Episode: Ethics Talk Videocast Transcript – COVID Dermatologic Disparities Go More Than Skin Deep

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TIM HOFF: Welcome to *Ethics Talk*, the *American Medical Association Journal of Ethics* podcast on ethics in health and health care. I'm your host, Tim Hoff. This episode is an audio version of a video interview conducted by the Journal's editor in chief, Dr Audiey Kao, with Dr Jenna Lester. Dr Lester is an Assistant Professor of Dermatology at the University of California, San Francisco. She joined us to talk about the racial and ethnic disparities in dermatologic care and its contributions to health inequities during the COVID-19 pandemic and beyond. To watch the full video interview, head to our site, JournalofEthics.org, or visit our YouTube channel.

DR AUDIEY KAO: Dr Lester, thank you for being a guest on *Ethics Talk* today. [music fades out]

DR JENNA LESTER: Thank you for having me, and thanks for highlighting this issue.

KAO: So, dermatological conditions and diseases among people of color are routinely overlooked and misdiagnosed. So, what are some of the dermatological manifestations of COVID? And more importantly, how has the inability to properly interpret dermatological conditions and diseases in patients of color exacerbated health inequities during this pandemic and beyond?

LESTER: So, I think possibly the most famous or well-known dermatologic manifestation of COVID is the so-called COVID toes or acral perniosis. And this is a purplish-red discoloration of the tops and tips of the toes that have been recognized in many patients with COVID-19. But there have been a wide number, a wide array, of cutaneous manifestations described: papulosquamous eruptions, pityriasis rosea-like eruptions, more vasculitic type lesions as well. And a lot of these have a basis of inflammation. And inflammation appears differently in different tones of skin. So, what may look red or pink in someone with light skin may actually look purple to blue or darker, just dark brown even, in someone with darker skin.

So, you can see how, you can understand how, if your eye is not trained to recognize these things in different skin tones, it might be quite easy to miss it. And even outside of the context of COVID-19, when we see some of these same sorts of rashes or patterns of inflammation, it's definitely different recognizing it in patients with darker skin.

KAO: Yeah.

LESTER: And to address the second part of your question about how has this created disparities in COVID-19? Well, one can only guess, because I don't really know that we can understand the magnitude of any contributor to disparities in this condition yet. I

imagine that that will be more of a retrospective analysis when we hopefully get to the other side of this pandemic.

But when we think about the fact that there's disparities in access to testing and the ways that the testing is distributed, who has access to those across the country, the difference in symptomatology that people experience, anything from very mild symptoms to much more serious symptoms that may prompt them to go to the doctor.

KAO: Yeah.

LESTER: One of the great things about the skin is that it's an external organ that the patients can look at with us. So, if doctors, and then subsequently patients, are aware of the manifestations in all different skin tones, so they can, doctors can counsel their patients of all different types of what this might look like, we might be able to say, "Hey, if you notice something like this on your skin, this could be a sign, an early sign of COVID-19. You should consider sheltering in place, self-isolating, getting testing if you can." So, you can imagine if any one of these cutaneous manifestations does end up being an early sign, once we have more research and examples to support that, if someone is not able to recognize this, they may spread it more broadly in their community, if they're not able to respond appropriately.

KAO: Yeah, I appreciate what you just said, and the point that beyond COVID, how cutaneous conditions manifest across many diseases is something that we need to keep attention on. So, given that, what do you think needs to be done to hold clinicians and educators more accountable for addressing racial and ethnic disparities in dermatological care that exacerbate health inequities?

LESTER: Yeah. I like to think of this, rather than an individual physician failure, I like to think of it as a systemic issue. There are many examples in medicine that we've been discussing more recently of structural racism or structural inequities. And I think the root of many of those exist in medical education. And that's one area that I'm focused on. Early on in my interest in this particular area, we looked at our common dermatology teaching textbooks and found that a minority of these photos are actually in patients with darker skin. So, when you look at psoriasis, you see many photos of psoriasis in patients with lighter skin, but you don't see it in darker skin. And furthermore, there's an overrepresentation of dark skin in the chapters on sexually transmitted infections.

KAO: Mm.

