

The paradigm shift in our approach to skin problems

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GENERAL PRACTICE has a longstanding emphasis on the patient, their social context and being visibly present in a community. General practitioners (GPs), because of our discipline's focus on patient-centred clinical methods, have advocated for medical system design to respond to people as complex, relational, dynamic entities.^{1,2} GPs serve in a wide range of communities and know that illness, healthcare and its associated costs vary between suburbs along the same train line, and that no two small towns are alike.

Many individuals experience poor health outcomes because they are unfairly marginalised by society.³ Some groups are also marginalised by medicine itself. Consider acute coronary syndrome (ACS); suspected ACS presentations were taught as typical and atypical chest pain just 20 years ago.⁴ This reflected historical conventions in textbooks and scientific publications, in which the 'white' and 'male' was regarded as the normal case.^{5,6} Implicit norms can condition students and junior doctors to a type of data bias, as disease in one group becomes classical or standard and all other symptoms and signs become variants. As students graduate and serve as clinicians and academics, these structural deficiencies are perpetuated when left unchallenged.

Collective medical blind spots in knowledge have an insidious effect on health outcomes. The illness experience, diagnostic process and management approach become negatively skewed for some, but the skewing goes undetected. Only when accompanied by a paradigm shift is primary data freshly disaggregated and analysed.

In this edition of the *Australian Journal of General Practice*, we focus on the profound change in holistic care of people with skin conditions.

Skin concerns account for 16 out of every 100 patient encounters in general practice.⁷ Skin conditions are not only debilitating in themselves, but can also signal systemic disease. In Australia, skin conditions affecting fair, white skin have been taught as the norm. Dermatology atlases, essential when visual perception and heuristics are key to diagnosis and management, lack equitable representations of a range of skin types.⁸ The traditional descriptors for rashes and lesions, also essential for diagnosis, cannot be applied universally.⁹

This paradigm is being reevaluated. New insights into our understanding of skin morphology, treatment and cultural contexts equip GPs to manage various skin diseases as they might present in all the individuals they serve.¹⁰ Whiteness is a social construct, and the phrase 'skin of colour' is currently accepted in referring to the heterogenous appearances of everyone else.¹⁰ Some readers might find it a reasonable step away from the deeply unsatisfactory language of forcibly assigned ethnicity and the hierarchy of race.

People with skin concerns have multifactorial needs that arise from interlinked biological, environmental, social and behavioural influences.¹⁰ Specific cases – a young child with vitiligo, a woman with acne, and children with atopic dermatitis – are also discussed as illustrations of thinking systematically through such factors to provide informed, equitable healthcare.^{11–13} There is great scope for further clinical and research contributions to the literature in this field.

Holistic primary care extends not just across an individual's lifespan, but also to people of all cultures, genders, orientations, beliefs and socio-economic position. Evidence-informed, dignified medical care is a standard all of us should be able to expect.

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