A Roadmap to Diversity in Dermatology

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Objectives

- Discuss the current state of diversity within medicine and the specialty of Dermatology
- Discuss the benefits of a diverse and inclusive training program and workforce
- Identify steps that individual programs can take to promote a diverse, equitable and inclusive environment
Diversity, Equity & Inclusion (DEI)

Diversity
Rich diversity of ideas, perspectives, values and overall excellence

Equity
Fair treatment, access to opportunity, and advancement for all

Inclusion
Feel welcomed, respected, supported, and valued
Why diversity matters?

- Increases productivity, creativity, language skills, cultural competence and reputation of a specialty
- Strong, positive effect on the quality of medical education
  - Break down stereotypes and racial biases
  - Broaden perspectives about racial, ethnic and cultural differences
  - Challenge assumptions
  - Increase awareness of health and health care disparities
Why now?
By the Numbers: Population

- Racial composition of the US population is projected to change
- The fastest-growing racial or ethnic group in the United States is people who are Two or More Races, followed by the Asian population and then Latinos

By the Numbers: Medicine

• Undergraduate Medical Education
  • Women have not only reached parity with men but have surpassed them
  • Gains in diversity were not shared by all groups

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

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

- Black dermatologists comprise only 3% of all dermatologists (12.8% of population)
- Latino dermatologists comprise 4.2% of all dermatologists (16.3% of population)
- Dermatology is one of the least ethnically/racially diverse specialties, only slightly better than orthopedics

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.

By the numbers: Academics

- Full-time U.S. medical school faculty by race/ethnicity in 2018
  - Among all U.S medical school full-time faculty in 2018, only 3.6% identified as Black and 5.5% identified as Latino.
  - For academic dermatology, the numbers are even lower, with 2.7% identifying as Black and 4.9% identifying as Latino.
By the numbers: Health Disparities

• Compared to Whites, Latino & Blacks
  • Comprise >50% of uninsured
  • Have poorer health outcomes
  • More likely to go without a doctor visit in the last year
  • Experience more bias, stereotyping, and prejudice in healthcare
  • Have lower quality care
  • Are under-represented in health care

Racial Disparities in Pain Management of Children With Appendicitis in Emergency Departments

Racial disparity in infant mortality

Racial and Ethnic Disparities in Maternal Morbidity and Mortality

Health and Racial Disparity in Breast Cancer

Racial Disparities in Joint Replacement Use Among Older Adults

Racial Differences in the Use of Cardiac Catheterization After Acute Myocardial Infarction

Colorectal Cancer Disparity in African Americans

Racial Differences in the Treatment of Early-Stage Lung Cancer
What about Dermatology?

Dermatology faces a reckoning: Lack of training about skin of color harms care for patients of color

Psoriasis in the US Medicare Population: Prevalence, Treatment, and Factors Associated with Biologic Use

The New York Times

Dermatology Has a Problem With Skin Color

Common conditions often manifest differently on dark skin. Yet physicians are trained mostly to diagnose them on white skin.

In dermatology, health disparities can be skin deep
Why a Diverse Workforce Matters?

Diversity and inclusion in the physician workforce increase access for underserved patients

• Minority physicians tend to practice in minority and underserved communities
• Minority medical scholars tend to study problems that impact minority communities
• Minority medical students report a greater desire to practice in minority and underserved communities

Why a Diverse Workforce Matters?

• Patient satisfaction
• Trust, respect, communication, self-advocacy
• Intention to adhere
• Clinical Outcomes?
Effects of a diversity in the learning environment

• Preparedness to care for patients from other racial and ethnic backgrounds

• Attitudes about equity and access to care

Student Body Racial and Ethnic Composition and Diversity-Related Outcomes in US Medical Schools

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Paul F. Wimmers, PhD
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Most medical schools in the United States explicitly seek to engender diversity within their student body. Academic leaders assert that diversity within their classrooms creates a robust learning environment, exposes students to a broad array of ideas, experiences, and perspectives, and thereby better prepares them to meet the needs of a multicultural American population. Among the many student characteristics medical schools consider in promoting diversity, race is perhaps the most contentious. Race-conscious policies and programs have been used to achieve racial diversity, and particularly to increase the numbers of black, Latino, and Native American individuals who are underrepresented in the physician workforce. In recent years, however, these policies have come under increasing scrutiny as being unnecessary and discriminatory.

In considering race and ethnicity, schools cite the educational benefits of

Context Many medical schools assert that a racially and ethnically diverse student body is an important element in educating physicians to meet the needs of a diverse society. However, there is limited evidence addressing the educational effects of student body racial diversity.

