In November 2020, Practical Dermatology® hosted a virtual roundtable discussion on Diversity and Inclusion in Dermatology. This discussion was supported by L’Oreal Dermatological Beauty brands CeraVe, La Roche-Posay and SkinCeuticals. A panel of dermatologists and industry executives discussed the challenges facing the field due to a lack of diversity in physician and industry representation, clinical trials, and more. From the effects on patient care to treatment outcomes, they share personal insights about the issues, what needs to change, and opportunities to make those changes a reality that will improve access to dermatology for people of all races and ethnicities.

**Patricia Brieva, PhD:** Director, Skin Care, L’Oréal USA Research & Innovation. She has 12 years of experience developing skincare products and also has a PhD in chemical engineering.

**Stephanie Manson Brown, MBBS, MRCS, MFPM:** Vice President, Head of Clinical Development, Aesthetic Medicine at Allergan Aesthetics at AbbVie. She has been with the company for more than six years primarily working in medical affairs or clinical development and R&D. She previously practiced plastic surgery before joining industry.

**Seemal R. Desai, MD:** Board-certified dermatologist in private and academic practice in Dallas, TX. He is the immediate past president of the Skin of Color Society, the largest international organization dedicated to skin of color dermatology and to board-certified dermatologists specializing in skin of color. He also serves on the Board of Directors of the American Academy of Dermatology, and as the only dermatologist on the US FDA’s Pharmacy Compounding Advisory.

**Jeanine Downie, MD:** Board-certified dermatologist and Director of image Dermatology in Montclair, NJ. She is also an Assistant Attending at Mountainside and Overlook hospitals in New Jersey.

**Corey Hartman, MD:** Board-certified dermatologist and founder and owner of Skin Wellness Dermatology in Birmingham, AL. He is a clinical assistant professor at the University of Alabama School of Medicine, Department of Dermatology. He is a member of the American Society for Dermatologic Surgery’s Diversity Equity and Inclusion Committee.

**Melissa Kanchanapoomi Levin, MD:** Board-certified dermatologist and founder and owner of Entière Dermatology in New York City. She is also a Clinical Assistant Professor at New York University Langone Medical Center, The Ronald O. Perelman Department of Dermatology, teaching dermatology residents.

**Chudy Nduaka, DVM, PhD, DABT:** Therapeutic Area Head, Dermatology, US Medical Affairs, AbbVie Inc. He has over 19 years of pharmaceutical industry experience, helping to develop drugs in the immunology therapeutic area. In his current role, he is responsible for medical strategies and tactical execution of medical plans for drug therapies used in treatment of chronic inflammatory skin disorders.

**Rhonda Peebles:** Head of US Dermatology, UCB with 23 years of experience in the health care industry across pharmaceutical, med devices, and consumer products. She also has a background in toxicology.

**Jonah Shacknai:** Executive Chairman, Dermaforce Partners, parent company of SkinBetter Science, which has partnered with Allergan Aesthetics to launch the DREAM Initiative to promote diversity and inclusion awareness within the aesthetics industry and within the dermatology field.
Diversity and Inclusion in Dermatology: Challenges and Opportunities

In part 1 of this 2-part series, a panel of dermatologists and industry professionals discuss why diversity in race and ethnicity is important in dermatology in everything from clinical trials to physician and industry representation.

The COVID-19 pandemic has brought attention to existing racial disparities in health care. Lack of diversity in the medical workforce, including dermatology, has been well documented. Roundtable participants agree that lack of diversity of race and ethnicity in the physician and industry workforce has many negative consequences, including an impact on patient care, and concur that the inequity must be addressed and corrected. The lack of representation of minority physicians and patients with skin of colors is one such issue that the group agrees must be addressed in order to move the specialty forward and ensure best outcomes for all patients.

“We, as the leaders in the industry, need to help other people to understand that diversity is not in dermatology at all. Only three percent of dermatologists are African-American across the country,” says Jeanine Downie, MD, a dermatologist in New Jersey. She notes that there is also a lack of representation in some of the bigger pharmaceutical companies in terms of African-Americans, Asian Americans, Latino Americans at the lower rungs as well as at the higher levels. “I think that can be improved upon as well as looking at the decision-makers for clinical trials, the decision-makers for who writes what paper, who gets up on the podium—all of that.”

