействии врача с пациентом, необходимости уважения автономии пациента и защиты конфиденциальности как в непосредственной клинической практике, так и в Интернет-пространстве. Показано, что совмещение врачами персонального и контент-стратегического аккаунтов в социальных сетях поднимает ряд этико-правовых вопросов, связанных с добровольным информированным согласием, соблюдением норм корпоративный этики, восприятием медицинского материала непрофессиональной аудиторией. В заключение отмечается, что соблюдение принципов и правил биомедицинской этики важно для установления конструктивных отношений в клинической практике в дерматологии, для социального доверия медицине и подготовки будущих специалистов. Вместе с тем необходимо обсуждать вопросы этики в профессиональном сообществе, постепенно формируя междисциплинарное пространство диалога врачей, организаторов здравоохранения, специалистов в области биоэтики, медицинского права, психологии и социологии медицины.

Ключевые слова: дерматология, биоэтика, взаимоотношения врач-пациент, интимное пространство пациента, социальные сети

Вклад авторов: А. С. Дворников— концепция и дизайн исследования, редактирование текста; О. В. Минкина — концепция и дизайн исследования, написание текста; Е. Г. Гребенщикова — концепция и дизайн исследования, написание текста; Е. В. Введенская — анализ источников, написание текста; И. С. Мыльникова — анализ источников, написание текста.

✉ **Для корреспонденции:** Елена Георгиевна Гребенщикова
ул. Островитянова, д. 1, г. Москва, 117997, Россия; aika45@ya.ru

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Ethical aspects of physician-patient relationship produce a significant influence on patients' readiness to communicate with a doctor and their adherence to treatment, success of therapeutic and diagnostic activities and level of satisfaction with the quality of medical services. Every area of medicine has inherent characteristics associated with moral aspects of doctor-patient communication. In dermatology, it is due to visuality and peculiarities of disease course, emotional and psychological background and concurrent diseases. Meanwhile, issues about necessary and accessible borders of intervention in the intimate zone of a patient, preferrable communication strategies, ways to respect autonomy and protect confidentiality arise not in direct clinical practice only, but also on the Internet, where doctors and patients exchange data, share opinions and experience, discuss own and other experience.

SPECIFIC NATURE OF DERMATOLOGY: BIOETHICAL ASPECTS

Just like any area of medicine, dermatology has its own peculiarities. They are associated with frequent chronization, chronic diseases and long-term doctor-patient relationships, visuality of clinical manifestations that constantly remind a patient of esthetic shortcomings related to the issues of self-perception and interaction with other people. Psychosocial disease consequences are as discomfortable as direct clinical

manifestations. That's why while estimating the disease severity, it is required to take into account not only 'the medical' complaints, but also the possible severity of concurrent psychoemotional feelings of a patient.

Thus, from a medical point of view, not the worst skin disease (Acne vulgaris) can result in suicide as severe depression is developed. People can't accept their appearance or cope with collective bullying. It is not accidental that previous models of doctor-patient relationships are substituted with patient-centered interaction strategies where a doctor's communication competency is important. A doctor must be able to ensure effective communication with a patient, listen to the patient and understand him/her, take into account non-verbal signs. Thus, a patient-centered approach and the corresponding mental atmosphere make it possible to estimate both objective signs of a disease, and dangers and expectations of a person, achieve shared understanding of a problem, and agree upon a plan of subsequent examination and treatment.

At the same time, patient centricity means to maintain communication boundaries, protect personal space and ensure certain emotional neutrality of the parties involved. An ability to feel empathy (emotional empathy), a doctor's ability to constant communication (empathic care) and cognitive empathy are considered equivalent to virtues. Can hyper-empathy produce a negative influence and turn a therapeutic process into close or compulsive relationships? Which consequences can arise when formal communication is turned to non-formal one?

