

Creating a diverse and inclusive pediatric infectious diseases workforce

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“...the burden belongs to the nation, and the hands of none of us are clean if we bend not our energies to righting these great wrongs.”

W.E.B. Du Bois

The Souls of Black Folk (1903)

Children represent the fastest growing population, with respect to racial and ethnic diversity, in the United States. Overall, the total number of children decreased over the last decade. However, the decrease was primarily attributable to a decrease in non-Hispanic White children (decreased 13%, from 39.7 million in 2010 to 34.6 million in 2020) who for the first time accounted for <50% of the 18 and under population [1]. At the same time, Hispanic and multiracial, non-Hispanic children increased by 9% and 76%, respectively. Likewise, the proportion of Asian children increased by 23% [1]. The growing diversity of our pediatric population, as measured by race and ethnicity, represents a major shift in our demography. Sadly, the pediatric workforce has failed to keep pace with this demographic shift as only 16% of pediatric residents and 13% of subspecialty fellows identify as racial and ethnic groups traditionally considered underrepresented in medicine (URiM) [2].

A confluence of events has placed diversity, equity, and inclusion squarely in the national spotlight. The murders of George Floyd and Breonna Taylor brought into focus the systemic racism contributing to the differential treatment of people of color. Their murders and the following widespread public outrage coincided with the beginning of the COVID-19 pandemic and created a perfect storm whose collective energy possesses the potential to transform many facets of society including medicine. Physicians and the patients they treat exist within the same unjust, racist system that ultimately led to the killing of Taylor and Floyd (and many other people of color) and

that continues to inflict a myriad of health disparities known to exist in the communities that Black, indigenous, and people of color (BIPoC) predominately inhabit. These health disparities were brought to the forefront early in the COVID-19 pandemic and we continue to witness the disproportionate effects of COVID-19 on the health of BIPoC including children. By many measures, BIPoC communities suffered excess deaths and reduced life expectancy [3] and are more likely to suffer the long-term consequences of COVID-19 for years to come.

The data supporting a diverse medical workforce to mitigate the effects of racism and health disparities are not new. Beyond the ethical and moral obligations guiding racial and ethnic equity in our workforce, data support workforce diversity increasing performance [4] and that patient-provider race concordance may ultimately improve clinical outcomes [5]. Nevertheless, the lack of workforce diversity in nearly every medical specialty has been noted for decades and recent data indicate that proportions of Black and Hispanic physicians has actually decreased [6]. Decreased ethnic and racial diversity has been observed at every level of training including medical school matriculants [7], entry into pediatric residency, and pediatric subspecialty training [2]. At current rates, parity will never be reached without sustained and multifaceted efforts at all levels.

The workforce diversity in pediatric infectious diseases (PID) is particularly troubling. Not only are the total number of pediatricians entering PID decreasing but as a subspecialty PID has shown the largest decrease in URiM trainees between 2007 (23.1%) and 2019 (11.7%) [2]. As of 2017, only 2% of Pediatric Infectious Diseases Society (PIDS) members identify as Black/African American and 6% identify as Hispanic/Latino. Even worse, <1% of PIDS members identified as American Indian/Alaskan Native [8]. Clearly, we have a lot of work ahead of us to achieve equity and to best serve the diverse populations we treat.

To begin addressing the glaring PID diversity gap, in 2019 PIDS initiated what has now become the Inclusion, Diversity, Access, & Equity (IDA&E) Task Force. Akin to the Task Force commissioned by our sister society (the Infectious Diseases Society of America, IDSA) [9], the PIDS IDA&E Task Force developed a number of goals designed to imbed the core principles of inclusion, diversity, access, and equity, within the strategic aims of the society as a whole. Since its inception, the PIDS IDA&E Task Force has guided the implementation of several programs. The Task Force rapidly recognized mentorship as key to recruiting and maintaining URiM in PID. To meet this need, PIDS established a collaboration with the Academic Pediatric Association (APA) and the Research in Academic Pediatrics Initiative on Diversity (RAPID) program. Using a mentor-centered approach, the APA RAPID program has shown tremendous success in scholar career advancement and increasing professional society (APA) diversity [10, 11]. In addition, the Task Force developed and disseminated the first PIDS “diversity survey” to society members as a means to assess and establish a baseline of beliefs and attitudes with respect to inclusion and diversity. A “Diversity Grand Rounds” was recently started to educate membership and promote discussion on important topics such as under-representation in PID, challenges of international medical graduates, and promoting diversity in positions of leadership. The above programs and initiatives represent only the beginning of our work toward improving diversity and inclusivity in our society with broader and more sustained efforts under development.

The goals of this supplement are two-fold. First, our hope is that the four articles presented here will provide useful information regarding pediatric health disparities to the broad *JPIDS* readership and inspire action to begin to reduce those disparities. The first article by Kronman et al. [12] examines pediatric health disparities from a historical perspective with a particular focus on access. Vicetti et al. [13] describe pediatric health disparities as they relate specifically to COVID-19,

including disease burden, access to testing, therapeutics, and telehealth services. The data presented herein also emphasize practical approaches to address some of these disparities, improve diversity in clinical research and avoid racism when communicating research results. Oliveira et al. [14] review the drivers of COVID-19 vaccine inequity and discuss strategies to reduce vaccine hesitancy and eliminate barriers to vaccine access. Second, we acknowledge that lack of diversity within our ranks is part of the problem. In the final article Rogo et al. [15] present challenges and potential solutions for increasing URiM representation in PID.

Admittedly, the articles included here should be viewed as a first step. In this supplement, we use the context of infectious diseases and COVID-19 to highlight pediatric health disparities and potential strategies to improve diversity within the PID workforce. Importantly, we present health disparities in children in the context of COVID-19 as it relates to race and ethnicity – demographics for which the most data are available. We recognize that patient and workforce diversity extend beyond these two social constructs and includes gender, gender identity, sexual orientation, and mental/physical ability among many other characteristics [16]. We hope to address diversity on a broader scale in future articles. Ultimately, our goal is that this supplement will begin an honest and productive discussion within our society that leads to meaningful change and better health outcomes for children.

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