LESTER: So, you can see how powerful biases are created in the minds of our learners when you're looking through textbooks, and sometimes your only exposure to a disease is your photo, the photos that you're looking at in these textbooks. So, I think we need to think about increasing representation of our photographs in dermatology specifically. But also not just photographs, thinking about how we teach dermatology so that we're teaching people to recognize things in all different skin tones. So, we're not saying this is "the salmon pink patches of psoriasis," which is how they're described, are classic presentations of psoriasis. Because psoriasis in someone with dark skin does not look like that. And are we then othering people with dark skin and saying they don't have classic presentations of types of disease?

KAO: Right.

LESTER: So, I think it goes beyond the photos. It goes to the language we use when we are teaching learners how to diagnose dermatologic disease.

And so, I think when you push people to do these things, it represents, or it manifests itself in other areas. So, they then think more about how are they balancing research studies when they go on to become attendings who are conducting original research? Are they representing all patients of all different races and ethnicities in their research studies? I think if you, so, this idea that representation is important early on in their medical education, and that is something that's not unusual to them as they go on throughout their medical career. So, I think it starts with education.

KAO: Yeah. I appreciate that. I think the systemic issues are ones that we definitely need to focus on and tackle. But I also know that you direct, at UCSF, Skin of Color clinic. Can you speak a little bit about that from a clinician standpoint as well?

LESTER: Mmhmm. Yeah, so, the Skin of Color program has a clinical aspect, we're developing a research aspect, and also an educational aspect as well. And so, clinical care is the most important thing or very important in all of this sort of three-arm approach to this program. And what I am trying to do is create a dermatologic home. There's research that suggests that patients of color, particularly Black patients, appreciate having a dermatology space that is built for them. They feel better getting care in a Skin of Color clinic than in a general dermatology clinic. My ultimate goal would be that these clinics don't have to exist, that we're able to provide this same type of care where patients feel as comfortable in any dermatology setting.

KAO: Right.

LESTER: But for now, I think it's important to create a place where these patients feel comfortable coming and returning to. And once we create a place where they feel more comfortable presenting, perhaps we'll see an alleviation of these issues where patients of color are less likely to seek dermatologic care, and they feel satisfied with their care. And as a result of them being in our clinics and in our academic learning spaces, residents and medical students have exposure to these patients and see the nuances that we have to engage in when we're caring for this group of patients.

KAO: Yeah.

LESTER: So, the idea is to center clinical care, and then education and research sort of come after that as an added addition to this program.

KAO: Yeah. As you just referenced a moment ago about accessing dermatological care. So, people of color, half as likely to seek outpatient dermatological care than White, non-Hispanic people. This access to care problem is due to several factors. You've already mentioned the comfort level that people may have in the settings that they are in vis a vis dermatological care, but also include shortages of dermatologists, and dermatologists being among specialties least likely to accept Medicaid. How can we address this access to care problem, given that dermatology is oftentimes seen a financially lucrative specialty, and it's highly competitive among medical students seeking a residency slot?

LESTER: Yeah. I think that is a really important question. And there are probably many different factors that go into this, and I don't pretend to be an expert on all of them. But I think one thing that you mentioned is this issue of Medicaid patients and their access and

disparities of care, which to my knowledge, exists across our medical system. And I mean, there are studies, really, in every disease process of how patients with Medicaid have poorer health outcomes. And thinking about why that could be, that could be an issue of payment. Doctors don't see these patients as having fair renumeration. And so, how can we, or how can the Medicaid system, think about creating a more fair reimbursement system for these patients so they're on par with Medicare and private payers? I think that is a really important question. And I'm not a health care economist, so I can't answer that. But I think that that's probably central to the conversation.

And then your point about medical students, this being seen as a lucrative specialty and medical students really wanting to come to dermatology, maybe for that reason, maybe for others. How can we address the level of debt that medical students are graduating with so they don't feel so pushed to go into a specialty that they see as financially lucrative, maybe for reasons other than caring for all different types of patients and really to make more money. Because the truth is that our medical students are graduating with hundreds of thousands of dollars of debt and with no foreseeable way to pay it off without making a ton of money. So, I think that there are, again, structural issues that feed into this problem. And we identify the issue and then think beyond it and think three steps upstream as to why that might be the case. I think those are two examples that I can think of.

