Pediatric RESEARCH

www.nature.com/pr

COMMENT

Valuing and achieving diversity in academic medicine

The APS and SPR Virtual Chat Series

Marva Moxey-Mims[1], Robin Steinhorn[2] and Elena Fuentes-Afflick[3]

Pediatric Research (2022) 92:349–356; https://doi.org/10.1038/s41390-020-01287-4

Steve Abman (SA): Once again, thanks for joining us today for another session of the American Pediatric Society (APS)—Society of Pediatric Research (SPR) Virtual Chat Series on academic pediatrics. This series was initiated to develop a new forum for discussing a wide range of topics as related to training, education and research; career development and transitions throughout one's academic lifespan; challenges facing academic leaders; balancing academic missions with financial stresses; achieving and sustaining values supportive of equity, diversity and inclusion; and other topics. Our audience continues to include a wide range of participants including students, residents and fellows; junior and senior faculty; section chiefs, department chairs and deans, and others, to enrich discussions and to better link the stages of multiple roles involved in the pursuit of our academic missions. These "chats" are informal or "conversational" in nature to encourage more straight talk from panel members and the participants.

We are delighted to have three outstanding panelists today to address the topic of "Valuing and Achieving Diversity in Academic Medicine." This is especially timely as we would like to begin our session by briefly reflecting on the very recent passing of two extraordinary women. First, we recognize the remarkable Ruth Bader Ginsburg, the legendary Supreme Court Justice, for her extraordinary achievements as a pioneering advocate for women's rights. Among so many lessons we have learned from her career, it is poignant that we recall that despite graduating number one in her class at Colombia Law School, she had difficulties finding work because she was viewed as being a woman, a mother, an immigrant, and a Jew. Her ability to successfully overcome these barriers to achieve her many successes and change society reflect her amazing brilliance, resilience and vision. The second is Dr. Maria Delivoria-Papadopoulos, whose outstanding career as an academic leader in Neonatology left an impressive legacy. In addition to her many achievements as a clinician-scientist, teacher and educator, Maria will be further remembered as a strong role model, especially for women who are developing academic careers.

As we reflect and honor their legacies, their impact sets the stage for our discussion today, which is on issues related to equality, diversity, and inclusion in academic pediatrics. We are very pleased to introduce our panelists for today's seminar. Dr. Marva Moxey-Mims is Professor of Pediatrics at George Washington University (GWU) and the Chief of Nephrology at National Children's Hospital. Her career is marked by outstanding leadership at the NIH, where she served in several roles, including the Director of Pediatric Nephrology and Deputy Director of Clinical Research at the NIDDK. In addition to her extensive CV, she is a member of the Anti-Racism Coalition Steering Committee at GWU.

We also are pleased to have Dr. Elena Fuentes-Afflick join us today. After completing her undergraduate and medical school at the University of Michigan, she headed to the University of California, San Francisco (UCSF) for training in Pediatrics, as well as epidemiology and health policy. Dr. Fuentes-Afflick joined the faculty at UCSF, where she rapidly ascended the ranks to many leadership positions, including Professor and Chief of Pediatrics at the Zuckerberg San Francisco General Hospital, and Vice Dean for Academic Affairs and Faculty Development for the UCSF School of Medicine. She has had numerous achievements and received many awards nationally, including serving as past president of the APS, Home Secretary of the National Academy of Medicine, and many others. Her scholarly work has focused on the impact of race, ethnicity, and culture on health outcomes, and she has been an extraordinary advocate for promoting diversity. Her training and mentorship record is especially remarkable, as she has deeply influenced so many professional careers.

Our third panelist is Dr. Robin Steinhorn, who has been an outstanding clinical, scientific and administrative leader in Neonatology and Pediatrics more broadly. Her research has markedly influenced our understanding of pulmonary vascular biology and neonatal lung diseases through basic and clinical studies. Dr. Steinhorn has served as Head of Neonatology at Northwestern University, the Chair of Pediatrics at UC Davis, Senior Vice President at Children's National Hospital, and currently is the President of Children's Specialists of San Diego at Rady Children's Hospital, San Diego.

Finally, I am pleased to introduce Dr. Stephanie Davis, President of the SPR and the Chair of Pediatrics at the University of North Carolina, who will be moderating our discussion today.

Stephanie Davis (SD): Thank you, Steve. We are really excited about having Dr. Steinhorn, Dr. Moxey-Mims, and Dr. Fuentes-Afflick serving on our panel today. Each speaker will share a personal story and I will then ask one question. After they've each spoken, we will then share questions and comments from the audience. Please type any questions or comments in the chat box. Our first speaker will be Dr. Robin Steinhorn.

[1]Children's National Hospital, Division of Nephrology, Department of Pediatrics, The George Washington University School of Medicine, Washington, DC, USA; [2]Rady Children's Hospital, San Diego, Department of Pediatrics, University of California, San Diego, San Diego, CA, USA and [3]Department of Pediatrics, Zuckerberg San Francisco General Hospital, University of California, San Francisco, San Francisco, CA, USA
Correspondence: Elena Fuentes-Afflick (Elena.fuentes-afflick@ucsf.edu)

Received: 28 October 2020 Accepted: 29 October 2020
Published online: 19 November 2020

Robin Steinhorn (RS): Thank you so much, Stephanie, and it's such a privilege to join a panel of this stature. I could certainly start with stories of applying to residency and being asked if I intended to marry and have children. These are true stories, but, frankly, it was common practice at the time, and nothing I thought very much of. I think I really began to confront issues of gender equality in the fall of 1990, when I was a newly minted neonatologist at the University of Minnesota and gave birth to my second child. Thankfully, I escaped a second encounter with premature delivery, but still found myself as a young assistant professor, trying to learn how to be an attending, how to do ECMO (very new technology at the time), what academic life was supposed to look like, as well as a mom to two young kids, along with a jealous and very high maintenance cat.

