Insuring the Future of Dermatology: Race and Ethnicity Matter

Bruce Wintroub, MD
Chair of Dermatology and Vice Dean
UCSF School of Medicine
MY MESSAGE

• A professional workforce that is as diverse as the population will improve the health of those we serve.

• To achieve quality healthcare for all, we must address inequality and healthcare disparities.

• The strongest predictor of health status is the color of that persons skin.
  • Minority patients receive less pain medication for fractures
  • White women are more likely to have breast cancer but people of color are 40% more likely to die from the disease
  • African American patients with psoriasis are less likely to receive biologic therapies
AGENDA

• My story
• Race Matters at UCSF
• Race, ethnicity and the dermatology workforce
• The pipeline
  • What can WE do?
  • Dermatology departments
  • Dermatologists
  • Organized dermatology
  • Medical Schools
  • Colleges and Universities
In 2013, 13.2% of Americans were African American and 17.1% were Latino Americans.

Because these populations (and others) are not represented in medicine at anything close to these percentages, African Americans, Latinos and other racial and ethnic groups are referred to as underrepresented in medicine (UIM).

3.5% of all dermatologists are black.

4.8% of all dermatologists are of Hispanic origin.
FUTURE DEMOGRAPHICS

• IN THE UNITED STATES:
  • By 2043, no single racial/ethnic group will be a majority.
  • Hispanics will increase from 53.3 million in 2012 to 128.8 million in 2060 and will comprise 31% of the population.
  • By 2060, 15% of Americans will be black, and 8.2% will be Asian.
UCSF SCHOOL OF MEDICINE 2015

• 647 MD Students
• 2015 Entering Class 149
  • 31% UIM
  • 50% Women
  • 71% California Residents
• 2300 Residents, Fellows and Post Docs
• 2337 Full-Time Faculty
• Over $2Billion annual operating budget
• #1 NIH biomedical research funding
OUR PROBLEMS AT UCSF

• Hiring practices-LCME
• “Climate” survey disclosed problems with regard to women and UIM faculty and staff
• Lack of faculty diversity-2% UIM
#WhiteCoats4BlackLives
**DID WE UNDERSTAND?**

- **Unconscious Bias**- ingrained judgments and biases that unconsciously influence behavior.
  - Implicit Association Test (IAT)
  - “Straight Talk for White Men”

- There is evidence that IAT-measured race attitudes of physicians do predict the quality of medical care they provide.
  - “Doctors who displayed stronger automatic White preference made cardiac treatment decisions that favored White patients relative to Blacks”. From BLINDSPOT by Mahzarin R. Banaji and Anthony D. Greenwald.
  - “Black patients of physicians who had stronger White preference perceived their physicians as being less helpful.” From BLINDSPOT.
DID WE UNDERSTAND?

Micro aggressions—every day verbal, nonverbal, and environmental slights, snubs, or insults, whether intentional or unintentional that communicate hostile, derogatory, or negative messages to target persons based solely upon their marginalized group membership.
EXAMPLES OF MICRO AGGRESSIONS

“You speak English very well”-You are a perpetual foreigner in your own country.

“You are a credit to your race”-People of color are generally not as intelligent as Whites.

“There is only one race, the human race”-Denying the significance of a person of color’s racial/ethnic experience and history.

Faculty of color mistaken for a service worker.

Female doctor mistaken as a nurse.
RACE MATTERS AT UCSF
OUTCOMES

- Designed Curriculum Review Process to eliminate micro aggressions and stereotypes
- Launched food security program
- Launched the Resident Holistic Review Project
- Launched Dean’s Diversity Fund
- Culture of Diversity and Inclusion a long term pillar of UCSF’s goals
- Reform hiring practices
It's All About People — Bruce Wintroub, MD
THE FUTURE OF DERMATOLOGY AND DIVERSITY OF OUR WORKFORCE
# Dermatologists by Race and Ethnicity

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<thead>
<tr>
<th></th>
<th>Asian</th>
<th>Black or African American</th>
<th>American Indian</th>
<th>Hispanic or Latino</th>
<th>Other Race</th>
<th>White</th>
<th>Unknown</th>
<th>Total</th>
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</thead>
<tbody>
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<td><strong>Dermatologists</strong></td>
<td>1,395</td>
<td>400</td>
<td>46</td>
<td>465</td>
<td>42</td>
<td>7,482</td>
<td>3,085</td>
<td>12,915</td>
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<tr>
<td><strong>All Physicians</strong></td>
<td>119,758</td>
<td>405,414</td>
<td>3,478</td>
<td>437,14</td>
<td>3,862</td>
<td>464,550</td>
<td>281,756</td>
<td>957,659</td>
</tr>
</tbody>
</table>


Total minority representation in Dermatology versus other fields, 2006-2013
WHY DOES DIVERSITY MATTER?