But as an academic dermatologist, I see all different types of patients. I see it as my responsibility and also my pleasure to do that. Because I went into medicine to address issues of access to care, to care for all patients, to not sort of eliminate someone based on their insurance type and am a part of a big institution, so we're able to do that. And I like to assume good intentions and think that if we align things in the right way, most physicians probably would take that stance. But because of the way that our health care system is set up, people feel pressured and are oftentimes unable to do that. So, I think that there are structural issues here that we really need to address in order to fix this problem and ultimately improve patient care and access.

KAO: Yeah, no. I appreciate the points that you've made throughout our conversation about the systemic level, the structural-level issues, the upstream-level issues that need to be addressed in providing quality care to all patients, whether it's in dermatology, whether you're a dermatologist or a non-dermatologist.

LESTER: Right.

KAO: So, I think your points are well taken. So finally, I'd like to end our conversation with a skin, but not necessarily dermatological example of health inequity amplified by this pandemic. So, the pulse oximeter is a device that measures blood oxygen saturation by shining two lights, one infrared and one red, through the finger and sensing how much comes through on the other side.

LESTER: Mmhmm.

KAO: However, studies dating back 15 years have found that dark skin decreases the accuracy of pulse oximetry. Given this and other examples of medical devices and algorithms that encode racial bias, what should dermatologists and the medical profession as a whole be doing to address these problems in advancing health equity?

LESTER: Yeah, I think that central to a lot of these issues is the lack of diversity within health care. If you think about a business team, like in corporate America, they have

shown that more diverse boards--advisory boards, executive boards--mean better products and more productivity, more financial productivity. I think we need to think of that sort of transposed in medicine. We are only as good as the teams that we build because diversity of teams means diversity of thoughts and ideas. And when I spoke to people about the work that I was doing, saying, "I only see dark skin when we're talking about sexually transmitted infections, and I don't see dark skin represented in any other aspect," when I spoke to some physicians about this, they were like, "I never thought of this before. Let's figure out how to fix this." So, sometimes people, I think often, people have good intentions, but they really can operate off their own experiences. I think some people are very good at taking on the experiences of others, and whether they're coming up with a project or interacting with a patient, using that empathy in a way to effect their ultimate product or the ultimate interaction. But some people really are best at using their own experiences when they're operating in life. And so, I think that it creates blind spots for all of us.

So, if we have more teams that have more diversity of thoughts and ideas, things like this wouldn't happen. So, we would have people that are, scientists who are saying, well, based on the physics of this light, we know that passing through a darker pigment may impact the way that the reader is picking up on the pulse ox. And so, we should think about that when we're creating this product.

And I think that medicine has an issue with diversity. Dermatology has an issue of diversity. We know that there are fewer Black men in medical school now than there were in the '70s. So, how can we as a profession diversify to people who make up our professions, that we have a diversity of thoughts and ideas and approaches to problems and solutions as well? I really think that that is central to solving a lot of these issues.

During this pandemic, we've seen, I don't know how active you are on Twitter, but I think Twitter is interesting because it sort of creates an egalitarian access to a podium for a lot of people.

KAO: Yeah.

LESTER: And I have personally noticed a lot of Black women, people that identify as women, being leaders in this sort of discussion of racial disparities. And so, what if we would have given these same people access to this same podium 10 years ago? How would our conversation be much different at this point? So, I think we've noticed the richness that these people bring to this conversation and that we need to enliven our discussion using people from diverse backgrounds or by promoting the voices and amplifying the voices of people from diverse backgrounds.

KAO: Yeah. Well, on that aspirational note, I want to thank Dr Lester for sharing her expertise and insights with our audience today. Dr Lester, thanks again for being a guest on *Ethics Talk*.

LESTER: Thank you so much for having me. I appreciate it.

KAO: For more COVID ethics resources, please visit the *AMA Journal of Ethics* at JournalofEthics.org. And to our viewing audience, be safe and be well. We'll see you next time on *Ethics Talk*. [bright theme music plays]