



University of California  
San Francisco

# Insuring the Future of Dermatology: *Race and Ethnicity Matter*

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# 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

# UNDERREPRESENTED IN MEDICINE

- 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 Parnassus campus

# 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

# **2015 LEADERSHIP RETREAT**

## **RACE MATTERS AT UCSF**

# 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

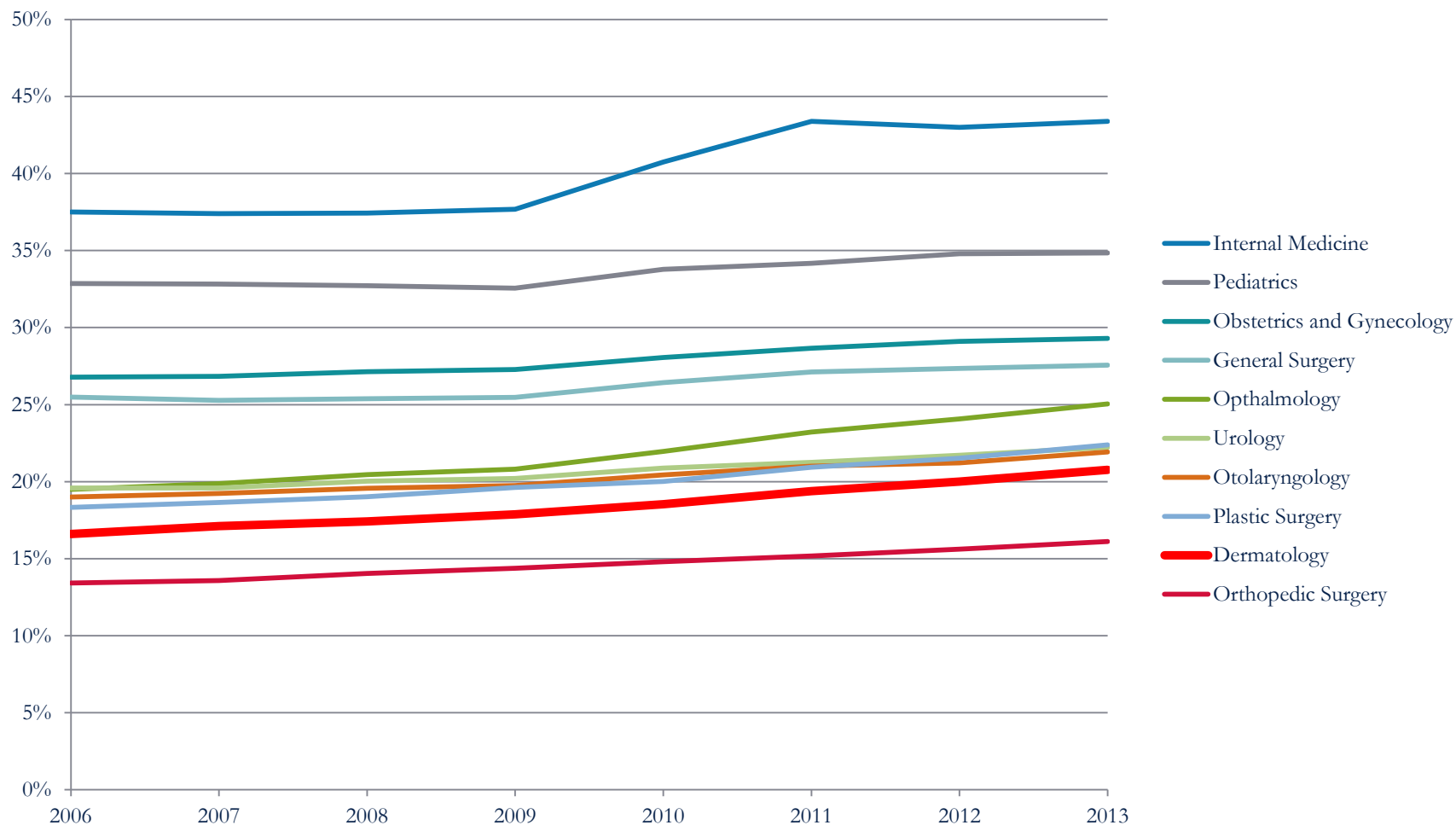


# THE FUTURE OF DERMATOLOGY AND DIVERSITY OF OUR WORKFORCE

# DERMATOLOGISTS BY RACE AND ETHNICITY

	Asian	Black or African American	American Indian	Hispanic Or Latino	Other Race	White	Un-known	Total
Dermatologists	1,395	400	46	465	42	7,482	3,085	12,915
All Physicians	119,758	405,41	3,478	437,14	3,862	464,550	281,756	957,659

## Total minority representation in Dermatology versus other fields, 2006-2013





# WHY DOES DIVERSITY MATTER?

1. Diversity among the medical work force 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 health care
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.

