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Getting "Our House" in Order: Re-building Academic Pediatrics by Dismantling the Anti-Black Racist Foundation

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***"I am no longer accepting the things I cannot change. I am changing the things I cannot accept."* —Angela Davis**

On the heels of the deaths of Ahmaud Arbery, Breonna Taylor, George Floyd, Rayshard Brooks and so many others, we celebrated the independence of our country from British rule. The paradox of the American values of "life, liberty, and the pursuit of happiness" could not be clearer for the lives of Black Americans, in a country built on land stolen from Indigenous peoples, and the free labor, subjugation, oppression and resilience of enslaved Black people. Amidst increased public consciousness, powerful protests, and countless organizations —from the Academic Pediatric Association (APA), [1] the American Academy of Pediatrics (AAP),[2] and the American Public Health Association (APHA)[3] to Apple, Twitter, and YouTube [4] —stating support for Black lives, pediatrics as a profession must initiate and sustain the steps necessary to ensure that this is not just the issue *du jour*. As academic pediatricians, we shape clinical practice, medical education, research, leadership, and advocacy. While we speak out against the brutal injustices committed by police,[5] it is also imperative that we critically examine injustices perpetuated within our own field. We, too, must get our own house in order.

Becoming anti-racist requires acknowledging our miseducation and racist programming, by striving to challenge and unlearn the views we hold closely, and examining the policies, structures and systems, in which we operate, that perpetuate racism. The very foundation of our profession is intertwined with racism and white supremacy – negatively impacting each aspect of academic pediatrics: clinical practice, research, education, workforce and leadership, as well as advocacy and community engagement. While we recognize that much of what we describe herein applies more broadly to all systemically oppressed groups, here we focus specifically on both the history and pain of anti-black racism while suggesting some initial steps in tearing down and rebuilding our foundation.

Anti-Black Racism in Pediatric Clinical Practice. We must do better.

Identify and eliminate disparities. Pediatric healthcare inequities have been described as "extensive, pervasive, and persistent."[6] A growing body of evidence shows disparities among Black children including asthma severity, [7] access to kidney transplants, [8] surgical outcomes, [9] pain management, [10,11] and more. Only after addressing racism as a critical social determinant of health, can we begin to extinguish these unjust differences. [12] Pediatricians can build anti-racism into their clinical practice by identifying and addressing disparities in patient outcome and experience data in their practices and organizations. Doing this requires ensuring that patient race, ethnicity and language are consistently and accurately documented. Once identified, such disparities must be carefully interpreted by recognizing all relevant social, environmental and structural factors for which race may serve as a proxy and naming racism explicitly. [12] Eliminating racial health disparities must then become a strategic priority of our institutions. As pillars of many communities, healthcare systems can form multi-sector partnerships with community members, local policymakers, educators, and others to form advisory boards to address disparate outcomes, community needs, and the strategies necessary to rectify them. These partnerships or coalitions could promote racial equity both inside and outside hospital walls.

Acknowledge Bias. Racism can operate interpersonally, manifesting as implicit bias. Physicians, including pediatricians, may have anti-Black bias, [13] recognized or not, and this bias can impact multiple facets of care, including access, patient-provider communication, diagnosis and treatment decisions for Black patients. [14,15] Eliminating disparities and being anti-racist requires pediatricians to identify and confront personal biases using strategies such as practicing empathy and perspective taking and focusing on shared identities with patients, as well as acknowledging/labeling stereotypes and replacing them with accurate representations that recognize patients as individuals. [16-18]

Change Policy. Though improving individual behaviors is necessary, it is not sufficient as racism also operates on a systems-level. Structural racism, invisible to many, pervades institutional policies and practices. Medical institutions and governing bodies must eliminate such policies and practices that perpetrate oppression, and create new policies using a racial equity lens.[19] For example, the presence of police or police-like figures within healthcare institutions may deter individuals from seeking health care. [20] Therefore, institutions should re-examine the role

of police and security, and identify approaches that assure safety without inflicting trauma on families. [20] Institutions and clinical practices must also rethink punitive practices such as no-show and late arrival policies that disproportionately impact low-income families as well as Black and other families of color due to underlying structural factors such as limited time-off, transportation barriers, holding multiple jobs, and others.

