

Contents

Preface: Diversity, Equity, and Inclusion in Dermatology **xiii**

Susan C. Taylor

Diversity, Equity, Inclusion and Belonging in Dermatology **239**

Bonnie Simpson Mason, Candrice Heath, Jennifer Parker, and Kamaria Coleman

Addressing continued inequities in medicine, and especially in dermatology, requires a strategic approach and meaningful actions that will yield and result in sustainable change in our medical, clinical, and learning environments. Heretofore, most solutions-based actions and programs in DEI have focused on developing and edifying the diverse learner or faculty member. Alternatively, accountability rests with the entities that wield the power and ability and authority to shift culture change such that the diverse learner, faculty member, and patient can receive equitable access to care and educational resources in environments within a culture of belonging.

Diversity in the Dermatology Workforce and in Academic Medicine **249**

Karina Grullon and Victoria Barbosa

Health disparities exist in marginalized patient populations throughout medical specialties, including in dermatology. It is important that the physician workforce reflect the diversity of the US population to address these disparities. At present, the dermatology workforce does not reflect the racial or ethnic diversity of the US population. The subspecialties of pediatric dermatology, dermatopathology, and dermatologic surgery are even less diverse than the dermatology workforce as a whole. Although women make up over half of the population of dermatologists, disparities still exist in areas such as compensation and presence in leadership positions.

Diversity, Equity, and Inclusion in Dermatology Residency **257**

Farinoosh Dadrass, Sacharitha Bowers, Kanade Shinkai, and Kiyanna Williams

Improving diversity, equity, and inclusion (DEI) in dermatology is a critical aim for the specialty to improve the workforce, clinical care, education, and research. This article outlines a framework for DEI initiatives at the residency training level: improving mentorship and residency selection process to improve representation of dermatology trainees; curricular development to train residents to provide expert care to all patients and to better understand principles of health equity and social determinants of health as they pertain to dermatology; establishing inclusive learning environments and mentoring structures that support residents to become successful future clinicians and leaders of the specialty.

Gender Equity in Medicine and Dermatology in the United States: The Long Road Traveled and the Journey ahead **265**

Janell M. Tully, Jenny E. Murase, Jane M. Grant-Kels, and Dedee F. Murrell

Over the past 50 years there has been an increase in the representation of women in medicine with similar rates of men and women graduating from medical training today. Nevertheless, gender gaps in leadership, research publications, and

compensation persist. Herein, we review trends in gender differences among leadership positions in academic medicine with a particular focus on dermatology, evaluate the roles of mentorship, motherhood, and gender bias on gender equity, and discuss constructive solutions for addressing gender inequities that persist in academic medicine today.

Cultural Competence and Humility

279

Ramiro Rodriguez and Amit G. Pandya

The increasing diversification of the United States has led to more racially and ethnically discordant visits between health care providers and patients; this is especially true in dermatology due to the lack of diversity in the field. Diversifying the health care workforce has been shown to reduce health care disparities and is an ongoing goal of dermatology. Improving cultural competence and humility among physicians is an important part of addressing health care inequities. This article reviews cultural competence, cultural humility, and practices dermatologists can incorporate to address this challenge.

Unconscious Bias

285

Temitayo A. Ogunleye

Unconscious biases (also known as implicit biases) are involuntary stereotypes or attitudes held about certain groups of people that may influence our behaviors, understandings, and actions, often with unintended detrimental consequences. Implicit bias appears in multiple facets of medical education, training, and promotion with negative effects on diversity and equity efforts. Notable health disparities exist among minority groups in the United States, which may partly be attributable to unconscious biases. Although there is little evidence supporting the effectiveness of current bias/diversity training programming, standardization and blinding may be helpful, evidence-based methods to reduce implicit bias.

Understanding and Addressing Microaggressions in Medicine

291

Michelle Weir

Microaggressions are directed unconsciously to people of color or other minority groups, and the accumulated experience of multiple microaggressions over a lifetime have detrimental effects on mental health. In the clinical setting, both physicians and patients can commit microaggressions. Patients experiencing a microaggression from their provider suffer emotional distress and distrust resulting in decreased service utilization, reduced adherence, and poorer physical and mental health. Physicians and medical trainees, particularly those of color, women and LGBTQIA members, have increasingly experienced microaggressions committed by patients. Learning to recognize and address microaggressions in the clinical setting creates a more supportive and inclusive environment.

Equity for Sexual and Gender Diverse Persons in Medicine and Dermatology

299

Julia L. Gao, Kanika Kamal, and Klint Peebles

Dermatologists can play a key role in improving health equity for sexual and gender diverse (SGD) patients through cultivating awareness of how their patients' sexual and gender identity may affect their skin health, developing SGD-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 public policy initiatives, or research.