1. Diversity among the medical workforce has been shown to improve patient care.

2. Race-concordant visits are longer have higher positive ratings than race-discordant visits.

3. Minority physicians are:
   • More likely to care for patients of their own race or ethnic group
   • Practice in areas that are underserved
   • Care for poorly insured or uninsured patients
   • Care for patients with poor health status and use emergency rooms for healthcare

4. Increasing UIM representation in the dermatology workforce may impact disparities in access to care and therapy.

5. A more diverse workforce may help address the growing discrepancy in geographic distribution of dermatologists.

6. A more diverse academic workforce may improve research focused on unique needs of UIM populations.
What is the Problem?
What can we do to fix it?
How long will it take to fix it?

- Dermatology Programs
- U.S. Medical Schools
- U.S. Colleges and Universities
- U.S. High Schools
African American representation among dermatology residents, medical students, college students and United States population 2002-2013
First, let’s look at the dermatology gap.

Are we doing all we can to attract and accept UIM applicants to dermatology?

How many medical students apply to dermatology training programs and how many are accepted?
# Dermatology Residency Applicants by Race and Ethnicity

<table>
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<tr>
<th>Race/Ethnicity</th>
<th>2014</th>
<th>2015-2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>433</td>
<td>392</td>
</tr>
<tr>
<td>Black/African American</td>
<td>47</td>
<td>46</td>
</tr>
<tr>
<td>Hispanic/Latino</td>
<td>47</td>
<td>21</td>
</tr>
<tr>
<td>Asian</td>
<td>173</td>
<td>138</td>
</tr>
<tr>
<td>Other</td>
<td>31</td>
<td>25</td>
</tr>
<tr>
<td>Total</td>
<td>731</td>
<td>622</td>
</tr>
</tbody>
</table>

Source: AAMC Data Tables C-5: Residency Applicants from U.S. MD-Granting Medical Schools by Specialty, Race/Ethnicity, 2015-2016 & Table 42: Applicants from U.S. M.D.-Granting Medical Schools by Specialty, Race and Ethnicity, 2014
Number of All Residents and Dermatology Residents by Race and Ethnicity

<table>
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</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total</td>
<td>Derm</td>
<td>Total</td>
<td>Derm</td>
</tr>
<tr>
<td>White</td>
<td>49,070</td>
<td>663</td>
<td>50,740</td>
<td>668</td>
</tr>
<tr>
<td>Black</td>
<td>5,317</td>
<td>50</td>
<td>5,517</td>
<td>46</td>
</tr>
<tr>
<td>Hispanic</td>
<td>5,529</td>
<td>35</td>
<td>5,588</td>
<td>36</td>
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<tr>
<td>Total</td>
<td>115,293</td>
<td>1,214</td>
<td>117,717</td>
<td>1,240</td>
</tr>
</tbody>
</table>

Source: Number of Residents by Specialty and Subspecialty and Ethnicity in ACGME Graduate Medical Education Data Resource Books

In 2014-15
4.6% of All Residents are African American
3.1% of Derm Residents are African American
4.8% of All Residents are Hispanic
3.6% of Derm Residents are Hispanic
The Bottom Line

1. 65 to 90 UIM medical students apply to dermatology programs each year.
2. 25 to 30 UIM medical students match to dermatology programs each year.
3. WE match 30-40% of UIM applicants each year.
4. The overall match rate ranges from 57%-68%.
5. How can we do better?
WHAT CAN WE DO?

• Dermatology departments (Imadojemu and James-Increasing African American Representation in Dermatology)

  • Match more UIM applicants. How?
    • Track record
    • Criteria
    • Second look

  • Attract more residency applicants. How?
    • Mentor students
    • Develop diversity program
    • Actively participate and lead in your schools diversity program

• Dermatologists - be a role model for patients from underrepresented populations
WHAT CAN WE DO?

