Dr. Marie Bernard
Oral History

Marie A. Bernard, M.D.

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Shirko: Today is February 28, 2024. My name is Matt Shirko, and I'm the Archival and Research Assistant at the Office of NIH History and Stetten Museum. Today I'll be speaking with Dr. Marie Bernard. Dr. Bernard is the NIH Chief Officer for Scientific Workforce Diversity (COSWD), based in the Office of the Director. Dr. Bernard is going to be speaking about the trajectory of her career as well as her current work. Thank you for sharing your story with us. To start, could you tell us a little bit about your personal background, including your family and any experiences or influences in your younger years that impacted your later career?

Bernard: Thank you. We have a lot of people with similar titles these days, but my charge as the NIH Chief Officer for Scientific Workforce Diversity is to look at things across NIH.

I am the daughter of two physicians—so people would say, “Of course she would become a physician; of course, she would go in this direction.” Even though it sounds like I come from an affluent background, my parents were practicing physicians in Oklahoma, where I grew up prior to Medicare and Medicaid. Many times, patients paid them with cookies, pies, cake, and things like that. But we were rich in valuing education.

You can tell from my grey hair that I’ve been around for a while. At the time I was growing up, Oklahoma was still segregated. When I was going to elementary school, I’d get textbooks that were written in before, and I would wonder, “Why is that?” There would be these awful smells from the sewage disposal plant that was in our neighborhood. Why was that near to us? Then there was a decision made for urban renewal that got rid of this beautiful park-like space between streets—something called Grand Boulevard in our neighborhood. That was for “urban renewal.”

By the time I was in high school, the schools were being integrated, so I was in a more diverse setting. But all of that certainly has played a role in the way I’ve looked at my career and the sorts of things I’ve been involved with—and was ultimately leading to this role as the Chief Officer of Scientific Workforce Diversity.

Shirko: Can you talk a little bit about your educational background and some of the training you've had?

Bernard: When I was graduating from high school, my mother—who was a very smart person—told me that I had to go to college at a Seven Sisters school in New York, Boston, or Philadelphia, because we had family members there. I had to apply early decision; we couldn’t deal with the uncertainty. I applied early decision to Bryn Mawr College.

I went there—sight unseen—and it was wonderful.

It was a women's college that did a great job of helping us figure out which direction we wanted to go in life. I planned to be a French major but found that speaking French with my Oklahoma accent and being there with women who had been to France four or five times just didn't cut it. But in the chemistry class, we all started off on an equal level. It was just a great chance to learn that I loved chemistry. I ended up as a chemistry major and ultimately did decide to go to medical school.

I went to medical school at the University of Pennsylvania School of Medicine there in Philadelphia. Being a "good Oklahoma girl," I got married between college and medical school, so it was a good place for us to be, allowing my husband to do his postgraduate studies as well. Similarly, because we wanted to be in the same city, I did my residency training at Temple University School of Medicine and got selected to be a Chief Resident after the standard residency training period. All my upper-level education was in Philadelphia.

Shirko: What spurred your interest in aging and geriatric medicine specifically?

Bernard: After residency training, I became a faculty member at Temple University School of Medicine in the Section of General Internal Medicine. When I started seeing patients there, the patient base was the Health Maintenance Organization of Pennsylvania, which ultimately became Aetna.

We saw a lot of young, healthy people and a lot of upper respiratory and urinary tract infections. Whenever I saw an older patient, they were just so much more interesting to talk to. They had a lot of different illnesses. Whenever I walked out of the exam room, I would say to the nurse, "That was an interesting patient." She said "Oh, that's not good for the patient!" [laughs] I liked those diagnostic challenges.

A little bit into my time there, my division director told me that he wanted me to write a grant about geriatrics and that I needed to go talk to this woman, Bernice Parlak, who was on the Temple main campus and head of the Pennsylvania Geriatric Education Center. Bernice said, "Well, I will give you information if you participate in our training program"—which was a week of intensive training in geriatrics, and then a year of follow-up activities. This is before there were a lot of formal geriatric medicine fellowship programs around. I did that week of intensive training.

It was an epiphany.

I just learned so much. I thought I knew geriatrics—I knew how to take care of hypertension, diabetes, heart failure—but there's so much more to the field and I was just enraptured. I did that training, got myself fully immersed, and went on from there.

Shirko: You've participated in a lot of research that focused on nutrition and function in older adults, specifically, underrepresented minorities. Could discuss some highlights of some of the things you were involved with?