Objective To determine whether student body racial and ethnic diversity is associated with diversity-related outcomes among US medical students.

Design, Setting, and Participants A Web-based survey (Graduation Questionnaire) administered by the Association of American Medical Colleges of 20,112 graduating medical students (64% of all graduating students in 2003 and 2004) from 118 allopathic medical schools in the United States. Historically black and Puerto Rican medical schools were excluded.

Main Outcome Measures Students' self-rated preparedness to care for patients from other racial and ethnic backgrounds, attitudes about equity and access to care, and intent to practice in an underserved area.

Results White students within the highest quintile for student body racial and ethnic diversity, measured by the proportion of minority (URM) students, were more likely to rate themselves as highly prepared to care for minority populations than those in the lowest diversity quintile (61.1% vs 53.9%, respectively; P < .001; adjusted odds ratio [OR], 1.33; 99% confidence interval [CI], 1.13-1.57). This association was strongest in schools in which students perceived a positive climate for inter-racial interaction. White students in the highest URM quintile were also more likely to have strong attitudes endorsing equitable access to care (54.8% vs 44.2%, respectively; P < .001; adjusted OR, 1.42; 95% CI, 1.15-1.74). For nonwhite students, after adjustment there were no significant associations between student body URM proportions and diversity-related outcomes. Student body URM proportions were not associated with white or nonwhite students' plans to practice in underserved communities, although URM students were substantially more likely than white or nonwhite/ non-URM students to plan to serve the underserved (48.7% vs 18.8% vs 16.2%, respectively; P < .001).

Conclusion Student body racial and ethnic diversity within US medical schools is associated with outcomes consistent with the goal of preparing students to meet the needs of a diverse population.

JAMA. 2008;300(10):1135-1145 www.jama.com
The Program, in partnership with its Sponsoring Institution, **must** engage in practices that focus on **mission-driven, ongoing, systematic recruitment** and **retention** of a **diverse workforce** of residents, fellows (if present), faculty members, senior administrative staff members, and other relevant members of its academic community.
Program specific initiatives

Workforce diversity
- Pipeline
- Mentorship
- Recruitment/retention

Equity and Inclusion
- Environment/culture of inclusion
- Holistic review
- Implicit bias

Health disparities
- Cultural competence
- Research/quality improvement
Workforce diversity

- Pipeline
- Mentorship
- Recruitment/Retention
• Metaphor describing the process of increasing the number of URM individuals who enter training pathways to become physicians
• There are not enough URMIs that reach training in GME
• GME is more of a recipient of the product than a driver of the fountainhead of the pipeline
• Can we turn a dribble into a gusher?
Mentorship

• Critical for student and trainees to thrive and succeed
• Awareness of the unique considerations in mentoring across differences
• Provide sponsorship (opening doors, providing resources and opportunities)
• Increasing exposure & visibility
• Coaching

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ACGME Systematic Recruitment

- Multi-level
  - Impacts each element of the workforce
- Multifaceted
  - Will require showing different approaches to address each category in its workforce plan
  - Should address pipeline of candidates specifically
  - Opportunity to address interprofessional collaboration
ACGME Systematic Retention

- A compliant program should demonstrate adequate support and mentorship for all trainees
- Workforce plan should address the removal of barriers that impede successful advancement of trainees
- Must include descriptions of how the clinical learning environment addresses inclusion of diverse candidates
- Objective numerical outcomes will be used to assess success of retention efforts
Equity and Inclusion

- Environment/culture of inclusion
- Holistic review
- Implicit bias
Environment/culture of inclusion

- Inclusion as a series of institutional practices and cultural norms which promote a high sense of belongingness of individuals within organizations or institutions, while simultaneously recognizing and valuing individuals’ uniqueness

- Construct of **Equity** impacts heavily on inclusion
Resident experiences

- Describes black residents' perceptions of the impact of race on medical training
- Discrimination
- Differing expectations
- Social isolation
- Career consequences and coping styles

In the Minority: Black Physicians in Residency and Their Experiences

Jane M. Liebschutz, MD, MPH; Godwin O. Darko, MD, MPH; Erin P. Finley; Jeanne M. Cawse; Monica Bharad, MD; and Jay D. Orlander, MD, MPH
Washington, District of Columbia; Atlanta, Georgia; and Worcester, Boston and Jamaica Plain, Massachusetts

Financial support: Dr. Liebschutz was supported in part by the Robert Wood Johnson Foundation Generalist Faculty Scholar Award Program (RWJF #045452).