Dr. Downie has vast experience—more than 25 of her 73 peer-reviewed articles have been on skin of color. She has been the primary investigator for 40 clinical trials since 2003. But, she says, she’s had to fight her way into many clinical trials. She explains that diversity in those performing the trials as well as those participating in them is extremely important. “I think that we should obviously be testing on all skin types and that we should open up the floor to more diversity,” Dr. Downie adds.

The Benefits of Diverse Representation of Skin Types and Ethnic Backgrounds in Medical Research

Corey Hartman, MD, a dermatologist in Birmingham, AL, says that it’s critical that all different skin types and ethnic backgrounds are represented in clinical trials in order to understand how all products interact with different populations. Including multiple races and ethnicities shows companies are interested in having those patients be part of the overall strategy for how these products will be used and who will use them in the long run.

“Part of the reason why it’s so difficult to get African-Americans, in particular, into studies is because of the history of medicine in this country and the instances of being taken advantage of and used throughout the years. That makes us less likely to participate or volunteer for clinical trials in the first place. So it becomes sort of a self-defeating, self-fulfilling prophecy, if you will, where people don’t want to participate, so no one participates,” Dr. Hartman says. “And at this point, the history is so deep, some of those wounds are so fresh, and it’s on the minds of a lot of people. So it really is going to take a concerted effort on the part of the people who are doing the research to go out and recruit these patients so that they can participate and also recruit Black doctors to conduct the trials so that you have participation at every level.”

He adds that it should be common sense for companies to ensure inclusion on the participant and physician level. Otherwise, there’s a strong possibility that at the end of the trial, the FDA will not approve a drug or device because there weren’t enough people of color included in the trial.

“If you just do it right from the start, you’ll save yourself a lot of trouble—it just makes sense. Not to mention the fact that going forward, the quote-unquote minority will become the majority,” Dr. Hartman explains. “So you’re shooting yourself in the foot financially. You’re shooting yourself in the foot from a moral perspective, an ethical perspective.”

Seemal R. Desai, MD agrees and emphasizes that from a political advocacy perspective, the need for diversity in clinical trials goes beyond FDA approvals to bigger-picture issues of drug policy and research funding needs. “I see this all the time from the advocacy perspective whether it’s through my involvement with clinical research, the FDA or when I’m in Washington with congressional work. You can’t say we have a diversity problem, or a clinical scenario issue, or a drug development issue unless you have outcomes data and numerical statistical objective ways to support that,” Dr. Desai explains. “And the only way to support that is to get more patients of color into clinical trials so that you have the numbers to give definitive objective data. For example, in psoriasis and skin of color, we see morbidity and more
issues with chronic psoriatic arthritis along with additional skin sequelae of a typically non-scarring skin disease." The only way to improve from a long-term health care perspective is to get outcomes data to support those claims. Practicing board-certified dermatologists already know those claims are valid, but no one’s going to listen without the clinical data. Dr. Desai notes that this is where things like DataDerm, the American Academy of Dermatology’s module for collecting data from electronic medical records, have value. Having one repository to pull information like the number of skin of color patients who were diagnosed with melanoma can show that a significantly higher number of skin of color patients are being diagnosed with melanoma than the Surveillance, Epidemiology, and End Results (SEER) show. This information can be used to advocate for more melanoma research funding.

From an industry perspective, lack of diversity in subjects in clinical trials not only ups the risk for not winning FDA approval, but can lead to a smaller potential customer base long-term and a lack of understanding of all potential treatment outcomes.

“Clearly one of the things we do in clinical trials is look at safety and efficacy. We have populations that are racially different—diverse ethnicities—and in some cases, in some disease areas, they do respond differently to the treatment that you’re giving them, whether it’s from a safety perspective or an efficacy perspective,” says Chudy Nduaka DVM, PHD, DABT, Therapeutic Area Head, Dermatology, US Medical Affairs, Abbvie. “So if you finish your trial and put the drug on the market and you have not tested it in these populations, you may end up with a very different effect in those populations that you have not tested when it comes to market. And that’s not the place to start looking at the differences that could come about from the drug treatment—the right place is in a controlled clinical trial. That’s why it’s so important as we do these trials, that we make sure that we have diverse representation.”