Increase Visibility. Many clinical and academic medical environments lack representation of people of color, visually communicating to marginalized populations that they do not belong. Photos, murals, magazines, and books in our clinical spaces must reflect our diverse world and create an environment that is welcoming and inclusive. Additionally, our profession should aim to encompass a workforce that more closely mirrors the racial and ethnic diversity within our nation. Healthcare institutions should seek to employ teams representative of our geographic and patient communities.

Anti-Black Racism in Pediatric Research. We must do better.

Name the problem. As researchers, we must attribute disease risk factors to their proper source. Race-based differences in health persist not due to underlying genetic and biological differences, but because of man-made, social differences.[21,22] Ancestry or ancestral admixtures may better predict the genetic differences that appear to be present by "race". [23] Being anti-racist in pediatric research therefore requires consistently collecting, reporting, interpreting, and presenting data on participants' race and ethnicity (including perceptions), [24] ancestry, national origin and experiences of racism [25] and attributing racism rather than race itself or lifestyle "choices" as a root cause of inequities.

Diversify. Research teams should include faculty, staff, and community members, traditionally under-represented in research and medicine. Encouraging their perspectives will inspire the pursuit of research topics and findings that may more easily translate across groups. Researchers should seek out and participate in national and institutional diversity-focused training programs, making research careers and opportunities more accessible to a range of trainees and early career faculty. Prior to participation in these programs, researchers should undergo implicit bias and bystander training, education that focuses on both bias awareness and how to respond to bias, in order foster to safe, anti-racist, and inclusive environments for their labs and team members. We must also recognize that the voices of Black scholars are too often silenced through their low numbers in academia, [26] significant funding gaps,[27] and divergent publication records.[28] It is critically important that Black scholars are hired and funded, and that their research is published, highlighted, and cited. [29,30]

Anti-Black Racism in Pediatric Education. We must do better.

Create Psychological Safety. Black students and trainees report race-based mistreatment including bigotry, microaggressions, and public humiliation.[31,32] Although less public, coded language can be just as detrimental, e.g. labeling white learners as 'energetic and engaged' and Black learners as 'combative and aggressive'; or "complimenting" a Black trainee by stating they

appear 'well-groomed' or 'polite.' [33] Often times these egregious acts go unchecked and we fail our trainees by our paralytic silence. As medical educators, it is our responsibility to speak out and follow up. Actionable systems should be created for reporting, investigating, and rectifying trainee accounts of racism and microaggressions. We must also avoid more subtle acts of racism that pervade the learning environment by providing Black trainees with ample educational and professional development opportunities so they can thrive in academic pediatrics. Such efforts by educators can be supported by organizations such as the Accreditation Council for Graduate Medical Education (ACGME), by requiring programs to have systems in place to address race-based mistreatment.

Recruit & Retain: Diversifying training programs will also help remedy trainees' experiences of racism. Notably, from 1980 to 2016, the percentage of Black matriculants to medical school have only increased by 1.1%. [34] To bolster the racial and ethnic diversity in pediatrics, we can invest in the future of young people, for instance by partnering with youth organizations to offer paid internships with a focus on exposing Black youth and other youth of color, who are underrepresented in medicine to health careers. Training programs can subsidize interview travel or away rotations for Black students and use a holistic approach to selection that values diversity and life experience over test scores. [35,36] While academic institutions often focus solely on recruitment, we must go beyond filling a quota and commit to the systemic changes that promote retention of Black trainees and faculty.[37] Retention begins with creating psychologically safe, welcoming, inclusive, and anti-racist environments. As these trainees become faculty, further resources are needed to ensure wellness and success, including peer support (e.g., cluster hiring programs), [38] career development and advancement opportunities (e.g. AAMC's minority faculty development program), [39] and support in the development of mentorship or sponsorship teams.[40]