• Organizations— AAD
  • Could be articulated component of AAD mission and a long term project
  • Diversity task force chaired by Amit Pandya
    • Mission statement
    • 10 training program incubators to pilot programs to attract resident applicants
    • Diversity mentorship grants for medical students
    • Develop national mentoring network
WHAT CAN WE DO?

- Organizations-APD
  - Adopt diversity as a component of mission
  - Develop goals
  - Examine matching process and remove and/or mitigate barriers
  - Develop similar evaluation processes and criteria
  - Hold each other accountable for success
Now, let’s look at the college to medical school gap.
Applicants to U.S. Medical School by Race and Ethnicity

<table>
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<tr>
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<th>1980</th>
<th>2013-2014</th>
<th>2015-2016</th>
<th>Δ</th>
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<tr>
<td></td>
<td>Number</td>
<td>%</td>
<td>Number</td>
<td>%</td>
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<tr>
<td>Total</td>
<td>35,326</td>
<td></td>
<td>48,014</td>
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<tr>
<td>African American/ Black</td>
<td>2,507</td>
<td>7.1</td>
<td>3,865</td>
<td>8.0</td>
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<tr>
<td>Hispanic/ Latino</td>
<td>1,764</td>
<td>5.0</td>
<td>3,999</td>
<td>8.3</td>
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# Matriculates to U.S. Medical Schools by Race and Ethnicity

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</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>%</td>
<td>Number</td>
<td>%</td>
<td>Number</td>
<td>%</td>
</tr>
<tr>
<td>Total</td>
<td>15,433</td>
<td>20,055</td>
<td>20,631</td>
<td>6.5</td>
<td>6.2</td>
<td>6.5</td>
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<tr>
<td>African American/ Black</td>
<td>999</td>
<td>6.5</td>
<td>1,234</td>
<td>6.2</td>
<td>1,349</td>
<td>6.5</td>
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<tr>
<td>Hispanic/ Latino</td>
<td>807</td>
<td>5.2</td>
<td>1,250</td>
<td>6.2</td>
<td>1,320</td>
<td>6.4</td>
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<tbody>
<tr>
<td>Total</td>
<td>44%</td>
<td>42%</td>
<td>39%</td>
</tr>
<tr>
<td>African American/ Black</td>
<td>39.4%</td>
<td>32%</td>
<td>29%</td>
</tr>
<tr>
<td>Hispanic/Latino</td>
<td>46%</td>
<td>31%</td>
<td>27%</td>
</tr>
<tr>
<td>Asian</td>
<td>41%</td>
<td>43%</td>
<td>40.5%</td>
</tr>
<tr>
<td>White</td>
<td>47.5%</td>
<td>44.5%</td>
<td>42%</td>
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How do UIMs fare in the medical school admissions process?

- AAMC data is available in aggregate form for 2013-2014 through 2015-2016.
- The data is presented as a MCAT and GPA grid for applicants by race and ethnicity.
- The grids look like this:
Table A-24.4: MCAT and GPA Grid for White Applicants and Acceptees to U.S. Medical Schools, 2013-2014 through 2015-2016 (Aggregated)