The Social Determinants of Health and Their Impact on Dermatologic Health, Part 1: The Social Determinants of Health and Their Dermatologic Implications 309

Sacharitha Bowers and Aileen Y. Chang

The social determinants of health (SDoH) have significant influences on health and lead to health disparities in a variety of complex and intersecting ways. They are the nonmedical factors that must be addressed to improve health outcomes and achieve greater health equity. They are shaped by the structural determinants of health and impact individual socioeconomic status as well as the health of entire communities. Part 1 of this 2-part review aims to shed light on how the SDoH impact health and their specific implications on dermatologic health disparities.

The Social Determinants of Health and Their Impact on Dermatologic Health, Part 2: Taking Action to Address the Social Determinants of Health 317

Aileen Y. Chang and Sacharitha Bowers

The social determinants of health (SDoH) impact health and lead to health disparities in a variety of complex and intersecting ways. They are the nonmedical factors that must be addressed to improve health outcomes and achieve greater health equity. The SDoH contribute to dermatologic health disparities and decreasing these disparities requires multilevel action. Part 2 of this 2-part review offers a framework that dermatologists can use to help address the SDoH both at the point of care and in the health care system at large.

Racial and Ethnic Health Disparities in Dermatology 325

Stafford G. Brown III, Caryn B.C. Cobb, and Valerie M. Harvey

Health disparities are differences in health or disease incidence, prevalence, severity, or disease burden that are experienced by disadvantaged populations. Their root causes are attributed in large part to socially determined factors, including educational level of attainment, socioeconomic status, and physical and social environments. There is an expanding body of evidence documenting differences in dermatologic health status among underserved populations. In this review, the authors highlight inequities in outcomes across 5 dermatologic conditions, including psoriasis, acne, cutaneous melanoma, hidradenitis suppurativa, and atopic dermatitis.

History of Race in America 335

Ellen N. Pritchett and Rebecca Vasquez

Racial and ethnic disparities exist across a wide range of disease areas and clinical services. Becoming familiar with the history of race in America, and how it has been used to structure laws or policies that drive inequities in the social determinants of health, even today, is necessary to mitigate these disparities across medicine.

Exploring Race, Racism, and Structural Racism in Medicine**345**

Pamela S. Allen and Natasha M. Mickel

Race and racism are rooted in the man-made belief that the color of a person's skin determines a person's hierarchical rank in humanity. Early scientific theories of polygenics and misleading scientific studies were used to promote the concept of the inferiority of people of color and to support and maintain the institution of slavery. These discriminatory practices have filtered into society as structural racism, including the field of medicine. Structural racism has led to health disparities in black and brown communities. Dismantling structural racism requires us all to become change agents at societal and institutional levels.

Racial and Ethnic Disparities in Research and Clinical Trials**351**

Nicole C. Syder and Nada Elbuluk

Clinical trials are an essential component of research for determining the safety and efficacy of treatments for medical diseases. In order for the results of clinical trials to be generalizable to diverse populations, they must include participants at ratios that are reflective of national and global populations. A significant number of dermatology studies not only lack racial/ethnic diversity but also fail to report data on minority recruitment and enrollment. Reasons for this are multifold and are discussed in this review. Although steps have been implemented to improve this issue, greater efforts are needed for sustained and meaningful change.

Diversity, Equity, and Inclusion Initiatives in Dermatology Organizations**359**

Ananya Munjal and Nkanyezi Ferguson

Over the past few years, there have been concerted efforts to increase diversity in the field of dermatology. This has been achieved through the creation of Diversity, Equity, and Inclusion (DEI) initiatives in dermatology organizations that strive to provide resources and opportunities for trainees who are underrepresented in medicine. This article compiles the ongoing DEI initiatives in the American Academy of Dermatology, Women's Dermatologic Society, Association of Professors of Dermatology Society, Society for Investigative Dermatology, Skin of Color Society, American Society for Dermatologic Surgery, The Dermatology Section of the National Medical Association, and Society for Pediatric Dermatology.

Steps Leaders Can Take to Increase Diversity, Enhance Inclusion, and Achieve Equity**371**

Henry W. Lim

The importance of skin of color and diversity, equity, and inclusion (DEI) started to be recognized in the late 1990s. Since then, because of the advocacy and effort of several highly visible leaders in dermatology, noticeable progress has been achieved. Leadership lessons learned for successful implementation of DEI include the following: (1) commitment by and continued engagement of highly visible leaders; (2) engagement of other societies in dermatology; (3) engagement of dermatology department leaders and educators; (4) education of the next generation of dermatologists; (5) inclusivity in DEI to include gender and sexual orientation; and (6) cultivation of allies and allyship.