Diversity and Inclusion: Strategies to Improve Pediatrics and Pediatric Health Care Delivery

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diversity, inclusion, racial and ethnic minorities in pediatrics, women in pediatrics

ABBREVIATIONS
AAMC—Association of American Medical Colleges
FOPO—Federation of Pediatric Organizations

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It is a great honor to be the recipient of the 2013 Joseph W. St. Geme, Jr, Award. I thank the leadership of the Federation of Pediatric Organizations (FOPO) for selecting me for this most meaningful tribute. I am proud to be considered among the important leaders in our field who have previously received this award.

I would also like to note that in this award's 25-year history, only 3 women have preceded me and, as far as I know, no other underrepresented minority has ever been selected. I therefore want to take this opportunity to share an important message of our continued need to address diversity and inclusion in the field of pediatrics.

I would like to recognize and applaud the FOPO for its attention to the value of women's issues through its Task Force on Women that began in 2003 and the recognition of FOPO's work in a series of important published reports (Table 1). In 2012, the FOPO established a Diversity and Inclusion Workgroup. The 4 domains to be addressed by this group are: workforce diversity, cultural competency, leadership diversity, and the development of a knowledge base regarding diverse populations.[1] The deliberations of this new workgroup, co-chaired by Fernando Mendoza, MD, and Leslie Walker, MD, are available at the FOPO Web site (http://www.fopo.org/Diversity_Inclusion.html) and reflect an in-depth evaluation of previous literature on this topic in preparation for a planned position statement that will further advance diversity and inclusion in pediatrics. The key consideration for this workgroup will be how leaders in pediatrics can embrace a commitment to foster diversity and inclusion. Institutional ability to meaningfully address diversity and inclusion depends on effective leadership, something the members hope to promote through the workgroup's position statement.

PROSPECTS FOR A DIVERSE PEDIATRIC WORKFORCE

Why is there a need for a strategic approach to diversity and inclusion in pediatrics? From 2003 to 2009, there was an increase in the proportion of women in the graduating classes of pediatric residents (69% to 75%; $P < .05$) and an increase in underrepresented minorities (ie, black, Hispanic, Native American) that did not reach statistical significance (9% to 15%; $P = .09$).[2] Moving further up the pediatric academic pipeline, we observe that diversity decreases as academic rank increases, with a disproportionate number of women and minorities at the instructor and assistant professor level and fewer at the associate and full professor level (Table 2). This finding suggests that either the pipeline is not growing or that women and minorities are around but not being promoted. Pediatrics had a greater percentage of women chairs compared with most other departments in the clinical sciences in 2012. About 20% of all pediatric chairs were women and 12% of these were categorized as underrepresented minorities or multiracial chairs.[3]

TABLE 1 Publications: FOPO Task Force on Women in Pediatrics

- Gordon MB, McGuinness GA, Stanton BF, et al. Part-time pediatric residency training: principles and practices, *Pediatrics*. 2008;122(4):e938–e944.
- Key LL Jr. Child care supplementation: aid for residents and advantages for residency programs. *J Pediatr*. 2008;153(4):449–450.
- Nazer D. Family-friendly conferences: a commitment to women in academia. *J Pediatr*. 2008;152(3):299–300.
- Alexander D, Boat T, Britto M, et al. Federation of Pediatric Organizations Task Force on Women in Pediatrics: considerations for part-time training and employment for research-intensive fellows and faculty. *J Pediatr*. 2009;154(1):1–3.e2.
- Britto MT, Fuentes-Afflick E, Sectish TC, Stanton B. Federation of Pediatric Organizations (FOPO) Task Force on Women in Pediatrics II: survey of active members of the Society for Pediatric Research regarding part-time work and flexible work. *J Pediatr*. 2009;155(4):459–460.e1.
- Stanton B, Felice M, Marshall SG, Sectish TC. A change in the pediatric leadership landscape. *J Pediatr*. 2011;158(3):347–348.e2.

RATIONALE FOR DIVERSITY IN HEALTH LEADERSHIP

What do we expect to accomplish by diversifying the workforce? A convincing rationale for racial and ethnic diversity was articulated in the 2004 Institute of Medicine report, *In the Nation's Compelling Interest: Ensuring Diversity in the Health Care Workforce*: "Increasing racial and ethnic diversity among health professionals is important because evidence indicates that diversity is associated with improved access to care for racial and ethnic minority patients, greater patient choice and satisfaction, and better educational experiences for health professional students among many other benefits."[4] Stanton et al[5] make an equally compelling statement on diversity in pediatric leadership, noting it as "an indication that the profession is able to select its leaders from a broad base, thereby increasing the range of available talent. Leaders from diverse backgrounds will identify different challenges and pursue alternative opportunities, thereby leading to a greater evolution and strength of the organization and profession."

NEXT STEPS

To do an even better job in improving the health care that children and their families receive, it is clear that we must mine all available talent. As an academic community, we are smarter, more effective, more passionate, and more respectful of other perspectives when we are surrounded by diverse colleagues and immersed in diverse environments. The presence of visible role models who are diverse communicates a message of possibility for the future of our patients and the positive value our society and institutions place on the viability and vitality of such unique and talented individuals.