<table>
<thead>
<tr>
<th>White Applicants</th>
<th>5-14</th>
<th>15-17</th>
<th>18-20</th>
<th>Total MCAT Scores</th>
<th>All Applicants</th>
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</thead>
<tbody>
<tr>
<td>Total GPA</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>3.00-3.19</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acceptees</td>
<td>1</td>
<td>3</td>
<td>7</td>
<td>90    767 2,931 4,923</td>
<td>47 160 2,250 778 15,910</td>
</tr>
<tr>
<td>Applicants</td>
<td>19</td>
<td>76</td>
<td>239</td>
<td>845   2,312 4,975 6,447</td>
<td>86 192  2,517 833 23,000</td>
</tr>
<tr>
<td>Acceptance rate %</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>11    33    59    76</td>
<td>86</td>
</tr>
<tr>
<td>3.40-3.59</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Acceptees</td>
<td>1</td>
<td>1</td>
<td>9</td>
<td>57    373 1,299 2,132</td>
<td>1,380  485  77</td>
</tr>
<tr>
<td>Applicants</td>
<td>97</td>
<td>164</td>
<td>53</td>
<td>1,273 2,671 4,453 4,450</td>
<td>2,216  671  100</td>
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<tr>
<td>Acceptance rate %</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>5     14    29    48</td>
<td>62</td>
</tr>
<tr>
<td>3.20-3.39</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acceptees</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>39    145  449   828</td>
<td>489</td>
</tr>
<tr>
<td>Applicants</td>
<td>102</td>
<td>171</td>
<td>444</td>
<td>974   1,736 2,412 2,451</td>
<td>1,040  286  55</td>
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<tr>
<td>Acceptance rate %</td>
<td>-</td>
<td>-</td>
<td>1</td>
<td>47    19    34    49</td>
<td>47</td>
</tr>
<tr>
<td>3.00-3.19</td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acceptees</td>
<td>2</td>
<td>-</td>
<td>-</td>
<td>21    79    161  273</td>
<td>137</td>
</tr>
<tr>
<td>Applicants</td>
<td>89</td>
<td>154</td>
<td>297</td>
<td>559   591 1,250 982</td>
<td>409</td>
</tr>
<tr>
<td>Acceptance rate %</td>
<td>-</td>
<td>0</td>
<td>0</td>
<td>4     8     15    28</td>
<td>34</td>
</tr>
<tr>
<td>2.80-2.99</td>
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<tr>
<td>Acceptees</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>5      29    53    77</td>
<td>41</td>
</tr>
<tr>
<td>Applicants</td>
<td>53</td>
<td>89</td>
<td>161</td>
<td>262   419 454 357</td>
<td>175</td>
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<tr>
<td>Acceptance rate %</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>2      7     12    22</td>
<td>23</td>
</tr>
<tr>
<td>2.60-2.79</td>
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<td></td>
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<tr>
<td>Acceptees</td>
<td>-</td>
<td>3</td>
<td>3</td>
<td>17    13  21  74</td>
<td>19</td>
</tr>
<tr>
<td>Applicants</td>
<td>46</td>
<td>54</td>
<td>94</td>
<td>130   189 165 171</td>
<td>63</td>
</tr>
<tr>
<td>Acceptance rate %</td>
<td>-</td>
<td>3</td>
<td>3</td>
<td>1      4     8   17</td>
<td>30</td>
</tr>
<tr>
<td>2.40-2.59</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acceptees</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>1      6    7    2</td>
<td>7</td>
</tr>
<tr>
<td>Applicants</td>
<td>28</td>
<td>23</td>
<td>42</td>
<td>68    82  70  44</td>
<td>26</td>
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<tr>
<td>Acceptance rate %</td>
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<td>-</td>
<td>-</td>
<td>2      4     9    16</td>
<td>27</td>
</tr>
<tr>
<td>2.20-2.39</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Acceptees</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>1      5    1    1</td>
<td>1</td>
</tr>
<tr>
<td>Applicants</td>
<td>24</td>
<td>24</td>
<td>20</td>
<td>23    25  33  21</td>
<td>9</td>
</tr>
<tr>
<td>Acceptance rate %</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>2      4     9    16</td>
<td>27</td>
</tr>
<tr>
<td>2.00-2.19</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acceptees</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>1      -    -    -</td>
<td>-</td>
</tr>
<tr>
<td>Applicants</td>
<td>11</td>
<td>4</td>
<td>3</td>
<td>8      8    3    4</td>
<td>2</td>
</tr>
<tr>
<td>Acceptance rate %</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>3      -    -    -</td>
<td>-</td>
</tr>
<tr>
<td>1.47-1.99</td>
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<tr>
<td>Acceptees</td>
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<td>-</td>
<td>-</td>
<td>-      -    -    -</td>
<td>-</td>
</tr>
<tr>
<td>Applicants</td>
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<td>1</td>
<td>2</td>
<td>3      -    -    -</td>
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<td>Acceptance rate %</td>
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<td>-      -    -    -</td>
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<tr>
<td>All Applicants</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acceptees</td>
<td>1</td>
<td>5</td>
<td>35</td>
<td>303   2,074 7,300 12,033</td>
<td>8,924</td>
</tr>
<tr>
<td>Applicants</td>
<td>525</td>
<td>915</td>
<td>2,306</td>
<td>5,372 11,477 19,313 20,835</td>
<td>12,285</td>
</tr>
<tr>
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<td>0</td>
<td>1</td>
<td>2</td>
<td>6      18   38   58</td>
<td>73</td>
</tr>
</tbody>
</table>

Note: In 2013-2014, the methodology for acquiring race/ethnicity information was updated. Rather than one question asking an applicant’s Hispanic origin and a second question asking the applicant’s race, the Hispanic origin and race response options are now listed together under a single question about how applicants self-identify. Applicants could select multiple response options.

