VIEWPOINT

It is not Black and White: A spotlight on racial diversity in paediatrics

Kaylita Chantiluke,1 Rie Yoshida,2 Ngaree Blow,3,4 Dani Hall,5,6 on behalf of Don’t Forget the Bubbles

1Paediatric Emergency Department, Sunshine Hospital, 2Melbourne Medical School, University of Melbourne, 3Department of Health, Victorian Government, Melbourne, Victoria, Australia, 4Department of Paediatrics, St Mary’s Hospital, 5Blizard Institute, Queen Mary University of London, London, United Kingdom and 6Department of Emergency Medicine, Children’s Health Ireland at Crumlin, Dublin, Ireland

Now more than ever, there is a recognition that the existing racial inequality within healthcare systems around the world must be addressed. Preserving this momentum is vital and every profession and specialty must be held accountable for their own shortcomings. In this article, we place a spotlight on the paediatric medical workforce. We explore key areas of concern including differential attainment and the under-representation of paediatricians from minoritised ethnic groups in leadership roles. We use the recent measures adopted by the Royal College of Paediatrics and Child Health in the United Kingdom as a framework for achieving inclusive work environments and equitable opportunities for all paediatricians.

Although not a new issue, racial inequity within healthcare has recently been put under the spotlight as a result of the Black Lives Matter movement and the COVID-19 pandemic.1 Just as the Black Lives Matter movement has only recently been recognised despite years of campaigning and protests from communities around the world, it is also true that minoritised ethnic and racialised groups have only recently been actively prioritised by governments during this pandemic. The difficult truth is that the status quo is no different in paediatrics. As it stands, paediatricians from minoritised ethnic and cultural groups are more likely to encounter discrimination and prejudice during training and face more barriers to career progression.2,3 As no adequate cohesive term exists, we have elected to use the term minoritised ethnic and racialised groups in the acknowledgement that individuals within these groups share being placed into socially constructed minorities.4,5 This can include, but is not limited to, ethnic and racialised groups also defined as Black, Indigenous (also referred to as First Nations) and people of colour. We have, however, kept any original terms used within the studies and documents referred.

In the United States (US), a study by Stoddard et al. in 2000 noted that the racial distribution of the US paediatric population was more diverse than that of US paediatricians, and that affirmative action was needed to address this discrepancy.6 It has been shown that Black and Hispanic paediatricians care for significantly more ethnically minoritised patients than White and Asian doctors, and that these patients tend to be racially concordant with their physician.7 The importance of racial concordance between doctors and patients has been shown in numerous studies, the most startling of which indicated that Black infants were more likely to survive if they were looked after by a racially concordant physician.8 This highlights the significant need for improved ethnic diversity in paediatric medicine in the US.

In Australia, there is an unfortunate paucity of national data regarding the racial diversity of general medical practitioners and specialists such as paediatricians. The majority of other ethnicities are not included in the quarterly registrant data reports produced by the Medical Board of Australia (MBA), despite the inclusion of other protected characteristics such as age and gender.9 Information regarding international medical graduates (IMGs) is available from the Australian census and annual specialist pathway reports from the MBA. However, as country of birth and racial identity are not synonymous, it is difficult to interpret this data in relation to ethnic diversity. Data on the proportion of Indigenous medical professionals was presented in a 2020 report by the Australian
Indigenous Doctors Association (AIDA) which highlighted that only 0.15% of medical specialists identify as Aboriginal or Torres Strait Islander. The report further states that accurate collection of data regarding Indigenous medical professionals is key to ensuring that issues of diversity are addressed, and this holds true for other minoritised ethnic groups in Australia. However, there is still a challenge on the accuracy of these numbers due to barriers within institutions such as hospitals and universities as a result of past racist policies and current ongoing discrimination associated with those policies and the lasting effects of colonisation.

In the United Kingdom (UK), national data regarding the ethnicity of medical professionals is relatively well documented. Reports by the UK General Medical Council and Royal College of Physicians have shown that trainees from minoritised ethnic groups perform less well in assessments and recruitment during postgraduate training. This is mirrored in paediatrics: a 2019 survey found that IMGs needed to submit significantly more job applications than UK graduates before being appointed to a paediatric consultant post. Furthermore, those from minoritised ethnic groups are underrepresented in volunteer positions within the Royal College of Paediatrics and Child Health (RCPCH), who hold roles such as examiners and committee members. Particular ethnicity discrepancies are evident in Black or Black British members, making up 5.0% of members but only 2.8% of volunteer roles. The reasons underlying differential attainment in assessments and recruitment are likely complex and systemic. However, the Fair Training Pathways for All report in the UK identified unconscious bias as one of the root problems.