Clinical trials are designed to show safety and efficacy, which are the basic requirements for FDA approval, but they really don’t call out vigilance or observation of particular consequences in populations that are known to react atypically to different treatments, adds Jonah Shacknai, Executive Chairman, Dermaforce Partners, parent company of SkinBetter Science. So in addition to diversifying representation in trials, it’s also important to look at trial design and be vigilant for effects that may be particular to one population or another represented in a study.

“There’s really inadequate attention paid to it so we can win the battle having greater representation in clinical trials, but still lose the war if we’re not looking for those discrete events that may be particular to certain communities. And if we just wait for them to fall through the cracks and have to do a retrospective analysis of data, or engage in post-marketing surveillance to try to answer a question, we’ve really failed from conception,” Mr. Shacknai says.

Stephanie Manson Brown, MBBS, MRCS, MFPM, Vice President, Head of Clinical Development, Aesthetic Medicine at Allergan Aesthetics, an AbbVie Company, says there’s massive room for improvement in clinical trials, including in the aesthetics space. And although it can be argued that the makeup of clinical trial participants for aesthetic trials being predominately white women reflects the current market for cosmetic procedures, according data from the American Society of Plastic Surgery, this is short-sighted. Dr. Manson Brown explains that it’s a self-perpetuating vicious circle—if you’re not studying a more diverse patient population, the same issues will persist. (See the sidebar What Does a Diverse Clinical Trial Look Like? on page 4.)

**Physician and Researcher Representation Matters**

In order to achieve better diversity in clinical trial subjects, the first step may be to ensure diversity among clinical trial investigators. Mr. Shacknai recalls time spent earlier in his career on the National Institute of Arthritis and Musculoskeletal and Skin Diseases (NIAMS) Advisory Council to the National Institutes of Health (NIH). Although he believes NIAMS is a relatively progressive institute that has promoted significant dermatologic research, he remembers being struck that there seemed to be no special interest in studying dermatologic diseases in populations other than Caucasians—Fitzpatrick skin types I through III.
“I don’t think it was deliberate, but if you look at the composition of the advisory board that I served on, there was very little diverse representation. And among the investigators whose grants we were reviewing, there was even less diversity, less representation from different groups,” Mr. Shacknai notes. “So there’s no question that this begins at a more basic level, because of a lack of representation and diversity in the sciences, in dermatologic research. If the investigators themselves are unrepresentative of the population, it’s quite probable that their interests will likewise be unrepresentative of the population.”

The fact that the clinical investigators and researchers have such poor representation among persons of color is definitely a factor. In clinical research that is not industry sponsored, in particular, there’s been so little representation.

Dr. Desai points to the need for diversity in the patient population that investigators serve. Without diversity among those leading clinical trials, diversity in clinical trial subjects will not be adequate.

“For example, I practice in Dallas; a very large portion of my practice is skin of color. Inherently, I am biased in our clinical trials that I am involved in because I have a higher proportion of skin of color patients in my census, that is my practice. I live in a very urban area and that’s what I have designed my practice to do. But Mary down the street from me, who may be excellent at treating skin of color dermatologic disease and does a lot of skin of color trials, may not have the right patient population to even recruit those subjects. This has come up recently in a lot of the atopic dermatitis work I’ve been involved in, because clearly atopic dermatitis is a disease that affects underrepresented minorities to a significant degree,” Dr. Desai explains.

Companies have to be very selective about which CROs they use, because as a part of site selection processes the CRO knows how to vet an investigator and the patient population of that investigator for the trial. They need to understand that a practice in a certain area may not have a diverse enough patient population. In certain geographies, it is not possible to recruit patients who are genuinely representative of a national population. They will represent locally, and we have to compensate for that by going to other places, Mr. Shacknai adds.

Work being done across the field seeks to connect industry to

What Does a Diverse Clinical Trial Look Like?

**Patricia Brieva, PhD:** I work in the cosmetic industry, so I know my constraints on claims and safety, but when it comes to certain upstream tests where we’re just looking at knowledge—not a final product—we’re just gathering knowledge, there are times that we specifically recruit 100 percent of a Hispanic population, for example, but there are other times that we base it on the population. So if the population is 15 percent African-American, 20 percent Hispanic, etc., then we try to mimic that. But we know in 20 years, those percentages are going to increase.

I’m curious about that perspective. Do we start already saying 25, 25, 25, or do we base it on the population, knowing that is the statistic from today, or should we be working toward what the statistics will be in the coming years?

