Diversity, Equity, Inclusion and Belonging in Dermatology

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KEYWORDS

• Diversity • Equity • Inclusion • Belonging • Healthcare • Dermatology

KEY POINTS

- Improving diversity, equity, inclusion, and belonging (DEIB) in deramtology leads to more accurate diagnoses; improved patient satisfaction, compliance, and outcomes; and overall decreased inequities in health and healthcare.
- To achieve a productive diverse workforce supportive and inclusive clinical and learning environments are required. The absence of emphasis on DEIB negatively impacts patients, practitioners, and the overall practice of dermatology.
- Efforts to address inequities require active implementation of equity practices and includive actions from specialty organizations and institutions that are responsible for education and care delivery.

INTRODUCTION

Diversity, equity, inclusion, and belonging (DEIB) are topics that are gaining much recognition in all specialties of medicine, especially in dermatology. The cause is multifactorial and is evident by a stark increase in DEIB literature, partially stemming from the social unrest in 2020 that occurred after the murder of George Floyd. It is also imperative to note that the stark health disparities *highlighted* in the United States during the height of the COVID-19 pandemic, coupled with the growing organizational interest, has started to recognize that efforts to address DEIB are not only needed—they are necessary. A marked increase in DEIB articles in PubMed supports this. In 2020, there were 193 articles on diversity, equity, and inclusion, and in 2021, this number more than doubled to 483. The literature highlights the both importance and the benefits of DEIB in medicine and health care. Most frequently cited benefits of increasing DEIB include producing more accurate diagnoses and improved patient satisfaction, increased patient compliance, publishing more articles with more citations, improved equipment to address health disparities, and an increase in the production and clinical studies that can benefit patients.[1,2]

Overview of the Relationship Among Diversity, Equity, Inclusion, and Belonging

Increasing diversity of the physician workforce has been a long-standing goal, which aims to have the composition of those rendering care be reflective of the composition of those cared for. This goal of parity of representation spans across categories of race and ethnicities, language preferences, abilities, geography, just to name a few indices of diversity. The long-term goal of establishing a diverse workforce is to be able to render better, culturally specific care resulting in better

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outcomes and decreased inequities in health and health care for patients.

However, focusing solely on increasing representation of diverse groups in medicine without creating supportive, inclusive clinical and learning environments, through the implementation of equity practices can be detrimental to members of the workforce and ultimately to patients. Equity, as described by Dr Camara Jones,[3] looks to optimize the workplace, for example, clinical and learning environments, for those in the workforce, for example, students, trainees, practicing physicians, staff and leaders. According to Dr Jones, in order to achieve this equity goal, the following are required:

- All persons and populations are valued equally,
- Historical and current injustices must be recognized and rectified, and
- Resources should be provided according to need.

Implementing practices that satisfy these aspects of equity learning and clinical environments serves to create an inclusive culture that actively honors and supports differing voices, talents, and experiences as being necessary contributors to excellence in the environment. The result for all individuals and groups within the workforce is a sense of belonging that allows all members of the workforce to present themselves authentically and subsequently perform maximally. Maximal performance in health care ultimately benefits the patient now that both quality of care and environmental safety are the positive downstream effects of ongoing development and implementation of meaningful and sustainable equity practices.

Wanting to belong is a basic human desire and some would argue that it is a necessity. It describes a feeling of being connected socially in a positive way to a group of others.[4–6] DEIB critically affect patients, physicians, clinicians, and the overall practice of medicine. Racism, microaggressions, and unconscious bias prevent some from feeling like they belong. This yearning to belong is a psychological need that improves well-being.[7] A positive well-being is necessary to serve our patients, who if marginalized, are also influenced negatively by the absence of emphasis on DEIB. We are all negatively influenced by social determinants of health and disparities, whether personally or indirectly.