Source: AAMC 12/15/2015

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Applicants and Acceptees by MCAT, GPA, Race and Ethnicity

Group I.
• 88.5 to 99.9 MCAT percentile
• 3.2 to 4.0 GPA

Group II
• 23.6 to 88.4 MCAT percentile
• 3.2 to 4.0 GPA
### Applicants and Acceptees by Race and Ethnicity for groups I & II

<table>
<thead>
<tr>
<th></th>
<th>White</th>
<th>Black/African American</th>
<th>Hispanic/Latino</th>
<th>Asian</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>I.</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Applicants</td>
<td>17,593</td>
<td>406</td>
<td>1,151</td>
<td>8,714</td>
</tr>
<tr>
<td>Acceptees</td>
<td>14,454</td>
<td>372</td>
<td>987</td>
<td>6551</td>
</tr>
<tr>
<td>% Accepted</td>
<td>82.1%</td>
<td>91.6%</td>
<td>85.8%</td>
<td>75.2%</td>
</tr>
<tr>
<td>% Total Applicants</td>
<td>22%</td>
<td>3.3%</td>
<td>8.8%</td>
<td>28.4%</td>
</tr>
<tr>
<td><strong>II.</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Applicants</td>
<td>50,724</td>
<td>5,142</td>
<td>7,254</td>
<td>16,938</td>
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<tr>
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<td>45.8%</td>
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Source: Table A-24: MCAT and GPA Grid for Applicants and Acceptees by Selected Race and Ethnicity, 2013-2014 through 2015-2016 (Aggregated)
Taken together this indicates that with respect to MCATS and GPAS:

- UIMs are advantaged with respect to whites.
- Asians may be relatively disadvantaged with respect to whites and UIMs.
- UIMs perform less well with respect to MCAT scores and GPAs. (this is well known)
- To improve medical student diversity with respect to race and ethnicity, many more UIMs must apply to medical schools.
- Why do underrepresented minorities apply to medical schools in such low numbers?
  - Debt?
  - Mentoring and role models?
  - Length of training?
  - Poor college advising and high dropout rate?
  - Other social and societal factors?
The College Dropout Problem

“What Can Stop Kids From Dropping Out” by David L. Kirp in NY Times, April 30, 2016

• “Only 53% of college freshmen earn a bachelor’s degree within six years.”
• 39% of community college freshmen earn a degree within six years.
• Graduation rates for Latino and black students are even worse.

Solutions?

• Personalized and useful academic attention, leveraging technology, to support students at scale
• Colleges can identify and mitigate roadblocks
  • Reach out to students at first hint of grade trouble
  • Tutors for first generation low income students
  • Fill tuition gap (can be just a few hundred dollars)
Let’s look further

This analysis shows that:

The group of individuals who, when in high school, express intentions to pursue a career as a physician are much more diverse than those who actually matriculate into medical school, and those who leak out the most are from groups least represented in medicine.
The Message

• A professional workforce that is as diverse as the population will improve the health of those we serve.
• Populations that are underrepresented in medicine are further underrepresented in dermatology and WE can take steps to change this.
• To solve the UIM problem more UIMs must apply to medical school. Why do they apply in such low numbers?
How long will it take to “fix” this problem?
“Take the first step in faith. You don’t have to see the whole staircase, just take the first step.”
Martin Luther King Jr.
Find African American Dermatologists and Dermatologists that specialize in Ethnic skin care issues.

BLACKDERMATOLOGISTS.ORG

FIND DERMATOLOGISTS THAT
SPECIALIZE IN ETHNIC SKIN CARE
Get Listed | Directory > United States > California

California Locations

**Dr. Pearl Grimes**
Director of the Vitiligo and Pigmentation Institute of Southern California has been addressing issues of pigmentation and pigmented disorders for over 20 years.

5670 Wilshire Boulevard, Suite 650 Los Angeles, California 90036 Phone: (323) 467-4389

**Wendy E. Roberts, MD, FAAD**
As a board-certified Dermatologist and a board-certified Dermatopathologist, Dr. Wendy E. Roberts specializes in Ethnic Skin of Color, Cosmetic Dermatology, Geriatric Dermatology, and Generational Dermatology.