**Corey Hartman, MD:** I would ask—before I answer that question—relative to the statistics and percentages as they are today, how are we doing? If we’re at four percent in clinical trials in the populations that are 15 percent, then maybe we just aim for 15 percent and just try to get on par with what it is now and let that be a good start. But are we trending with these trials on pace to match the current population. Or are we lagging far behind?

**Chudy Nduaka, DVM, PhD, DABT:** I think we are lagging behind, and it certainly varies from therapeutic area to therapeutic area. In some disease states, you have more representation of people of color, but clearly in all the disease states and a lot more, you don’t even have half of what you would want. So I think that we should clearly want to make sure that we represent what the population is in the United States. And if that population is about 13 percent, that’s what we should be targeting and not anything lower than that. If you do target lower, then you’re actually going to get even lower percentage of people in your trials.

**Stephanie Manson Brown, MBBS, MRCS, MFPM:** To be able to better represent the patient population, I think the best starting point is to be able to reflect our current situation and then move from there. So I think even with regard to that, there is a lot of work that needs to be done to bring up the numbers in the better representation across the board clinical trials.

**Melissa Kanchanapoomi Levin, MD:** I think it’s so great that you’re thinking ahead and the direction that the population of the US is going to. I don’t know exactly for all the medical disease states for dermatology, but I know within cancer research, the government-funded clinical trials have been specifically focused on minorities in less than two percent. To me that is an embarrassment—the US is regarded as the global leader. We’re regarded as exemplary when it comes to biomedical and clinical health research since the 80s, but we’ve really lagged behind and I find that there are other places in the world that have kind of really taken over and almost don’t even feel interested in looking at American or US-led clinical trials.

I can speak to this from the standpoint of Asia. Asia has done a remarkable kind of growth in clinical research that’s really focused on East Asian, Southeast Asian, and South Asian. I feel like the US has failed not only from a recruitment standpoint, but also from the thought concept of even wanting to include and reflect our population. I think it’s not just about scientific integrity, but it also boils all the way down to a matter of social justice and also financial responsibility to your consumers and to our patients.
minority physicians or health care providers who are interested in being clinical investigators. For example, Dr. Hartman says the Dermatology Section of the National Medical Association offers a research component to bridge that gap between industry and member. The Skin of Color Society also helps to connect companies with investigators of diverse races.

“You can go to one place and not have to reinvent the wheel, and know that you’re going to recruit high-quality investigators, physicians who have theses built-in patient populations that you’re looking for to get the patients that you need in the studies,” Dr. Hartman says.

Companies and CROs need to be aware of and take advantage of existing resources.

“At this point in time, it’s beyond anything that’s even remotely excusable for ignorance, not to have awareness of the need for diversity in clinical trials and in investigators,” Mr. Shacknai adds.

Dr. Manson Brown also points out another important benefit of having diversity in clinical investigators. One of the barriers for patients from a diverse or an underrepresented background to participate in clinical trials often is mistrust, as Dr. Hartman also noted. “There’s plenty of data out there to demonstrate that patients have better health outcomes when they’re treated by a doctor they can identify with. They’re going to have a better trust in their doctor. Therefore, if they see a doctor who’s participating in a trial, then they’re more likely to have trust in participating in that trial,” she says. (See the sidebar Overcoming Participant Recruitment Challenges on page 6.)

A Diverse Workforce: The Benefit to Patient Care

Noting the importance of addressing issues of diversity and inclusion, Dr. Downie shares her recent experience being asked to review a piece from International Journal of Women’s Dermatology, “talking about meaningful reforms in terms of diversity, and in it, it says, as physicians, we carry privileged status in a trusted voice that engenders a greater responsibility to meet the demands for the moment.

‘I think that should be changed to ‘as physicians, some of us carry privileged status.’ And then it should say that skin of color physicians, unfortunately, may not. Because as a black physician, I have to contend with the fact that my color will bring me discrimination and bias, because I walk in the room and my race walks in the room before I walk in the room. So many times, and it’s not intentional, but people will call me the wrong name of somebody that they’ve seen me with, or that I might not even be friendly with, that’s an African-American physician or industry,” she explains. “It’s necessary to realize that all this implicit bias exists. Health care disparities are a form of racism, and it’s time to focus on the health care disparities within the dermatological industry and try to cure these things.