Thus, DEIB efforts can be categorized into 3 main areas of impact: patients, practitioners, and the overall practice of dermatology (**Fig. 1**). These efforts to diversify the physician workforce in every specialty must be coupled with equity practices that yield inclusive health care and learning environments that lead to a culture of belonging, thereby optimizing access, patient safety, and quality of care rendered.

As these concepts are not mutually exclusive, efforts to address inequities in health and health care that have not considered this integrated approach have unsurprisingly fallen short as evidenced by persisting and disparate morbidity and mortality of diverse US populations.

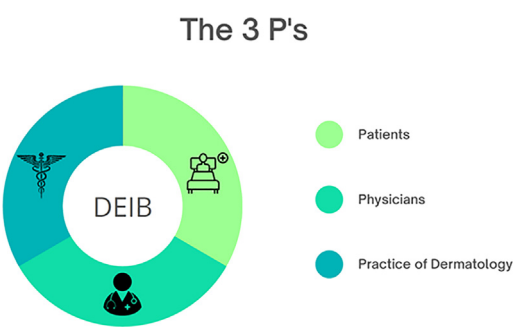

Fig. 1. Patients, Physicians, and the Practice of Dermatology (Medicine) can represent 3 categories of impact for efforts in diversity, equity, inclusion, and belonging.

Background

Inequities in access and delivery of care due to structural and systemic racism and the resulting social and legal determinants of health continue to result in disparities in health and health care primarily for historically and currently marginalized populations in the United States. In 2002, Unequal Treatment published by the Institute of Medicine cited that in every chronic disease category, Black Americans suffered disproportionately greater than White Americans. Specifically, racial and ethnic differences in health care, not otherwise attributable to known factors such as access to care, were consistently found across a wide range of disease areas and clinical services. Even when clinical factors, such as stage of disease presentation, comorbidities, age, and severity of disease are considered, disparities between black and White patients persisted irrespective of the clinical settings in which care was rendered, including public and private hospitals, teaching and nonteaching hospitals, and so forth.[8] Ultimately, the literature shows that disparities in care are associated with higher mortality among minorities.[9,10]

Studies demonstrate that people of color do not have optimal access to medical screenings, interventions, and are at risk for surgical

complications.[11] Black patients are 30% less likely to receive revascularization during coronary angioplasty and 40% less likely to receive coronary bypass surgery. Black women are 40% more likely to die from breast cancer than their White counterparts. Black and Hispanic youth are more likely to die from diabetes complications.[1] In fact, the adverse effect on patients remains no matter where they are engaging with our current medical system. Lack of health equity is prevalent in access to medical screenings, rates of surgical complications, and even treatment in the hospital.[1,11]

There are also several examples within dermatology highlighting the disparities in health outcomes among patients of color. In one study by Barbieri and colleagues, almost 30,000 patients were examined for associations between patient demographic and socioeconomic characteristics with the health care utilization and acne treatment during 1 year of follow-up.[12] The findings revealed that although non-Hispanic Black patients were more likely to be seen by a dermatologist (odds ratio 1.20, 95% CI 1.09–1.31) than non-Hispanic White patients, they received fewer prescriptions for acne medications (Incidence Rate Ratio 0.89, 95% CI 0.84–0.95).[12] In addition, Black patients were more likely to receive topical retinoids and topical antibiotics compared with oral antibiotics, spironolactone, and isotretinoin.[12] Similar disparities are seen with management of psoriasis in Black patients. Retrospective review of diagnosis confirmed psoriasis patients at 4 institutions revealed that psoriatic skin disease was more severe in Black patients compared with White patients (Psoriasis Area and Severity Index 8.4 vs 5.5) with greater psychological impact and impaired quality of life. However, use of biological therapies was greater in White patients than Black patients (42.2% vs 13.3%).[13] A similar phenomenon is noted in the pediatric dermatology population.[14]

A systematic review of racial, ethnic, and socioeconomic health disparities showed increased risk of impaired access to dermatologic care, more severe atopic dermatitis, ineffective sun protection education, and advanced stage of skin cancer at diagnosis.[14] As an example, the review showed Black and Hispanic children are less likely to see providers, have more severe disease, more persistent disease, greater school absenteeism, and more likely to need multiple visits for good disease control.[14] Medicaid insurance increases the likelihood of emergency department usage and reduces access to dermatologists, who often do not accept Medicaid insurance. There are more comorbidities in non-White patients.[14] There are also ongoing racial disparities in melanoma. Qian and colleagues analyzed 381,035 patients from the SEER registry.