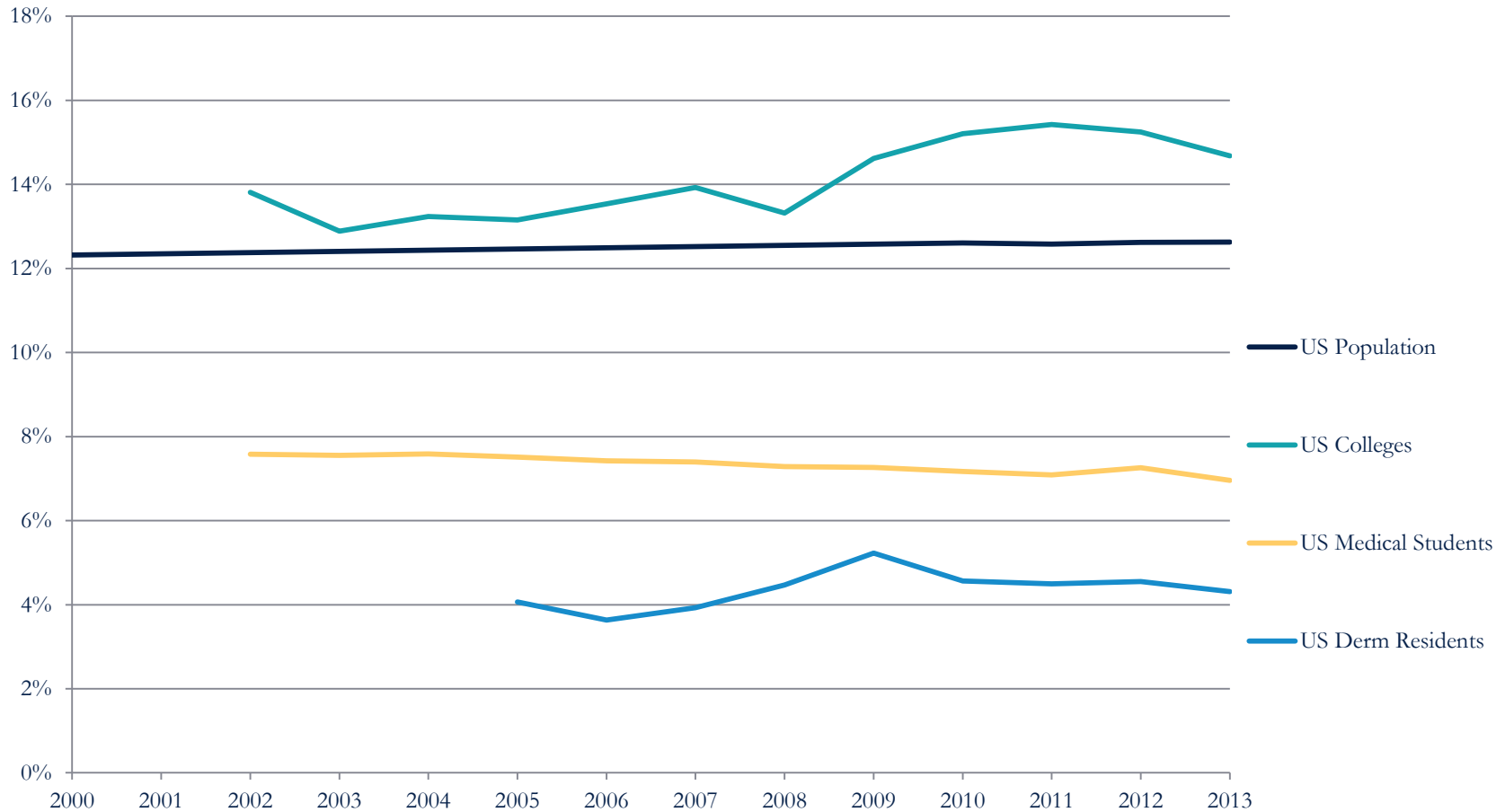
# What is the Problem?