When answering the questions, it's necessary to consider the image of a dermatologist. Long-term and emotionally-colored doctor-patient relationships and a doctor's mistakes while establishing the rules of communication can result in erroneous understanding of relations as appropriately close, searches for consultations with relatives, friends, colleagues by correspondence, attempts to communicate with a doctor outside of working hours or during vacation. Besides, this can lead to distant consultations and distribution of a doctor's contacts without permission of the latter when a patient finds it useless or is unwilling to fix an appointment or spend time on an in-person visit.

It is not a secret that social networks are highly important both for the medical society, and for the citizens with common interests in health issues. This is a convenient tool to exchange experience and opinions, provide mutual aid, and widely distribute data about medical organizations or certain specialists. According to the US-based research, 81% of adults had social profiles; almost 1/3 of consumer activity associated with health issues run through social networks; about 2/3 of consumers searched for a medical representative using social media as well [1].

Based on another review, almost half of Internet users accepted that social networks influence their subsequent decisions related to health issues; over half of those surveyed expressed confidence in publications and blogs of doctors on the Internet [2].

Based on medical content analysis of texts of one of the most popular Russian social network (VKontakte), the most popular topics assessed and discussed include healthcare professionals, their activity and clinics, whereas patients are very rarely discussed [3]. When a patient pressed a 'Like' button to assess publications of his friend dermatologist who consequently ignored him and didn't provide feedback or didn't make an appointment, the unsatisfied patient could probably leave an open abusive comment or a vicious remark that could influence the doctor's reputation.

In this context, it's important to consider the accessibility of a doctor's personal data in social media. It is mainly due to linking of personal and strategic accounts because of clear reasons such as attraction of new patients to a clinic, expansion of the target audience, increased trust of subscribers, improved level of income and development of an expert image using a certain nosology.

Dermatologists and cosmetologists often publish in one click photos and videos 'before, during and after' or 'share own opinion' to demonstrate their professionalism. But they don't always analyze ethical issues of submitting information to a wide lay audience and legality of their actions. Even if a patient expresses his or her consent to make and subsequently distribute health-related photos/videos orally or in writing, there are still obvious doubts. A patient can wonder whether the doctor always observes the conditions of consent obtaining; what guarantees can be given about non-distribution of the patient's body images; whether the photos or videos can enter other Internet platforms without the patient's consent.

Growing availability of online libraries with digital images of high quality and archival photos and videos posted by dermatologists and cosmetologists in social media is definitely of educational value. At the same time there is a possibility that medical information can be misused, for instance, with the purpose of searching for and distributing sexual images, including pornography.

Thus, DermAtlas (the largest open repository of highly qualitative clinical and histological images in dermatology) can be accessed via a search system using various criteria. Analysis of 3,664,191 queries of users from October 2004 to March 2005 has shown that seven body sites out of 10 were most commonly searched for. 10,307 analyzed queries simultaneously included body sites and age: 'genital area' for 33.4% of users, and 'children' for 72.6% of users [4].

Thus, justifiable doubts arise about a proper use of DermAtlas online library image database and other photos and videos on professional dermatology sites, as they undermine confidence in confidentiality of information related to those patients who gave their consent to the use of photos and personal data for educational purposes.

COMORBIDITY AND POLYMORBIDITY IN DERMATOLOGY: MORAL MEASUREMENTS

Comorbidity and polymorbidity (when a patient has not only skin diseases, but also one or several disturbances that coincide in time or are interconnected with single pathogenetic mechanisms) belong to another peculiarity of a dermatologist's clinical practice. According to some authors, one-third of a dermatologist's patients have comorbid mental disorders (psychophysiological dermatoses, stress-reactive dermatoses) of various intensity [5]. This influences the type of doctor-patient relationship and sometimes requires participation of a psychotherapist or psychiatrist in treatment of dermatology patients, developing the model of 'integrative medicine'. Urgency of the issue confirms active development of psychodermatology used by doctors to build functional relations with patients, obtain optimal results of treatment and rehabilitation [6].