“As a skin of color physician, I’m very passionate about this. If we don’t deal with this, it’s just going to keep growing and getting worse, and it’s the elephant in the room because a lot of majority doctors, they do treat me with respect, the majority of doctors in my industry. They absolutely do,” she says. “But every single doctor on this panel will say that they feel like we need to be on more panels at conferences, we need to be listened to, and we need to be co-authors and co-investigators and basically totally co-exist—be an integral part of the dermatologic experience.”

Dr. Desai agrees, saying that this is a reason why it’s so important to empower and mentor current residents to help continue to take the lead on these issues going forward, encouraging more inclusion of dermatologists of various ethnic and racial groups to be on panels, to do research.

“Young dermatologists who are the next wave of our specialty, probably don’t even know some of the opportunities that are out there. I think it’s our job to continue to mentor and expose them to as many of those as we can,” Dr. Desai says.

To make meaningful change, roundtable participants say, really requires outreach to students in medical schools to recruit them into dermatology residencies, because the number of minority dermatologists in the US is very low. It has been reported that approximately three percent of dermatologists in the US are Black, and 4.2 percent are Hispanic, compared with 12.8 and 16.3 percent, respectively, of the total population. Race demographics of US medical school applicants and matriculants also fail to reflect the general population. There is significant underrepresentation of racial and ethnic minorities. In fact, in 2014, dermatology residents in the US were 68.8 percent white, 3.9 percent Black, 6.7 percent Hispanic, 20.3 percent Asian, 0.2 percent Native American/Alaskan Native, 0.2 percent Native Hawaiian/Pacific Islander, 1.9 percent multiracial, and 4.8 other/unknown.

“We should look back to see how we can devise programs that will help medical students thinking about careers in dermatology, especially the minority medical students,” Dr. Nduaka adds.

In fact, the Skin of Color Society has taken a lead on
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Dr. Downie agrees, describing how a recent Juvéderm campaign that included women with brown skin, a Black woman, and an older white woman with gray hair has bought many new different patients into her office. “My Black patients feel like it’s marketed to them, my white patients feel like it’s marketed to them. I think there’s somebody that looks like she could be Latina in there, I mean, so that is to me a great aesthetic commercial that’s brought in more patients,” she says.

There’s no question that industry has done a poor job representing a diverse population in marketing and advertising and that there is a significant effort now underway to correct this and be more representative.

Rhonda Peebles, Head of US Dermatology, UCB echoes the call for diversification across the industry. “Not as my role at UCB and in medical dermatology, but as a patient, I can tell you that there is a feeling when you’re sitting in the waiting room, wondering if they know why you’re there, or if they see beauty, the way that you need them to, or you’d like them to, or you want them to. I can tell you that I did not feel comfortable in going to a dermatologist office until I visited Dr. Downie, because I actually saw her at a meeting and said, ‘That’s someone who probably would understand my goals, and that’s someone who looks like me.’ Without that connection, she saw no ads with patients who looked like her or reason for her to know that a dermatologist would understand her goals.

Overcoming Participant Recruitment Challenges

Many barriers to ensuring racially and ethnically diverse clinical trials beyond recruitment need to be addressed.

**Rhonda Peebles:** I think that there are logistical challenges, particularly when you think about patients in the African-American community. We all want for patients of all skin colors to be in clinical trials, but even thinking about technology and the barriers for how people will even get from their home to a site or to a doctor’s office, there are all so many challenges. So I think it’s important that we meet patients where they are, because just to say that even if every company increases their efforts 80-fold, and every physician who is part of clinical trials did the same thing, there’s also the logistics of getting patients from A to B. I think that there are some limitations there that we have to be realistic about it.

**Chudy Nduaka, DVM, PhD, DABT:** You’re absolutely right. I know for sure transportation could be a problem, but I think some clinical trials will give you stipends for that. And I also know that flexibility for time is an issue, because minorities sometimes take multiple jobs and they may not be able to work according to the hours that are prescribed for them in the trial. So having trial designs that can be flexible, that someone can come at 6:00 rather than at 3:00 in the afternoon could really be very helpful to communities in need.