## 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

Race/Ethnicity	2014	2015-2016
White	433	392
Black/African American	47	46
Hispanic/Latino	47	21
Asian	173	138
Other	31	25
Total	731	622

*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

	2011-12		2012-13		2013-14		2014-15	
	Total	Derm	Total	Derm	Total	Derm	Total	Derm
White	49,070	663	50,740	668	52,063	680	52,877	699
Black	5,317	50	5,517	46	5,594	45	5,649	40
Hispanic	5,529	35	5,588	36	5,790	44	5,942	47
Total	115,293	1,214	117,717	1,240	120,108	1,262	121,579	1,275

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

	1980		2013-2014		2015-2016		
	Number	%	Number	%	Number	%	Δ
Total	35,326		48,014		52,550		17,224
African American/ Black	2,507	7.1	3,865	8.0	4,661	8.9	2154
Hispanic/ Latino	1,764	5.0	3,999	8.3	4,839	9.2	3075

Source: *Reflections on Diversity and Inclusion in Academic Medicine: Commemorating Dr. Herbert W. Nickens' Legacy*. (2014). Washington, D.C.: Association of American Medical Colleges and Table A-13: Race/Ethnicity of Applicants to U.S. Medical Schools, 2013-2014 through 2015-2016 : Association of American Medical Colleges

# Matriculates to U.S. Medical Schools by Race and Ethnicity

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	1980		2013-2014		2015-2016	
	Number	%	Number	%	Number	%
Total	15,433		20,055		20,631	
African American/ Black	999	6.5	1,234	6.2	1,349	6.5
Hispanic/ Latino	807	5.2	1,250	6.2	1,320	6.4

Source: Reflections on Diversity and Inclusion in Academic Medicine: Commemorating Dr. Herbert W. Nickens' Legacy. (2014). Washington, D.C.: Association of American Medical Colleges. And Table A-12: Applicants, First-Time Applicants, Acceptee, and Matric Matriculants to U.S. Medical Schools by Race/Ethnicity, 2013-2014 through 2015-2016: Association of American Medical Colleges.

# Per Cent Applicants Matriculated to U.S. Medical Schools by Race and Ethnicity

	1980	2013-2014	2015-2016
Total	44%	42%	39%
African American/ Black	39.4%	32%	29%
Hispanic/Latino	46%	31%	27%
Asian	41%	43%	40.5%
White	47.5%	44.5%	42%

Source: *Reflections on Diversity and Inclusion in Academic Medicine: Commemorating Dr. Herbert W. Nickens' Legacy*. (2014). Washington, D.C.: Association of American Medical Colleges and Table A-12: Applicants, First-Time Applicants, Acceptee, and Matriculants to U.S. Medical Schools by Race/Ethnicity, 2013-2014 through 2015-2016: Association of American Medical Colleges.

# 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-24.2: MCAT and GPA Grid for Black or African American Applicants and Acceptees to U.S. Medical Schools, 2013-2014 through 2015-2016 (Aggregated)**

The table below displays the acceptance rates at different MCAT and GPA levels for applicants and accepted applicants who self-identified as Black or African American from 2013-2014 through 2015-2016. Please email us at [datamgmt@aamc.org](mailto:datamgmt@aamc.org) if you need further assistance or have additional inquiries.

