Psoriasis as a complex long-term condition: What do healthcare professionals understand?

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BACKGROUND: Psoriasis, a long-term inflammatory skin condition, is associated with significant psychological and physical impact. Illness beliefs or ‘personal models’ underpin psoriasis patients’ mood and self-management. Given the well-recognised link between understanding an illness and behaviour in relation to said illness, healthcare practitioners’ illness beliefs (in this case about psoriasis) are likely to influence their behaviour, i.e. management of psoriasis. However, little is known about how healthcare practitioners’ illness beliefs inform their clinical management of psoriasis. We therefore aimed to identify health professionals’ personal models about psoriasis.

METHODS: Semi-structured interviews were conducted with 23 primary and secondary care clinicians managing people with psoriasis. Purposive sampling was used to achieve maximum variation regarding practitioner discipline, level of experience, gender and age. Data analysis was informed by Leventhal et al’s Common Sense Model, using principles of Framework Analysis to generate key issues.

RESULTS: Five overarching themes emerged from the data: 1) Seeing the complexities of psoriasis: where practitioners recognised complex links between psoriasis, psychological and lifestyle factors (e.g. exacerbation of flares impinging upon treatment and adherence, risk of co-morbidities), they also acknowledged interactions with mood and coping; 2) Skin first: despite understanding these complexities, practitioners demonstrated a narrow skin-focus in clinical management, e.g. describing psoriasis as a long-term condition (LTC), while also reporting working towards complete skin clearance; 3) Patient first: A minority of practitioners demonstrated sophisticated, congruent models where they recognised psoriasis-related complexity and felt responsible for addressing this in practice; 4) Episodic care: whereby patients were discharged after skin improvement rather than managed within a LTC model. 5) Emotional response: Practitioners with ‘skin first’ models reported frustration and lack of control when a psoriasis patient consulted, whereas those with sophisticated models reported positive affect towards patient improvement.

CONCLUSION: Some practitioners held conflicting beliefs about psoriasis and reported skin-focused management behaviour. Others held more sophisticated models of the condition and reported patient-focused rather than skin-focused care. Existing knowledge of psoriasis-related complexities may not translate to optimal management of psoriasis without further training. Research should investigate the impact of personal models upon observable care provision.