In recognition of the need for action, the American Academy of Paediatrics produced an exceptional policy statement highlighting the fact that racism is a social determinant of child health, as well as identifying the myriad ways in which paediatricians could attempt to address this. While we highly recommend this policy statement, it unfortunately pays little attention to the lack of racial diversity in paediatricians in the US and the ways this can be rectified. Similarly, the Australian Medical Association produced an anti-racism statement in 2018 which, whilst providing important clarification on the varying forms of racism that exist in the medical workforce, did not identify any specific action that could be taken to tackle racism and improve diversity.

In 2021, the UK RCPCH announced its equality, diversity and inclusion action plan. The proposed action plan is comprehensive and commendable and as such, we have built on these proposed actions using evidenced strategies from the medical literature to support our recommendations. We suggest that they be adopted and adapted by paediatric facilities world-wide in the hope that they will offer a more equitable future.

Transparency in Performance

Solutions cannot be proposed without explicitly describing the problem. By improving data collection and developing knowledge of the paediatric workforce’s diversity and lived experience, there can be transparency about the delivery of diversity outcomes within paediatrics. Initial steps in obtaining this crucial data include providing physicians with the opportunity to include their ethnicity and/or cultural background on national and specialty registration documents. The importance of medical institutions collecting and analysing this information has been highlighted by the recent work of an independent consultancy firm in the UK. They found that Black doctors in London were six times less likely to be appointed to a medical position compared with their White counterparts. This comparison is key to identifying the issue and demonstrating privilege as the other side of the coin to discrimination and racism. As highlighted by McIntosh’s work, ‘White’ as an ethnicity or race has often been excluded from the conversation and historically omitted from racial discussions in order to reaffirm the invisibility of white-ness. A lack of a transparency of whiteness in turn creates a system that inherently benefits White people at cost of non-White groups in society, thereby leading to systemic racism. In the aforementioned case, the firm argues that it is the role of central health organisations to identify these issues of systemic racism and set accountable targets for hospitals that are the worst offenders.

Overcome Bias in Recruitment

Efforts have been made to mitigate recruitment bias at undergraduate entry by using tools such as the United Kingdom Clinical Aptitude Test (UKCAT), but studies have shown that its introduction has not led to increased numbers of students from ethnically minoritised groups obtaining medical school offers. Its introduction is a step in the right direction but other solutions, such as explicit action to reduce faculty bias, need to be considered. While it is now being demonstrated that there is a growing representation of ethnic and racialised groups in medical schools across Australia, including an increasing number of First Nations doctors, there is still some way to go to achieve population parity. It has also been suggested that health outcomes not only may improve the health of Indigenous people, the growing numbers of Indigenous medical educators will also enrich the training of doctors overall.

Empower Individuals to Speak Up About Issues of Racial Harassment and Instigate Change

The British Medical Association has established a Racial Harassment Charter for Medical Schools; currently, 28 of the UK’s 35 medical schools have committed to supporting the charter. This is a significant step forward; establishments now must demonstrate proactive, timely implementation of this or their own iteration of the charter’s recommendations in order to ensure that a positive, tangible change is made towards racial equity in medical schools.
**Monitoring of Clinical Training Placements**

During training, clinical placements should be inclusive work environments with trainees receiving effective supervision and mentoring. Trainees should have the opportunity to speak up about experiences of bullying as well as being empowered to highlight experiences of racial harassment, microaggressions and placements demonstrating inclusive practices. The RCPCH has created the new role of equality, diversity and inclusion representative on the Trainees Committee, a role that will be pivotal in focusing on matters raised by trainees including differential attainment and career progression.