Dermatological nosologies are often associated with gastrointestinal diseases, infectious and inflammatory or allergic respiratory diseases, endocrine and metabolic disturbances. They require interdisciplinary interaction. Thus, occurrence of the combined pathology makes up to 69% among patients aged 18 to 44; up to 93% among those aged 45 to 64; and up to 98% among those elder than 65 [7]. Many patients simultaneously see three or even more doctors. According to Russian bioethics T. D. Tishchenko, 'while trying to solve the

problems of their suffering *flesh'*, patients move from one doctor to another one, *uniting* disciplinary and institutionally isolated medical practices in more or less effective network structures. Their *flesh* dissected into a variety of *bodies* under the faceted disciplinary stare of doctors is healing (acquires a rationed linkage) in the biographical route of a certain patient' [8].

In the future, medicine will probably get away from the disciplinary separation of the 'suffering flesh'. However, the current common practice is represented by a nosological approach to diagnostics and treatment. The approach doesn't always ensure therapeutic success and satisfaction of people with the obtained aid. Doesn't a doctor face such a complex ethical issue as taking the responsibility for grouping isolated consultations into the single system of aid considering a patient-centered approach?

LIMITS OF CONFIDENCE AND INTIMATE PART OF DERMATOLOGICAL EXAMINATION

Dermatologist-patient interrelation often includes an intimate examination, tactile interaction, delicate interrogations and dialogues. This sometimes causes difficulties associated with age- and gender-related shyness, and can threaten with disturbances of sexual boundaries both on the part of a doctor, and on the part of a patient. Disturbed sexual boundaries include not only obvious cases of entering (or wishing to enter) into sexual relations with a patient irrespective of the will of the latter. In certain cases, an unsound medical examination can be treated as sexual violence or abuse. Besides, cases of sexual boundary violations can also involve sexual comments, including indecent humor or hints, affected manners, sexually touching patients, use of words or actions that can be reasonably interpreted as the ones intended for excitation or satisfaction of a sexual wish, asking patients about their sexual history or preferences that have no relation to medical service without giving an explanation why the issues must be discussed. Finally, asking a patient to remove more clothes than it is necessary can be taken as violation of allowable boundaries.

Doctors carry full responsibility for establishing and maintaining sexual boundaries with their patients [9]. In these relations, sexual contacts by mutual agreement and comments or undue behavior associated with sexual abuse are inacceptable.

Tense situations faced during a consultation with a dermatologist when a patient or a doctor can feel extremely uneasy or be emotional over violation of sexual boundaries include a medical examination. It is especially true about an intimate examination, the stressogenicity of which can pose a serious problem both for a doctor, and a patient. An intimate examination is an examination and palpation of mammary glands, external examination of the genital area or internal examination (vaginal or rectal). In the interview, the students of the Faculty of Medical Sciences from Newcastle University (Great Britain) reported bigger mental discomfort during an intimate examination of young patients as compared with the elderly, and a greater stress during an examination in patients of the opposite sex. Some students described their attitude to an intimate examination as something that needed 'to be done as quickly as possible', failed to use some research methods to decrease a patient's discomfort or stress, and mentioned that the greatest inconvenience was experienced when male students were examining female patients [10].

It must be noted that limited time spent on learning techniques and conditions of a patient's intimate examination (role modeling of clinical situations, use of imitation models, theoretical literacy) during the process of a doctor's preparation results in insufficient competence of a young specialist in real clinical conditions and can involve direct (physical trauma) and indirect (insufficient examination, mental stress) harm to a patient.

Religious context, upbringing traditions, social status and education can influence the ideas of intimacy and must be taken into account. Being diplomatic and showing respect for a patient's opinion when discussing the necessity in an intimate examination ensure comfort, improve trust in doctors and increase effectiveness of the subsequent therapeutic and diagnostic process. Considering delicacy of an intimate examination and investigation, a dermatovenerologist needs to take into account the following rules:

- present a plan and sequence of a physical examination in simple words, explain the necessity in certain manipulations, use of certain instruments, give a patient a chance to ask questions or refuse from an examination;
- obtain informed consent to an intimate examination;
- obtain written consent of a patient to the presence of students or another third person during an examination or consultation. It should also be taken into consideration that an unsound medical examination performed without a proper execution of medical documentation and clinical substantiation can be taken as a form of sexual abuse;
- provide for comfortable mental and technical conditions to prepare a patient for an intimate examination (removal of/putting on clothes without an external observation, minimum of time spent by the naked patient outside the procedure; closing the door or windows, if any). A doctor needs to avoid helping a patient to remove/put on the clothes except for the cases when the patient has difficulties in doing so and asks for help;
- to ensure additional comfort during a consultation owing to the presence of a third person who supports the patient and if the patient gives such consent or requests so. Many specialists believe that the presence of a third person who witnesses the consultation should be useful. These can be doctors and nurses, a parent, caretaker, spouse, family member. The observer must understand the function fulfilled on the part of a patient, be a person acceptable for the patient, respect the patient's private life and dignity, and keep confidentiality. At the same time, a patient has a right to refuse the attendance of a third person. In this case, a doctor needs to take a decision whether he/she is ready to continue a consultation in the absence of the third person.

An examination needs to be carried out with a certain hint of delicacy including:

- supervision of a patient: any verbal or non-verbal sign can mean that a patient wants to withdraw a consent to the examination;
- exclusion of side conversations in an examination room when a patient is getting ready for an examination (both face-to-face and by phone), any use of mobile devices (opening applications, printing text messages), telling indecent or ambiguous jokes, inappropriate discussion of other patients or telling 'funny' stories occurred during a previous physical examination;
- obvious for a patient decontamination of hands while getting ready for an examination of the genital area, mammary glands, internal examination and after a physical examination (washing hands, removal of jewelry that prevents proper hygienic procedures, use of antiseptic external means, obligatory use of examination gloves). Examination gloves are required not only to

protect the hands of a dermatologist, but also to create a barrier during tactile interaction as they keep heat transfer and subjective sensations of touching the skin or mucous to a minimum.

Another problematic issue in medical practice includes the issue of consultation surveillance and video protocolling right at a doctor's office, both at the initiative of a medical preventive institution (MPI), and as desired by a patient. According to Government regulation as of January 13, 2019 No. 8 and part 13 of art. 30 of FL as of December 30, 2009 No. 384, MPI administration must conduct surveillance of the situation in the entire MPI, archive and store data during 30 days in order to withstand terrorism and illegal actions, and protect visitors and personnel. However, is it possible to compare significance of video monitoring in common areas of a medical organization, an operating room or a special care ward with video surveillance in a diagnostic room of a dermatovenerologist?

On the one hand, video surveillance can be good for medical personnel and administration of an MPI, as it allows to analyze the doctor-patient interaction model, timely and properly react to disputable situations or complaints of a patient, and to improve a doctor's communication skills. This is also associated with certain risks of confidentiality disturbances as the images of a face or body parts of a patient or a doctor, and voice recording represent personal data protected at the level of the federal legislation.

Besides, more data have appeared lately about unauthorized (hidden) or direct video- or audio recording of a doctor's appointment by patients. This happens because a consumer of medical services doesn't understand or poorly remembers information provided at a doctor's office and wants to listen to the data later as many times as it is necessary to collect material for possible subsequent public use or document a claim against the MPI. Which instruments are at a dermatologist's disposal to prevent illegal collection and distribution of personal data? Can videorecording of the consultative and diagnostic process performed without a doctor's consent be a sound argument for premature termination of an appointment and denying medical services to a patient?

CONCLUSION

Thus, both doctor-patient communication in clinical practice, and exchange of medical data and experience on different Internet resources are connected to a set of ethical standards and issues. It is essential to follow the principles and rules of biomedical ethics to establish positive and good relations in clinical dermatological practice, to express social trust in medicine and for professional preparation of future specialists. It is also necessary to discuss ethical issues in a professional community, slowly forming an interdisciplinary space of communication between physicians, health officials, specialists in bioethics, medical law, psychology and sociology of medicine to search for reactions to complicated moral challenges of modern biomedicine.

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