Bernard: When I first got back to Oklahoma as a faculty member in the Department of Internal Medicine, that was my interest. When I was at Temple, I had been involved with the Nutrition Support Team, which means you gave force-feeding to older adults who were quite ill.

When I got to Oklahoma, I wanted to pivot to enhance the nutrition and function of older adults before they got to the hospital—because, quite honestly, when they called the Nutrition Support Team, it was kind of the final benediction. I wanted to go in and do something before people become that ill. As I said, I grew up in Oklahoma. So, I started off doing a project just off the campus in these high-rise towers housing primarily African Americans. I was partnering with a childhood friend, an African American woman who was a faculty member at another school. We initially had a lot of challenges getting our project going, doing a survey of nutritional status of the population there. They didn't trust us, even though we grew up in that area. We were the academics who were coming in. Just like with other clinical studies, we had to develop relationships and build trust. But ultimately, it became a very productive relationship. We got a lot of nice publications out of it. As I transitioned into the department chair role, I ended up delegating that sort of activity to my faculty, but it was a great foundation for what we did with the department.

Shirko: You were the Associate Chief of Staff for Geriatrics and Extended Care at the Oklahoma City Veterans Affairs (VA) Medical Center. Will you talk a little bit about this role, and specifically what it was like working with veterans?

Bernard: The VA is the Cadillac of geriatric care. The VA has recognized that they have an obligation to a population of veterans from World War II, the Vietnam conflict, and now from Iraq and Afghanistan. They had home care available, along with outpatient, inpatient, nursing home, and hospice care—so really the full spectrum of activities needed to support older adults.

Even though I was a full-time faculty member in the OU College of Medicine, our activities were primarily across the street at the VA, where you had that whole spectrum of care. Of course, we did things at other facilities across the city to make sure our trainees had experiences with women. The veterans themselves were, again, interesting. They always had lots of stories, interesting backgrounds, and complex illnesses that were challenging for me with my internal medicine background. I love trying to solve these sorts of puzzles. It was a wonderful environment, for me, for my faculty, and for our trainees.

Shirko: You were the founding chairperson of just the third geriatric department in the U.S., at the University of Oklahoma (OU) Donald W. Reynolds Department of Geriatric Medicine. Discuss that experience in terms of developing and standing up a geriatric department, especially during a time they were far less common. What were some of the challenges and successes with that?

Bernard: That was an exceptional opportunity that just kind of plopped down in front of us. The Donald W. Reynolds Foundation was established after Mr. Reynolds, who was a journalism magnate in Oklahoma, Arkansas, and Nevada, died. He designated funds to be spent within 50 years of his death. The Foundation decided they wanted to do something on aging. They got Dr. Robert Butler, who was the Founding Director of

the NIH National Institute on Aging, as their consultant. Dr. Butler said, “If you want to really have an impact on older adult populations, you should establish departments of geriatric medicine because if you train the physicians, they will influence the entire health care system.”

They gave Oklahoma, Arkansas, and Nevada the opportunity to compete for funds to establish a department. I told my provost and dean that Arkansas was going to win that competition because they virtually had a department—they had a Geriatric Research, Education, and Clinical Care Center from the Department of Veterans Affairs that had been in place since 1979, and this is the mid-1990s at this point. And sure enough, they did win. A lot of time and effort was devoted to developing our application, but it suffered from being developed by committee. You could tell by looking at the application. Nonetheless, the provost said it was a good idea and we should do it anyhow. He went to the state and to the VA and got some startup funds for us to develop a department. I was leading geriatric activities for the Department of Medicine at the VA hospital, so I got to take the lead on implementing the use of the funds. I was also the head of a geriatric education center at that point—the same sort of program that had trained me. So, we got started with me, a geriatric medicine trained fellow, and a PhD educator as the core faculty, but relied on the broad network of academics and clinicians at the VA and in the Geriatric Education Center.

Then I got this call from Dr. Butler. He said, “Marie, do I understand that you established a Department of Geriatric Medicine without funds from the Reynolds Foundation?” I said, “Yes sir, that’s true.” He said, “Well, can we come visit?” They came to visit, and they gave us another chance to apply for department funding. This time I took the lead in writing a cohesive application based on the work that we were doing, and we got the funding - $12.5M. It was the largest grant that the OU Health Sciences campus had received to that point, with the stipulation that within five years, we would not only establish a department, but require a geriatrics rotation for all third-year medical students. That’s 150 students between Oklahoma City and Tulsa.

