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WHO GETS SEEN? RETHINKING ACCESS IN RURAL DERMATOLOGY

In a single afternoon, we screened over 175 patients at a free skin cancer event in rural Virginia. Many had not seen a dermatologist in years, some in decades. Several pointed to lesions they had been “watching” for months, even years, unsure if they were worth the long drive, the cost, or the time away from work.

Dermatology is often described as a visual specialty, one in which diagnosis begins the moment a lesion is seen. But that assumption overlooks a fundamental truth. Access determines who is ever seen in the first place.

Skin cancer is one of the most visible forms of disease, yet patients in rural and underserved communities continue to present with more advanced pathology. The reasons are not rooted in biology alone, but in systems. Geographic isolation, limited specialist availability, transportation challenges, cost barriers, and gaps in health literacy all shape when or if patients seek care. In many areas, a dermatology appointment may require months of waiting and hours of travel.

For patients balancing work, caregiving, and financial strain, a changing mole rarely feels urgent enough to justify those sacrifices.

At our screening event, visibility came all at once. Lesions that had gone unexamined for years were evaluated in minutes. Suspicious growths were identified, biopsies were recommended, and patients left with a new sense of urgency and often relief. Events like these are powerful. They are also insufficient.

One day screenings create snapshots of access, not continuity of care. They answer the question of who can be seen today, but not who will be followed tomorrow. What happens after the tents are packed up? For many patients, the same barriers remain. Limited access to dermatologic follow up, delays in biopsy or treatment, and fragmented care coordination persist. Without longitudinal solutions, we risk identifying disease without ensuring its resolution.

If dermatology is to truly serve all patients, we must expand our definition of access beyond episodic outreach. Teledermatology offers one avenue, particularly in triaging lesions and reducing unnecessary travel, but it depends on reliable technology and digital literacy, resources not universally available. Integrating dermatologic training into primary care settings can help bridge gaps, empowering frontline providers to recognize concerning lesions earlier. Mobile clinics, community partnerships, and longitudinal outreach programs may offer more sustainable engagement than isolated screening events.

Equally important is awareness. Several patients we encountered did not recognize their lesions as potentially dangerous. Others assumed that without pain or rapid change, evaluation was unnecessary. Public health messaging in rural communities must move beyond general recommendations and meet patients where they are, culturally, geographically, and economically.

As a medical student, this experience reshaped how I think about dermatology. It is not just about pattern recognition or procedural skill, but about presence. Who we reach, who we miss, and why. The patients we saw that afternoon were not exceptions. They were representatives of a broader, persistent gap in care.

Dermatology prides itself on early detection. But early detection requires early access. Until we address the structural barriers that determine who is seen, we will continue to diagnose preventable disease too late, not because it was invisible, but because it was unseen.