Medical practice today is marred by a lack of workforce diversity, and the problem shows no signs of improving. Race demographics of US medical school applicants and matriculants fail to reflect the general population, with significant underrepresentation of racial minorities. Analysis shows the underrepresentation of black and Hispanic individuals has increased in most specialties and reveals that underrepresentation is more significant now than in 1990 across all ranks and specialties analyzed (except for black women in obstetrics and gynecology).

While dermatology has made strides in terms of representation of women in the specialty (though work remains to be done), there remains an underrepresentation of physicians of color in the specialty. Underrepresentation of people of color in medical school and medical practice is a legacy of overt racial discrimination in the US, which persists, as well as more covert discrimination that is seen today. Additionally, there is lingering influence of institutional racism and implicit racial bias.

Lack of racial and ethnic diversity in the physician workforce is of concern for several reasons. Underrepresentation of racial and ethnic backgrounds in the medical community means that the insights and rich experience of persons of color are not proportionately influencing the practice of medicine and contributing to the innovation and advancement needed to improve patient care. Additionally, there is evidence that patient care may suffer as a direct consequence of lack of diversity in the medical community. Finally, racial inequity is an injustice that warrants correction.

RACIAL DISPARITIES IN MEDICINE

Racial and ethnic minorities are under-represented in the US workforce in general. The Bureau of Labor Statistics (BLS) shows the unemployment rate for black men and women in 2017 was nearly double the rate for white men and women, at 7.5 and 3.8 percent, respectively. The disparity improved slightly in 2018, when the unemployment rate for whites was 3.5 percent, compared to 6.5 percent for blacks.

The latest data from the BLS show that whites and Asians have similar, relatively high levels of representation in management and professional careers while black and Hispanic individuals have notably lower levels of representation. Among white and Asian men, 17.4 percent and 16.9 percent, respectively, are in management, business, and financial operations occupations, while among white and Asian women, representation is 14.7 and 15.4 percent, respectively. Among black men and Hispanic or Latino men, 9.7 percent, and 7.7 percent are in management, respectively, compared to 11.2 percent and 8.9 percent of black or Hispanic or Latino women, respectively.

For professional and related occupations, 17.6 and 27.6 percent of white men and women, respectively, are in such roles, compared to 32.3 percent and 29 percent of Asian men and women, respectively. Contrast this to 13.8 and 22.9 percent of black men and women, respectively, in professional occupations, and 7.9 percent and 16.3 percent of Hispanic or Latino men and women, respectively.

Among professional occupations, medicine has a particularly low level of representation of racial and ethnic minorities. Data from the Association of American Medical Colleges (AAMC) show that blacks, who comprise approximately 13 percent of the US population, account for only four percent of physicians and less than seven percent of recent medical school graduates. This may be a direct consequence of the substantially lower acceptance rate for African American or black medical school applicants. The 2015 medical school acceptance rate was 41.1 percent overall. White (44
percent), Asian (42 percent), and Hispanic or Latino (42 percent) applicants had similar rates of acceptance in line with this benchmark. However, the acceptance rate for African American or black applicants was just 34 percent.

Percentages of medical school graduates by race and ethnicity have remained consistent, with whites (58.8 percent) and Asians (19.8 percent) representing the largest proportion of medical school graduates. Black or African American and Hispanic or Latino students account for just 5.7 percent and 4.6 percent of medical school graduates, respectively.

Once students are accepted into medical school, they may continue to face bias and discrimination. Data suggest that student members of underrepresented minorities may be more likely to receive lower grades and assessments than their white counterparts.3,4 There is some evidence that membership in the prestigious Alpha Omega Alpha Medical honor society may be racially inequitable, as research shows that white medical students are twice as likely as Asian students and six-times as likely as black students to be accepted.5

When medical students were asked about their interest in specialty practice, there were no significant differences among whites, blacks, Hispanics, Asians or other racial groups in trends toward Family medicine, internal medicine, pediatrics, or other. However, slightly higher proportions of black (70.6 percent) and Hispanic (67.6 percent) students indicated interest in medical specialties, relative to white students (66.4 percent) (AACC).

Yet, dermatology—arguably among the most competitive specialties today—is not drawing significant residency applicants from underrepresented minority groups. Of 739 dermatology applicants for 2018/2019, 53 were black or African American (seven percent of applicants to dermatology) and 43 were Hispanic or Latino (5.8 percent of applicants); 50 were of multiple race/ethnicity.

An evaluation of 2015 data shows similar trends. While Hispanic or Latino individuals made up six percent of total residency applicants, they accounted for just three percent of dermatology residency applicants that year. Black/African American applicants accounted for eight percent of total residency applicants in 2015, but just seven percent of dermatology applicants. Dermatology ranked 35 (out of 46 programs) in terms of attracting a diverse applicant pool. For the same year, 4.2 percent of practicing dermatologists self-identified as Hispanic and three percent of practicing dermatologists self-identified as black or African American.6

**IMPLICATIONS FOR PATIENT CARE**

It should be noted that research on the impact of racial concordance between patients and physicians is inconclusive. Widely differing methodologies and endpoints in studies make it difficult to compare findings. However, the trends in the data suggest that there is a benefit. Put simply: patients may have better healthcare outcomes when they are treated by physicians who look like them.

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**A Note on Women**

As a black woman physician, I am sensitive to the problems of both racial and sexual underrepresentation in medicine. The focus of this article is broadly on race, but it is important to acknowledge the substantial challenges still facing women—and especially women of color—in medicine. The January edition of *Practical Dermatology* covered the role of women in dermatology, and I contributed commentary to that edition. I encourage readers to visit pracderm.com/Jan19 for more.