Racial disparity worsened from before the year 2000 to 2010 or later for Hispanic ($P < .001$), non-Hispanic Blacks ($P = .024$), and non-Hispanic Asian Pacific Islanders ($P < .001$) patients.[15] Across all minority groups, patients with localized disease suffered increasing disparity. Of those with regional and distant disease, Hispanic patients experienced worsening disparity.[15]

In addition, the effects of structural and systemic racism are evident in medical education at all levels, as well. In 2016, researchers at the University of Virginia investigated the beliefs and knowledge of their students and residents based on race.[16] In this study, 222 White medical students from the University of Virginia were asked to read made-up cases; one about a black patient and the other about a White patient and then rate their perceived pain on a scale from 1 to 10. These students were then asked to evaluate 15 “facts” regarding biological differences between the races. All but 4 of the facts were fake. The actual facts were that black patients were more at risk for heart disease and stroke, had higher bone densities than Whites, and were less at risk for spinal cord diseases. The researchers made up facts, which included Blacks’ nerve endings are less sensitive than Whites’ and Blacks’ skin is thicker than Whites’. Fifty percent of the students thought that at least 1 of the fake statements was “possibly, probably, or definitely true.” Those who believed the fake facts were more likely to show a “racial bias” in how they assessed *and* treated the pain of the White and Black patients. A hundred and six non-White students had no correlation. Moreover, the initial results showed that 40% of participants held thoughts that black patients’ skin was thicker than that of White patients. After an educational intervention that addressed these same points was implemented, 25% of participants continued to answer these questions incorrectly. The clinical implications resulting from lack of knowledge or right held thoughts belie studies, which reveal that Blacks and Latino receive:

- Less pain medication,
- Fewer and later referrals for specialty oncologic care, and
- Fewer elective operative procedures.

The medical student-based study results of perceived differences black and white skin, uniquely, applies dermatology. The basis for the study of skin disease is visual and has been historically described and depicted on white skin, thus

Table 1
Patients

Culture of Belonging Scenario	Culture of Belonging Response Option 1	Response Option 2
A patient of different skin tone, race, ethnicity, or hair texture from the physician enters the room. Patient stares skeptically at the physician during the introduction	After introducing themselves, the physician states, "I know that there is a perception that because I am [insert race here] I am not equipped to handle your concerns. I can assure you that I have been trained on your skin type. I look forward to working together. How do you feel about that?" Patient thanks the physician for opening the visit with that acknowledgment. The patient leaves the visit satisfied, feeling valued, and listened to with a deeper knowledge of their skin condition and with appreciation for their dermatologist. They look forward to following up with this same provider	Approaching visits with cultural humility is the foundation for patient belonging. Although obtaining information for the history of present illness, the questions asked demonstrate the physician's insights into the patient's personal experience with darker skin tones or naturally tightly coiled hair. In absence of this knowledge, as a premise of cultural humility, physician creates atmosphere of unintentional harm. Offering options for treatments—variety of vehicles and frequencies that fit with patient preferences[22]
Culture of Belonging Scenario	**Not Culture of Belonging Response Option 1**	**Response Option 2**
Patient of different skin tone, race, ethnicity, or hair texture from the physician enters the room. Patient stares skeptically at the physician during the introduction	After introducing themselves, the physician notices the patient skeptically looking at them. The physician proceeds with the examination, offers a diagnosis, and ends the visit. Patient asks the provider if they are sure of the diagnosis based on their race and skin complexion. Provider responds that they have had the proper training and race does not influence the current diagnosis The patient leaves the visit unsatisfied, feeling disregarded and unlistened to, with no understanding of their skin condition. They decide to change providers	In a study by Gorbatenko-Roth, patients reported a dermatologist *who does not engage in the physical examination*[20] When examining of the hair of a patient with tightly coiled hair, approaching with cultural humility is advised.[22] Additionally, patient–dermatologist racial concordance was preferred but not necessary for a positive patient experience[20] Creating a culture of belonging would allow dermatologists of all races and ethnicities to acknowledge that there are perceived biases around race, which is a social construct. However, these biases are not concrete and can be changed