Desert Dermatology Skin Institute 72-301 Country Club Drive, Suite 101 Rancho Mirage CA 92270 (Around the back of the building)

**Dorothy J. Buckner, M.D.,**
Dr. Buckner’s Cosmetic Laser Center 2577 Samaritan Drive, Suite #820, San Jose, CA 95124-4012 (408) 355-8150

Cosmetic Dermatologist, provides cosmetic skin care treatments to reduce the visible signs of aging for healthy, more beautiful skin. Treatments include botox, collagen, and laser procedure.
Epitaph

Who was Donald M. Pillsbury?
Albert M. Kligman, M.D., Ph.D. Philadelphia, PA

It is easy to praise famous men. It is much more difficult to find out what they were really like and how they accomplished so much.

Pillsbury was the most influential dermatologist of the twentieth century. The foundations of modern cutaneous science and the greatly enhanced status of dermatologists in the medical establishment were the products, almost single-handedly, of this man’s foresight and generosity.

Judging by the number of high positions he held, Pillsbury was probably the most successful dermatologist of all time. He was president of every national dermatologic organization (Society for Investigative Dermatology, American Dermatological Association, American Academy of Dermatology, etc.), president of the International Congress in 1962, chairman or member of almost two dozen medical agencies sponsored by the government, chief dermatologic consultant to the Army in the European and North African theaters in World War II (later founding the U.S. Army Commission on Skin Disease), advisor to the National Research Council, recipient of medals and honors from a half-dozen countries, as well as the U.S. Legion of Merit. He held honorary memberships in numerous foreign societies, was president of the American Board of Dermatology, one of the founding fathers of the Society for Investigative Dermatology (at a meeting held in Philadelphia in 1937), and the only dermatologist elected to two prestigious societies of internal medicine. He had indefatigable energy but always seemed relaxed. He was a successful insomniac who never seemed tired. The work ethic was bred into him from his midwestern origins, having always held at least two jobs during his school years. Nonetheless, Don was a balanced, uncompulsive character who could play the piano and sing Gilbert and Sullivan operettas with gusto. He was a zesty raconteur but never uttered an obscene word in his life.

His ascension to the chairmanship in 1946 marked the end of a long, black period of paleodermatology. It is sobering to recall that until then there was, in America, only one full-time investigator in a department of dermatology. This was Fred Weidman, also of the University of Pennsylvania, who labored for small pay in histopathology and mycology.

Paleodermatologists saw no need for experimentation. It was enough to observe, describe, and classify. Don abruptly changed this. He was

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Reprint requests to: Dr. Albert M. Kligman, Department of Dermatology, University of Pennsylvania, GM Room 244, 229 Medical Education Bldg., 36th & Hamilton Walk, Philadelphia, PA 19104.

532
a clear, lucid thinker who saw that polysyllabic language, rooted in Greek and Latin terminology, was a grand cover for ignorance. He hated pedantry and pomposity. He wrote concisely and concretely. The proof of this was that little literary gem written at the Army's behalf in World War II, The Manual of Dermatology, the sole source of practical instruction for thousands of medical officers. Later, his textbook, Dermatology, revealed the same devotion to crisp, sensible exposition. He was a breath of fresh air in a specialty choking on scholarly gas.

I have merely listed his accomplishments but these do not illuminate his central mission, which enabled him to start dermatology on a new, exciting course. Obvious as it now seems, Pillsbury's singular insight was his realization that dermatology could enter the mainstream of medicine by only one route, namely, by research. He knew that investigation was the royal road to knowledge and that two things had to come together to start down this path: (1) bright, young researchers who saw a chance to do some pioneering work in a backwater specialty and (2) laboratories equipped with more than microscopes. He provided for both. His first great coup was to obtain from the Rockefeller Foundation a $100,000 grant for basic research, an impressive sum for those days. After that, many doors to various treasuries opened up; young investigators suddenly saw the possibility of academic careers in a born-again specialty. He knew, from his vast experience, who the people with influence were and how they could be mobilized to support his mission.

Don, all agree, did not hog money, men, and material for himself alone. He was an exceedingly generous man who shared his largesse with others. He was in the service of dermatology at large and not simply an architect of the research edifice at Penn. He was instrumental in setting up investigative programs in a number of universities. Further, he saw to it that these were headed by like-minded scholars. It is not well known that two contemporary giants, Steven Rothman and Marion Sulzberger, both owed a great deal to Pillsbury for his material support, including their academic positions. While raising up the banners of research dermatology, he seemed to be everywhere. His message was simple and persuasive. Dermatologic disease is common and costly, especially in time of war. (He wrote the history of dermatology of World War II.) Don was the prophet who went up and down the land crying that if you want to prevent and treat dermatologic diseases more effectively, you must provide funds for studies of the pathogenesis of skin disease. Out of understanding will come rational rules for preventing and treating dermatoses.