**Stephanie Manson Brown, MBBS, MRCS, MFPM:** That’s a great point. I think the pandemic has actually accelerated a lot of exploration into virtual applications and also bringing certain elements to the patient and actually setting up a very patient-centric approach really to reduce the burden. I think that that’s something not just in the aesthetics, but across all the different therapeutic areas, which really should help and actually should overcome some of the challenges with regards to patients having to go to multiple visits and for efficacy evaluations or safety evaluations. It’s something that is definitely being addressed, and I think in a way the silver lining with the pandemic is that it’s really boosted a lot of those different avenues and applications. I think it is a great point as well, just to really get to the bottom and understand what the patient’s needs are and potential patient burden. And also to make sure that there’s a raised awareness with regards to participating in clinical trials and making it easier and also helping to just promote the understanding of what’s involved in participating in clinical trials.

**Ms. Peebles:** I do think you’re right: the pandemic is giving rise to that. I know that at UCB we certainly have tweaked our clinical trial practices accordingly. I think across all of pharma we have to do so. We have to think about meeting those patients where they are and to your point, it’s a great time to do that.
Improving Training and Education

With relatively few minority dermatologists in the United States, there are a lot more patients with skin of color in the US than there are dermatologists. Industry has a key role to play in modeling what patients should look like and feel like, but what happens when someone successfully wants an aesthetic procedure, they show up in the waiting room, and they’re feeling different because the staff and other patients in the office are not representative of what their community looks like?

This is a comprehensive issue, and as noted earlier, it requires systemic changes to introduce children to the option of medicine at an early age, to connect in high school to put things where it doesn’t even really apply.

Different because the staff and other patients in the office are not representative of what their community looks like?

Particularly those practitioners who may not have adequate sensitivity to the needs of communities other than their own, to make people feel comfortable. It starts in the waiting room, it starts with having a staff that looks like everybody

Is it Time to Rethink the Fitzpatrick Scale and Other Clinical Trial Measurements?

Are the scales that used in clinical studies, appropriate against various skin types?

Jeannine Downie, MD: I would say yes. Sometimes if there is erythema in the skin it could look hyperpigmented or brown. I always tell patients there are links between rosacea and melasma for sure— a lot of people who have inflammation from rosacea wind up with melasma later, and that’s skin of color and lighter skin, Asian, Latino, and white skin as well.

But I think the scales could be improved upon. Some of them are good, some of them are mediocre, but they could all be improved upon. I wouldn’t say any of them are terrible.

Corey Hartman, MD: I agree. I think that the whole Fitzpatrick scale needs to be completely redone in the first place. If anybody needs more variation, it’s people with skin of color, but we’re all lumped in one or two little groups. This is a new day where we have to think about other factors that matter.

It’s not just skin color, it’s also ethnicity. That’s part of the conversation that I have with patients all the time, because I need an understanding of what’s going on beneath the surface. Lack of thoughtfulness can lead to potential problems if I don’t have a good understanding of the ethnic background that makes up that particular skin color. I think we need to start all over.

And when it comes to clinical trials, there are definitely diagnoses that are missed. We know that because we know they’re missed in clinic every day. It has been revealed that the residents aren’t even getting the basics that they need to identify different skin disorders during dermatology training.

Melissa Kanchanapoomi Levin, MD: As Dr. Hartman said, the Fitzpatrick skin phenotype is problematic. We use that as a common method to describe different pigmented phenotypes, but the basis of it is how you respond and assess to sunburns. So, we say Fitzpatrick skin type V, VI, but a lot of skin types V and VI actually burn. We need a new one. We need to say goodbye to that.

Dr. Hartman: You’re right. And we extrapolate that to use it for so many things where it doesn’t even really apply.

Stephanie Manson Brown: This has been used as a proxy for race and it really doesn’t give the diversity that we’re looking for. And it goes back to that question: How do you actually define diversity? It needs to have a lot more layers integrated into it, as well as looking at the different skin colors, as well as looking at older age, etc. There are so many different factors that need to be taken into account when we’re talking about diversity.

Jonah Shacknai: Dr. Tom Fitzpatrick was a mentor, and there’s no question that he made major and lasting contributions to dermatology, but he was a creature of another era. I would argue that the underpinnings of the Fitzpatrick classification system were well-intentioned, but in reality the system has probably outlived its usefulness in many ways as a standard. And it is the standard in clinical trials for the recruitment and the sectioning of patients by skin type and clinical response. I think Dr. Hartman and Dr. Levin have identified a real need to take a harder look at the classification system. MED levels are really not the solely appropriate way to classify skin. The other flaw in the system is that as we become a multi-racial society with people of different skin types and backgrounds intermarrying, the subsets become multiplied dramatically. So it might be that skin types are actually I through XII as Dr. Hartman suggests, but this conclusion demands rigorous assessment and classification. Fundamentally, Drs. Hartman and Levin are dead on.

