

The challenges of dark skin tone assessment: the importance of language



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As you are probably aware, at *Wounds UK* we are invested in raising the profile of the challenges of assessing the skin of patients with dark skin tones. We have an amazing Best Practice Statement document "*Addressing skin tone bias in wound care: assessing signs and symptoms in people with dark skin tones*" (Wounds UK, 2021) and held a very successful conference on the topic in Manchester in May.

The day after the conference I was randomly scrolling through the TV channels and noticed a programme titled *Tan France: Beauty and the Bleach, about Colourism* (<https://www.bbc.co.uk/programmes/m0016tzt>). Thinking it was probably relevant I decided to watch it and I am so glad that I did.

In our guidance in the Best Practice Statement, we talk about asking the patient how they describe their skin and to be cognizant that there may be a cultural significance to the colour or tone of the skin — but until I watched this programme I had no idea of the extent of that. Tan France, the presenter of the documentary, discussed his personal journey and how the depth of skin tone and comments from his extended family and friends led him to attempt to bleach his skin at just 9 years old. Tan described how he felt compelled to do this to please his South Asian community, who, according to Tan, see light skin as a passport to the best jobs, careers and marriage partners.

As a 9 year old in the 1970s, he hoped that things had improved when he spoke to secondary school pupils of dark skin tones. Both Black and Asian students identified that there was significant pressure from within their own communities to be 'light-skinned' as a sign of attractiveness or achievement potential. They still felt under pressure to do skin lightening, which is reflected in the published literature (Cradock et al, 2018).

Skin lightening is not unique to the South Asian community — the trend exists in Black, Asian and Middle Eastern communities across the UK and beyond. It can be extreme to the point where one person in the programme

literally peeled off their own skin in their quest to have light skin.

Why is this relevant? Well firstly, I think it reinforces how little I know about what it is like to have dark skin, but, more importantly, for our current quest about improving skin assessment in people with dark skin tones it reinforces the importance of language. What we say and what that means to the person may be two completely different things. I had not appreciated how differently people may describe their own skin colour, why and what that may mean in terms of how we deliver better care (Shivakumar and Jafferany, 2020). It may feel like these may be incredibly difficult conversations to have, but it's essential to welcome difficult conversations and give people the grace and space to stumble over their words. Saying something and showing care is always better than saying nothing. We also need to be aware of why people may have different skin tones across their body and look for possible issues caused by skin lightening products, such as changes in epidermal thickness (Saqib et al 2019) or more severe systemic problems (Ricketts et al, 2020; Rudge et al, 2019).

There is still a significant amount of work to be done in this area of practice, as we identified in the Best Practice Statement. The focus was initially on pressure ulcers (PU) and the use of the term 'redness' in the descriptor of category 1, but there are many other areas that need to be addressed. For example, the term 'red legs' is still commonly used, but what does this mean for patients with dark skin? Do people with dark skin tones get 'red legs', or do we just not see it and, therefore, not offer appropriate care? What about the clinical signs of infection? Again, we accept heat, redness, pain and swelling — how does this manifest in those with dark skin, do we miss infected wounds until the patient becomes systemically unwell or their pain is such that we treat on that?

We need to start to challenge these terms across the board, not just in PUs! But importantly we need to also champion good skin assessment, that focuses

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on using all the senses, not just the visual; this has to improve the equity of what we do. In most cases what we are looking for is inflammation (and once again we have heat redness and swelling) but two of those three rely on touch not visuals, so we need to put them first.

This needs to be built into all policies, protocols and pathways in the future. But it needs to be done sensibly, we are not 'banning' the use of redness, we are simply saying it is one of several symptoms and may present differently in different skin tones. If your patient has a skin tone that displays redness and you did not advise them that, for example a red spot over a bone should trigger contact with their clinician, you would be failing them, so it's about the use of appropriate language for that individual. In the same way I would be happy to talk to a patient about a bed sore, I need to be comfortable to talk about skin going red, or saying, *'I'm not sure what happens to skin of your colour, what have you seen before on your skin if you got a rash etc'*.

I'm sure I have still not got it even halfway right

but the most important part I guess is to start finding out what I have got wrong and how I can improve! So I hope I can encourage all of you to watch the programme on BBC iPlayer and to make use of the resources we are developing (more news in the next issue) both in your own practice and in your teaching.

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