So, a couple of months later, my husband, a pediatric intensivist, very proudly comes home and announces that we are moving to Buffalo, New York, so he can help launch their PICU program. This was not great news, but since he was my life partner, I soldiered on and went to interview, feeling every inch the trailing spouse and thinking my professional life was over. Instead, my time in Buffalo launched my career in a way I could not have imagined at the time.

I will always treasure my time in Buffalo, largely due to three truly extraordinary mentors: Bruder Stapleton, who was the Department Chair, Rick Morin, the Division Head, and James Russell, my Research Director. All three men helped me step by step, as I tried new things and navigated the inevitable failures, which included my first three grant applications coming back in flames onto my desk. For quite a while, I'm pretty sure they believed in me way more than I believed in myself! Thanks to their support, my professional life was far from over. Instead, these mentors helped me establish my career with my first independent science project and R award. And as a result, 9 years later, I accepted a Division Head position at Children's Memorial Hospital in Chicago (a move that was only possible because that same husband said heck yes and moved his position to Chicago without hesitation).

In Chicago, one of my most important teachers turned out to be one of my faculty members, Ruth Deddish, who was a brilliant clinician and who helped hammer the concept of work-life balance through my thick head as it became clear that my mother was dying and entering her last weeks of life. I remember Ruth telling me that it was not a sign of weakness to take a leave to take care of my mother. That year was, without doubt, my least productive year academically, but I will always view it as one of the most meaningful pillars of my life. And when I came back to work, my division, my clinical expertise, and my science were waiting for me. In return, during my 14 years at Children's, I built a division of brilliant faculty members that just happened to be mostly women. I learned, some years later, that there was a regional joke that I only hired women. This was puzzling to me at the time, because I was doing only what came naturally, with a focus on finding the best people, and frankly, our division simply reflected the national demographic of pediatrics.

In 2012, I left Chicago to become Chair of Pediatrics at UC Davis. This was a period of intense learning for me as a leader and I was incredibly fortunate to work with David Acosta before he went to the AAMC as the Chief Diversity and Inclusion Officer. David is the person who taught me that diversity is only achievable when we are intentional and focused. At first, these concepts felt daunting to me, and I was more than a little embarrassed by my lack of knowledge, much the way I felt back when I was a young trainee. But in his soft-spoken way, David held small group sessions and taught specific skills on how to overcome our individual and collective unconscious biases, and recruit faculty and trainees that represented diverse backgrounds. And, like any trainee, I got better over time as I learned and put these practical strategies to work. These concepts have served me well over the last decade and have led me to recruit leaders who have been more competent, resourceful, and diverse than I ever would have expected. Working with these leaders has been one of the greatest pleasures of my career.

So, to finish up, here are three things I would like you to know. The first is that what Steve and Stephanie have put into motion through these chats is incredibly important. We need to share our stories and learn from each other, and then enlist each other. My most powerful learning about diversity and equity has happened through the gifts of stories from my colleagues. Young women have taught me that the challenges they are facing in at creating work life balance in 2020 are, in most ways, much harder than what I faced in 1990. Intelligent, capable, and trusted black colleagues have told me about their fear of being pulled over by the police, which was unimaginable to me, and made the problem feel like a close and personal one. And when I came here to Rady Children's, our Chief Medical Officer described her reaction after the death of George Floyd with the grief and tears of a mother of three black sons. She made me see what had happened in Minneapolis with new eyes and I hurt as a fellow mother. These stories have deepened my resolve to do whatever I can to create a better career and life for our female, black and URM trainees, faculty, and leaders. All of this takes courage and patience. Speaking out is hard. Listening and learning is hard, but that discomfort is essential to making real progress.

The second thing is no matter what else we're dealing with, we must continue and sharpen our focus on women. We are a specialty that is majority female, but we have continued leaks in the pipeline and unacceptable underrepresentation at the Division Head, Department Chair and Dean levels. More than a third of women report overt sexual harassment during their medical school and postgraduate training years, and we lose too much female potential during mid-career, as women navigate the challenges of raising children, taking care of their parents, and ultimately lose touch with their optimism.

Even today, I regularly hear colleagues refer to childbearing as a problem for the women in their divisions. While I agree it's always messy to figure out the logistical issues of clinical coverage, we need to stop being surprised when women of childbearing age bear children! I'll add that enlisting men to 'lean in' at home by creating paternity leave and other family-oriented policies is good for dads and absolutely great for kids.

Finally, mentors and sponsors really are the secret sauce to success. I mentioned Bruder Stapleton as a major factor in launching my career. It was more than 20 years later, during his APS Presidential address, that I realized how intentionally he had supported the careers of women and URM faculty. And his influence was so broad and extensive, I wouldn't be at all surprised if Elena and Marva mentioned him during their chats. Your mentor does not need to look like you to do their job, and you don't need to look like your mentee to do a great job for him or her. All of the mentors and sponsors that were most influential in my life have been men!

