identified as black, Hispanic, or Asian often did not find skin cancer to be relevant to ethnic people. It was suggested that relevance of melanoma education to ethnic people may be improved by using the term melanoma skin cancer, showing photographs of early melanoma in people with dark skin, and providing guidance on how to inspect hands and feet for suspicious moles. Furthermore, perceived risk of melanoma also was related to seeking medical attention. Those who could not state a level of risk were less likely to seek help.

**PROVIDER EDUCATION**

We must critically assess access to dermatologic care. Provider education and surveillance must go well beyond dermatologists. Most physician-identified melanomas are detected by primary care physicians. Lower rates of physician surveillance in darker-pigmented persons, possibly due to reduced awareness of melanoma presentation, likely contribute to our current practice gap. Primary care physicians are positioned to perform integrated skin examinations, counseling, and triage. Teaching melanoma screening to medical students and reinforcing the skills with primary care resident physicians are essential to professional education. As dermatologists, we should be teaching medical students, resident physicians, and primary care providers (ie, physicians, physician extenders, and nurses) about integrated skin examinations for skin cancer detection in all populations.

Prompt recognition of melanoma in all patients, regardless of ethnic group, is paramount. It is essential to continue to expand our knowledge, identify practice gaps, and, in turn, improve patient outcomes. The measured effects will likely be found in the next decade after a population-based review is repeated. We hope that by then we will have closed the gap.

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