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Special Article

American Pediatric Society 2012 Presidential Address: mind the gap

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My American Pediatric Society (APS) presidential address today is titled, "Mind the Gap." It is a call for action using the word "mind" in the sense of recognizing and addressing an important pediatric issue, or "gap." This is a gap that we as leaders in pediatrics must "mind" to optimize the health of children.

Many of us have visited London and traveled by the subway or "tube". At every stop, "Mind the Gap" is broadcasted, which draws attention to the distance between the train and the adjacent platform. The message is so ubiquitous that it is impossible to ignore.

Today, I draw our attention to a growing distance between the racial and ethnic composition of children (our patients) in the United States and the academic and clinical pediatric workforce. As APS president, I considered how the APS might address the diversity gap. As a first step, I looked for data on the degree of diversity within our membership. Although these data are not available, I suspect that we have rather limited diversity among our members. I do know that I was unable to identify an officer or councilor in our 124-year history who was Hispanic, black, Alaska Native, or American Indian. I am pleased to say that, this year, this has changed.

It is important to recognize that diversity is a broad topic and excellence in all environments is enriched by inclusiveness of all members of our society. Today, I will be focusing on racial and ethnic diversity, but I want to emphasize that the importance of inclusiveness is not limited to race and ethnicity (**Table 1**).

What is this pediatric diversity gap and how wide is it? In 2009, there were 73.9 million children and adolescents under the age of 18 in the United States (1). Of that group, 40.6% of our children were from underrepresented minority communities, 3.7% were Asian, and 55.7% were non-Hispanic white (1). The distribution of the pediatric population shows that 24.25 million are between 12 and 17 years, 24.28 million are between 6 and 11 years, and the largest group is the 25.4 million children younger than 6 years. When diversity is assessed in each of these age groups, one can easily see how the demographics of the pediatric population are changing. Among the group of 12–17-year olds, 38.7% are underrepresented minorities; among the 6–11-year group, 40.6% are underrepresented minorities; and among the group younger than 6 years, 42.4% are underrepresented minorities (1) (**Figure 1**). The greatest pediatric population growth has been in the Hispanic population. This growing minority pediatric population now outnumbers Asian and non-Hispanic white children in 12 states and the District of Columbia (2).

The pediatric physician workforce looks dramatically different. Data from the Association of American Medical Colleges show that pediatricians in the United States are 73.2% non-Hispanic white and 12.3% Asian. Only 14.3% of US pediatricians are from underrepresented populations (3). The discrepancy in the demographics of children and pediatricians is dramatic (**Figure 2**).The current wide gap between the underrepresented in the pediatrician workforce and the minority pediatric population was predicted in 2000, when the relative ratio of minority pediatricians to the minority pediatric population was approximately twice what we see today (4).

Demographic data for academic pediatricians are not available. A survey of the Academic Pediatric Association asked members to self-identify their race and ethnicity. Approximately 4% of members identified as Hispanic and 4.4% as black (Benard Dreyer, personal communication). It appears that a pediatric diversity gap exists within our academic community.

Although a gap in numbers exists, I do not perceive the primary goal of developing a more diverse and inclusive pediatric community as reaching a numbers target. Rather, I would like to see a healthy "place" for all children and pediatricians from all backgrounds within our pediatric community. When I was a medical student, women did not have a "place" in medicine. Only 7% of my medical school class was composed of women. Due to the exclusion of many female applicants to medical school, for many years medicine was deprived of half the talent pool. With widespread attention, the gender gap, in terms of numbers, has improved greatly. But without including representatives of all racial and ethnic backgrounds in the field of pediatrics, we continue to be deprived of a significant talent pool in our quest to improve the health of children.