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**US Labor Force by Race and Sex**

The caveat is that all physicians treating all patients must be racially, ethnically, and religiously sensitive. That way, good healthcare outcomes are available to all patients. In a very unfortunate case out of Tennessee in 2017 a Caucasian doctor who was training a Caucasian physician assistant reportedly greeted his return visit African American patient by saying, “Hi, Aunt Jemima…” He repeatedly called the patient Aunt Jemima. The shocked patient is reportedly suing the physician.

I would submit that somebody like that should not see a diverse patient population until s/he undergoes racial sensitivity training. Researchers have identified that perceived personal similarity is associated with higher ratings of trust, satisfaction, and intention to adhere to a care plan. (Race concordance is the primary but not sole predictor of perceived similarity; physicians’ use of patient-centered communication is another key factor.) When provided with a choice, patients are more likely to have a physician of the same race/ethnicity. Compared to patients whose regular doctors are of a different race, patients who are of the same racial or ethnic group as their physicians were found to be more likely to use needed health services; were less likely to postpone or delay seeking care; and reported higher volume use of health services, compared to patients with doctors of a different race. This is especially true among white and African American patients. Patient-provider gender concordance positively affected cancer screening overall, but patient-provider ethnic concordance was inversely associated with cancer screening among Hispanics.

Racial concordance could positively influence patient/physician communication. Research shows that black patients consistently experienced poorer communication quality and information-giving and had less participation and contribution to decision-making than white patients, overall. Racial concordance, however, was associated with better communication across multiple domains.

Gender and race concordance between doctors and patients is associated with reduced mortality in the hospital setting. It is interesting to note that patients in an unmatched sample who were treated by female physicians were more likely to survive, regardless of patient gender; female patients treated by male physicians were least likely to survive a given episode of in-hospital care.

America continues to grapple with challenges to patient access to care, and trends suggest that members of racial

Obagi has launched a campaign called Skinclusion, as the company is interested in improving diversity in the cosmeceuticals and pharma arenas. (Disclosure: I am involved with the program and serve as a panelist, and I applaud their efforts.) As part of the program, the company has provided free access to a tool for assessing implicit bias. I recommend that everyone go to skinclusion.com to take the implicit bias test to see what their biases are. If you don’t know what you are biased against, you cannot address it and be so informed. I know that I have a bias against individuals who smoke—a group not readily identified even by the implicit bias test. Therefore, I make a conscious effort to be patient and modulate my tone when I am talking about how bad smoking/vaping is for my patients.

Blacks and Hispanics comprise 13% and 18%, respectively, of the US population. But they are under-represented in dermatology practice (left, data for 2015) and dermatology residency applications (right, data for 2018/19, AACM).
and ethnic minorities may be more attuned to the needs of underserved populations. Whereas 22.5 percent of white medical school matriculants expressed interest in practicing in underserved areas, the rates among American Indian/Alaska natives, Asians, blacks/African Americans, Hispanic/Latinos, and Native Hawaiian/Pacifica Islanders, were 37 percent, 22.5 percent, 51.1 percent, 39.2 percent, and 34.2 percent, respectively. Attracting and graduating more students of color could lead to a more robust work force for underserved areas.

MAKING CHANGE

The absence of black males in medical school represents an “American crisis that threatens efforts to effectively address health disparities and excellence in clinical care,” according to Smith et al. The crisis extends to lack of representation of males and females of all underrepresented minorities. Clearly, change is necessary to increase diversity in the US physician workforce in general and in dermatology, specifically. Positive change is possible through several key steps.

Acknowledgement. The notable mismatch between the racial/ethnic make-up of the US population overall and the medical student/physician workforce is a clear indication of need for change. The factors contributing to underrepresentation are numerous and complex, and the consequences of a lack of diversity are substantial. These factors must be addressed and cannot be ignored.

It must also be noted—though beyond the scope of this conversation—that there is also a lack of diversity in medical research, including in skin of color, that also must be addressed. Hopefully, increased diversity in medical practice will lead to increased diversity in medical research.

Mentorship. The AMA recently identified increasing workforce diversity as a key goal and continues to support its Accelerating Change in Medical Education Consortium. In announcing its commitment to increased diversity, AMA cited the work of consortium member Morehouse College of Medicine, which has established an extensive pipeline of programs with local colleges to provide mentoring support from current students and alumni. Programs designed to mentor and cultivate interest in medicine among underrepresented minority students as early as high school have shown promise.

Researchers have concluded that pipeline programs for medical schools are necessary to maintain a diverse applicant pool.

Holistic Review. Vick et al. explore the potentially positive impact of “holistic review” on improved representation of minority groups in medical education, calling it “a flexible, individualized way of assessing an applicant’s capabilities by which balanced consideration is made on how the individual might contribute value as a medical student and physician.”

The sad reality is that members of underrepresented minorities in the US may disproportionately lack the educational opportunities, the support and mentorship, and the opportunities for advancement that non-minority students do. This may negatively reflect in traditional measures of success and achievement that lead to the exclusion of these students from advanced education.

Realistic expectations. Finally, as medical schools and medical specialties focus on outreach and mentorship and increasing diversity, care must be taken not to misrepresent the goals of a more inclusive physician force. Patient/physician racial concordance can have benefits, and the inclusion of more persons of color in the delivery of medical care should ultimately improve the care of patients overall. However, this is not to say that members of underrepresented minorities should face “deterministic expectations” to provide care to minority populations.

These are just a few broad steps that may be taken to help steer the medical community in the right direction. On an individual level, each of us as dermatologists can participate in mentorship and activism to increase interest in dermatology as a medical specialty for black and Hispanic medical students and to improve the experiences of patients of color.

Dr. Downie is founder and director of Image Dermatology in Montclair, NJ. She is on staff at Mountainside and Overlook Hospitals.