But the good news in this category is that a lot of clinical measurements in trials now are performed by instrumentation. So the Canfield visual systems and those of others are capturing images and changes in the skin that really are so discrete that they often elude an investigator’s eye, and to some extent, become an equalizer among skin types. It’s worth noting that the instrumentation companies should be really thoughtful in calibrating their analysis, and maybe the units themselves to be able to reflect the diversity of patients that needed in a clinical trial. We all know this has been a problem historically, where many instruments, including pulse oximeters are “normed” to white patients. Certainly in the aesthetics category, there is an increasing reliance on these instrumentation measurements, and the FDA has by and large accepted them as proxies for clinical assessments, or at least adjunctive to clinical assessment.

Dr. Tom Fitzpatrick was a mentor, and there’s no question that he made major and lasting contributions to dermatology, but he was a creature of another era. I would argue that the underpinnings of the Fitzpatrick classification system were well-intentioned, but in reality the system has probably outlived its usefulness in many ways as a standard. And it is the standard in clinical trials for the recruitment and the sectioning of patients by skin type and clinical response. I think Dr. Hartman and Dr. Levin have identified a need to take a harder look at the classification system. MED levels are really not the solely appropriate way to classify skin. The other flaw in the system is that as we become a multi-racial society with people of different skin types and backgrounds intermarrying, the subsets become multiplied dramatically. So it might be that skin types are actually I through XII as Dr. Hartman suggests, but this conclusion demands rigorous assessment and classification. Fundamentally, Drs. Hartman and Levin are dead on.
in the community, and it ends with an understanding of cultural sensitivity of beauty.”

He says this is one of the reasons Allergan Aesthetics and Skinbetter Science have launched a new long-term, educational initiative—DREAM: Driving Racial Equity in Aesthetic Medicine—to further the principles of racial and ethnic diversity, inclusion, respect and understanding in the fields of dermatology and plastic surgery. “We’re trying to educate physicians and the media in particular, that there are different perceptions of beauty, and that a white physician cannot look at an Asian patient or a Black patient and say, this is the way I’m going to treat you, because this is the prototype of what a white woman is supposed to look like,” he explains.

We need to shift the mindset—there’s not a common set of goals for all ethnicities and race, says Dr. Manson Brown. Aesthetic treatment goals should include preserving racial and ethnic features. And that starts with research and trials and physician training.

“I think we need to be making sure that we’re designing clinical trials to ensure that we are looking at indications that complete different diverse patient populations, rather than going for one indication that is more beneficial for white females. It’s really important that we need to be looking at all the different needs of our patient population,” she says. (See the sidebar Is it Time to Rethink the Fitzpatrick Skin Types and Other Clinical Trial Measurements? on page 7.)

In addition to failing to foster sensitivity to all patients, there are repercussions to inadequate training programs and research that don’t include a broad range of skin types. Many people are not trained on what various skin conditions look like in skin of color, says Dr. Downie, which can lead to misdiagnosis.

“I believe that part of the initiative of DREAM is to educate doctors, because right now there seems to be a diversity problem also in the dermatology books. It can’t just be white skin except for syphilis and keloids and sexually transmitted diseases, because that has such negative undertones,” she explains.

The DREAM Initiative is sponsoring the development of “The Full Spectrum of Dermatologic Disease: A Diverse and Inclusive Atlas,” a comprehensive textbook photo atlas that will present the characteristics of skin conditions across the full range of skin types. The text will be disseminated to residents, faculty, and program libraries and will be available as a resource for clinical practitioners worldwide.

This is such a vital issue, Melissa Kanchanapoomi Levin, MD says, “One of the biggest reasons why I wanted to train in New York is because I wanted to train in a patient population that spanned all different skin types. But unfortunately so much of our country doesn’t allow for seeing all these different skin types, so having more comprehensive Kodachromes, which are photos that we use in dermatology to learn, is something that’s so important. It needs to be prioritized at the residency level,” Dr. Levin explains. There is also a need to develop a curriculum for aesthetic dermatology. She says this is significant deficit in the field. She encourages the development or deepening of an aesthetic dermatology curriculum that actually teaches young dermatologists how to identify different definitions of beauty, and how to then deliver those aesthetic goals.