**Include Equity, Inclusion and Diversity in Paediatric Curricula**

As future leaders of the paediatric medical workforce, trainees should be knowledgeable about equity, inclusion and diversity and welcome open and informed discussions on the topic. Paediatricians should be aware of the social and cultural determinants of health inequities, including racism and act as representatives and advocates for our diverse patient population. There are many reports and policies that relate to First Nations communities, as the group most affected by inequities in Australia, including the Be Seen. Be Heard. Flourish report from the commissioner for Aboriginal children and young people. The report identifies that the state government still has much to do to authentically support Aboriginal children and young people and prevent another wave of Stolen Generations. The RCPCH, Australian Commissioner for Aboriginal Children and Young People, and the Medical Council of New Zealand in partnership with Te Ohy Rata O Aotearoa have all pledged to review health outcomes for children and young people and address health inequalities in children from minority groups.

**Development Programmes/Mentoring Schemes**

As senior clinicians, it is our responsibility to support students, trainees and other colleagues from ethnically and culturally diverse backgrounds to initiate change for the better. Health Education England has a toolkit for supervisors on differential attainment as well as online training on how to support internationally educated health professionals. The literature supports the success of these programmes: the New Century Scholars Program, run by the Academic Pediatric Association, provides a model for successful mentorship. In response to the lack of diversity in academic medicine, the program offers mentorship to paediatricians from underrepresented minorities. About 63% of the paediatricians from minoritised ethnic groups who entered the program between 2004 and 2015 went on to enter academic careers in paediatrics. Peer support networks have been a positive step to overcome cultural barriers for Māori doctors in New Zealand. Some allow Māori doctors to collectively find solutions to racism; others foster peer-learning and support. As a cultural peer-mentoring initiative, they are described by Māori doctors as ‘safe spaces’ for discussion.

**Create Diversity in Senior Staff**

Medical students from minoritised ethnic and cultural groups have better experiences with, and feel more supported by, racially concordant medical staff. The RCPCH has pledged to promote identifiable role models from ethnically diverse backgrounds with an aim that by 2030, those in voluntary roles will truly reflect the diversity of its membership. As well as identifying potential volunteers from underrepresented groups, the college will clarify the expectations of volunteer roles, to improve accessibility to members from minoritised backgrounds. To ensure measures are adopted to improve the inclusivity and diversity of future senior leaders in paediatrics, both in the college and in hospital organisations, hospitals lacking ethnic diversity in leadership positions will be encouraged to seek mentoring from organisations that have proven to be more effective in addressing this gap.

In addition to the institutional changes that need to be made, there is an emergence of exciting initiatives borne out of the efforts of individuals. The Australian Indigenous Doctors Association (AIDA) is an example of an organisation established to advocate for Indigenous patients and doctors as well as promote cultural diversity in the Australian medical workforce. Utilising strategies such as identifying doctors’ ethnicity at a national level and inclusion of community advisory committees on workforce groups as a part of Reconciliation Action Plans could have a profound effect on increasing representation of ethnically minoritised groups more broadly in the medical workforce. In the US, the National Medical Association is a long-standing collective of over 50,000 African-American doctors who focus on tackling the public health issues facing Black Americans in addition to supporting the medical and professional education of its members. The UK, groups such as Melanin Medics and Team Soft Landing have aimed to provide a safe space for ethnically minoritised medics, with Team Soft Landing providing specific support for IMG paediatricians in the UK with workshops and mentoring.

Promoting respect, equity and diversity is a fundamental part of our role as paediatricians. The RCPCH actions and initiatives as discussed here are achievable and it is every paediatrician’s duty to champion them, wherever they work. Ultimately, a more empowered, diverse workforce will be better equipped to address the appalling health inequities at a population level to which children are falling victim internationally.

**References**

1. Isaacs D, Tarnow-Mordi WO, Sherwood J. The black lives matter movement: The time for nice words and good intentions is over. J. Paediatr. Child Health 2020; 56: 1327–9.
2. Royal College of Paediatrics and Child Health. CCT Class of 2017: Where Are They Now? RCPCH; 2019. Available from: https://www.rcpch.ac.uk/sites/default/files/2019-10/workforce_cct_2019_1.6.pdf [accessed December 2020].
3. Royal College of Paediatrics and Child Health. Putting Ladders Down. Ways to Open Up Voluntary Roles at the RCPCH for the 21st Century. RCPCH; 2020. Available from: www.rcpch.ac.uk/sites/default/files/2020-07/ladders_down_030120_2.1.pdf [accessed January 2021].
4. Milner A, Jumbe S. Using the right words to address racial disparities in COVID-19. Lancet Public Health 2020; 5: 419–20.
5. Selvarahaj S, Deivanayagam TA, Lasco G et al. Categorisation and minoritisation. BMI Glob. Health 2020; 5: e004508.
Racial diversity in paediatrics

K Chantiluke et al.

