



COMMENT

Diversity and inclusion in pediatrics: imperative, not optional

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A recent commentary in *Pediatric Research* by Jagsi, Rivkees, and Oipari, published in response to an editorial by Bearer and Molloy, highlighted the need to simultaneously understand and decrease gender bias in academic medicine.^{1,2} Jagsi et al. noted that data from various studies of manuscript principal authorship have demonstrated a lower than expected proportion of women as first or corresponding authors. Reports from the Association of American Medical Colleges (AAMC) and American Medical Association show that women have represented the majority of pediatric trainees for more than a decade, are 57% of academic pediatricians, and that currently represent two thirds of all pediatricians under the age of 54 years.³ Based on these significant changes in the gender composition of pediatric trainees, faculty, and pediatricians, one would expect a higher proportion of women among first and senior authors of scientific papers as well in leadership positions. This disproportionality is a direct rebuttal to any assumption that increased numbers of women in Pediatrics will naturally produce women leaders in equal percentages to women in the field. Consequently, we interpret the low proportion of women in leadership roles as a warning that equity and inclusion will remain an elusive goal unless intentional and sustained action is taken.

In 2015, we published an article assessing diversity and inclusion within departments of pediatrics, based on a survey of the Association of Medical School Pediatric Department Chairs.⁴ The survey was done by the Federation of Pediatric Organizations' (FOPO) Diversity and Inclusion Working Group and had a 49% response rate. The survey found that three-quarters of departments reported having a diversity and inclusion plan that targets gender, race, ethnicity, LGBTQ (lesbian, gay, bisexual, transgender, and queer), and low social class groups. The results showed that three-quarters of residents were women, as compared to half (54%) of faculty and only a quarter (26%) of department chairs. Reported racial and ethnic diversity was low, with <10% for trainees and 0–14% for faculty and leadership positions. Yet, the majority of chairs (69%) reported that they would grade their department as “above average” in terms of diversity-related accomplishments. We interpreted the chairs' positive interpretations of diversity success as an indication of low expectations or a lack of awareness of their data. This discrepancy raises concerns about pediatric leaders' perspectives about diversity, the value of diversity to them, and their ability to advance it.

Whereas the proportion of women in medical schools has reached parity in recent years, the proportion of African Americans, Latinos, and Native Americans (Underrepresented in Medicine (URIM)) is far from achieving population parity. According to 2015 data from the AAMC, 6% of medical school

graduates were African American, 5% were Latino and 0.3% Native American, which is >50% lower than their representation in the national population: 13.4, 18.1, and 1%, respectively. These groups are also underrepresented among pediatricians: Latinos 7.1%, African Americans 5.4%, and 0.2% Native Americans, and even lower for pediatric faculty in US medical schools: Latinos 3.8%, African Americans 4.2%, and Native Americans 0.2%.⁵ Thus, for URIM, improving population equity is essential for improving diversity in pediatrics. In contrast, Asian Americans (6% of US population) represent 15.9% of pediatricians overall and 17.4% of pediatric faculty. However, in our study of department chairs, Asian American faculty was underrepresented among leaders, which suggests that there may be problems with inclusion.

The small percentage of URIM individuals in the health professions pipeline, from medical school to pediatric leadership positions, has been linked to the low numbers of URIM students who have the opportunity to seek a career in the health professions, which is linked to their limited educational and/or financial resources. Yet, even if URIM students are able to enter the health professions, both conscious and unconscious bias limit their academic advancement and leadership opportunities. A review of the literature on minorities in academic medicine by Nivet noted that systemic segregation, discrimination, departmental culture, and elitism in academics affected recruitment, retention, and career advancement of URIM individuals.⁶ A study of 24 US medical schools reported that URIM faculty received tenure at lower rates even after controlling for academic factors.⁷ This finding was reaffirmed in a study that analyzed the AAMC Faculty Roster System. Analyses of National Institutes of Health (NIH) grant funding have reported that URIM faculty received grants at a lower rate than their white counterparts.⁸ In order better understand the academic experiences of URIM faculty, Pololi et al. undertook a qualitative study of URIM faculty in five medical schools and found that URIM faculty reported difficulty related to cross-cultural relationships, the feeling of invisibility, lack of mentoring, lack of role models, overt and covert bias, different performance expectations related to race/ethnicity, devaluing research on community and health disparities, and an unfair burden for responsibility for diversity issues.⁹ While these studies included faculty from all fields of medicine, the findings reflect our anecdotal conversations with colleagues.

In 2002, the Institute of Medicine issued a report, *Unequal Treatment*, and recommended increasing the number of underrepresented minorities in the health workforce as a key to decrease health disparities in the nation and called for action on this issue from national leadership.¹⁰ Unfortunately, these proclamations, positions, and calls to action have not moved us

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closer to equity and inclusion in medicine. This lack of progress is concerning considering the changing demographics and health status of the country, particularly in minority communities, which have the highest levels of health disparities. By 2020, Latinos, African Americans, and Asian Americans will represent the majority of all children, and majority of these children will live in a family in which at least one parent is foreign-born. The growing proportion of ethnically and culturally diverse children is not solely a domestic reality. In the European Union, 80% of population growth from 2012 to 2016 was attributed to immigrants.¹¹ Thus the issues of diversity, inclusion, and equity are also critical for the global pediatric community.

All nations need to maximize the potential of their human capital in order to succeed. With the demographic changes noted above, both in pediatrics and in society, we must maximize our efforts and go beyond the limited progress we made over the past 50 years with regards to gender, racial, ethnic, and cultural diversity. Movement forward will need to include leadership for system change, starting in our educational system and continuing in our academic communities. This change requires consistent data monitoring for evaluation of success and the identification of innovative strategies. We need to examine all systems that impact the pipeline for developing diverse physicians and scientists: premedical education, professional training, professional development, and academic and funding processes that support success.

Thus far, the history of efforts to promote diversity and inclusion in pediatrics has been characterized by uncoordinated and limited data-driven efforts in departments, medical schools, societies, and federal agencies. We call on leaders in pediatric societies, in partnership with AAMC and the NIH, to develop new collaborations through groups such as FOPO to define common ground and thereby integrate professional perspectives and priorities into novel, unified efforts for diversity, inclusion, and equity. We are hopeful that innovative, widespread, and sustained collaborative efforts will culminate in meaningful advances. In our unique role as pediatricians, academic leaders, and child health researchers, we recognize that the world has changed and our future success depends largely upon our ability, motivation,

and will to access all of our human capital to address our most pressing challenges that affect the health and well-being of children, now and in the future.

AUTHOR CONTRIBUTIONS

All the authors were responsible for the conception and design of the commentary, drafting and revising the commentary, and approved the final version

ADDITIONAL INFORMATION

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