Finally, Steve mentioned the notorious RBG, who was such an icon for the rights of women and minority groups. We've lost somebody who only comes once in a generation. One of her quotes has always stuck with me: "I would like to be remembered as someone who used whatever talent she had to do her work to the very best of her ability". As I thought about the words of this giant of a woman over the weekend, I hope we will all honor her and pay forward the blessings of our careers through mentorship of the next generation of physician leaders. They will undoubtedly contribute more than we have.

SD: Thank you, Robin! That was fantastic and thank you for sharing your experiences and how it has really shaped your approach to dealing with equity, diversity, and inclusion in academic medicine. What programs have you implemented in your institution to promote diversity, equity, and inclusion?

RS: My answer is one that continues to evolve over time. As I join different institutions and learn along the way, I would say, that recruiting practices that bring in a full and diverse slate of qualified leaders is key. I learned from Dr. Acosta that always demanding a list of finalists with at least one woman and one person from a URM background is a best practice and one that I follow to this day. I've learned to be quick to bring in a search firm to accomplish this goal if needed. I know it costs more money, but a search firm has the time to find and talk to more people than I am likely to do as an individual.

As I arrived at Rady Children's, the national crisis around diversity has thrown a spotlight on the importance of our institutional diversity practices. I have joined our organization in creating an action plan and diversity council and have invested in an external consultant to facilitate specific listening sessions and training for our physician group. I have also used my connections through my former institutions as well as APS to connect my Rady Children's colleagues to others who have adopted best practices in implementing an anti-racist approach to residency recruitment.

Finally, providing support to leaders as they come into an organization is a best practice for everybody, but I think it's particularly essential for women and URM leaders. I would normally send new leaders away to the Harvard course to really get them immersed in leadership training and networking. I can't do that right now thanks to the pandemic but continued to search for those opportunities to invest in and create connections for our young and growing leaders.

SD: Thank you! Very wise words for all of us! Dr. Moxey-Mims will be our next speaker. She will share her personal story and how she approaches equity, diversity, and inclusion in academic medicine.

MMM: Thank you. I wanted to start first by thanking APS and SPR for asking me to be part of this panel. I was quite overwhelmed to be invited to be on a panel with Robin and Elena, and I really appreciate you giving me this opportunity. So, my perspective may be a little different. I'm from the Bahamas. Coming from a country that's majority black, and growing up where all the leaders are black, doesn't strike you as odd, because it's how you grew up. I will say, however we did have a television. And while we didn't, at that time, have any local television stations, we did see all the US television stations, and I don't need to tell you what we saw on the TV. It gave me a particular perspective about what was going on in the US.

So, when it came time for higher education, I will say that the US was not a place that readily came to mind. It didn't look as if it would be a necessarily welcoming place for someone who looks like me. I actually went to college in Canada. I was at McGill, which was very diverse, and I thoroughly enjoyed my time there. But when it came time for medical school, for some strange reason, I thought, you know, I have never gone to school in the US and maybe it would be an interesting place to go to school. But I purposely decided I wanted to go to an HBCU. My rationale was that one hears that medical school is plenty difficult and intense enough. And I thought, why would I want to make my life more complicated by being in the minority in the school where I went? And for those people who are of minority background, whether in the Caribbean or Africa or elsewhere, Howard University has the moniker of being "The Mecca " for medical education for minorities. And so that's where I decided to go to medical school. I thought I was going to be in an environment where I was comfortable, and my focus could be on my studies and not on all of the social stuff that might impact me.

And there, we were surrounded by examples of excellence by minority physicians. I felt very much at home. We had people like Dr. Roland Scott, who I know Dr. Fuentes-Afflick mentioned in her address several years ago, who was, I think, the first African American to become a member of APS. We had Dr. LaSalle Leffall, Dr. Lester Henry, Dr. Melvin Jenkins (the Chair of Pediatrics), when I was there. You were just surrounded by these people who pushed you and told you that the only acceptable standard was excellence. But that was also where I began to hear the mantra that you have to be better, to be considered equal. We were in a protective bubble, but we would have to branch out for our careers, and doing something just as well as the other person who is the majority might not get you the deserved recognition.

I chose to come to Children's for my pediatric residency. It was an easy choice. It was local. I liked Washington, I didn't have to move, and they had a great program. I was one of, I can't remember exactly how many, a handful of underrepresented minority residents, but we were a close-knit group, and I think we had a wonderful time here.

My first real job after training was at Buffalo Children's. As Robin mentioned, one of my mentors, one of my first and best mentors was Dr. Bruder Stapleton. I often tell people he's probably the only person on the face of God's earth that could have convinced me to move to Buffalo, New York. I remember my husband and I talking to each other wondering if they even had black people in Buffalo. Do we really know what's going to happen when we move there? But we did move there, and there was a small minority community. The hospital itself was very welcoming, and I think that's a credit to Bruder's clarity about inclusion and diversity, and the fact that he wasn't going to accept anything less.

We eventually moved back to Washington. My husband's dad became ill. We wanted to be closer to family, so we returned to DC. And I was again here at Children's for a few years. I had a couple of kids and, made the tough decision at the time, that I just didn't have the work-life balance that I needed to be in academic medicine, and to take care of my small kids, with the size faculty that we had in the division at the time, and so I left.

I had a short stint at the FDA, and then took on a job that I thought was better suited to me at the NIH, where, as was mentioned, I spent a significant amount of time, about 15 years, before returning to Children's as Division Chief.