Table description: As you can see in the scenarios above, a culture of belonging focuses on creating an environment where practitioners and patients have the ability to freely discuss these issues and create a solution together to move forward. The principals from the above scenario can be applied to racially discordant patients and overall interactions with all patients. Ultimately, the ultimate goal of the interaction would be to advance and strengthen the patient–physician relationship.

perpetuating health inequities before a diagnosis is even made. This limited provision of diverse representation of the appearance of pathologic condition on black and brown skin serves to disadvantage skin specialists and ultimately negatively affects the subsequent care delivered to delay or failure to diagnose disease. In dermatology, there is a significant and well-documented lack of training in skin of color in both textbooks and online resources. This disparity in medical education adversely affects dermatologist practitioners and patients. If dermatology is now only increasing the skin of color learning opportunities, we can only predict that other specialties lag behind, as well. With 7% of all primary care visits having a dermatologic focus,[17] physicians and practitioners who are exposed to fewer skin of color examples results in less opportunity to develop the crucial skill of pattern recognition. Patients are adversely affected because the provider may not have had exposure to the specific condition seen in the patient's skin tone. This could result in delayed, missed, and even misdiagnosis.[18] Combined with the difficulty marginalized communities face accessing dermatologists, patients of color are greatly impacted by the paucity of skin of color specific training across specialties.[19]

Research shows that Black patients seen by a dermatologist trained in skin of color report increased satisfaction compared with prior experiences. The improvement in satisfaction is linked to

Table 2
Physicians

Culture of Belonging Scenario	Culture of Belonging Response Option 1	Response Option 2
A resident is experiencing symptoms of burnout. They have fallen behind on their notes, have not been appropriately answering consults, and have been arriving to work late	The program director is aware of the incidents with the resident. They set up a meeting with them to discuss efficiency, dealing with life stressors, and offer to pair them with a senior resident for a few shifts to observe their workflow. After a few weeks of working with the senior resident and weekly meetings with the program director, the resident has been more efficient at work, offering timely consults, and arriving to work on time	According to Youmans et al,[23] building an inclusive environment that focuses on belonging for all can help increase recruitment and retention, decrease isolation, and lack of belonging for underrepresented in medicine trainees[23]
Culture of Belonging Scenario	**Not Culture of Belonging Response Option 1**	**Response Option 2**
A resident is experiencing symptoms of burnout. They have fallen behind on their notes, have not been appropriately answering consults, and have been arriving to work late	The fellow residents of the resident who is falling behind, talk behind their back about their slack and need to "pick up the pace." They discuss the resident issues with the program director who keeps the complaints in a file. At the end of the year, the resident is told that they need a year of remediation if they wish to continue with the program	According to Shanefelt, dermatology has the highest increase in the prevalence of burnout, increasing from 37% in 2011 to 57% in 2014. [24] Burnout is not limited to practicing physicians but affects trainees as well. The 2 most contributing factors to burnout were autonomy and appropriate work–life balance[25]

Table description: Creating an environment that focuses on belonging would provide ways for burnout in physicians, trainees, and students to be identified and then mitigated appropriately. Possible solutions are not widely applicable to all solutions but require an intense focus on individual needs.

several factors including practitioner knowledge about black skin and hair and a culturally sensitive interaction style. It is imperative to mention that patient–dermatologist racial concordance was preferred but not necessary for a positive patient experience.[20] Creating a culture of belonging would allow dermatologists of all races and ethnicities to acknowledge that there are perceived biases around race, which is a social construct. However, these biases are not concrete and can be changed. A physician workforce with such beliefs will only continue to deliver inequitable care unless the foundation of medical education actively works to address medical educational curricula in all specialties.