Redesign the curriculum. As teachers, we are obligated to prepare students and trainees to combat health inequities by integrating anti-racism training into our curricula. [41] It is our responsibility to teach our trainees about racial equity through educational offerings that go beyond antiquated concepts such as "cultural competency" and move toward historical and structural competency along with humility. [42,43] Anti-racism teaching must extend beyond isolated lectures and should be woven into all aspects of medical education (e.g., grand rounds, journal clubs, noon conferences, simulations, visual diagnosis reviews, case conferences, bedside teaching, nighttime curriculum, professionalism series, etc.) This will require institutional buy-in that affords both educators and trainees protected time for such learnings. Regarding content, MedEdPortal's "Anti-Racism in Medicine Collection" is a place to start. [44] However, more work must be done to understand best practices for integrating anti-racism teaching into medical education. Such educational efforts can also be facilitated by organizing bodies such as the APA and AAP who can increase educators' capacity to provide such training to their learners, thereby also ensuring that this essential work does not only fall on the shoulders of Black faculty. The ACGME can also go beyond competencies that require trainees to gain skills in communicating effectively with patients across various cultural backgrounds and further require an understanding of race, racism, and its impact on health.[45]

Anti-Black Racism in the Pediatric Workforce and Leadership. We must do better.

Restructure for Success. Ample evidence shows that Blacks are not well represented in academic pediatrics, especially at the highest ranks. Black faculty are promoted more slowly and retained poorly, while unfairly burdened or taxed [46] with diversity efforts that are usually uncompensated and detract from academic success and promotion.[47] To address these problems, anti-racist leaders and institutions must evaluate racial disparities within hiring processes, loan repayment, salary and bonus structures, leadership decisions, and promotion outcomes. Aligning racial equity work with promotion criteria would allow more equitable distribution of labor and more rapid career advancement for Black faculty and other faculty of color, who lead this work. Achieving a "critical mass" of Black faculty and other faculty of color accompanied with an inclusive institutional culture will increase not only mentorship and sponsorship but also success that will undoubtedly have a positive impact on healthcare and our communities as a whole.[48] Anti-racist leaders must ensure that leadership positions within diversity and equity roles (DEI) have the authority, status, salary, budget and influence to enact meaningful change.

Anti-Black Racism in Pediatric Advocacy and Community Engagement. We must do better.

Rename & Re-center. Anti-racist pediatric advocates should re-center themselves as activists to harness the true power they wield in dismantling structural racism.[49] Anti-racist activists write (e.g., letters, op-eds, position statements), speak up (e.g., testify, provide media interviews), and partner with communities, government, and the private sector to combat injustice. [50-52] They may also engage in civic engagement such as voter registration and education that supports programs and policies that advance child health. [53] Further, pediatric leaders should recognize such work on the pathways to promotion and tenure.

Become an Anchor institution. Academic pediatricians can also advocate for their healthcare systems to embrace principles of "anchor Institutions." [54] Anchor institutions practice sustained, comprehensive community engagement while analyzing the system's purchasing agreements, supply chains, capital, and community investments to ensure alignment with anti-racist practices.

The racist foundation that our house was built on must be dismantled. We all must do better.

Academic pediatricians have an opportunity to take decisive steps towards dismantling anti-black racism, across all of our spheres of influence. We can no longer accept the racism that is pervasive and instead, we must leverage our power and privilege to bring about change. We must also push our institutions and governing bodies to make the structural changes necessary to support and sustain such transformation. As we commit to this lifelong learning, unlearning, and dedication to transformative change, we must draw on the voices of our many colleagues, who have toiled without recognition, appreciation, or the fruits of change to eradicate systemic racism in pediatrics and in healthcare broadly. [55-61] During this national reckoning, we recognize these leaders, we learn from them, and most importantly, we join them.

The need for accountability and reform among police officers is irrefutable, yet the ever-present racism that led to the murder of George Floyd and too many others, is the very same racism embedded in our own field. As our society reimagines law enforcement as an institution, we must also demand the same from our ourselves, our institutions, and our profession. While these recommendations are only the tip of the iceberg, we are hopeful they will guide our profession towards meaningful change. We can no longer idly sit back and perpetuate white supremacy and racism and claim ignorance. Now is our opportunity to destroy and rebuild our proverbial house on a new foundation of antiracist practices, policies, and advocacy that makes those American ideals of life and liberty real and attainable for all.