Many medical reasons exist for closing the diversity gap. Diseases discriminate against some segments of our population. Hypertension is one example of a health disparity. Prehypertension and hypertension have become significantly more prevalent in Mexican–American and African–American children (5). The terrible toll of prematurity and its consequences are severe in the African–American community. In 2010, 17.15%

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Table 1. Domains of diversity

Ethnicity	Gender
Race	Lifestyle
Socioeconomics	Spirituality
Age	Political views
Sexual orientation	Religion
Experiences	Context: school, work, social set, community, organization, geography, family
Physical abilities	

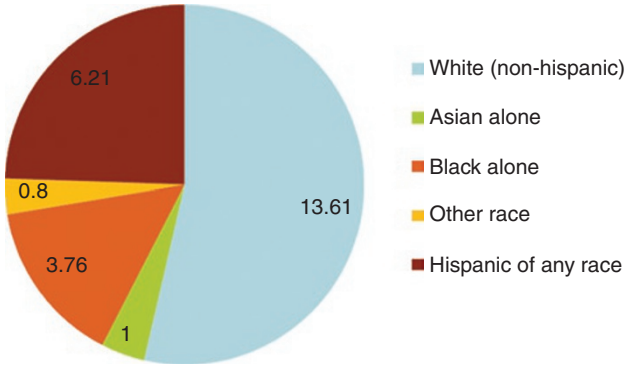

Figure 1. Ethnic and racial distribution of US children younger than 6 years (in millions). Raw data source: ref. (1).

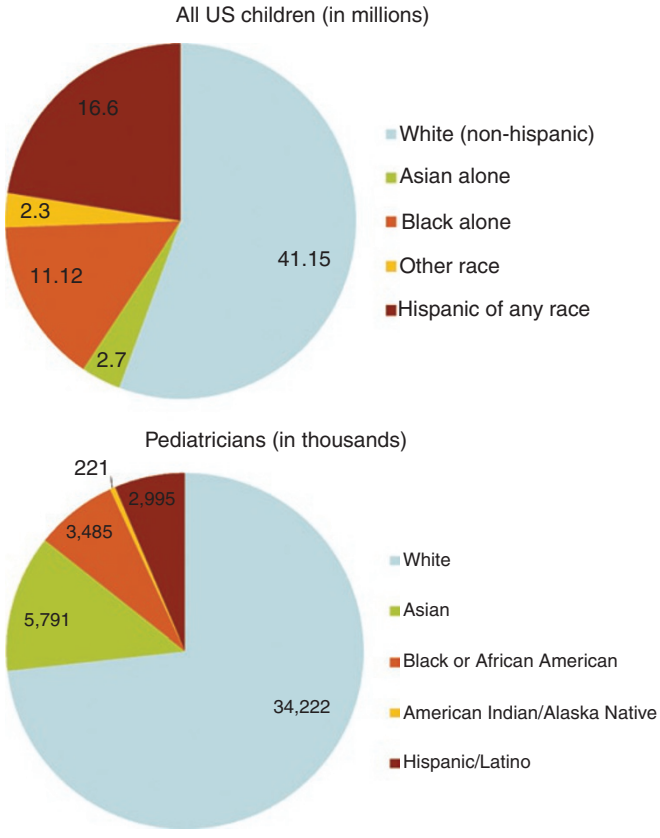

Figure 2. The gap between US children and pediatricians by race and ethnicity. Raw data sources: refs. (1,3).

of African–American births occurred prematurely (6). The dramatic epidemic of childhood obesity disproportionately affects minority populations (7). Even worse, the consequences of these disorders also are not egalitarian. Although one-third of obese children in our country are at risk for developing diabetes, one-half of minority children who are obese are at risk for developing diabetes (8,9). These examples are just some of the disparities that exist in many areas of child health (10–12).

Research examining health disparities has not seen adequate progress. One explanation is the lack of inclusion of minority communities in clinical trials. The common belief is that patients from minority communities refuse to participate because they do not trust the research community. Although there is a level of truth to this belief, studies show that when asked to participate, minority patients participate at the same rate as white patients (13,14). An additional potential challenge to research in health disparities may be the reduced funding of minority scientists. Ginther reported that R01 applications from PhD African–American scientists have a lower funding rate, and grants from minority scientists represent a small proportion of the pool of grant applicants (15).