Total GPA	Black Applicants <sup>1</sup>	Total MCAT Scores										All Applicants
		5-14	15-17	18-20	21-23	24-26	27-29	30-32	33-35	36-38	39-45	
3.80-4.00	Acceptees	-	-	6	78	188	202	154	81	32	12	733
	Applicants	23	39	91	210	224	220	164	88	54	12	1,305
	Acceptance rate %	-	-	6.6	37.1	84.2	91.8	93.9	91.0	59.1	100.0	145.1
3.60-3.79	Acceptees	-	3	13	121	271	272	179	85	16	4	966
	Applicants	34	105	215	315	362	314	291	91	36	4	1,717
	Acceptance rate %	-	2.9	6.1	38.4	74.9	86.6	61.2	93.4	44.4	100.0	56.3
3.40-3.59	Acceptees	-	3	10	117	322	302	186	66	16	3	1,015
	Applicants	115	181	314	471	480	372	214	77	38	3	2,349
	Acceptance rate %	-	1.6	3.2	24.8	67.1	81.2	86.9	85.7	100.0	100.0	43.6
3.20-3.39	Acceptees	-	-	10	94	281	278	149	43	11	3	869
	Applicants	184	228	360	517	698	589	381	50	12	5	2,402
	Acceptance rate %	-	-	2.8	18.2	40.4	47.3	39.1	86.0	91.7	100.0	36.2
3.00-3.19	Acceptees	-	-	6	35	107	145	85	19	4	1	478
	Applicants	172	230	318	418	443	346	210	25	6	1	1,891
	Acceptance rate %	-	-	1.9	8.4	24.2	41.3	40.5	76.0	66.7	100.0	24.8
2.80-2.99	Acceptees	-	8	6	27	76	78	52	11	1	-	214
	Applicants	177	164	240	281	242	158	62	15	1	-	1,340
	Acceptance rate %	-	4.9	2.5	9.6	31.4	49.4	84.0	73.3	100.0	-	17.5
2.60-2.79	Acceptees	-	1	4	7	28	24	11	5	-	-	81
	Applicants	132	104	142	154	134	64	21	10	-	-	793
	Acceptance rate %	-	1.0	2.8	4.5	20.9	37.5	52.4	50.0	-	-	10.6
2.40-2.59	Acceptees	-	-	2	6	5	9	4	2	-	-	26
	Applicants	100	64	70	80	38	30	15	4	-	-	401
	Acceptance rate %	-	-	2.9	7.5	13.2	28.6	26.7	50.0	-	-	6.5
2.20-2.39	Acceptees	-	-	-	-	6	2	3	-	-	-	11
	Applicants	61	36	36	36	24	10	8	3	-	-	214
	Acceptance rate %	-	-	-	-	25.0	20.0	37.5	-	-	-	5.1
2.00-2.19	Acceptees	-	-	-	-	-	-	1	-	-	-	1
	Applicants	23	18	18	18	9	3	2	1	-	-	79
	Acceptance rate %	-	-	-	-	-	-	100.0	-	-	-	1.4
1.87-1.99	Acceptees	-	-	-	-	1	1	-	-	-	-	2
	Applicants	21	4	5	1	5	-	-	-	-	-	34
	Acceptance rate %	-	-	-	-	20.0	100.0	-	-	-	-	5.9
All Applicants	Acceptees	1,064	1,172	1,819	2,554	2,455	1,785	967	363	85	25	12,289
	Applicants	6,064	5,954	8,243	11,122	11,122	8,802	5,212	89	24	4	44,446
	Acceptance rate %	-	-	21.8	22.9	21.9	20.3	18.4	40.8	35.4	62.5	27.9

<sup>1</sup>Applicants who self-identified as Black or African American are a subset of all Black or African American applicants who self-identified as Black or African American.

Note: In 2013-2014, the methodology for reporting acceptance rates was updated. For that year, acceptance rates for applicants and accepted applicants are based on the number of applicants who self-identified as Black or African American and the number of accepted applicants who self-identified as Black or African American.

Source: AAMC 12/2016

Black/African American

**Table A-24.4: MCAT and GPA Grid for White Applicants and Acceptees to U.S. Medical Schools, 2013-2014 through 2015-2016 (Aggregated)**

The table below displays the acceptance rates at different MCAT and GPA levels for applicants and accepted applicants who self-identified as White from 2013-2014 through 2015-2016. Please email us at [datamgmt@aamc.org](mailto:datamgmt@aamc.org) if you need further assistance or have additional inquiries.