This unassuming man was a great solicitor and rather like his co-Philadelphian, Benjamin Franklin, there were few who could resist his persuasive proposals. He also knew how to leave creative young people alone. At one time we had nearly fifty residents! The laboratories were full of feisty young Turks who sometimes collided with each other but never thought of going to the "chief" with their complaints.

He had an astoundingly effective technique for being heard in sessions with important people. Most zealous individuals with deeply held convictions invariably find themselves raising up the decibel level with accompanying dramatic gestures of the hands. Don did just the opposite. He whispered. Everyone had to shut up in order to hear what this more or less motionless man was saying. With this demeanor, controversy usually gave way to concordance. Don was a diplomat and statesman. He was a master of the art of listening.

I will close briefly citing other attributes which enabled Don Pillsbury to become the patron saint of investigative dermatology:

1. He was scrupulously honest in all his dealing with other people. He was no pretender. Consequently, everyone believed and trusted in him.
2. He was a powerful magnet for attracting creative people. He did not scout them out for recruitment. They came to him because of the "pull" of his beliefs and principles. Don never pushed nor pressured. It was his high expectations that kept us looking skyward. He had an invisible presence that permeated the laboratories.
3. Don was the gentlest of men. He was utterly incapable of putting anyone down. He simply would not listen to demeaning statements and
never engaged in gaseous gossip. Marion Sulzbacher had this to say, "In all my associations with Pillsbury, I never saw him perform an unjust act, utter an undeserved reproach, express a mean thought." 

4. Don practiced dermatology in a remarkably enlightened and sincere manner. He was one of the few world-famous figures who scrupulously followed Virchow's advice for instilling modesty in physicians. Virchow urged young doctors to learn how to say "Ich weiss nicht" (I don't know). When confronted with a baffling case, Don would softly say something like "it beats me." The letters he wrote to referring doctors were literary gems containing sage medical counsel. They should be collected for posterity.

Don also studiously followed the Hippocratic precept *premium non nocere* (first, do no harm). He railed against the heedless, excessive use of x-rays. He condemned the use of toxic medications, of unproved efficacy, for example, arsenic in Fowler's solution.

For those of us who knew him, or felt his influence, there is no disagreement regarding his sterling character and achievements. He was a man of exceptional virtue and foresight. His invisible presence is felt in all of our affairs.

The portrait suggests that Pillsbury was a saint. (Indeed, he was)

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**Abstracts**

**Systemic lupus erythematosus in an adult population in southern Sweden: Incidence, prevalence and validity of ARA revised classification criteria**


The numbers are, per 100,000 persons, a mortality of 1.3, a prevalence of 39, and an annual incidence of 4.8.

*P. C. Anderson, M.D.*

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**Synthetic retinoids in dermatology**


A review of retinoids is given with emphasis on adverse effects as well as activity. Diseases formerly untreatable now are manageable, but problems, for instance the teratogenicity of the drugs, remain.

*P. C. Anderson, M.D.*

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**Torre-Muir syndrome. An association with isolated sebaceous carcinoma**


Multiple neoplasms are discussed in this review of Torre's syndrome and three new cases are added. Sebaceous carcinomas were found.

*P. C. Anderson, M.D.*

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**Antibodies to human T cell leukemia virus are absent in patients with systemic lupus erythematosus**


The systemic lupus erythematosus of mice is associated with a type C oncornavirus, and the same idea was projected over to humans. Some type C-related proteins have been found in human tissue. Now this careful new technic of looking for antibody to this virus finds no new evidence for type C virus.

*P. C. Anderson, M.D.*

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**Nifedipine and esophageal dysfunction in progressive systemic sclerosis. A controlled manometric study**


Possibly, this new experimental therapy for severe scleroderma may have some adverse effects on esophageal functions.