One of the interesting things I learned, even though I kind of intuitively knew it from practice, (but being at the NIH and having time to look at the data and confirm), was the significant disparities in certain diseases including within my specific specialty. And I'm embarrassed to say that it wasn't until I was at the NIH that I learned about the Heckler Report. It was this huge report that had been put out by the U.S. Department of Health in 1985 that clearly delineated, even then, the disparities in a myriad of chronic diseases in the minority populations. And I only learned about it in 2015 when there was discussion about the fact that it was then 30 years since this report had been issued. And so, I took the time to go through it and I've learned many things.

The other thing that coalesced with that, was that I'd been aware of being in many rooms where I was maybe the only person of color in the room of my subspecialty partners, or, maybe there were one or two others. There were only two people that I can think of as black pediatric nephrologists at the time that were going through my training. I'm happy to see that the numbers have grown now, which is particularly important, because the diseases that we deal with impact the minority population so much more, that I think it only makes sense that you would want to have more minority physicians in the field. I think it's helpful for patients to see people who look like them, and who they feel they can relate to.

You know, I work here in DC, where we see a diverse group of patients, and I think, again, it just makes sense that the people who are taking care of these patients should also reflect that diversity. Let me tell you about one of the things that made me speak out in the past. People who've known me for a while, know that my reflex is to avoid conflict and I've had to learn to overcome that reflex. An organization that I belong to, a professional organization, a few years ago, like many organizations, decided that they were going to make a push for more diversity and inclusion. And they put out this

grand statement that they wanted to do this. But in that statement that they put out, near the end, they made this comment about, but that doesn't mean we're lowering our standards. And that just made my hair catch on fire. So, I called up the President of the organization and I asked why they would feel it necessary to say that, since it should go without saying. People have to meet all these various criteria professionally to become members, so why was that comment necessary? And I am disappointed to say I didn't get a satisfactory answer. It's one of the things that really, really got under my skin, especially because, as I told you, of this push in my training all along from medical school, that our goal is excellence. And so, to have somebody imply that if they're going to increase diversity, that might mean that excellence is compromised, really hurt me to the core.

So, to move on to my situation right now, I will say that I am honored to be here at Children's National, especially in these past few months with everything that's been going on. Our CEO, Dr. Kurt Newman started a series in the last several months highlighting people from underrepresented backgrounds, having town halls where people could tell their story, their journey dealing with racial bias and insensitivity. And it's just been, so moving. There are people who have been in our auditorium speaking to the entire hospital community in tears, about not just their experience, but the ability to now share that experience, which allows people to see them as a whole person, not just somebody walking down the hall and you don't know what they've been through.

I've been brought to tears myself, watching and listening to some of the stories that have come out. We now have a diversity and inclusion town hall twice monthly. As was mentioned during my introduction, I'm one of the representatives from Children's on the GW Anti-Racism Coalition Steering Committee, and I'm really looking forward to the type of work that we can do. I've hired five people in the 3 years that I've been here at Children's. Like Robin, it's coincidence, they've all been women, and two of them are black women, of which I'm very proud.

I've heard comments from parents, that they are just thrilled. It's amazing how people come up to you and say, you know, doctor so and so was just wonderful. Or my daughter was just so happy to see somebody who looks like her taking care of her. I think I'm going to stop because I wasn't watching the timer. I don't know if my time is up, but, certainly, there will be opportunities to answer questions as well. So, thank you.

SD: That was great! Thank you for your honesty and for sharing your personal story. As a Division Chief, how have you personally promoted diversity, equity, and inclusion within your division?

MMM: Yes, as I mentioned, two of the five people that I've hired in the last couple of years were black women. So that's one way of doing it. The other way, I think, is supporting the people that you hire, letting them know that you have their back.

I went to Robin's Office one time, when she was still here, because I got wind of something that had happened with not one but two of my minority faculty having a negative interaction with a nurse. And, again, with my background, racial bias and prejudice isn't necessarily the first thing that comes to mind. And I know that may seem like I'm naïve. I'm always thinking, well it must be something else, but in this instance, I just thought, this was bias. And I actually went to Robin and I said "Am I crazy?" I described what happened and she was very supportive and I ran it up the hierarchy and all the way up to the higher levels of nursing to have it addressed. I think that is one of the things that's really important in dealing with folks you hire, letting them know that you have got their back and you're not going to hang them out there to try and figure it out on their own. I think we owe that to somebody if we hire them.

SD: Thank you so much. Our third speaker is Dr. Fuentes-Afflick. She will now share her personal story and how she approaches equity, diversity, and inclusion in academic medicine.

EFA: Thank you. Good afternoon, everyone. Greetings from San Francisco. Steve and Stephanie, thank you so much for including me in this panel. Robin and Marva, thank you for sharing your own stories. I've learned that it's hard to be the final panelist! I'm going to try to offer comments that haven't already been shared but much of what has been said resonates with me. As panelists, we were asked to comment on whether or not there was a sentinel experience that solidified or crystallized, our commitment to diversity, equity, and inclusion. For me, these issues have been central to my personal and professional lives as long as I can remember.

In 1986, as Steve mentioned, I moved from the University of Michigan to the University of California, San Francisco, to begin my internship. And I've always been based at San Francisco General Hospital, the public hospital within a public university, which, as we like to say, is it's as real as it gets. In 1986, it didn't get too much more real. At that time, AIDS was in full swing, crack cocaine was everywhere, and gang-related violence was an everyday experience in the clinical setting.