Total GPA	White Applicants <sup>1</sup>	Total MCAT Scores										All Applicants
		5-14	15-17	18-20	21-23	24-26	27-29	30-32	33-35	36-38	39-45	
3.80-4.00	Acceptees	1	3	7	30	767	2,931	4,923	4,160	2,230	778	15,910
	Applicants	19	76	219	843	2,312	4,975	6,447	4,818	2,517	831	23,080
	Acceptance rate %	5.3	3.9	3.2	3.6	33.2	59.0	76.3	86.3	88.6	92.4	68.9
3.60-3.79	Acceptees	-	1	13	89	470	2,347	3,767	2,690	1,003	250	10,830
	Applicants	39	155	467	1,219	3,044	5,514	5,960	3,321	1,244	249	21,496
	Acceptance rate %	-	0.6	2.8	7.3	15.4	42.6	63.2	81.0	80.7	87.9	50.2
3.40-3.59	Acceptees	-	1	9	57	371	1,299	2,132	1,380	485	177	5,813
	Applicants	97	164	327	1,273	2,671	4,431	4,450	2,116	671	100	16,412
	Acceptance rate %	-	0.6	2.8	4.5	13.9	29.3	48.1	65.2	72.7	77.7	35.5
3.20-3.39	Acceptees	-	-	2	19	163	449	828	609	134	27	2,153
	Applicants	102	171	444	974	1,736	2,412	2,431	1,040	286	55	9,651
	Acceptance rate %	-	-	0.5	1.9	9.4	18.6	34.1	58.5	46.9	22.0	2.3
3.00-3.19	Acceptees	-	-	1	11	79	181	273	117	32	10	784
	Applicants	89	134	297	559	991	1,250	982	409	129	19	4,879
	Acceptance rate %	-	-	0.3	2.0	8.0	14.4	27.7	28.6	24.8	52.6	1.6
2.80-2.99	Acceptees	-	-	-	5	29	59	77	41	12	3	210
	Applicants	55	89	161	262	419	454	357	176	30	11	2,012
	Acceptance rate %	-	-	-	1.9	7.0	13.0	17.0	23.3	40.0	27.3	1.5
2.60-2.79	Acceptees	-	-	3	1	7	11	21	19	8	2	74
	Applicants	40	54	94	110	189	165	121	63	21	8	891
	Acceptance rate %	-	-	3.2	0.9	3.7	6.7	17.4	30.1	38.1	25.0	0.8
2.40-2.59	Acceptees	-	-	-	1	3	6	7	7	2	1	27
	Applicants	28	24	42	66	82	70	44	26	10	1	395
	Acceptance rate %	-	-	-	1.5	3.6	8.6	15.9	26.9	20.0	10.0	0.3
2.20-2.39	Acceptees	-	-	-	-	1	5	1	-	-	-	7
	Applicants	24	24	20	23	25	30	21	9	3	2	184
	Acceptance rate %	-	-	-	-	4.0	16.7	4.8	5.6	3.3	6.7	0.4
2.00-2.19	Acceptees	-	-	-	-	-	8	-	-	-	-	1
	Applicants	11	4	3	8	8	3	-	-	-	-	43
	Acceptance rate %	-	-	-	-	-	100.0	-	-	-	-	2.3
1.87-1.99	Acceptees	-	-	-	-	-	-	-	-	-	-	-
	Applicants	9	1	2	3	-	-	-	-	-	-	15
	Acceptance rate %	-	-	-	-	-	-	-	-	-	-	0.0
All Applicants	Acceptees	1	5	15	305	2,074	7,300	12,033	8,824	3,966	1,148	55,789
	Applicants	525	915	2,306	5,372	11,477	19,311	20,815	12,083	4,913	1,519	79,280
	Acceptance rate %	0.2	0.5	0.6	5.7	18.2	37.3	57.8	73.7	81.0	75.7	70.4

<sup>1</sup>Applicants who self-identified as White are a subset of all White applicants who self-identified as White.

Note: In 2013-2014, the methodology for reporting acceptance rates was updated. For that year, acceptance rates for applicants and accepted applicants are based on the number of applicants who self-identified as White and the number of accepted applicants who self-identified as White.

Source: AAMC 12/2016

White

Table A-24.4: MCAT and GPA Grid for White Applicants and Acceptees to U.S. Medical Schools, 2013-2014 through 2015-2016 (Aggregated)



The table below displays the acceptance rates at different MCAT and GPA levels for applicants and accepted applicants who self-identified as White from 2013-2014 through 2015-2016. Please email us at [datarequest@aamc.org](mailto:datarequest@aamc.org) if you need further assistance or have additional inquiries.