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Table/Box 1. Creating an Anti-racist Profession with Objectives and Accountable Parties, by Domain

DOMAIN	OBJECTIVES	ACCOUNTABLE/RESPONSIBLE PARTIES
PEDIATRIC CLINICAL PRACTICE		
IDENTIFY AND ELIMINATE DISPARITIES	• Placing (racial) health equity as a top strategic priority • Consistently collecting and accurately documented patient race, ethnicity, and language information • Examine disparities in patient outcome and experience data • Creating multi-sector partnerships with community members, local policymakers, educators, and others to form advisory boards to discuss disparate outcomes, community needs, and the strategies necessary to rectify them. These partnerships or coalitions could promote racial equity both inside and outside hospital walls	**Pediatric Institutions:** Clinics, FQHCs, Hospitals, Private Practices, Rehabilitation Hospitals **Pediatric Leadership:** CEO, CMO, CIO or CDIO, Chair, Division Heads, Medical Directors **Healthcare Team:** Advance Practice Nurses, Community Health Workers, Medical Assistants, Nurses, Physician Assistants, Physicians, Psychologist, Patient Registration Staff, Language Services Staff, Social Workers **Community-facing Entities:** Public Relations, Community Affairs **Other Parties:** EHR companies, Patient Registration Software Companies
ACKNOWLEDGE BIAS	• Implicit bias and bystander training • Ongoing training to reduce or strategies mitigate bias	**Licensure and Certifying Entities:** State Medical Licensure Boards, Pediatric Certifying Boards (i.e., ABP) **Pediatric Institutions:** Clinics, FQHCs, Hospitals, Private Practices, Rehabilitation Hospitals **Pediatric Professional Bodies:** AAP; APA; APS; APSA; APSNA; ASPHO; FOPO; SPR; CoPS; IPA; NAPNAP; SDBP
CHANGE POLICY	• Extensive policies and practices review using a racial equity lens • Re-examine the role of police and security presence	**Pediatric Institutions:** Clinics, FQHCs, Hospitals, Private Practices, Rehabilitation Hospitals **Pediatric Leadership:** CEO, CMO, Chair, Division Heads, Medical Directors **Police, Safety and Security Officers**
INCREASE VISIBILITY AND CAREER ACCESS	• Ensure visual representation of Black, Indigenous, and people of color (e.g., photos, murals, magazines, and books) • Aim to employ a workforce that mirrors the geographic community in which we practice and the patient community, whom we serve	**Pediatric Leadership:** CEO, CMO, CBO, Division Heads, Medical Directors **Space-Planners:** Designers, Architects, Contractors, Marketing
PEDIATRIC RESEARCH		
NAME RACISM AS THE PROBLEM	• Collecting, reporting, interpreting, and presenting data on participants' race and ethnicity (including perceptions), ancestry, national origin, and experiences with racism	**Funding Bodies:** federal funders, state and local funders, private funders, institutional funders **Publishing Bodies:** Journals, Editors, Reviewers

	• Developing interventions that seek to mitigate racism or overcome its effects	**Research Institutes** **Pediatric researchers**
DIVERSIFY RESEARCH TEAMS	• Create research teams that include those traditionally under-represented in research and medicine • Participate in national and institutional diversity-focused training program • Implicit bias and bystander training • Hire, fund, publish, and cite Black scholars • Protect Black scholars from disproportionately high service loads and committee work	**IRB entities** **Research Institutes** **Pediatric researchers**
PEDIATRIC EDUCATION		
CREATE PSYCHOLOGICAL SAFETY	• Implement actionable systems for reporting, investigating, and rectifying accounts of racism and microaggressions • Re-think and revise coded language used in evaluations and recommendation letters • Provide and financial cover ample educational and professional development opportunities for trainees	**Medical & Residency Leadership:** Medical Student Deans, Pediatric Chair, Clerkship directors, Pediatric Program Directors **Pediatric Leadership:** CEO, CMO, Chair, DEI offices Division Heads, Human Resources, Medical Directors **Pediatric Educators:** Attendings, Clinic preceptors, Healthcare team, Staff