“I continually learn from my patients, because I have a big patient population that comes from Asia, and their beauty definitions are completely different. I’m learning to deliver that and also training my eye. It needs to be an ongoing curriculum that dermatologists, particularly those who are committed to cosmetic dermatology, continually train ourselves on, because definitions of beauty do change over time. I think we have a long way to go, but I think what you’re starting with the DREAM initiative at the residency level is very needed,” she says.

There is additional encouraging news on the horizon. The AAD will be launching the first ever skin of color curriculum, which will be an A to Z skin of color educational module-based system for residents. And the Skin of Color Society is also working on an initiative that specifically tackles these issues, such as how to look for erythema and redness in a patient with skin of color.

“I think a lot of that work is starting to be done…in a way it’s fantastic that we’re all working on all of these things together, but it’s also a travesty that there even needs to be a book about skin of color dermatologic disease. We should not even be at the point of needing a dedicated curriculum for this, because this should just be so second nature and part of what we do, that there should be no reason that we’re this excited about an entire curriculum from the AAD, or a book, or a chapter. And so hopefully 20 years from now, it’ll be so mainstream, it’s part of every already thing that’s out there,” Dr. Desai says.

In Part 2, the roundtable participants continue the discussion about diversity and inclusion with a focus on the impact of systemic racism on health care and potential opportunities to affect meaningful change.

In November 2020, Practical Dermatology® hosted a virtual roundtable discussion supported by L’Oreal on Diversity and Inclusion in Dermatology. A panel of dermatologists and industry executives discussed the challenges the field faces as a result of a lack of diversity in physician and industry representation, clinical trials, and more. From the effects on patient care to treatment outcomes, they share personal insights about the issues, what needs to change, and opportunities to make those changes a reality that will improve access to dermatology for people of all races and ethnicities.

Patricia Brieva, PhD: Director, Skin Care, L’oréal USA Research & Innovation. She has 12 years of experience developing skincare products and also has a PhD in chemical engineering.

Stephanie Manson Brown, MBBS, MRCS, MFPM: Vice President, Head of Clinical Development, Aesthetic Medicine at Allergan Aesthetics at AbbVie. She has been with the company for more than six years primarily working in medical affairs or clinical development and R&D. She previously practised plastic surgery before joining industry.

Seemal R. Desai, MD: Board-certified dermatologist in private and academic practice in Dallas, TX. He is the immediate past president of the Skin of Color Society, the largest international organization dedicated to skin of color dermatology and to board-certified dermatologists specializing in skin of color. He also serves on the Board of Directors of the American Academy of Dermatology, and as the only dermatologist on the US FDA’s Pharmacy Compounding Advisory.

Jeanine Downie, MD: Board-certified dermatologist and Director of image Dermatology in Montclair, NJ. She is also an Assistant Attending at Mountainside and Overlook hospitals in New Jersey.

Corey Hartman, MD: Board-certified dermatologist and founder and owner of Skin Wellness Dermatology in Birmingham, AL. He is a clinical assistant professor at the University of Alabama School of Medicine, Department of Dermatology as a clinical assistant professor. He is a member of the American Society for Dermatologic Surgery’s Diversity Equity and Inclusion Committee.

Melissa Kanchanapoomi Levin, MD: Board-certified dermatologist and founder and owner of Entière Dermatology in New York City. She is also a Clinical Assistant Professor at New York University Langone, The Ronald O. Perelman Department of Dermatology, teaching dermatology residents.

Chudy Nduaka DVM, PhD, DABT: Therapeutic Area Head, Dermatology, US Medical Affairs, Abbvie Inc. He has over 19 years of pharmaceutical industry experience, helping to develop drugs in the immunology therapeutic area. In his current role, he is responsible for medical strategies & tactical execution of medical plans for drug therapies used in treatment of chronic inflammatory skin disorders.

Rhonda Peebles: Head of US Dermatology, UCB Head of US Dermatology, UCB with 23 years of experience in the health care industry across pharmaceutical, med devices, and consumer products. She also has a background in toxicology.

Jonah Shacknai: Executive Chairman, Dermaforce Partners, Parent company of SkinBetter Science, which has partnered with Allergan Aesthetics to launch the DREAM Initiative to promote diversity and inclusion awareness within the aesthetics industry and within the dermatology field.