White Applicants <sup>1</sup>					Total MCAT Scores							All Applicants
		5-14	15-17	18-20	21-23	24-26	27-29	30-32	33-35	36-38	39-45	
Total GPA												
3.80-4.00	Acceptees	1	3	7	90	767	2,931	4,923	4,160	2,250	778	15,910
	Applicants	19	76	239	843	2,312	4,975	6,447	4,819	2,517	833	23,080
	Acceptance rate %	5	4	3	11	33	59	76	86	89	93	69
3.60-3.79	Acceptees	-	1	13	89	670	2,367	3,767	2,690	1,003	250	10,850
	Applicants	53	155	467	1,229	3,044	5,514	5,980	3,523	1,244	289	21,498
	Acceptance rate %	-	1	3	7	22	43	63	76	81	87	51
3.40-3.59	Acceptees	-	1	9	57	373	1,299	2,132	1,380	485	77	5,813
	Applicants	97	164	537	1,273	2,671	4,433	4,450	2,216	671	100	16,612
	Acceptance rate %	-	1	2	5	14	29	48	62	72	77	35
3.20-3.39	Acceptees	-	-	2	39	145	449	828	489	154	27	2,133
	Applicants	102	171	444	974	1,736	2,412	2,431	1,040	286	55	9,651
	Acceptance rate %	-	-	1	4	8	19	34	47	54	49	22
3.00-3.19	Acceptees	-	-	1	21	79	181	273	137	52	10	754
	Applicants	89	154	297	559	991	1,250	982	409	129	19	4,879
	Acceptance rate %	-	-	0	4	8	15	28	34	40	53	16
2.80-2.99	Acceptees	-	-	-	5	29	53	77	41	12	3	220
	Applicants	53	89	161	262	419	454	357	176	30	11	2,012
	Acceptance rate %	-	-	-	2	7	12	22	23	40	27	11
2.60-2.79	Acceptees	-	-	3	1	7	13	21	19	8	2	74
	Applicants	46	54	94	130	189	165	121	63	21	8	891
	Acceptance rate %	-	-	3	1	4	8	17	30	38	25	8
2.40-2.59	Acceptees	-	-	-	1	3	6	7	7	2	1	27
	Applicants	28	23	42	68	82	70	44	26	10	2	395
	Acceptance rate %	-	-	-	2	4	9	16	27	20	50	7
2.20-2.39	Acceptees	-	-	-	-	-	1	5	1	-	-	7
	Applicants	24	24	20	23	25	33	21	9	3	2	184
	Acceptance rate %	-	-	-	-	-	3	24	11	-	-	4
2.00-2.19	Acceptees	-	-	-	-	1	-	-	-	-	-	1
	Applicants	11	4	3	8	8	3	-	4	2	-	43
	Acceptance rate %	-	-	-	-	13	-	-	-	-	-	2
1.47-1.99	Acceptees	-	-	-	-	-	-	-	-	-	-	-
	Applicants	3	1	2	3	-	4	2	-	-	-	15
	Acceptance rate %	-	-	-	-	-	-	-	-	-	-	-
All Applicants	Acceptees	1	5	35	303	2,074	7,300	12,033	8,924	3,966	1,148	35,789
	Applicants	525	915	2,306	5,372	11,477	19,313	20,835	12,285	4,913	1,319	79,260
	Acceptance rate %	0	1	2	6	18	38	58	73	81	87	45

<sup>1</sup>Applicants who are U.S. citizens or permanent residents that self-identified as White alone or in combination with other races or ethnicities.

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.

# 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

		White	Black/African American	Hispanic/Latino	Asian
I.	Applicants	17,593	406	1,151	8,714
	Acceptees	14,454	372	987	6551
	% Accepted	82.1%	91.6%	85.8%	75.2%
	% Total Applicants	22%	3.3%	8.8%	28.4%
II.	Applicants	50,724	5,142	7,254	16,938
	Acceptees	28,926	3,194	4,071	6,059
	% Accepted	41.3%	62.1%	56.1%	35.8%
	% Total Applicants	64%	41.8%	55.6%	55.1%
I + II	% of Applicants	86%	45.8%	64.4%	83.5%

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



## **An Analysis of the Medical School Pipeline: A High School Aspirant to Applicant and Enrollment View**

### 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.





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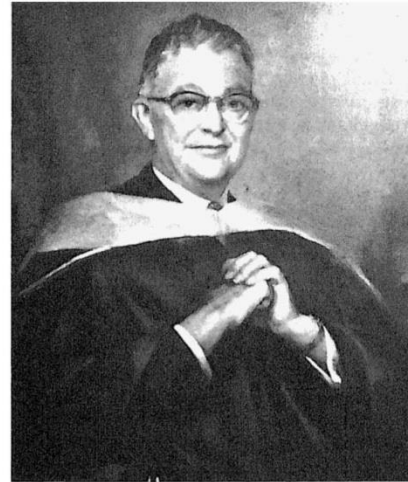
## Who was Donald M. Pillsbury?

