Increasing racial and ethnic diversity in dermatology: A call to action

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The population of the United States is becoming increasingly diverse. Diversity includes differences between individuals based on gender, race, ethnicity, socioeconomic status, disability, and sexual orientation. Efforts by many organizations, including the Women's Dermatologic Society, have helped improve gender diversity in dermatology, moving our specialty toward a workforce that reflects the patients it serves. Although dermatology has done well in reducing gender disparities, persistent disparities remain when it comes to race and ethnicity.

By 2043, no single racial/ethnic group will make up a majority of Americans.[1] The largest change will be among Hispanics, who will increase from 53.3 million in 2012 to 128.8 million in 2060, comprising 31% of the population. By 2060, 15% of Americans will be black, and 8.2% will be Asian.

Unfortunately, the population of dermatologists is not following this trend—in fact, we are falling behind. Black dermatologists comprise only 3% of all dermatologists, despite the fact that 12.8% of Americans are black. For Hispanics, the statistics are just as sobering, with only 4.2% of dermatologists of Hispanic origin compared with 16.3% in the general population. These differences are worse for dermatology than physicians overall, and we are one of the least ethnically/racially diverse specialties, only slightly better than orthopedics (Fig 1).[2-10] Moreover, the discrepancy between the overall population and dermatologists is getting worse over time. Fig 2 reflects the widening gap between Hispanics in the general population, college, medical school, and dermatology. The statistics are similar among blacks (Fig 3). The term "underrepresented in medicine" (UIM), as defined by the Association of American Medical Colleges, describes racial and ethnic populations that are underrepresented in the medical profession relative to their numbers in the general population. Blacks, Hispanics, and Native Americans are considered UIM in dermatology.

Why does this matter? Diversity among the medical work force has been shown to improve patient care.[11] Studies have shown that race-concordant visits are longer and have higher ratings of patient positive affect than race-discordant visits.[11] Patients in race-concordant visits are more satisfied, and rate their physicians as more participatory, regardless of the communication that occurred during the visit. This suggests one of the best strategies to improve health care experiences for ethnic minorities is to increase ethnic diversity among physicians. Minority physicians are more likely to care for patients of their own race or ethnic group; practice in areas that are underserved or have health care manpower shortages; care for poor patients, patients with Medicaid insurance, or no health insurance; and care for patients who report poor health status and use more acute medical services such as emergency departments and hospital care.[12-14] Increasing UIM representation in the dermatology workforce has the potential to positively impact disparities in access to care and help address the growing discrepancy in geographic distribution of dermatologists.[12]

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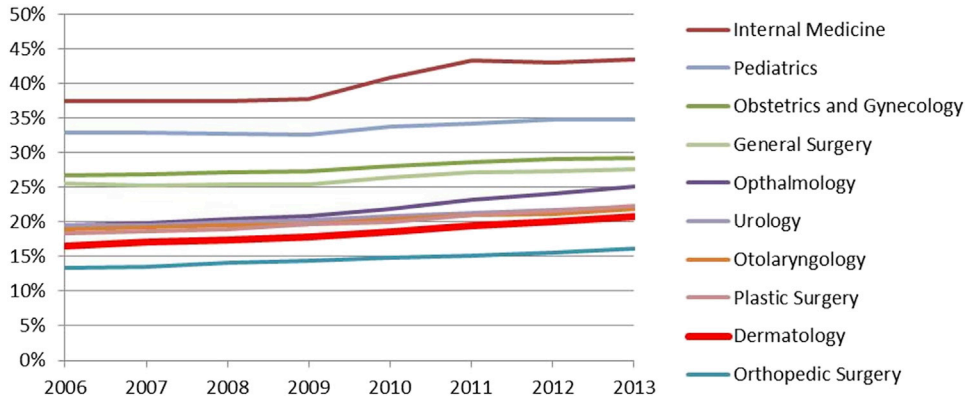

Fig 1. Total minority representation in dermatology versus other fields, 2006-2013, including Hispanics, African Americans, Asians, American Indians/Alaskan Natives, and Native Hawaiians/Pacific Islanders.

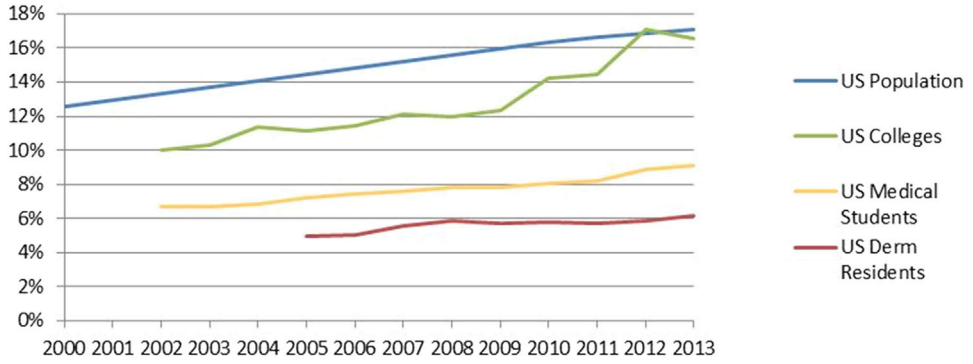

Fig 2. Hispanic representation among dermatology residents, medical students, college students, and US population, 2002-2013.