*P. C. Anderson, M.D.*

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The DF—A “Significant Force in the Specialty”

When the DF was established in 1964, there were few departments of dermatology, limited research progress and a lack of full-time dermatologists at many major medical centers. It was then that a group of ten forward-thinking dermatologists and scientists formed the Dermatology Foundation to further the specialty by providing grants for basic training in dermatologic research. Dr. Eugene Van Scott, one of the ten founders, recalls the DF’s start and has witnessed its evolution to its current role—a critical resource for the advancement of dermatology.

For Dr. Van Scott, the Dermatology Foundation actually came into being on the day that his good friend Dr. Thomas B. Fitzpatrick came to meet with him at the National Institutes of Health (NIH). He was Chief of the NIH Dermatology Branch at that time. Dr. Fitzpatrick was chair of Harvard’s Department of Dermatology and arrived at the NIH with his research colleague Irving Blank, Ph.D.

“They came to discuss Tom’s concept for a new organization in dermatology,” Dr. Van Scott recounts. “Tom had the foresight to realize that the welfare and future of dermatology depended upon good research, and the increasingly stiff competition for NIH funds had come to worry him a great deal. He felt that dermatology had to assure its own future, and he and Irv talked about a foundation that would be supported by dermatologists because it was in their best interest.”

They convinced Donald M. Pillsbury, M.D., head of Dermatology at the University of Pennsylvania and one of the most respected members of the specialty, to lead this new foundation. When the DF became a formal entity in 1964, six more visionary dermatologists had joined as founders: Herman Beerman, M.D.; Robert R. Kienland, M.D.; Clarence S. Livingood, M.D.; J. Lowry Miller, M.D.; Wiley M. Sims, M.D.; and Marcon B. Sulsberger, M.D.

Dr. Van Scott recalls that the DF’s first years were that of a small start-up organization. “It took some time before we raised the funds needed to have a substantial impact,” he says. “And then it emerged with voltage and energy as a significant force in the specialty.” He emphasizes that “critical to the success was its volunteer leadership. Their long-term commitment to the DF’s mission enabled the Foundation to evolve and flourish. As a result, the DF attracted inventive, research-minded young people to the specialty—who in turn have become the leaders, innovative investigators and teachers of today.”

In the early 1960’s, “dermatology was really trivialized by medicine,” Dr. Van Scott remembers. “Donald Pillsbury was convinced that the country needed only a dozen or so departments and now there are over 100.” Today, dermatology is center stage. He characterizes the role the Foundation played in the specialty’s transformation as “immense.” The DF “has succeeded in supporting not only basic research, but in drawing more physician-scientists to research.”

Because their investigations are the bridge enabling basic research discoveries to reach patient care, “the physician-researcher is especially important,” he notes.

Looking ahead, Dr. Van Scott sees the DF continuing to play a critical part in the growth of the specialty. “Fundamental research on the frontiers of science is so important to the overall interest of the specialty—and that is what must keep going. Continually meeting this challenge is what lies ahead—for the specialty and its Foundation.”
Hair Care Practices as a Barrier to Physical Activity in African American Women

Rebecca R. Hall, MD; Shani Francis, MD, MBA; Melicia Whitt-Glover, PhD; Kismet Loftin-Bell, MS; Katrina Swett, MS; Amy J. McMichael, MD

Objective: To characterize the influence of hairstyle maintenance on exercise behavior in African American women.

Design: A 40-item survey with questions concerning hair care practices, physical activity, and the relationship between the two.

Setting: University-affiliated dermatology department at an academic medical center in Winston-Salem, North Carolina.

Participants: A total of 123 African American women from 21 to 60 years of age were surveyed; 103 women completed the questionnaire.

Main Outcome Measures: The statistical significance of relationships between hair care practices and physical activity was determined.

Results: Fifty percent of African American women surveyed have modified their hairstyle to accommodate exercise and nearly 40% (37.9%) avoid exercise at times owing to hair-related issues. Respondents who exercised less owing to hair concerns were 2.9 times less likely to exercise more than 150 min/wk (95% CI, 0.9-9.4; P = .08).

Conclusion: Dermatologists can discuss hair management strategies during exercise that facilitate routinely performing exercise.

Published online December 17, 2012.
Hispanic representation among dermatology residents, medical students, college students and United States population 2002-2013
## Race/Ethnicity: U.S. Population and Physicians

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Adapted from AAD Leadership Institute Underrepresented by Specialty Report
https://www.aad.org/File%20Library/Main%20navigation/Member%20resources%20and%20programs/Leadership%20Institute/Underrepresented_by-Specialty.pdf