As a trainee, within the walls of the hospital, our clinical experience was influenced by fear, discrimination, racism, and trying to define the way that the community should respond to these public health crises. I remember very vividly that there was a vigorous public debate between two orthopedic surgeons in San Francisco, one who had a very public position on caring for anyone who presented for care and another who refused to operate on HIV-infected patients. The controversy between these surgeons, which was in the public domain, opened my eyes to the ongoing way that discrimination can affect the care that we deliver, and inspired me to use our professional platform as a way of being actively engaged. I also witnessed, from my own colleagues, the way that some people responded to the patients we took care of, particularly those who had been wounded in shootings, stabbings, and other types of violent incidents, which were very common at the time. These young patients were mostly African American and Latino men, and some of my colleagues seemed to act as if the young men deserved what happened to them because of what they may have been doing. This was an example of how race and ethnicity can influence our clinical care.

My clinical practice has always focused on the care of Latino patients, primarily immigrant families. I've experienced the challenges of our national immigration policy through the eyes of my patients, because most of the children in my practice are US-born, but many of their parents are undocumented, and I have helped families deal with many factors that affect mixed status families. The families have taught me a lot about our policies about discrimination, and that was way before COVID. But the impact of discrimination is evident, including the disproportionate impact of the COVID epidemic on Latino and African American patients, which we have experienced at San Francisco General Hospital.

Apart from my clinical experiences, I've been actively engaged with issues related to diversity, equity, and inclusion in many organizations. I really hope that Dr. Bruder Stapleton is participating in our seminar today, because although we didn't script it, Bruder has also had a powerful impact on my own career. As a newly-minted APS member, Bruder asked me to chair a task force on diversity, equity, and inclusion for the APS. We soon became a committee and we implemented scientific programming at the PAS Meetings. Our committee also created a database of APS members, so we could track the diversity of our members. At the time we formed the task force, we didn't know the gender or racial/ethnic representation of our members. I believe that our Committee on Diversity and Inclusion has created a path for the APS. I've also been involved in efforts with the Academy of Pediatrics, and, more recently, with the National Academy of Medicine. It is my fervent hope that as our organizations react to what is happening in our country and world that we actively

embrace the goals of diversity, equity, and inclusion, and that we achieve meaningful change.

Finally, as a Latina woman who's married to a black man from Jamaica and has two adult sons, the issues of race, ethnicity, opportunity, and discrimination are never far from my mind or my heart. Thank you.

SD: Thank you. That was really great. Can you describe barriers you encountered when promoting diversity, equity, and inclusion at your institution?

EFA: UCSF is a special place, California is unique, and while every place may be unique, in San Francisco we're proud of our openness of spirit. Even so, our university is not as diverse as we need to be. In my Dean's role, I've worked with Dean Talmadge King, who is an ardent and long-standing supporter of diversity and inclusion. I participated in the creation of the School of Medicine's Differences Matter initiative, which is a multi-year, multi-million dollar effort to promote diversity and inclusion.

We have also tried to disseminate these efforts to the level where we all engage, committee service. In my first year in the Dean's office, I signed many forms to approve committee membership. At the time, committee chairs had to document that there was at least one woman or underrepresented person on each committee. As I signed the forms, I became convinced that one woman or underrepresented person on each committee seemed like a token. We need to do better! After a year, I worked with my colleagues in the other health professional schools at UCSF and we changed the expectation to 25% women or underrepresented people. The following year, I pushed for an increase to 50%, but my colleagues weren't ready. So, I turned to Dr. Talmadge King, Dean of the School of Medicine, and he agreed to implement the expectation that 50% of all committees within the School of Medicine would be comprised of women or underrepresented individuals.

In response to the question about barriers, when I presented the plan of increasing the representation of female and underrepresented committee members to the department chairs, some were concerned that they wouldn't be able to identify sufficient numbers of women or underrepresented people for every committee. We analyzed the faculty members and realized that among our 2,700 faculty members, 52% are women and underrepresented men, so you could almost pick names from a hat and achieve the 50% goal. We also reminded the Chairs that they could appoint faculty members from another division or another department to achieve the committee composition and we have not had any pushback. In terms of barriers, sometimes people are concerned but when you present data, because we're data-driven people, we are able to resolve the concerns.

SD Thank you, Elena! Thank you, Robin and Marva! Steve and I really appreciate your transparency, honesty, and your personal stories, which are helpful for all of us, as we promote diversity, equity, and inclusion at each of our institutions. I've received several questions.

This is specific for Marva. You mentioned the Town Hall meetings at Children's. Can you tell us a bit more about the stories that were shared at these Town Hall meetings?

MMM: Absolutely. Some of the stories have been people's experiences in college. One of the most moving stories that I heard, was from our Vice President of the hospital. She described her time in college—a great college that she attended and finding signs from people telling her to go home. She described crying and calling her parents and telling them she wanted to come home, but she stayed and toughed it out.

Another example of someone of mixed racial background, describing their child being stopped by the police and being fearful, but remembering, as you've all heard on the news, that so many black families have "the talk" with their sons. And her son trying to remember and reminding himself that he wanted to make it home to his family.

Another really moving story was from one of our residents, whose family is from Ghana, so similar to me. Even though they live here in the US, his family would make sure that they went back to Ghana, each year to stay with family and to make sure he understood his culture. And he wrote a reflection that, when he heard the news about George Floyd, in his mind, it was, "Yeah another black man killed", and that he frankly didn't have much of a response. He felt numb. And the thing that moved him, he said, was a text from his mother wanting to make sure that he was OK, and she was worried about him. And that, he said, moved him and made him angry, because anything that would make his mother have to worry was something that he didn't want to deal with. So, those are just, briefly, some of the really personal and intense stories that people have shared during these town halls.