Dermatology is not alone in lack of diversity among its workforce. A study of orthopedic surgeons revealed significant underrepresentation of African Americans and Hispanics among orthopedic residents.[15] This gap was found to be the result of sequential losses in representation that occurred with the transitions from college to medical school and from medical school to residency. These losses in representation appear to be increasing over time, as demonstrated by the differential rates of change observed in these groups. These findings are in stark contrast to the trend observed among Asians, whose representation among orthopedic residents is not only higher than that seen among college students and the general population but also increasing at a faster rate than in those groups. The same trend is seen in dermatology.

How did we get here? Are underrepresented minorities uncomfortable within our organizations, including health care institutions? Is unconscious bias part of the problem? Although we are not aware of institutional racism in dermatology today, we have not, as a profession, embraced the idea that dermatology needs many more physicians from underrepresented minority populations. Does race plays a role in how we hire and develop our faculty in ways that we are not conscious of? The problem may begin before our current intervention strategies occur. Medical school students from underrepresented populations generally do not choose dermatology. The reasons are not clear but must be explored. In orthopedics it was found that earlier exposure of medical students to musculoskeletal topics in medical school increased applications to orthopedics residencies by UIM groups. Late exposure to dermatology in medical school may be part of the problem.[16]

So what can be done to improve this problem? First and foremost, we must make the achievement of racial/ethnic diversity a goal for dermatology. The definition of racial/ethnic diversity may vary from one location to another, based on regional population characteristics. Although mirroring of the dermatology workforce with the population it serves may be the ultimate goal, milestones toward achieving parity should be established and worked

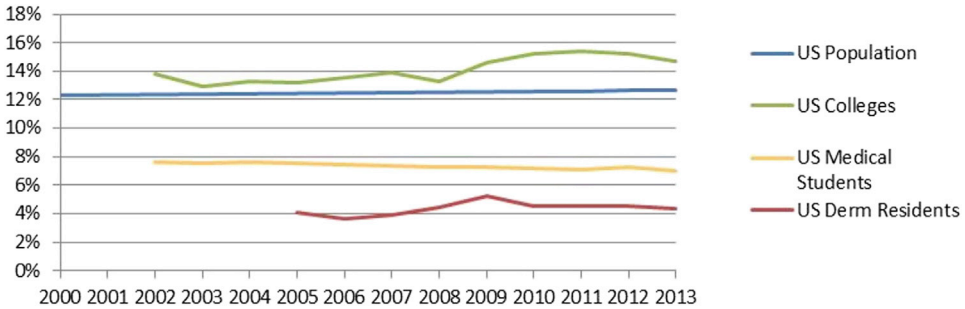

Fig 3. African American representation among dermatology residents, medical students, college students, and the US population, 2002-2013.

toward. This would involve our dermatologic organizations, dermatology departments and residency programs, and our medical schools. Anecdotal evidence from Johns Hopkins, Harvard, and the Hospital for Special Surgery suggests that a commitment to diversity can increase minority representation in orthopedic residency programs without compromising quality.[15] At Johns Hopkins, because of a commitment on the part of the chair, during the 1990s UIM groups represented 20% or more of their orthopedics residents while the national average was substantially lower.[17] Second, dermatology residency selection committees can give strong positive value to a wider range of accomplishments and talents, such as cultural competence, likelihood to care for the underserved (of which UIM status is a positive predictor),[18] and interpersonal intelligence when evaluating candidates for residency positions. Third, early exposure to dermatology in medical school would expose UIM students to a specialty they might not have had experience with or even considered as a career.[16] Further research into the reasons why UIM groups do not choose dermatology as a specialty should be performed, followed by evidence-based programs focused on these barriers. Fourth, because financial constraints are a common barrier for UIM applicants, federally funded programs for scholarship and loan repayment should be expanded and institutional resources should be made available to increase diversity. Fifth, dermatologists should encourage and support programs within their own medical schools that increase the number of UIM students because an increase in the pool of UIM medical students could result in more UIM students applying to dermatology. Sixth, one of the most important activities to increase diversity is outreach, mentoring, and tutoring at all educational levels—including elementary school, middle school, high school, and college—to encourage students from underrepresented minorities to pursue careers in science and health.[19,20] These "pipeline" programs with a strong mentoring component can both increase the number of UIM students who seek a career in health care and enhance their likelihood to reach their full potential within medicine. Finally, every dermatologist can participate in the goal of achieving diversity in dermatology. Talk to your high school—and college-aged patients from underrepresented groups. Encourage them to enter medicine. Sell them on dermatology as a specialty. It will make a difference.

The current state of racial/ethnic diversity in dermatology is poor. Our specialty does not mirror the US population. Other types of diversity inequality also exist and should be addressed. Working to make dermatology look more like the rest of America will improve our ability to treat our patients, and make dermatology more accessible to all Americans. In addition, all dermatologists should continually improve their cultural competence to better understand and manage an increasingly diverse patient base. Let's all work together and make diversity a priority for our specialty. This is a call to action. The time is NOW!

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