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



Donald M. Pillsbury

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

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.

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 pompousness. 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 treasures 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 greats, 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 sweet, 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 technic 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 Sulzburger 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 *primum non nocere* (first, do no harm). He railed against the heedless, excessive use of x-rays. He condemned the use of toxic medicaments, 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 our affairs.

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

#### ABSTRACTS

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

Nived O, Sturfelt G, Wollheim F: Br J Rheumatol 24:147-154, 1985

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.

##### **Synthetic retinoids in dermatology**

Heller EH, Shiffman NJ: Can Med Assoc J 132:1129-1136, 1985

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

P. C. Anderson, M.D.

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

Graham R, McKee P, McGibbon D, et al: Cancer 55:12868-2873, 1985

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.

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

Koike T, Kagami M, Takabayashi K, et al: Arthritis Rheum 28:481-484, 1985

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.

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

Kahan A, Bour A, Couturier D, et al: Arthritis Rheum 28:490-495, 1985

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

P. C. Anderson, M.D.

## 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.



EUGENE J. VAN SCOTT, M.D.

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, PhD.

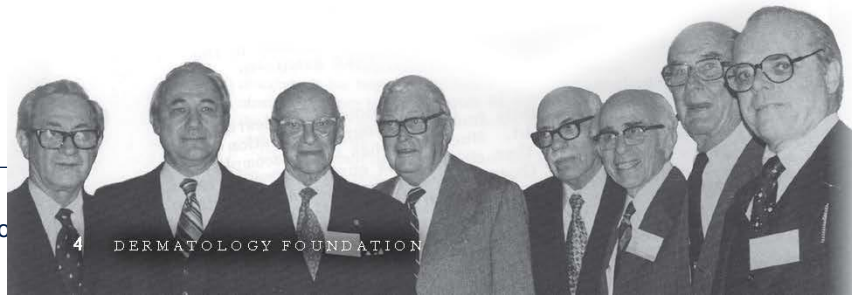
"They came to discuss Tom's concept for a new organization in dermatology," Dr. Van Scott recounts. "Tom had the foresight to realize that the welfare and future of dermatology depended upon good research, and the increasingly stiff competition for NIH funds had come to worry him a great deal. He felt 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, MD, 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, MD, Robert R. Kierland, MD, Clarence S. Livingood, MD, J. Lowry Miller, MD, Wiley M. Sams, MD, and Marion B. Sulzberger, MD.

Dr. Van Scott recalls that the DF's first years were that of a small start-up organization. "It took some time before it 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 this 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."



FROM LEFT TO RIGHT:  
CLARENCE S. LIVINGOOD, M.D.;  
EUGENE J. VAN SCOTT, M.D.;  
MARION B. SULZBERGER, M.D.;  
DONALD M. PILLSBURY, M.D.;  
HERMAN BEERMAN, M.D.;  
IRVING H. BLANK, PH.D.;  
ROBERT R. KIERLAND, M.D.; AND  
THOMAS B. FITZPATRICK, M.D.,  
PH.D. NOT SHOWN: J. LOWRY  
MILLER, M.D. AND WILEY M.  
SAMS, M.D.

ONLINE FIRST

# 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 signifi-

cance 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;  $P=.08$ ).