In dermatology, a lack of diversity, equity, and inclusion is present at several levels including

Table 3
Practice of dermatology

Culture of Belonging Scenario	Culture of Belonging Response Option 1	Response Option 2
A survey is conducted that asks medical trainees to identify melanoma on darker skin. More than 50% of participants miss the diagnosis of melanoma on non-White/darker skin	After getting the results of the survey, the program director of the residency adds images on skin of color for commonly missed diagnosis in darker skin. Images are also added for the most common dermatology images on darker skin. By the end of the residency, training residents feel adequately prepared to both diagnose and treat diseases on skin of color individuals	The misdiagnosis of melanoma should not be the only focus on education. In fact, this diagnosis can be used to discuss health disparities in dermatology. According to Youmans, creating safe and open spaces for dialog is essential for building inclusive environments.[23] By creating open dialog, leaders can provide spaces for trainees to reflect on formative parts of their identity. In this way, trainees from all backgrounds can grow in safe spaces in an open and inclusive environment[23]
Culture of Belonging Scenario	**Not Culture of Belonging Response Option 1**	**Response Option 2**
A survey is conducted that asks medical trainees to identify melanoma on darker skin. More than 50% of participants miss the diagnosis of melanoma on non-White/darker skin	After getting the results of the survey, the program director of the residency decides that the survey was not an adequate representation of the training that residents received. They decide not to create any specific educational objectives and thought that the patient population is diverse enough to provide the needed number for sufficient pattern recognition. At the end of residency, the trainees feel indifferent in their ability to diagnose and treat diseases on skin of color individuals	According to Buster, although melanoma is more common in non-Hispanic Whites and individuals with high SES, Blacks and those with low SES present with more clinically advanced disease or suffer from increased mortality. In order to create a culture of belonging in dermatology, there must be advances in screening and detection that allow those with a lesser incidence of melanoma to be adequately detected[19]

Table description: Creating an inclusive environment that emphasizes belonging for all requires intentionality. In order to foster the space for belonging our current systems must be open to creating systems that provide space for all to be seen and resources for all members to be adequately accessed.

Fig. 2. Those in leadership roles at specialty, institutional, and departmental levels have the opportunity to implement and be accountable for affecting structural and systemic changes in DEIB at the policy, practice, and ultimately the cultural environment (clinical and learning) levels.

recruitment, residency retention, faculty development, dermatology workforce, and beyond.[21]

Addressing Inequities

Efforts to address inequities require the active implementation of equity practices and inclusive actions from specialty organizations and institutions responsible for education and care delivery, which starts with individual commitments from leaders, faculty, staff, trainees, and students. These efforts are only capable in driving transformational change if coupled with institutional/organizational, as well as individual accountability.

The goal of creating a medical environment that recognizes diversity, equity, and inclusion is to create a culture of belonging for both patients and practitioners. By creating a culture of belonging, we will then be able to improve our practice of medicine.

DEI efforts abound, belonging is, however, the missing piece. For learners and practicing physicians in medicine, the sense of belonging could be replaced by feelings of isolation. We fear that, with increased DEI efforts, doing the work to succeed will result only in a shift in numbers but leave that majority still feeling isolated. Dermatology is among the least diverse specialties.

Only a minority of the members of the dermatology workforce identify as racial and ethnic minorities, and/or sexual and gender minorities.

