Skimming the surface

A brief history of skin conditions

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The first clinical descriptions of skin conditions and their treatments date back to 1600 BCE in ancient Egypt, where medicinal healers treated such conditions as psoriasis, ulcers, alopecia, hypertrichosis, and scabies. Hippocrates, Pluto, and Aristotle, ancient Greek physicians, adopted Egyptian healing traditions for skin disorders and coined many of the technical terms, such as alopecia, exanthem, lichen, psoriasis, leprosy, gangrene, and edema, that we still use in dermatology today. Although few advances in our understanding of skin disorders occurred during the Middle Ages, we did acquire a broader understanding of venereal diseases and leprosy.[1]

The first English book on cutaneous disorders, *De Morbis Cutaneis*, was written by the English surgeon Daniel Turner and published in 1714. For the first time, Turner attempted to classify skin conditions according to body area. In 1790, Robert Willan, a general practitioner in London, expanded classification of skin diseases in his book, *Description and Treatment of Cutaneous Diseases*, and introduced new clinical entities such as erythema nodosum. He was awarded a gold medal by the Medical Society of London and is considered the father of modern dermatology in the Western world.[2]

Today, as in the past, most skin conditions are diagnosed and managed by family physicians. Timely diagnosis, appropriate treatment, and adequate recognition of the burden of skin diseases are important to practising good family medicine. For this reason, this issue of *Canadian Family Physician* is dedicated to the science and art of cutaneous medicine.

The issue touches on several interesting topics. Afifi and colleagues (**page 519**) review approaches to topical treatment of psoriasis. Affecting 1% to 3% of the population, this condition is commonly seen and managed by family physicians. Most patients present with a mild form of the disease and require only topical treatment. Despite recent advances in our understanding of the pathogenesis of psoriasis, corticosteroids remain at the forefront of treatment. Other topical therapies (eg, vitamin D analogues and retinoids alone or in combination with steroids) offer promising results and will likely be among first-line psoriasis therapies widely used by family physicians in the future.

Cheung and colleagues (**page 527**) review four common acneiform facial eruptions in young women: acne vulgaris, rosacea, folliculitis, and perioral dermatitis. These four conditions are commonly seen in primary care and often provide a diagnostic and therapeutic challenge for family physicians. Fortunately, there are subtle morphologic and historic differences in presentation of these conditions that are helpful in differentiating them. Correct diagnosis is essential for selecting appropriate treatment. The authors provide a useful framework for diagnosis of common acneiform facial eruptions in young women and provide an evidence-based review of management of these conditions.

Four Dermacase quizzes presented in this issue are intended to provide a diagnostic challenge for readers and a brief overview of four conditions. Can you recognize the four skin conditions in this issue? Are you up-to-date on their diagnosis and management? *Canadian Family Physician* invites you to challenge yourself and to continue to strive for broader knowledge and better patient care.

The challenge continues. Today, as never before, there are increased demands on family physicians to learn more, work harder, and provide more services. Dermatology is one of many areas of family physicians' expertise that places high demands on them to keep up with advanced medical knowledge. This issue is dedicated to all of you who take pride in your unique balance of skill, medical knowledge, and compassion, who provide high-quality primary care on a daily basis, and who successfully treat patients with skin conditions.

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Is cultural sensitivity sometimes insensitive?

Leigh Turner, PHD

Physicians and other health care professionals are often urged to provide "culturally sensitive" care.[1] Numerous guidebooks describe how clinicians should provide care to patients from different cultures.[2,3] Synthesizing survey data, case studies from the medical literature, ethnographic reports, and cultural guides for clinicians offer general standards and practical tips concerning how members of particular ethnic groups should be treated. By now, clinicians will be familiar with many of the assertions made in such guides. Navajos want to hear positive news; they do not want to receive "bad" news about terminal diagnoses. Koreans are highly sociocentric; family members of patients will most likely want to make health-related decisions for these patients when they are seriously ill. Many other standard claims about the values, social practices, family arrangements, and rites of passage of particular cultures could be added to this list.

The concept of culture can play a useful role in medical education, medical research, and clinical practice.[4] Attending to the role of culture in various social settings can serve as a useful reminder that what seems obvious to one person might not be obvious at all to someone else.[5] While some scholars argue that it is time to discard the concept of culture, I do not think it is possible to eliminate all references to culture. We need to be cautious, however, when making claims about a particular patient's "cultural framework."

Culturally sensitive care

There is much to be said for promoting the concept of culturally sensitive care. While ethical and legal limits to accommodating cultural and religious differences need to be recognized, modern health care providers practise in multicultural, multifaith, and multilingual social settings. Just as patients need to understand what their caregivers are saying, clinicians need to comprehend how patients make sense of health, illness, injury, suffering, treatments, and risks. If patients are making important health-related decisions on the basis of explanatory models of health and illness quite distinct from clinicians' biomedical model, it is crucial that health care providers explore how these patients understand matters.

Misunderstandings can be connected to language differences and different understanding of health, illness, and treatment. An awareness of how patients experience the world is particularly important in family medicine where treatment of medical problems commonly requires a detailed