Comment on "Racial Limitations of Fitzpatrick Skin Type"

Matthew A. Pimentel, MD

To the Editor:

It is with great interest that I read the article by Ware et al,[1] "Racial Limitations of Fitzpatrick Skin Type." Within my own department, the issue of the appropriateness of using Fitzpatrick skin type (FST) as a surrogate to describe skin color has been raised with mixed responses.

As in many dermatology residency programs across the country, first-year dermatology residents are asked to describe the morphology of a lesion/eruption seen on a patient during Grand Rounds. Preceding the morphologic description, many providers describe the appearance of the patient including their skin color, as constitutive skin color can impact understanding of the morphologic descriptions, favor different diagnoses based on disease epidemiology, and guide subsequent treatment recommendations.[2,3] During one of my first Grand Rounds as an early dermatology resident, a patient was described as a "well-appearing brown boy," which led to a lively discussion regarding the terms that should be used to describe skin color, with some in the audience preferring FST, others including myself preferring degree of pigmentation (eg, light, moderate, dark), and lastly others preferring an inferred ethnicity based on the patient's appearance. One audience member commented, "I am brown, therefore I think it is fine to say 'brown boy,'" which adds to findings from Ware et al[1] that there may be differences in what providers prefer to utilize to describe a patient's skin color based on their own constitutive skin color.

I inquired with 2 other first-year dermatology residents with skin of color at other programs. When asked what terminology they use to describe a patient for Grand Rounds or in clinic, one resident replied, "It's stylistic but if it's your one liner [for assessment and plan] use their ethnicity [whereas] if it's [for] a physical exam use their Fitzpatrick skin type." The other resident replied, "I use Fitzpatrick skin type even though it's technically subjective and therefore not appropriate for use within objective data, such as the physical exam, however it's a language that most colleagues understand as a substitute for skin color." I also raised the same question to an attending dermatologist at a primarily skin-of-color community hospital. She replied, "I think when unsure about ethnicity, Fitzpatrick type is an appropriate way to describe someone. It's not really correct to say [a patient's ethnicity] when you don't know for sure."

Unfortunately, as Ware and colleagues[1] indicated, there is no consensus by which to objectively classify nonwhite skin color. Within the dermatology literature, it has been proposed that race should not be used to express skin color, and this article proposes that FST is an inappropriate surrogate for race/ethnicity.[4] Although I agree that appropriate use of FST should be emphasized in training, is there a vocabulary that Ware et al[1] recommend we use instead? Does the Skin of Color Society have suggestions on preferred language among its members? Finally, what efforts are being made to develop "culturally appropriate and clinically relevant methods for describing skin of color," as the authors stated, within our own Skin of Color Society, or to whom does this responsibility ultimately fall?

REFERENCES

1. Ware OR, Dawson JE, Shinohara MM, et al. Racial limitations of Fitzpatrick skin type. *Cutis.* 2020;105:77-80.
2. Sachdeva S. Fitzpatrick skin typing: applications in dermatology. *Indian J Dermatol Venereol Leprol.* 2009;75:93-96.
3. Kelly AP, Taylor SC, Lim HW, et al. *Taylor and Kelly's Dermatology for Skin of Color.* 2nd ed. New York, NY: McGraw-Hill Education; 2016.
4. Bigby M, Thaler D. Describing patients' "race" in clinical presentations should be abandoned. *J Am Acad Dermatol.* 2006;54:1074-1076.

Author's Response

My colleagues and I thank Dr. Pimentel for his insights regarding the article, "Racial Limitations of Fitzpatrick Skin Type."[1] The conundrum on how to appropriately categorize skin color for descriptive and epidemiologic purposes continues to remain unsolved today. However, attempts have been made in the past. For example, in September 2006, Dr. Susan C. Taylor (Philadelphia, Pennsylvania), formed and chaired a workshop session titled "A New Classification System for All Skin Types." Dermatology leaders with skin of color expertise were invited from around the world for a weekend in New York, New York, to brainstorm a new skin color classification system. This

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endeavor did not produce any successful alternatives, but it has remained a pertinent topic of discussion in academic dermatology, including the Skin of Color Society, since then.

When unsure about ethnicity, my colleagues and I continue to advocate that the Fitzpatrick scale is not an appropriate substitute to describe skin color. This usage of Fitzpatrick skin type (FST) perpetuates the idea that the Fitzpatrick scale is a suitable proxy to describe ethnicity or race, which it is not. It is important to remember that race is a social classification construct, not a biological one.[2] The topic of race in contemporary culture undoubtedly invokes strong emotional connotations. The language around race is constantly evolving. I would argue that fear and discomfort of using incorrect racial language promotes the inappropriate use of FST, as the FST may be perceived as a more scientific and pseudoapplicable form of classification. To gain knowledge about a patient's ethnicity/race to assess epidemiologic ethnic trends, we recommend asking the patient in an intake form or during consultation to self-identify his/her ethnicity or race,[3] which takes the guesswork out for providers. However, caution must be exercised to avoid using race and ethnicity to later describe skin color.

Until a more culturally and medically relevant method of skin color classification is created, my colleagues and I recommend using basic color adjectives such as brown, black, pink, tan, or white supplemented with light, medium, or dark predescriptors. For example, "A 35-year-old self-identified African American woman with a dark brown skin hue presents with a 2-week flare of itchy, dark purple plaques with white scale on the scalp and extensor surfaces of the knees and elbows." These basic descriptions for constitutive skin color conjure ample visual information for the listener/reader to understand morphologic descriptions, presentation of erythema, changes in pigmentation, and more. For a more specific skin color classification, we recommend developing a user-friendly Pantone-like color system to classify constitutive skin color.[4]

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REFERENCES

1. Ware OR, Dawson JE, Shinohara MM, et al. Racial limitations of Fitzpatrick skin type. *Cutis.* 2020;105:77-80.
2. Ifekwunigwe JO, Wagner JK, Yu JH, et al. A qualitative analysis of how anthropologists interpret the race construct. *Am Anthropol.* 2017;119:422-434.
3. Hasnain-Wynia R, Baker DW. Obtaining data on patient race, ethnicity, and primary language in health care organizations: current challenges and proposed solutions. *Health Serv Res.* 2006;41:1501-1518.
4. What is the Pantone color system? Pantone website. https://www.pantone.com/color-systems/pantone-color-systems-explained. Accesed May 13, 2020.