Preface

Diversity, Equity, and Inclusion in Dermatology

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Editor

Of all the forms of inequality, injustice in health care is the most shocking and inhumane.

—Dr Martin Luther King Jr

What exactly is diversity, equity, inclusion (DEI), and more importantly, why is it important in medicine and dermatology? The genesis of this *Dermatologic Clinics* is to explore and more deeply understand DEI and its impact on the health and care of our patients, the working and learning environments of dermatologists and trainees, and clinical trial research.

The article in this issue by Mason, "Diversity, Equity, Inclusion and Belonging in Dermatology," provides a foundational understanding of DEI, including definitions and a perspective on the importance of DEI in medicine and dermatology. An argument is made that DEI is essential for excellence in dermatologic care for all patients, serves to address health disparities that exist in marginalized patient populations and provides a healthy and enriched work environment for dermatologists and trainees.

The article by Barbosa delves into "Diversity, Equity, and Inclusion in the Dermatology Workforce and Academic Medicine," and the article by Shinkai et al. focuses on "Diversity and Inclusion in Dermatology Residency," the precursor of the dermatology workforce. The goal of these articles is to understand how and why it is important for the physician workforce to reflect the diversity of the US population and how to begin to achieve this goal. In the article by Barbosa, the subspecialties of pediatric dermatology, dermatopathology and dermatologic surgery are highlighted as even less racially and ethnically diverse than the dermatology workforce as a whole. In the article by Shinkai et al., the authors outline a framework for DEI initiatives at the residency training level, which includes establishing inclusive learning environments and mentoring structures that support residents, as well as instituting improvements in the residency selection process. The authors also discuss the development of curricula to train residents to provide expert care to all patients, and for them to better understand principles of health equity and social determinants of health. This article also initiates a discussion of gender diversity in dermatology and academic medicine.

The article by Murrell and colleagues provides an in-depth look at "Gender Equity in Medicine and Dermatology," highlighting the gains that women have made as academic faculty members and dermatology resident trainees, which is in contrast to the limited number of women in academic leadership positions. The role of gender bias and the dearth of role models are discussed as underlying reasons for these inequities.

An underpinning of the specialty of dermatology is excellence in dermatologic care for all patients. Personal, cultural, and social impediments hinder the attainment of this goal and contribute to health disparities. The articles by Pandya and Rodriguez Jr, Ogunleye, Weir, and Peebles discuss how to begin to overcome some of these impediments. The article by Pandya and Rodriguez Jr reviews

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"Cultural Competence and Humility," that practicing dermatologists can incorporate to meet the needs and nuances that occur during racially and ethnically discordant visits between health care providers and patients. The authors emphasize that learning cultural competence and humility are lifelong processes and the fact that it is important to join existing efforts within professional dermatology associations to encourage competence and humility development. They include the idea that improving cultural competence and humility are two ways dermatologists can help lessen the burden of health care disparities.

In the article by Ogunleye, "Unconscious Biases" (also known as implicit biases) are defined as involuntary stereotypes or attitudes held about certain groups of people that may influence behaviors, understandings, and actions, often with unintended detrimental consequences, particularly for diverse populations. Health disparities may partly be attributable to unconscious biases. Implicit bias appears in multiple facets of medical education, training, and promotion with negative effects on diversity and equity efforts. The author discusses evidence (or the lack thereof) supporting the effectiveness of current bias/diversity training programming and the use of standardization and blinding as well as evidence-based methods to reduce implicit bias.

In the clinical setting, both physicians and patients can commit microaggressions or be the targets of microaggression. In "Understanding and Addressing Microagressions in Medicine" Weir discusses microaggressions, which are aggressions that are delivered unconsciously through words, tone, gestures, or looks, and which convey disparaging sentiments to people of color, women, sexual or gender minority, or other minority groups. Patients who experience microaggression from their provider suffer emotional distress and distrust, resulting in decreased service utilization, reduced treatment compliance, and poorer physical and mental health. Minority group physicians and medical trainees are increasingly the targets of microaggressions committed by patients. This article provides instruction on how to recognize and address microaggressions in the clinical setting and how to create a more supportive and inclusive environment for patients, dermatologists, and our trainees.

A comprehensive discussion of "Achieving Equity for Sexual and Gender Minority Persons in Medicine and Dermatology" occurs in the article by Peebles et al. The authors emphasize the key role that dermatologists play in improving health equity for sexual and gender minority patients through cultivating awareness of how their patients' sexual and gender identity may impact their skin health. They also emphasize that dermatologists must be instrumental in developing sexual and gender minority–inclusive curricula and safe spaces in medical training, promoting workforce diversity, practicing with intersectionality in mind, and engaging in advocacy for their patients, whether it be through daily practice, legislative and/or public policy initiatives, or research.

Structural impediments also hinder the attainment of excellence in dermatologic care for all patients. The articles by Bowers and colleagues provide an understanding of the principles of social determinants of health and health equity as they pertain to dermatology, particularly for marginalized patient populations. Social determinants of health are the nonmedical factors, such as housing, education level, access to food and clean water, neighborhood safety, and economic stability, that must be addressed to improve health outcomes and achieve greater health equity. Social Determinants of Health—Part A aims to shed light on how these determinants impact health and their implications on dermatologic health disparities, whereas Part B offers a framework that dermatologists can employ to help address social determinants of health both at the point of care and in the health care system at large. Social determinants of health are shaped by structural determinants of health, and the article by Vasquez and Pritchett discusses the "History of Race and Ethnicity in America," while the article by Allen and Mickel explores race, racism, and structural racism in medicine. These articles provide a framework for understanding "Racial and Ethnic Health Disparities in Dermatology," which is found in the article by Harvey and colleagues. Health disparities are differences in health or disease incidence, prevalence, severity, or disease burden that are experienced by disadvantaged populations. Health disparities are complex and multifactorial and are often linked to social and economic disadvantage. They originate from dynamic interactions of genetic, biologic, environmental, social, economic, and health system–related factors.

To better understand additional principles of health equity, clinical research trials, an essential component of research for determining the safety and efficacy of treatments for medical diseases, are discussed in the article by Elbuluk and Syder, "Racial Disparities in Research and Clinical Trials." Clinical trials have significantly lagged behind in diverse participation across demographic groups, particularly in regard to race and ethnicity. Within dermatologic randomized clinical trials, studies on conditions such as alopecia areata, atopic dermatitis, and acne have been shown to have a

significant majority of white participants. In addition, there are a limited number of trials concerning conditions that disproportionately affect patients with skin of color, and a significant number of dermatology studies fail to report data on minority recruitment and enrollment. These gaps negatively impact health equity, and the authors discuss needed efforts for sustained and meaningful change.

In this issue of *Dermatologic Clinics*, several articles support the case for the role of the dermatologist and our professional dermatology associations in building a diverse, equitable, and inclusive environment for patients and colleagues in clinical care, education, and research. The final articles of the issue discuss opportunities to achieve DEI in dermatology, mechanisms to address health inequities, as well as racial and ethnic intolerance and discrimination. The article by Ferguson and Munjal details the ongoing efforts and DEI initiatives being undertaken by US professional dermatology associations. Each organization had demonstrated a strong commitment to initiatives designed to improve patient care for people of all backgrounds, reduce health disparities, and increase physician education and the number of diverse dermatologists and trainees. Finally, the article by Lim outlines "Steps Leaders Can Take to Increase Diversity, Enhance Inclusion, and Achieve Equity" in dermatology. The author highlights the noticeable progress that has been achieved by the advocacy and effort of several highly visible leaders in dermatology and reviews six key leadership lessons learned for successful implementation of DEI.

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