Unfortunately, persistent barriers to the success of women and minority faculty are well documented by research. Barriers for women include inequity in compensation, inflexibility in the tenure track path, and a climate of gender discrimination and gender insensitivity.[6] Minority faculty may regularly encounter racial and ethnic discrimination.[7,8] Both women and minority faculty experience inadequate mentoring and insufficient support of mentoring activities.[6,7] Developing a system for mentoring and advising junior faculty benefits all faculty, regardless of gender or race/ethnicity. Institutional commitments to leadership development and leadership transitioning programs are useful in attracting and retaining diverse faculty members.[9] The American Academy of Pediatrics' Committee on the Pediatrician Workforce recommends that institutions commit to improve workforce diversity through formal programs as an effort to ensure that minority individuals are supported in their efforts to rise to their leadership potential. There was also recognition that similar efforts to support faculty on the basis of religious or sexual orientation may require approaches different from those for race.[10] Promoting training activities in diversity and cultural competence support a positive school climate for all faculty members, students, and staff, which all directly improve patient care.

My message to leaders in pediatrics is that they must reach beyond their comfort zone and be role models and champions within institutions for embracing and supporting talent development across the academic community and include people whose background may otherwise preclude them from being recognized for their leadership potential. Acknowledgment of core attributes for diversity expectations for chairs exists in the AAMC monograph, *The Successful Medical School Department Chair,* which states that, "A chair must encourage and support diversity among a department's constituents creating an environment of professionalism, respect, tolerance and acceptance" and "a chair must be aware of the subtle challenges preventing women and minority students and faculty from realizing their full potentials, and must work to address these challenges."[11]

TABLE 2 Distribution of Full-Time Pediatrics Faculty, Rank, and Gender, 2012

Academic Rank	No. of Men	No. of Women	% of Women
Instructor	548	1410	72
Assistant professor	3374	4557	57
Associate professor	1871	1605	46
Full professor	2427	1019	30
Total, all ranks	8313	8775	51

AAMC Faculty Roster, May 2012, Permission granted for display of data.

However, there is also an expectation for our trainees and junior faculty. Young people, I encourage you to reach out, step across that roadblock into territory that helps you develop new skills, meet new people, engage and grow your professional network, and break through to the next level. Block out negativity from people who do not embrace you for your capabilities and your potential. When you get an opportunity to participate in an important project or have the opportunity for an important position, do an awesome job.

Finally, for those of us who have broken through to higher academic and leadership positions, we must support talented individuals with diverse backgrounds and help them be recognized and achieve success.

In closing, I must do 3 things. First, I want to acknowledge my sisterhood: the women who walk with me and beside me: Lissa McAnarney, MD, who was honored with the 2013 John Howland Award; my sister workgroup from our child health disparities center, a collaboration between Howard University, Children's National Medical Center, and Johns Hopkins University; my sister department chairs whom I have worked with in the Association of Medical School Pediatric Department Chairs and my current chair at Howard University, Dr Michal Young; my sister pediatric leaders during the time I was American Academy of Pediatrics president, Tina Cheng, MD, and Danielle Laraque, MD, for the Academic Pediatric Association and Phyllis Dennery, MD, for the Society for Pediatric Research; my sister American Academy of Pediatrics past-presidents, Toni Eaton, MD, Carol Berkowitz, MD, Eileen Ouellette, MD, Judy Palfrey, MD, and Betty Lowe, MD; and my sister friends who give me spiritual support and grounding. I would also like to honor the theme of creating the future by acknowledging 2 younger women succeeding in leadership now who have publicly given me credit for encouraging them: Leslie Walker, MD, past-president of the Society for Adolescent Health and Medicine and co-chair of the Diversity and Inclusion Workgroup, and Denice Cora-Bramble, MD, chief medical officer for Ambulatory and Community Health Services at Children's National Medical Center. I also want to acknowledge their chairs, Bruder Stapleton, MD, and Mark Batshaw, MD, for recognizing and nurturing their talent.

Finally, I would like to repeat the comment from Jordan Cohen, MD, the former president of the AAMC, who captured the importance of diversity for women faculty that I feel has applicability to all diverse faculty: "Cultivating diversity in our faculty and in our leadership is an indispensable strategic instrument for meeting the challenges that academic medicine faces in the 21st century. Grooming women for leadership positions and eradicating the barrier currently impeding their success are essential components of this strategy. Those institutions that fail to seize the advantages offered by elevating talented women to positions of power are destined to be eclipsed by those that do."[12]

Let's work together to promote diversity and inclusion so that children's health can truly benefit from the talent that each of us uniquely brings to improving the health of children in this country and around the world. Thank you again for the honor of being this year's St. Geme awardee.

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HEALTH IS MORE THAN SKIN DEEP: *While eating healthy, exercising, and getting adequate sleep are well-known staples of a healthy lifestyle, it appears that molecular biology plays a major role as well. New research indicates that the health risks associated with obesity may not result solely from an increase in weight.*

As reported in The New York Times *(Well: October 9, 2013), researchers found an underlying biological difference between the "healthy obese" who are significantly overweight without any abnormal lab tests and blood pressure readings, and obese individuals with metabolic derangements. Obese individuals who were "metabolically unhealthy" had impaired mitochondrial functioning and increased fat cell breakage. Fat cell death leads to inflammation and ectopic deposition in organs such as the liver and heart. It is this fat deposition that is associated with metabolic derangements and an increased risk of diabetes. In contrast, "healthy obese" individuals are able to continue to make new fat cells which tend to accumulate in the subcutaneous tissue causing little damage.*

How long a person remains in this "healthy obese" state is not known. However, a large study of Australian adults suggested that one-third will become metabolically unhealthy within 10 years. While these data suggest that some people can remain healthy in spite of obesity, we still should continue to strive to maintain an appropriate weight.

Noted by Leah H. Carr, BS, MS-IV

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