Position Statement
on
Dermatology Workforce Diversity and Health Disparities
(Approved by the Board of Directors: 11/6/2021)

Health disparities in medicine exist and are associated with worse health outcomes.[1] Health disparities occur in the context of broader inequities which may be influenced by various patient characteristics, including race/ethnicity, sexual orientation, gender identity, income, education, disability status, religion, and geography. In this document, the American Academy of Dermatology affirms its commitment to eliminating health inequities and increasing access to care led by dermatologists, who are Fellows of the American Academy of Dermatology (FAAD dermatologist(s)), for all underserved communities.

In the United States, racial/ethnic minorities consistently experience higher rates of morbidity and mortality when compared to non-minorities, even when accounting for factors known to contribute to health disparities.[1-4] This problem will become increasingly relevant as the racial and ethnic composition of the US population becomes increasingly diverse. Racial/ethnic health disparities, in particular, occur in the context of broader current and historic social and economic inequities and involve contributing factors such as bias, discrimination, and systemic racism at the individual, institutional and broader healthcare system.[1] In addition, the social and cultural discrimination faced by sexual and gender minority (SGM) individuals is perpetuated by inadequate access to high-quality, sensitive, and respectful healthcare.[5] FAAD dermatologists must be able to care for all patients, without structural or institutional barriers. This underscores the importance of diversifying the dermatology workforce, providing culturally competent care, reducing bias in the healthcare setting, and ensuring ethical and inclusive research.[6-9]

Understanding the underlying cause of health disparities should be grounded in an evidence-based and data-driven approach that explores the contributing role of structural inequities as determinants of health.[10-11] Interventions to eliminate health disparities must be comprehensive and integrated into the education of FAAD dermatologists and our trainees. Educational training on important concepts including cultural competence, implicit bias, structural competence, and health disparities is important in bridging sociocultural differences between patients and FAAD dermatologists. [1]

In an effort to further fulfill the American Academy of Dermatology's commitment to increasing dermatologic services to underserved populations and foster dermatology workforce diversity; and in accordance with AAD's core values of patient-centered medicine and visionary leadership,[12] the following positions are recognized by the American Academy of Dermatology:

Recognition and collaboration: The AAD strongly opposes all forms of bias and discrimination based upon an individual's identity group (including but not limited to race, ethnicity, gender, sexual orientation, gender identity, national origin, religion, disability, age, socioeconomic status, education, marital status, language, geography, immigration status, etc.) and endorse sound policies and initiatives designed to ensure nondiscrimination. We acknowledge that racism and discrimination in its systemic, structural, institutional, and interpersonal form is an urgent threat to public health, the advancement of health equity, and is a barrier to excellence in the provision of dermatologic care. We support elevating physician awareness of social determinants of health, health disparities, and cultural differences that may impact the provision of care.

Caring for marginalized patients and communities: The AAD strongly advocates for improved access to care led by FAAD dermatologists for marginalized and underserved communities and the delivery of high quality, comprehensive, and equitable care. We recognize that health disparities result from many factors, including inequitable access to and delivery of quality dermatologic care.[13] We acknowledge that being uninsured or underinsured may limit access to dermatologic care and commit to supporting policy that improve access to FAAD dermatologist-led care for these patients. We commit to actively working to combat racist and discriminatory policies and practices in the healthcare system and dermatology and

commit to encouraging a sense of professional responsibility to reduce health disparities. We advocate for and support policies that allow FAAD dermatologists across practice settings to deliver care to all patients who suffer from skin disease and need care.

Research, scholarship and publication: The AAD recognizes that an intentional and concerted effort is needed to ensure that research, scholarship and publication ethically addresses, measures, and promotes health equity. We recognize that race is not a reliable proxy for genetic differences and that clinicians, educators and researchers should focus on genetics and biology, and social determinants of health when describing risk factors for disease.[11] We support research, data collection, and evidence-based performance measures that promote equity in care and impact social determinants of health to identify and reduce health disparities within dermatology. We support efforts to develop and increase scientific research of dermatology disorders that occur disproportionately in racially and ethnically diverse groups.

Diverse and inclusive excellence: The AAD strives for inclusive excellence and supports measures to diversify the FAAD dermatologist workforce and organizational leadership. We support pipeline efforts to enhance diversity among FAAD dermatologists through programs that support, prepare, and motivate members from groups underrepresented in medicine throughout all levels of training and integration of best practices for the sustainability and success of healthcare career pipeline programs.[13] Further, use of holistic assessments of residency applicants allows for a flexible and individualized way of assessing an applicant's capabilities and gives equal consideration of experiences, attributes, competencies, and academic scholarly metrics. We are committed to accelerating diversity, equity, and inclusion initiatives to prepare the current and future FAAD dermatologist-led workforce to adequately care for an increasingly diverse U.S. population through increased representation of skin of color topics and clinical images, and inclusion of topics on cultural competence, structural competence and health disparities. We actively support the promotion of leadership and faculty development of underrepresented minority physicians in dermatology.

Policy and advocacy: The AADA actively supports sound health care policy that seeks to eliminate inequities in the delivery of health care and in health outcomes. The AADA will also, in collaboration with other physician organizations and relevant stakeholders, consider supporting policies addressing systemic and institutional inequities outside of health care that lead to poor health outcomes, as appropriate.

Relevant definitions:

1. Health disparities: differences in the quality of healthcare that are not due to access-related factors or clinical needs, preferences, and appropriateness of intervention
2. Racial and ethnic minority groups: Five categories for racial groups (American Indian or Alaska Native, Asian, Black or African American, Native Hawaiian or other Pacific Islander, and White), and two categories for ethnic groups (Hispanic or Latino and Not Hispanic or Latino)
3. Social determinants of health: Social determinants of health are the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks
4. Structural competence: The ability of health care professionals to appreciate how symptoms, clinical problems, diseases, and attitudes toward patients, populations, and health systems are influenced by social determinants of health
5. Health equity: Optimal health for all
6. Cultural competence: The ability of providers and organizations to effectively deliver health care services that meet the social, cultural, and linguistic needs of patients

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