SD: Marva when you have the Town Halls, is there a moderator? What is the set-up?

MMM: Yes, there's a moderator, and speakers are decided beforehand. I think people sign up or are invited to give their perspective. So, it's not a free-for-all, there's a specific number of speakers, two or three speakers at each town hall. And in their allotted time they share what they feel comfortable sharing or sometimes what they're uncomfortable sharing. One comment that I've heard a couple of times from people is that they're telling stories that they previously never shared outside their families or outside their home, and now to open up about this in a public forum is really quite cathartic.

SD: Wow, thank you. The next question is really for all three of you. What do you think are the reasons for the lack of diversity and disparity in health care outcomes?

EFA: That's a very tricky question. My focus has been on perinatal outcomes but many of the same concepts can be applied to other outcomes. In general, we have approached ethnic disparities, or racial disparities, as social disparities.

As a country, our perspective was shaped by the war on poverty, thinking that poverty was the cause of a lot of bad things. And it certainly is. But we have learned that poverty is not the sole contributor to racial or ethnic disparities in health outcomes. As we have now moved to more nuanced understandings, we are understanding that discrimination plays a role, apart from poverty. In general, this is an area of active investigation, active hypothesis generation, an area for future scholarship, and I hope that some of the attendees will be inspired to analyze whatever outcome is of interest to them. Because, unfortunately, there are disparities in nearly all outcomes. To move forward, we need to understand disparities and develop the clinical and policy interventions to mitigate and prevent them.

SD: Great. Thank you, Elena. Another participant asked how one can promote hiring of underrepresented minority faculty? How best to do this? How do I solicit a more diverse candidate pool?

MMM: Of course, what we hear often is "where are the minority candidates?" And I think you have to do specific outreach. I can tell you about one of the things they used to do, when I was at the NIH, and I'm assuming that they still do this. Most places will advertise in the New England Journal of Medicine or JAMA or some professional society web pages. So, one of the things that the NIH does is to advertise, not only in JAMA, but also advertise in the Journal of the National Medical Association, reach out to the Association of American Indian Physicians and to the Latino and Hispanic medical groups. I think Robin's example of hiring a search firm that may also be able to successfully tap into other resources and not necessarily just relying on the usual source of advertising is great. I think when you take that extra step, it's telling people that you truly are interested.

RS: I want to echo Marva's comments that a search firm can be invaluable in identifying the full pool of candidates, including minority candidates. And as Elena commented, the University of California has an expectation for a diverse candidate pool, and searches can't move forward without achieving that goal. This is

what I meant by being intentional toward prioritizing a diverse faculty and candidate list, followed by learning how you're going to tap into those talent pools through strategic advertising and outreach. If you don't know how to accomplish it, you have to ask others to help and teach you.

I'll also say that every faculty move is both a push and a pull. When you're trying to recruit somebody, you have to create what that 'hook' is going to be for that candidate to decide to move to your institution. You have to get into the mindset of what this faculty candidate is most interested in and how you can meet those needs, including the kind of welcoming, collegial environment and other resources that person is going to need to be successful. If Bruder Stapleton could get Marva and me to move to Buffalo (a department and city we both came to love), we all can figure this out!

EFA: I would add that sometimes we are too parochial in academic institutions because we think we're great, people will just want to come work in our institution, but we have to be intentional. Dr. Gary Freed, at the University of Michigan, has employed an effective strategy. Dr. Freed was leading a large training program and wanted to ensure diversity as a core element of his cohort. To achieve that goal, Dr. Freed attended the annual meeting of the National Medical Association for several years, and got to know people, because this is not just like, hi, I want to grab you and have you join my faculty, this is about relationships. Dr. Freed approached the issue in an intentional way, based on creating relationships, and was very successful.

Perhaps you are not recruiting faculty but you attend the PAS meeting, including the poster sessions. As we walk around the posters, we can make an effort to meet those who are presenting and introduce ourselves. Move out of your regular circle and create new relationships!

SD: Can you educate us about opportunities where you can learn more about diversity, equity, and inclusion? Are there certain workshops or other learning opportunities that people can attend?

EFA: In San Francisco, in the wake of everything that's been happening the last several months, the leadership group of our department, including vice chairs and division chiefs, tried to consider how to grow as a group and contribute. We decided on the 21 Day Challenge. It's a structured series of readings and discussion questions, and we found it to be very powerful. For us, it provided an opportunity to work with people who you know; you come together to discuss things that you don't discuss every day. There are other options but I highly recommend the 21 Day Challenge.

MMM: I think also there are a couple of people, again falling back on my NIH days and my NIH experience, who do an excellent job of discussing diversity, inclusion, and how to be intentional. One of them is Dr. Hannah Valantine. She is the NIH Chief Officer for Scientific Workforce Diversity. She has some wonderful talks. I think you can pull them up on YouTube. Similarly, the Director of the National Institute on Minority Health and Health Disparities at the NIH, Dr. Eliseo Pérez-Stable. He is also a wonderful speaker and has that ability to speak to views on diversity and inclusion. So, if you're the type of person that likes to surf the web and pull up things on YouTube, you can probably find a lot from the two of them that's very helpful.

RS: I will add, part of why Steve and Stephanie started these chats was due to cancelling this year's PAS meeting; this opportunity has led to a really great forum for workshops on diversity. Elena was very modest in describing the work that she did to create and grow our Committee on Diversity and Inclusion. The strength of presenters and content of the Committee on Diversity and Inclusion workshops at PAS has just blossomed. I tend to be a very practical, solution-oriented person and have found these sessions to be invaluable: after investing a couple of hours, you are very likely to walk out with one or two things that you would do differently. So that's another easy place for our membership to look.