The cost of health inequities in our country is significant not only in social currency but also in dollars and cents. Health disparities in minorities increased direct medical care expenditures by $229.4 billion for the years 2003–2006. On the other hand, eliminating health inequalities for minorities would have reduced indirect costs associated with illness and premature death by more than $1 trillion between 2003 and 2006 (16).

Quality of care also demonstrates disparities. Faculty at our institution reported that serious adverse events in a hospital setting are more common in families in which English is not the first language. Use of interpreters did not lower the risk (17). In an era where quality of care is a focus of every health system, provider, and payer, quality of care is actually worsening for a third to half of minority patients as compared with white patients (18).

Gaps between racial and ethnic communities erode trust, and there are trust issues in health care. In a study examining responses to clinical vignettes, investigators found that medical students had implicit preferences for working with white patients (19). Implicit biases are unconscious influences on our actions. A similar study found that pediatricians also have implicit preferences for white parents. This implicit preference was associated with perceived noncompliance in African–American parents (20). In a study of patient trust, African–American families had greater trust with their providers when they received medical care in community health settings rather than in private offices or university hospitals (21).

We are taking action to narrow the diversity gap. As the officers of the APS and I began to review our strategic plan this past year, we realized that we had not adequately considered diversity and inclusiveness in our initial strategic planning. I would like to acknowledge that the Academic Pediatric Association, in contrast to our Society, has included the issue of diversity and inclusiveness as an organizational priority for a number of years.

As I assumed the APS presidency, I formed a task force of leaders in our Society to guide us in considering how we might address

Table 2. Our more inclusive mission statement

The mission of APS is to advance academic pediatrics.
APS will accomplish this mission by promoting pediatric research and scholarship, serving as a strong and effective advocate for academic pediatrics, recognizing and honoring achievement, and cultivating excellence, diversity, and equity in the field of pediatrics through advocacy, scholarship, education, and leadership development.

APS, American Pediatric Society.

the diversity gap. Dr. Elena Fuentes-Afflick chaired our task force. This task force was charged with recommending how the APS should include diversity and inclusiveness in our mission, values, and strategic plan. The report was submitted to the Council in fall of 2011. On the basis of their recommendations, our mission statement has been amended to include the values of diversity and inclusiveness (Table 2). In addition, a new core value was added to our APS value statement. This value states: "Diversity, equity, and inclusion are essential values for academic pediatrics, pediatricians in training, and the practice of pediatrics." Another recommendation that was accepted from the task force was to form a standing committee for diversity and inclusiveness. I urge you to learn more about the activities of this committee and to support the committee's initiatives as they are developed.

The APS is composed of leaders in the field of pediatrics. We have tremendous influence over our national and local organizations and their cultures. I encourage you to study how one can be more effective in creating an inclusive culture in one's own sphere of influence. Excellent references exist to assist you as you begin your journey (22).

What can we do as individual leaders in our local environments to make a difference in addressing the diversity gap? First, we can look at our own departments' and divisions' commitment to diversity. Does your department's mission statement make explicit how diversity and inclusiveness relate to your mission? Under the leadership of Dr. Leslie Walker, professor and chief of the Division of Adolescent Medicine, our Department of Pediatrics at the University of Washington recently updated our mission statement to clearly identify a commitment to inclusiveness. Our faculty was very enthusiastic about this clarification in our mission. Dr. Walker has also been an inspirational leader in developing an inclusive culture in the Society for Adolescent Health and Medicine (23).

I urge you to get involved with underrepresented students at your institutions and introduce them to the career opportunities in pediatrics. Perhaps with our active engagement, a greater number of underrepresented students will join us as pediatrician colleagues.

Just like the subway in London bellows "Mind the Gap," I urge you to make inclusiveness and diversity a clarion value that is heard and acted upon whenever you have the opportunity to recruit, or to appoint members to local and national committees. Without underrepresented colleagues on our nominating committees, it is less likely that our outstanding minority colleagues will be identified as candidates for leadership positions. Our department is in the process of developing tool kits for search committees to guide broad-based inclusive searches as another effort to identify diverse candidates. There are many opportunities for each of us to begin to close the diversity gap. Thank you for your commitment to improving the health of children from all communities.