RECRUIT & RETAIN	• Recruitment:
	  ○ Subsidizing interview travel or away rotations for students of color
	  ○ Using a more holistic approach that values diversity and life experience
	• Retention
	  ○ Financial needs (e.g., salary, loan repayment)
	  ○ Peer support (e.g., cluster hiring programs)
	  ○ Career development opportunities (e.g. AAMC's minority faculty development program)
	  ○ Mentorship and sponsorship teams
		Medical & Residency Leadership: Medical Student Deans, Pediatric Chair, Clerkship directors, Pediatric Program Directors
		
		Pediatric Leadership: CEO, CMO, COO, Chair, DEI offices Division Heads, Human Resources, Medical Directors
		
		Philanthropic/Development/Foundation offices

REDESIGN THE CURRICULUM	• Integrate anti-racism training into our curricula using historical and structural competency along with humility (e.g., grand rounds, journal clubs, etc.)	**Graduate Medical Education:** ACGME, Institutional GME offices **Pediatric Institutions:** Clinics, FQHCs, Hospitals, Private Practices, Rehabilitation Hospitals **Medical School & Residency Leadership:** Medical Student Deans, Pediatric Chair, Clerkship directors, Pediatric Program

		Directors **Pediatric Educators:** Attendings, Clinic preceptors, Healthcare team, Staff
PEDIATRIC WORKFORCE AND LEADERSHIP		
RESTRUCTURE FOR SUCCESS	• Evaluate racial disparities within hiring processes, salary and bonus structures, leadership decisions, and promotion outcomes. • Aligning racial equity work with promotion criteria • Create an inclusive institutional culture • Ensure DEI leadership positions are equipped with the authority, status, salary, budget and influence to enact meaningful change	**Pediatric Institutions:** Clinics, FQHCs, Hospitals, Private Practices, Rehabilitation Hospitals **Medical School Leadership:** Medical Student Deans, Pediatric Chair, APT committees **Pediatric Faculty** (especially senior faculty) **Diversity Committees or Councils**
PEDIATRIC ADVOCACY AND COMMUNITY ENGAGEMENT		
RENAME & RE-CENTER	• Anti-racist activists write letters, op-eds, position statements • Anti-racist activists testify, provide media interviews • Anti-racist activists partner with communities, government, and the private sector • Activist/Advocacy work is recognized for promotion and tenure	**Pediatric Activist** (Advocates) **Community-facing Entities:** Public Relations, Media Relations, Community Affairs, Government Affairs **Pediatric Leadership:** Medical School Dean, DEI offices, Chairs, APT committee
BECOME AN ANCHOR INSTITUTION	• Sustain, comprehensive community engagement • Analyze the system's purchasing agreements, supply chains, capital, and community investments to ensure alignment with anti-racist practices.	**Pediatric Leadership:** CEO, CMO, COO, Chair, Division Heads, Medical Directors **Community-facing Entities:** Public Relations, Media Relations, Community Affairs, Government Affairs Coalitions,

Abbreviations: CEO-Chief Executive Officer; CBO- Chief Branding Officer; CMO- Chief Medical Officer; CIO- Chief Information Officer; CDIO-Chief Digital Information Officer; EHR-Electronic Health Record; ABP-American Board of Pediatrics; AAP-American Academy of Pediatrics; APA- Academic Pediatric Association; APS- American Pediatric Society; APSA-American Pediatric Surgical Association; APSNA- American Pediatric Surgical Nurses Association; ASPHO- American Society of Pediatric Hematology/Oncology; FOPO- Federation of Pediatric Organizations; SPR-Society for Pediatric Research; CoPS-Council of Pediatric Subspecialties; IPA-International Pediatric Association; NAPNAP-National Association of Pediatric Nurse Practitioners; SDBP-Society for Developmental Behavioral Pediatrics; NHMA-National Hispanic Medical Association; NMA-National Medical Association;