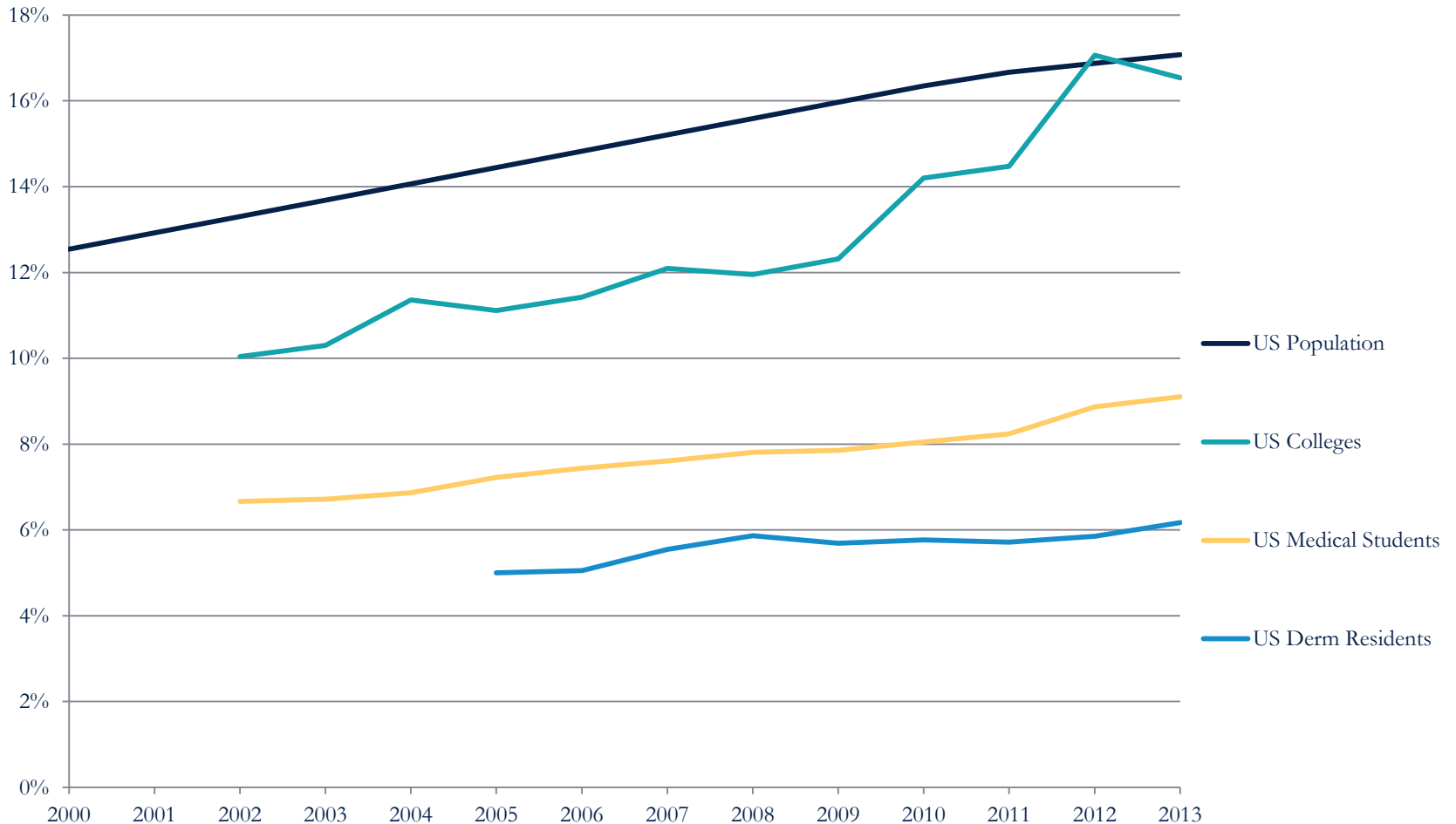
**Conclusion:** Dermatologists can discuss hair management strategies during exercise that facilitate routinely performing exercise.

*JAMA Dermatol.* 2013;149(3):310-314.

Published online December 17, 2012.

doi:10.1001/jamadermatol.2013.1946

## Hispanic representation among dermatology residents, medical students, college students and United States population 2002-2013



# Race/Ethnicity: U.S. Population and Physicians

Race/Ethnicity	Dermatology	Plastic Surgery	Ophthalmology	All Physicians	US Census (2010)
White	80.6%	79%	76.7%	79.3%	55.9%
African American/Black	3.5%	3%	2.9%	4.8%	12.8%
Hispanic	4.8%	5.7%	4.6%	6.5%	16.3%
Asian	9.9%	10.9%	13.9%	17.4%	4.8%
Other^	1.0%	1.2%	1.7%	1.7%	9.3%
American Indian/Alaskan Native	0.2%	0.2%	0.1%	0.2%	0.9%
Total	100%	100%	100%	100%	100%

Adapted from AAD Leadership Institute Underrepresented by Specialty Report

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