SD: Great! The next participant states "the children are our future." I could not agree more. How do we improve diversity in academic medicine through outreach to our medical students?

MMM: Again, I think, not just medical students. I think even before that, college students and high school students. Getting them interested in science and again, reaching out to a diverse group of students If students can see somebody who looks like them, they may come to believe that they can also do this. Reaching out to medical students all over, and if you're particularly interested in minority medical students, certainly reaching out to the HBCU medical schools. Within the majority of medical schools, there is often some type of minority student association that you can reach out to, and encourage interest in research, or a particular subspecialty.

RS: I would add our medical students, both men and women, white and underrepresented minorities, are extremely passionate about this. They have a lot to teach us. As I arrived here at Rady Children's, the medical students, and our residents were one of the big forces that helped push us all in the right direction. I think we need to show up and listen, and to take this group seriously.

EFA: I would add that we also have the unique opportunity of direct contact with children, and I'm a generalist, Marva is a Nephrologist, Robin is a Neonatologist. Nearly all of us have the opportunity to directly interact with children. And they are so curious about health, and their bodies, we have the opportunity to teach them. If my patient says that she'd like to be a doctor when she grows up, I say, great, I'll work in this room, you work in the room next door and we'll work together. We can instill a future-oriented focus, inspire confidence, and explain to them why it's important to do well in school. We have the opportunity; we have direct contact with the future. So, for us, all of the outreach suggestions are great, and I totally support them and engage in them, but we have a powerful role with our patients, and we shouldn't squander these opportunities.

SD: When hiring faculty, how do you ask the candidates how they will contribute to equity, diversity, and inclusion in the workplace?

RS: Elena, I bet it's the same at UCSF, all faculty applicants, as they receive an offer from the University of California have to submit a statement on their approach and accomplishments in diversity and inclusion. As I've started to read some of them, there are some great stories. It's a very powerful thing to put pen to paper for something that is this important.

SD: Great, Robin this question is for you. One of the participants said they've had a lot of challenges with search firms not identifying diverse candidate pools. Any suggestions about how to best vet these search firms in regard to their ability to identify a diverse applicant pool?

RS: That's a great question, I would tend to agree. I've worked with great search firms, but others that are less effective. You should always interview more than one, which gives you more negotiating power on price and terms, and allows them to compete in the aspects of the search you're most interested in. A good search firm will be able to describe to you what their recruitment and strategy is for achieving diversity. To Marva's earlier point, it's about making sure you've cast a wide net and expanded the talent pool, beyond where you might normally do as an individual. So, recruiters who are well connected and have been successful in the past will be able to describe to you why they've been successful. And I've had very good experiences with firms like that. They aren't necessarily the most expensive ones, either.

SD: Thanks Robin. Marva this question is for you. Would you comment on NIH R grant success rates for minorities and thoughts on how this could be improved? Could you also comment on how to increase physician scientists who are underrepresented minorities?

MMM: I haven't seen the most recent data, but certainly, when I was there, this was something that was evaluated on multiple levels in terms of MDs, PHDs, etc., where there was definitely a disparity in funding, even when you equalized everything else, there seemed to be some type of bias there. I know that improvements have occurred, but I don't have, absolute numbers. I could probably find them online, they may even be published, similar to the data that were published, that originally brought this to light.

One issue that I know was bounced around in the community and at NIH was this idea of reviewing grants blindly, removing the name, the institution, and really just judging the grant based on the idea. I think that was tried, in some form but not widely. As I said, I've been gone 3 years, so I no longer have access to inside information. But I know that there had been a lot of discussions about ways to minimize implicit bias in grant application reviews.

One of the pieces of advice I would also give people is, when they're submitting an application, speak to the program officer at the NIH. Get their input, get their advice. They're there to help, and the advice they give can be very useful, in terms of helping people know if their idea is likely to move forward or not.

SD: Thank you, Marva! Would one of you comment on solutions for women encountering barriers during mid-career and how they successfully move into leadership roles?

RS: This is a straightforward question that is hard to answer, as there is no 'one size fits all' approach that works for every person. I suspect the person asking the question is a leader looking to help other women move through the pipeline. Being interested, knowing and learning about what your faculty are facing, and helping them retain their long-term goals, a sense of optimism and resilience are all key. The barriers are not a lack of talent or skill, instead, published data clearly show that women face greater time pressures compared to men during midcareer. Supporting women through those difficult years, through formal and informal mentorship will help them emerge as some of your most productive faculty, leaders and mentors.

EFA: We need to understand that mentoring is a lifelong commitment and valuable across the lifespan. We often focus on junior faculty, which is entirely appropriate. But every phase has different challenges, and I think sometimes the challenges that we face, as women, that we face as underrepresented people, are slightly different. You need a network; you need people you can talk to. If you can find someone who looks like you, or who you think exemplifies what you're looking for, great. But often, that's not possible. In that case, you have to piece it together and build a broad network.

There are programs like the Executive Leadership in Academic Medicine (ELAM) program, which was beneficial to me. The Association of American Medical Colleges offers programs. The American Pediatric Society is developing ideas around coaching. Most importantly, we have to have the mindset that professional development is a lifelong commitment, not just when we're junior faculty members.