That was fun and exciting. Part of the allure from the standpoint of the Reynolds Foundation was that the grant would be matched dollar-for-dollar by a fund in Oklahoma that supported endowed chairs. Thus, I was able to start building the department with a series of 10 endowed two-million-dollar chairs. There were faculty members at OU that said “Well, I guess if I get a lot of money, I can start a department,” and there were students who were saying “Well, Dr. Bernard’s going to make us change bedpans and take care of pressure ulcers—bed sores.” But we got it done.

By the end of the five years there were 10 faculty in endowed chairs, an additional 20 affiliated faculty, and a required four-week geriatrics rotation for all 150 medical students in Oklahoma City and Tulsa. We had faculty from all walks of life, demonstrating the benefit of a diversity of perspectives. The students took the rotation and loved it. They felt that they learned and enhanced their abilities as a physician. However, rarely did they want to become a geriatrician because they thought the field was too complex.

The Reynolds Foundation was so pleased with our performance that they gave us an opportunity to apply for additional funds to support our research. We developed a proposal that was successful in getting an additional

six endowed chairs for researchers. Thus, when I moved to my position at NIH, I left behind a more than thirty-two-million-dollar endowment for faculty positions.

Shirko: In 2008, you joined NIH at the National Institute on Aging [NIA] as Deputy Director. What prompted you to take this role, and what were your primary responsibilities?

Bernard: At the point at which the opportunity to go to the National Institute on Aging arose, I'd been the Chair of the Reynolds Department of Geriatric Medicine for a decade. There's this rule of thumb that leadership roles should turn over every decade or so, so that new ideas and new energy can be brought in. I was aware of that. I didn't want to be one of those people who's just hanging on by my fingernails, saying "Don't take me away."

I wanted to see what the next opportunities were for the department and for myself, and I was already thinking actively about what the next step was. Then a couple of colleagues took me aside and said, "Marie, this is opening up—you should really think about it; it's a great opportunity at a national level, as opposed to a local and regional level." And I'd been on the National Institute on Aging Advisory Council, so I was very familiar with NIA. To my delight, I applied and was selected.

I spent 13 productive years at the side of Richard Hodes, the Director of the National Institute on Aging, helping to navigate that large ship of state—the research agenda in aging—and got to see neat things. When I first arrived, there was a study that was being planned to look at the impact of aspirin supplementation in older adults—is it beneficial or not? I got to see the whole thing get implemented and the analysis. The results changed the United States Preventive Services Task Force recommendations for aspirin supplementation for prevention in older adults. Prior to that study, we routinely thought that, yes, you should give aspirin as a prophylactic for strokes for older adults. The data doesn't support that at all. In fact, the data suggest that there could be damage rather than benefit in the absence of documented heart disease or prior stroke. And I was in the middle of all of that. I got a chance to see exciting results like that and others before they were published in the New England Journal of Medicine. For a real nerd like me, it was perfect! [laughs].

Shirko: That ties into the next question well. You've done several analyses of research and administrative policies, procedure, and outcomes at NIA, NIH, HHS [U.S. Department of Health and Human Services] and even for other federal agencies, relative to the representation of older adults and underrepresented minorities, including workplace and workforce issues and clinical trial inclusion policies. It's a broad topic, but is there anything you can share in terms of highlights of the discoveries and impacts of some of this research and analysis?

Bernard: One of the things I'm most excited about, from that group of things that have been done, is the work we did to demonstrate that there is not sufficient inclusion of older adults in clinical studies. What I knew from having seen patients on a regular basis as an academician is that I would often have a patient in my office who was 80 or 85 years old, and I was trying to apply evidence for care of their hypertension, diabetes, or whatever that was based upon people who were 50 and 60 years old. There are differences as you age, and there are differences if you have multiple illnesses and interacting medications.

What we did was to look at what's called "phase 3 clinical trials" at NIH—these are the trials that are meant to generate generalizable conclusions that are to be disseminated broadly—and looked at how well older adults were represented in those studies addressing the top ten causes for hospitalization or illness for older adults. We found that there was not an appropriate representation of older adults given the expression of those illnesses in the general population. This contributed to the development of the NIH-wide policy that's in place, "Inclusion Across the Lifespan." We had a couple of workshops with that title. The policy mandates that when a scientist is submitting a clinical trial proposal to NIH, they must include children and older adults proportional to their representation in the general population that suffers with that illness. That's something I've been very pleased with. The policy has been in place now for about five years, so they're just getting to the point that they can really analyze whether the policy has been impactful—but that would not have happened had our team not done that analysis, published about it, and had workshops about it.