6 Stoddard JJ, Back MR, Brotherton SE. The respective racial and ethnic diversity of US pediatricians and American children. Pediatrics (Internet) 2000; 105: 27–31. Available from: http://pediatrics.aappublications.org/content/105/1/27.abstract.

7 Basco WT, Cull WL, O’Connor KG, Shipman SA. Assessing trends in practice demographics of underrepresented minority pediatricians, 1993-2007. Pediatr. Int. 2010; 125: 460–7. Available from: http://pediatrics.aappublications.org/content/125/3/460.abstract.

8 Greenwood BN, Hardeman RR, Huang L, Sojourner A. Physician–patient racial concordance and disparities in birthing mortality for newborns. Proc Natl Acad Sci U S A [Internet] 2020; 13: 201913405. Available from: http://www.pnas.org/content/early/2020/08/12/1913405117.abstract.

9 Medical Board of Australia. Registration Data [Internet]. (AU): Registrant Data Table September, 2021 [updated 2021; cited 2021 Oct 13]. Available from: https://www.medicalboard.gov.au/news/statistics.aspx

10 Australian Indigenous Doctors Association [Internet]. (AU): Growing the Number of Aboriginal and Torres Strait Islander Medical Specialists. 2020 [updated 2020; cited 2021 Oct 13]. Available from: https://aida.org.au/app/uploads/2021/01/Growing-the-number-of-Aboriginal-and-Torres-Strait-Islander-medical-specialists.pdf

11 Henry BR, Houston S, Mooney GM. Institutional racism in Australian healthcare: A plea for decency. Med. J. Aust. 2004; 180: 517–20.

12 Nolan-Isles D, Macniven R, Hunter K et al. Enablers and barriers to accessing healthcare services for Aboriginal People in New South Wales, Australia. Int. J. Environ. Res. Public Health 2021; 18: 3014.

13 General Medical Council. Interactive Reports to Investigate Factors that Affect Progression of Doctors in Training GMC 2015. Available from: https://www.gmc-uk.org/-/media/documents/briefing-note—exams-and-recruitment-outcome-outcomes.pdf-60609977_pdf-60086282_pdf-62012305.pdf [accessed January 2021].

14 Royal College of Physicians. 2019 Survey of Medical Certificate of Completion of Training (CCT) Holders’ Career Progression. RCP; 2020. Available from: https://www.rcplondon.ac.uk/projects/outputs/2019-survey-medical-certificate-completion-training-cct-holders-career-progression [accessed January 2021].

15 Woolf K, Rich A, Viney, R et al. Fair Training Pathways for all: Understanding Experiences of Progression. London: UCL Medical School, ACME 2016. Available from: https://www.gmc-uk.org/-/media/documents/briefing-note—exams-and-recruitment-outcome-outcomes.pdf-60609977_pdf-60086282_pdf-62012305.pdf [accessed December 2020].

16 Trent M, Dooley DG, Dougé J, Section on Adolescent Health; Council on Community Pediatrics; Committee on Adolescence. The impact of racism on child and adolescent health. Pediatr. Int. 2019; 144: e20191765. Available from: http://pediatrics.aappublications.org/content/144/2/e20191765.abstract.

17 Australian Medical Association. [Internet]. Equity, Diversity and Inclusion; 2018 [updated 2018; cited 2021 Oct 13]. Available from: https://www.ama.com.au/articles/equity-diversity-and-inclusion

18 Royal College of Paediatrics and Child Health. RCPCH: Equality, Diversity and Inclusion. Working Lives of Paediatricians. RCP; 2020. Available from: https://www.rcpch.ac.uk/sites/default/files/2021-03/RCPCH-EDI-Working-lives-of-paediatricians.pdf [accessed March 2021].

19 Cunliffe S. [Internet]. Corporate Gaslighting – Race Recruitment & Denial in the NHS; 2021 [updated 2021; cited 2021 Nov 11]. p. 37. Available from: https://ctou.com/wp-content/uploads/2021/10/Race-and-Recruitment-Report-FINAL-2.10-21.pdf

20 McIntosh, P. White privilege: Unpacking the invisible knapsack. Peace and Freedom Magazine; 10–12 July–August 1989. Available from: https://psychology.umbc.edu/files/2016/10/White-Privilege_McIntosh-1989.pdf

21 McIntosh P. Extending the knapsack: Using the White privilege analysis to examine conferred advantage and disadvantage. Women Ther. 2015; 38: 232–45.