RS: I love what Elena said and I would echo her comments about coaching. Often, women wrestle with specific skill sets, and aren't quite sure how to acquire them. Skillsets like negotiating or program building are not necessarily what your mentor will teach you, and coaching is a brilliant solution. Coaching tends to be a shorter engagement but can really help you get past a particular issue that you feel is holding you back.

SD: I agree and I just want to echo that ELAM is a fantastic program for women interested in executive leadership. ELAM really pushes you to pursue opportunities that you may otherwise believe is beyond your reach.

SD: This question is for Elena. What's the role of a Dean of Diversity in community outreach programs and what is their role in diversifying the health care workforce?

EFA: In general, academic institutions across the country have had a bit of an expansion in leadership titles. And leadership of diversity is one of them, whether it's departmental leader for diversity, or school of medicine, or at the level of the campus. For the most part, these positions often focus on statistics and how to improve outreach and recruitment.

At UCSF we have a Vice Chancellor for Diversity and Outreach who has purview over the entire campus. One challenge is that sometimes these positions have responsibility without authority or resources. Thus, the leader experiences pressure to achieve benchmarks but has limited ability to effect change and must work in partnership with Chairs or other leaders to recruit. I would suggest that we haven't yet determined the best structure for these roles, with an appropriate balance of authority and resources. On occasion, the person represents the institution's commitment to diversity issues but their role is isolated, as if that person does the diversity work and we do all the other work.

I believe that successful institutions must diversify at all levels, faculty, staff, trainees, etc. We have to address the health issues that affect our country, the health disparities that affect all of us. This requires a collective commitment to addressing disparities, not just underrepresented people. Perhaps underrepresented individuals have a greater interest, motivation or personal connection, but the crisis we have in maternal mortality, infant mortality, so many diseases, are important for all of us. Thus, my concern about the proliferation of the diversity leadership roles is that we may isolate the issue, rather than making it a widespread institutional commitment. If properly structured and resourced, an individual can serve very powerfully in this position.

SD: Great, thank you! Marva, this question is for you. Are there unique issues in academic medicine that create barriers that are distinct when a trainee competes for subspecialty training? In academic medicine, do we create barriers that are distinct to trainees who are competing for subspecialty training, compared to those going into a private practice?

MMM: I'd like to hope not. I think the issue for subspecialties are the same as getting into medical school, and then getting into residency, and then getting into a subspecialty, the numbers become smaller and smaller and smaller. It becomes more competitive along the way, which I think is the biggest barrier. But, again, the next barrier is that of implicit bias. People have to be aware of their own biases as they interview candidates. In the past couple of years, I have been thrilled at the increased level of diversity in fellowship candidates that I wouldn't have seen years ago.

So, I hope that if people are truly interested in a subspecialty that they will move forward with that interest. And certainly, I know there's a movement to try and recruit as many people of diverse backgrounds into the medical subspecialties.

SD: Great! Once you are part of a subspecialty, are the barriers different to sustain that academic career compared to a career as part of a private practice or community?

MMM: Some of this issue has to do with support—familial support, professional support, and the rest. I was on a taskforce for the American Society of Nephrology focused on barriers to diversity in the subspecialties. One of the issues that came up was a socioeconomic barrier. When evaluating people attending medical school, and depending on their level of debt, are they going to be interested in pursuing further subspecialty training that's going to delay them entering the work force? Or would it be simpler for them to go into private practice and start making some real money upfront to start paying off their debt?

Just evaluating these issues, in terms of economics, and helping people not to have to worry about debt so that they may be willing to pursue a subspecialty is important. There are now grants, loan repayment grants, that people can pursue. Of course, those are not bottomless in terms of the availability, but they are certainly options that people can pursue to ease that burden. One of the discussions that's always occurring in nephrology and I'm sure other subspecialties, is do we pay people fairly for the amount of work they do?

I think, honestly, if you are passionate, that's going to overcome a lot of what you have to do for a particular subspecialty. And seeking appropriate mentors who can help you overcome some of these barriers is helpful.

SD: Great, thank you! One of the participants stated that individuals definitely should think about the diversity training supplements that are opportunities associated with many of the NIH grants. Marva, I don't know if you want to comment a little bit about that, since you worked at the NIH.

MMM: Those supplements are very helpful. What you need is to have a mentor who has NIH funding, and your project needs to be related to theirs. So, if you have a mentor, this person doesn't even have to be at your own institution, and they're doing research that's of interest to you, and you have a project that fits, you can apply for diversity supplements. Unless things have changed, unlike the regular NIH grant applications that are three times a year, you can apply anytime for these. They support some salary and some supplies for the diversity candidate. Seek out people. You should be able to look them up on your institution's website or ask people what research they're doing that may interest you and ask if you can partner with them in putting together an application. So yes, that's absolutely something people should pursue.

SD: I want to thank Robin, Marva, and Elena. I have learned so much listening to your personal stories, and wise answers to all the questions. One of the participants asked, about how we plan to continue to offer APS and SPR leadership topics and how we will continue this momentum. We are continuing to host these virtual chats. We have scheduled 10 virtual chats through the New Year. We are publishing these in *Pediatric Research*. I'm going to turn this over to my friend, Steve, who can expand on this a bit more. Thank you to our panelists and to our participants.

SA: I'd like to also thank each of our panelists for their fantastic presentations, insights and wisdom. As Stephanie mentioned, these joint APS–SPR Virtual Chats are available on the APS and SPR websites and will also be published as a series of topics in *Pediatric Research*.

ADDITIONAL INFORMATION

Competing interests: The authors declare no competing interests.

Patient consent: Not applicable.