REFERENCES

1. A Child's Day, Characteristics of children under 18 and their designated parents, 2009 (http://www.census.gov/hhes/socdemo/children/data/sipp/well2009/tables.html.) Accessed May 2012.
2. US Census, Population Estimates, State Characteristics, 2011. (http://www.census.gov/popest/data/state/asrh/2011/index.html.) Accessed May 2012.
3. AAMC. Diversity in the physician workforce: Facts and figures 2010. 2010:75.
4. Stoddard JJ, Back MR, Brotherton SE. The respective racial and ethnic diversity of US pediatricians and American children. Pediatrics 2000;105(1 Pt 1):27–31.
5. Din-Dzietham R, Liu Y, Bielo MV, Shamsa F. High blood pressure trends in children and adolescents in national surveys, 1963 to 2002. Circulation 2007;116:1488–96.
6. National Vital Statistics Reports. Vol 60, No 2. November 17, 2011. Births: Preliminary data for 2010. <http://www.cdc.gov/nchs/data/nvsr/nvsr60/nvsr60_02.pdf>.
7. Anderson SE, Whitaker RC. Prevalence of obesity among US preschool children in different racial and ethnic groups. Arch Pediatr Adolesc Med 2009;163:344–8.
8. Narayan KM, Boyle JP, Thompson TJ, Sorensen SW, Williamson DF. Lifetime risk for diabetes mellitus in the United States. JAMA 2003;290:1884–90.
9. Mokdad AH, Marks JS, Stroup DF, Gerberding JL. Actual causes of death in the United States, 2000. JAMA 2004;291:1238–45.
10. Floros J, Londono D, Gordon D, et al. IL-18R1 and IL-18RAP SNPs may be associated with bronchopulmonary dysplasia in African-American infants. Pediatr Res 2012;71:107–14.
11. Wu AC, Smith L, Bokhour B, Hohman KH, Lieu TA. Racial/ethnic variation in parent perceptions of asthma. Ambul Pediatr 2008;8:89–97.
12. Montes G, Halterman JS. White-black disparities in family-centered care among children with autism in the United States: evidence from the NS-CSHCN 2005-2006. Acad Pediatr 2011;11:297–304.
13. Getz K, Faden L. Racial disparities among clinical research investigators. Am J Therapeutics 2008; 15:2–11.
14. Murthy VH, Krumholz HM, Gross CP. Participation in cancer clinical trials: race-, sex-, and age-based disparities. JAMA 2004;291:2720–6.
15. Ginther DK, Schaffer WT, Schnell J, et al. Race, ethnicity, and NIH research awards. Science 2011;333:1015–9.
16. LaViest TA, Gaskin DJ, Richard P. The economic burden of health inequalities in the United States. Joint Center for Political and Economic Studies 2009:1–15.
17. Cohen AL, Rivara F, Marcuse EK, McPhillips H, Davis R. Are language barriers associated with serious medical events in hospitalized pediatric patients? Pediatrics 2005;116:575–9.
18. Distribution of changes over time in racial, ethnic, and socioeconomic disparities for selected core quality measures, 2000–2002 to 2005–2007. Unequal treatment. Confronting, racial and ethnic disparities in healthcare. US Department of Health and Human Services, 2009.
19. Haider AH, Sexton J, Sriram N, et al. Association of unconscious race and social class bias with vignette-based clinical assessments by medical students. JAMA 2011;306:942–51.
20. Sabin JA, Rivara FP, Greenwald AG. Physician implicit attitudes and stereotypes about race and quality of medical care. Med Care 2008;46:678–85.
21. Horn IB, Mitchell SJ, Joseph JG, Wissow LS. African-American parents' perceptions of partnership with their child's primary care provider. J Pediatr 2011;159:262–7.
22. Loden, Marilyn. Implementing Diversity. Chicago, IL: Irwin Professional Publishing, 1996.
23. Walker LR. Health equity and adolescent health: a call to action for the Society for Adolescent Health and Medicine. J Adolesc Health 2011; 48:530–2.