Shirko: In 2015, you helped develop the NIA Health Disparities Research Framework, which showcases the priorities for investigating health disparities related to aging. Could you explain the Framework and your role in establishing it?

Bernard: That was generated at the request of the National Institute on Aging Advisory Council subcommittee, the Minority Working Group. When I was a Council member, I chaired the group. As the Deputy Director, I supported it. I had a staff member who led something called the Office of Special Populations (OSP). When she left, we needed to step back and evaluate what had been happening in our health disparities and minority health research, and our diversity efforts in general. As a result of that analysis, the recommendation from Council was that we develop a framework to structure our research. Our new Director of the OSP who I recruited, Dr. Carl Hill, led the effort with me and Dr. Eliseo Pérez-Stable, who is now Director of the National Institute on Minority Health and Health Disparities (NIMHD) but was then Chair of the Minority Working Group; Dr. Norman Anderson, who was head of the American Psychological Association at that time; and others. This Framework is meant to help researchers think broadly about health disparities and minority health research—whether you are a basic researcher, clinical researcher, or epidemiologist. I'm really delighted that Dr. Pérez-Stable and colleagues, as they established the NIMHD [National Institute on Minority Health and Health Disparities] Minority Health Framework, gave credit to the NIA framework. Of course, he helped to develop it, so that's a reason for him to do so. [laughs]

Shirko: You chair the Women of Color committee of the NIH-wide Working Group on Women in Biomedical Careers. Could you talk a little bit about the working group's objectives and accomplishments?

Bernard: I should note that I gave up that role when I became the NIH COSWD. However, the Women of Color Committee is a subcommittee of the NIH-wide Working Group on Women in Biomedical Careers. I was asked to step into the role of leading that group when Dr. J Taylor Harden, my Director of the Office of Special Populations left, as she was the former chair. It was clear that the intent of the group was to facilitate interactions among women of color and their allies. There was something called the Women of Color Research Network (WoCRn) that had been established.

Under my leadership, we expanded the WoCRn to make sure that there were robust conversations among women of color and their allies. We also engaged with Dr. Donna Ginter, who led a landmark study, published in 2011 in Science, that looked at challenges with receipt of NIH R01 [NIH Research Grant Program] funding by race and ethnicity. We invited her to talk with us, because the Science article was silent about whether there were gender differences. She was able to bring us data that showed that, yes, there are gender differences. There are gender differences in general with women not applying as frequently and not having as much funding as men. That's compounded by coming from a racial or ethnic group that's underrepresented. We postulated that part of what may have been contributing to that was that women weren't as well networked and weren't as well recognized.

We, thus, worked systematically to increase the visibility of successful women of color scientists. We started nominating highly qualified women of color scientists for the very prestigious NIH Wednesday Afternoon Lecture Series [WALS]. It's now been six or seven years, and we have been credited with markedly increasing the diversity of that group.

Shirko: It's very interesting to be able to see some of the impact that some of these things have had. You're the co-chair of the Inclusion Governance Committee, which ensures appropriate inclusion of individuals in clinical studies, including by sex, gender, race, ethnicity, and age. Please talk about the committee's goals and accomplishments.

Bernard: I gave up that role when I became the Chief Officer for Scientific Workforce Diversity, but the work I was talking about in terms of inclusion by age was in my role as the cochair of the Inclusion Governance Committee.

Shirko: As the Chief Officer for Scientific Workforce Diversity (COSWD), you lead NIH thought regarding scientific workforce diversity, assuring that the full range of talent is accessed to promote scientific creativity and innovation. Can you describe your role as COSWD and some of the functions of your team? It's probably a loaded question.

Bernard: I could probably talk for two hours. But as the COSWD, as I am called, my role is to be the chief adviser to the NIH Director about scientific workforce diversity issues, and to catalyze and leverage programs across NIH and beyond to make sure that we have a diversity of perspectives at the table. There are data that show that when you have diverse perspectives, you get better outcomes, more creativity, and more innovation in science. And quite honestly, if we don't do that, we risk losing our leadership role in biomedical and behavioral research across the globe. I have a tiny team; there are only 12 of us. I like to think of us as the tip of the spear that's working on facilitating diverse perspectives, but we have lots of allies across NIH and beyond. It's been joyful being in this role.

Shirko: You co-led the development of the Fiscal Years 2023 to 2027 NIH-wide Strategic Plan for Diversity, Equity, Inclusion, and Accessibility (DEIA) and are working on its implementation. Could you discuss the core

themes and objectives of the strategic plan, what the drafting process was like, and how that implementation is working?