22 Mathers J, Sitch A, Parry J. Longitudinal assessment of the impact of the use of the UK clinical aptitude test for medical student selection. Med. Educ. 2016; 50: 1033–44.

23 Fielding S, Tiffin PA, Greattrix R et al. Do changing medical admissions practices in the UK impact on who is admitted? An interrupted time series analysis. BMJ Open 2018; 8: e023274.

24 Lawson KA, Armstrong RM, Van Der Weyden MB. Training indigenous doctors for Australia: Shooting for goal. Med. J. Austral. 2007; 186: 547–50.

25 Capers QV, Clinchot D, McDougle L, Greenwald AG. Implicit racial bias in medical school admissions. Acad. Med. 2017; 92: 365–9.

26 Crampton P, Weaver N, Howard A. Holding a mirror to society? Progress towards achieving better sociodemographic representation among the University of Otago’s health professional students. N. Z. Med. J. 2018; 131: 59–69.

27 British Medical Association. Racial Harassment Charter for Medical School. BMA; 2020. Available from: www.bma.org.uk/advice-support/discrimination-and-harassment/racial-harassment-in-medical-schools/racial-harassment-charter-for-medical-schools [accessed January 2021].

28 Lawrie A. South Australia’s Commissioner for Aboriginal Children and Young People Inaugural Report December 2019. ‘Be Seen. Be Heard. Flourish.’; 2019. Available from: https://cacyp.com.au/wp-content/uploads/2020/05/South-Ab供给al-Commissioner-for-Aboriginal-Children-and-Young-People-Inaugural-Report-December-2019.pdf

29 Royal College of Paediatrics and Child Health. RCPCH: Equality, Diversity and Inclusion. Health Outcomes For Children And Young People. RCPCH; 2021. Available from: https://www.rcpch.ac.uk/sites/default/files/2021-03/RCPCH-EDI-Health-outcomes-CYP.pdf

30 Connolly H. Commissioner for Children and Young People, South Australia. Annu. Rep. 2020/2021; 2021. Available from: https://www.cccp.com.au/wp-content/uploads/2022/01/SA-Commissioner-for-Children-and-Young-People-Annual-Report-2020-2021.pdf

31 Baseline Data Capture: Cultural Safety, Partnership And Health Equity Initiatives. Medical Council of New Zealand and Te Ohu Rata O Aotearoa (Te ORA). Allen + Clarke; 2020. Available from: https://www.mcnz.org.nz/assets/Publications/Reports/f5c692d6b0/Cultural-Safety-Baseline-Data-Report-FINAL-September-2020.pdf

32 Differential Attainment Toolkit. London and South East Postgraduate Medical and Dental Education, Health Education England. c2021 [cited 2021 Jan 20]. Available from: https://www.ipmde.ac.uk/professional-development/da

33 Internationally Educated Health Professionals. London and South East Postgraduate Medical and Dental Education, Health Education England. c2021 [cited 2021 Jan 20]. Available from: https://www.ipmde.ac.uk/professional-development/iehp

34 Pachter L, Kodj C. New century scholars. Acad. Med. 2015; 90: 881–7.

35 Baseline Data Capture: Cultural Safety, Partnership and Health Equity Initiatives Final Report. Allen + Clarke; September 2020. Available from: http://www.mcnz.org.nz/our-standards/current-standards/cultural-safety/

36 Morrison N, Machado M, Blackburn C. Student perspectives on barriers to performance for black and minority ethnic graduate-entry medical students: A qualitative study in a West Midlands medical school. BMJ Open 2019; 9: e032493.

37 Chairs and Non-Executives in the NHS: The Need for Diverse Leadership. NHS Confederation; c2021 [cited 2021 Jan 20]. Available from: www.nhscconfed.org/-/media/Confederation/Files/Publications/Chairs-and-non-executives-in-the-NHS.pdf

38 National Medical Association. Available from: https://www.nmanet.org/ [accessed May 2022].

39 Melanin Medics. Available from: https://www.melaninmedics.com/ [accessed March 2021].

40 Team Soft Landing. Available from: https://www.softlanding.org/ [accessed December 2021].