Table 4
Recommendations for accountability measures for leadership at all levels

Levels of Accountability for DEI and Belonging	Specialty	Hospital Systems/ Institution	Physicians in Training and in Practice—(Academic and Nonhospital Based)
Policies	Beyond written statements alone, leadership commitment from specialty associations and board certifying bodies should be reflected in strategic planning and resource allocation in budgeting Hold board of directors members accountable for operationalizing DEIB efforts at all levels	Ensure that system and institutional DEI commitments are verbalized and represented throughout one's campus Confidential feedback mechanisms for patients and healthcare workforce should be implemented	Listen, inquire, and advocate for policies promoting equity practices, eg, parity in representation and pay equity
Practices	Implement standardized demographic data collections to determine recruitment, retention/attrition	Bias response strategies should be planned, rehearsed, and socialized enterprise-wide	Commit to engaging all individuals, especially those from diverse backgrounds

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Table 4
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Levels of Accountability for DEI and Belonging	Specialty	Hospital Systems/ Institution	Physicians in Training and in Practice—(Academic and Nonhospital Based)
Culture/Environment	Perform environmental/ culture assessments at the undergraduate medical education, graduate medical education, and continuing medical education levels to measure impact of DEI efforts	Espouse core values prioritizing the creation safe, equitable, and inclusive learning and clinical environments for workforce and patients	Reject cultural norms that promote competition and mistrust. Instead invest in cultural humility, and collegial accountability with support

Diversity, equity, inclusion, and belonging are important topics that affect patients, providers, and the overall practice of medicine. By creating an inclusive culture that is reflective of DEI, we aim to cultivate an environment that can help improve patient outcomes, access to health care, decrease burnout in providers, and provide a space for everyone to feel valued, seen, and ultimately provide a space for everyone to belong.

The task of DEI and fostering belonging must be comprehensive. From approaching patients and colleagues with cultural humility to harnessing the power of dermatology organizations, this has to be a united leadership priority. By creating an inclusive culture that is truly reflective of DEIB, physicians and the health-care workforce must become educated and be trained on with the requisite skills to the aim is to cultivate an environment that helps to improve patient outcomes, access to health care, decrease burnout among health-care team members, and provide a space for everyone to feel valued, seen, and ultimately provide a space for everyone to belong.

Case-Scenarios in Addressing Inequities

The following case scenarios are examples of lived experiences that are evident in patients (**Table 1**), physicians (**Table 2**), and the practice of dermatology (**Table 3**). Along with each scenario are suggested approaches to address the described inequalities.

SUMMARY

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. This will require a paradigm shift likened to the reverse ideation approach, which will require that leadership at the specialty, institutional, and physician levels be held responsible and accountable for the culture shift necessary to create safe equitable and inclusive environments for the health-care workforce such that better quality of care can be rendered to all patients. 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. The onus and accountability must rest on the shoulders of the entities that have both the willingness and authority to allocate resources, set strategic direction and institute attainable metrics that leadership at the levels of the board of directors of specialty associations, hospital systems, and academic institutions must be held liable for through frequent and transparent communication of impact and outcomes (**Fig. 2**).

The following are recommendations for accountability measures for leadership at all levels for those seeking to achieve a culture of belonging in all aspects of medicine (**Table 4**).

CLINICS CARE POINTS

- Review of diversity evidenced-based research specific to healthcare revealed positive associations between diversity, care quality, and financial performance.
- Surveys of minority dermatology patients reveal patients prefer race concordant dermatologists alluding to the necessity of diversifying the dermatology workforce and strengthening of cultural competency in training to offset the adverse effects.
- Dermatologic disparities which need to be addressed have been identified in studies examining outcomes in patients of color with acne, psoriasis, atopic dermatitis, and melanoma.
- To establish a fruitful diverse workforce a sense of belonging is required. Social belonging exerpiments data have demonstrated increased well-being, improved academic performance, and health outcomes for the participants..

DISCLOSURE

The authors have nothing to disclose.

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