This work was presented at the Society of General Internal Medicine Annual Meeting, Boston, MA, May 2000.

Objective: To describe black residents' perceptions of the impact of race on medical training.

Materials and Methods: Open-ended interviews were conducted of black physicians in postgraduate year 2 who had graduated from U.S. medical schools and were enrolled in residency programs at one medical school. Using Grounded Theory tenets of qualitative research, data was culled for common themes through repeated readings; later participants commented on themes from earlier interviews.

© 2006. From the Section of General Internal Medicine (Liebschutz, Darko, Finley, Cawse, Orlander); Boston Medical Center (Liebschutz, Darko, Finley, Cawse, Bharad, Orlander); Boston University Schools of Medicine (Liebschutz, Darko, Finley, Cawse, Bharad, Orlander) and Public Health (Liebschutz); Health Care for Homeless (Bharad); and VA Boston HealthCare System, Boston, MA (Orlander); General Internal Medicine, Washington Hospital Center, Washington, DC (Darko); Department of Anthropology, Emory University, Atlanta, GA (Finley, doctoral student); University of Massachusetts School of Medicine, Worcester, MA (Cawse, medical student). Send correspondence and reprint requests for: Kathleen H. Goodale, MSW, GPR: 5669; 441-1448 to: Dr. Jane Liebschutz; Section of General Internal Medicine, Boston Medical Center, Boston University Schools of Medicine and Public Health, Boston, MA 02118; phone: (617) 414-7299; fax: (617) 414-4676; e-mail: jliebs@bu.edu

INTRODUCTION

Black students enter medical training at half the expected rate compared to their representation in the U.S. population, and have higher attrition rates from medical schools. The available literature...
Resident experiences

- Workplace experiences of black, Hispanic, and Native American resident physicians:
  - Daily barrage of microaggressions & bias
  - Tasked as race/ethnicity ambassadors
  - Challenges negotiating professional and personal identity while seen as “other”
Inclusion in the clinical learning environment

• Building inclusive spaces for dialogue
• Moving forward towards more inclusive learning environments
Holistic Review

Holistic Review considers the “whole” applicant.

Holistic Review refers to mission-aligned admissions or selection processes that take into consideration applicants’ experiences, attributes, and acumen as well as the role an applicant would contribute to creating a diverse and inclusive learning environment. Holistic Review allows admissions committees to consider “whole” applicants, rather than disproportionately focusing on only one aspect of an applicant’s background.

The core principles of holistic review are outlined below:

Core Principles

1. Applicant selection criteria are broad, clearly linked to school mission and goals, and promote numerous aspects of an applicant’s characteristics.
2. Selection criteria include experiences and attributes as well as academic performance. These criteria are:
   a. Used to assess applicants in light of their unique backgrounds and with the intent of creating a diverse and inclusive student body.
   b. Applied equally across the entire candidate pool.
   c. Supported by student performance data that show that certain experiences or characteristics are linked to student performance.
3. Schools consider each applicant’s potential contribution to both the school and the field of medicine, allowing them flexibility to weigh and balance the range of criteria needed to achieve their institutional mission and goals.
4. Race and ethnicity may be considered as factors when making admission-related decisions only when aligned with related educational interests and goals associated with student diversity and when considered as a broader mix of which may include personal attributes, experiential factors, demographics, or other considerations.

Additional resources:
- Activity 1: Applicant Criteria Identification and Prioritization (Excel)
- Overview of the Holistic Review Framework to SMF Selection

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https://www.aamc.org/services/member-capacity-building/holistic-review
Holistic review

- Flexible, individualized way of assessing an applicant’s capabilities
- Balanced consideration is given to experiences, attributes, competencies, and academic or scholarly metrics
- Applied equitably across the entire applicant pool
- Core Principles
  - Broad-based
  - Linked to institutional and program mission and goals
  - Promote diversity and inclusion as essential to excellence
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<td><strong>Definition:</strong> How do you define it?</td>
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**Assess:** What evidence will satisfy this requirement? Do my current recruitment and selection materials allow me to assess this criterion? What, if any, changes are needed?

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**Assess:** What evidence will satisfy this requirement? Do my current recruitment and selection materials allow me to assess this criterion? What, if any, changes are needed?
Implicit Bias

- Attitudes or stereotypes that affect our understanding, actions and decisions at an unconscious level
Implicit Bias

- Once learned, stereotypes and prejudices resist change
Implicit Association Test (IAT)

https://implicit.harvard.edu/implicit/takeatest.html
Implicit Association Test (IAT)

• “Dear Harvard People: There is no way that I prefer Martha Stewart over Oprah Winfrey. Please fix your tests. Sincerely, Frank.”
Unconscious Bias Resources for Health Professionals

At academic medical centers, unconscious biases can compromise diversity and inclusion efforts in admissions, curriculum development, counseling, and faculty advising, among other functions.

The AAMC provides resources and trainings to assist these institutions to meet their goals around addressing unconscious biases.

Addressing Implicit Bias in Virtual Interviews

The AAMC now provides a "Conducting Interviews During the Coronavirus Pandemic" resources page. This page also includes a webinar addressing implicit bias in virtual interviews. During this webinar, participants will receive an overview of unconscious bias, reflect upon how their own biases manifest, and receive guidance on how to recognize and mitigate their biases when conducting, reviewing, and scoring virtual or in-person interviews. This webinar is strongly recommended for anyone conducting interviews or evaluating interview responses.

Online Seminar: The Science of Unconscious Bias and What To Do About it in the Search and Recruitment Process

Bias in Virtual Recruitment

Being Conscious of Bias in Virtual Recruitment
Interview Do's and Don'ts

Dos and Don'ts for Conducting Interviews

**Do**
- Ask job-related questions.
- Use positive body language such as smiling and nodding occasionally.
- Refocus the applicant if he or she goes off track, by making a brief comment about the applicant’s remarks (such as, “OK”) and then firmly move back to the original question.
- Spend more time listening than talking.

**Don’t**
- Use negative body language such as raising an eyebrow, frowning, or using a harsh tone of voice.
- Give feedback to the applicant about his or her performance during the interview (such as, “Good” or “Great”).
- Ask judgmental, why, leading, or yes/no questions.

Things to Consider when Evaluating Interview Responses

**Dos and Don'ts**

**Do**
- Stay objective—focus on facts, not opinions.
- Focus on the applicant’s responses to the question.
- Focus on one question or dimension at a time.
- Focus on comparing applicants’ responses.

**Don’t**
- “Fill in” parts of the answer based on your own opinions.
- Judge an applicant based on anything other than their responses.
- Compare responses of one applicant with another.

- Did the candidate address all aspects of the interview question?
- Am I rating the interviewee based on his/her response to the interview question or other irrelevant information included in the person’s response?
- Is the length of response impacting my rating?
- Am I keeping the behavioral statements for the appropriate competency in mind or am I rating the interview based on my own perceptions?
- Have I rated the interviewee’s response solely based on his/her previous responses to influence my rating?
- Have I rated the interviewee on his/her actual responses or have I rated him/her compared to other interviewees?
Health Disparities

- Cultural competence
- Research/Quality improvement
Cultural Competency

• Healthcare delivery is only as good as the context in which it is delivered
• Cultural competency
  • Cultural awareness, knowledge, attitudes, and skills
• Culturally competent health promotion

Can Cultural Competency Reduce Racial And Ethnic Health Disparities? A Review And Conceptual Model

Cindy Brach
Irene Fraser
Agency for Healthcare Research and Quality

This article develops a conceptual model of cultural competency’s potential to reduce racial and ethnic health disparities, using the cultural competency and disparities literature to lay the foundation for the model and inform assessments of its validity. The authors identify nine major cultural competency techniques: interpreter services, recruitment and retention policies, training, coordinating with traditional healers, use of community health workers, culturally competent health promotion, including family/community members, immersion into another culture, and administrative and organizational accommodations. The conceptual model shows how these techniques could theoretically improve the ability of health systems and their clinicians to deliver appropriate services to diverse populations, thereby improving outcomes and reducing disparities. The authors conclude that while there is substantial research evidence to suggest that cultural competency should in fact work, health systems have little evidence about which cultural competency techniques are effective and less evidence on when and how to implement them properly.
Conclusion

• Racial and ethnic disparities in healthcare are persistent and unacceptable
• Lack of diversity in dermatology is worse than almost all other specialties
• Increasing diversity among healthcare workers is an essential step in closing the gap in healthcare disparities
• Through active participation in pipeline programs, mentorship, and efforts to reduce bias in our selection process, dermatologists can improve diversity in our specialty
Conclusion

https://paballet.org/deia-portal/
VIRTUAL DIVERSITY CHAMPION WORKSHOP

Be A Champion.

2020 Virtual Diversity Champion Workshop

September 25

Join other dermatology faculty champions virtually on Friday, September 25, from 2:00-7:00 p.m. CDT, to discuss dermatology diversity outreach programs and initiatives, exchange ideas, and share success stories.
Questions?