Bernard: Yes, developing the DEIA Strategic Plan was an intriguing process. It was bringing together two mandates. There was a mandate in the fiscal year 2021 NIH budget to develop a Diversity, Equity, and Inclusion Strategic Plan, including focusing on diversity research, and making sure there's a diversity of scientists that are funded. Then an Executive Order came from the Biden administration requiring all operating divisions within the government to develop a diversity, equity, inclusion, and accessibility plan that's an internally facing plan.

When you look at the DEIA Strategic Plan for NIH, it has three objectives—two of which are generally internally facing, the third is externally facing looking at research issues. I had the privilege of co-leading the development of that with my colleagues, the Director of the Office of Equity, Diversity, and Inclusion, and the Director of the Office of Human Resources. We had 100+ volunteers who were involved in the process. I continue to be very grateful to Dr. Marina Volkov and her team in the Division of Program Coordination, Planning, and Strategic Initiatives, or DPCPSI, as we call them, who were really the motor behind all of this. Somehow or another, after lots of meetings, we got a cohesive document that is representative of the way that we see things going forward over the next many years. We made liberal use of my additional role as cochair of the NIH Steering Committee's Diversity, Equity, Inclusion, and Accessibility Working Group, which is comprised of Institute and Center Directors, Deputy Directors, and Executive Officers, to review and vet what's there because we needed to make sure this is in keeping with what is feasible. It lays out a very nice framework for what people can anticipate coming from NIH over the next many years.

Shirko: You're the co-chair of NIH's UNITE Initiative to identify and address structural racism within NIH and throughout the biomedical and behavioral workforce. Can you describe the UNITE initiative and your role as co-leader?

Bernard: The NIH UNITE Initiative was getting launched as I became the Acting COSWD. I was the Deputy Director of the National Institute on Aging for many years. In August of 2020, I got a call that Dr. Francis Collins, the then-NIH Director, wanted to talk to me. Even though I was a Deputy Director, I didn't usually talk to the NIH Director. I thought, "Oh, my goodness, what did I do wrong?" Then I thought about it. I thought, "He wants to ask me to do something—someone was probably leaving, probably Hannah Valantine, the founding COSWD. He probably wants me to do that." And sure enough, that is what he asked me to do. I became the Acting COSWD in October 2020. I am really honored to have been selected to be the permanent COSWD after a national search in May of 2021.

In October 2020, as I was stepping in as Acting COSWD, UNITE was getting launched internally. It was generated by the disparate morbidity and mortality that we were seeing because of the COVID pandemic, where communities of color were disproportionally experiencing hospitalizations and deaths. Then we saw racialized violence, particularly highlighted by the videotaped murder of George Floyd.

There was a lot of internal examination of what we should do, as was the case across the country—a lot of intense Institute and Center Director discussions that summer of 2020, which I got the privilege of participating in as one of the few women of color in a relatively high position. The decision was that we were going to start this initiative that we named UNITE internally in October. I was asked to be one of the co-leads with the Principal Deputy Director Dr. Larry Tabak and the Deputy Director of Management Dr. Alfred C. Johnson, and 80+ volunteers from across NIH. Every Institute and Center had at least three representatives. We had senior people, junior people, scientists, and nonscientists.

As UNITE got started, it was kind of like everyone was speaking a different language. We spent a lot of time getting to understand each other, with the viewpoint that no input was invaluable. Over the course of October through January, we developed this goal of "promoting diversity." When the Biden administration came on board with multiple executive order to address racial and ethnic disparities, we reframed our language. On February 26, 2021, the initiative was publicly unveiled at a special meeting of the Advisory Committee to the Director. We said that our goal—very audacious—is to end structural racism.

Now, structural racism is a much larger issue than is under the purview of NIH. It has to do with things like what I saw when I was growing up. Where do you put your sewage plants? Where do you do your urban renewal? What is the quality of education? We don't have control of those things. But we are the largest funder of biomedical and behavioral research in the country—and we do have control of that.

Over the last three years, we have systematically used a racial and ethnic equity lens in evaluating everything that we do. This initiative is a people-centered and data-driven effort focusing on three content areas: minority health and health disparities research, what we do internally at NIH, and what we do externally. And it's yielded some excellent outcomes. From the standpoint of minority health and health disparities research, there's been significantly increased investment in that area. There's a UNITE-inspired Common Fund initiative that was unveiled in fiscal year 2023—ComPASS—Community Partnerships to Advance Science for Society. In ComPASS NIH is for the first time putting a lot of money towards letting communities say what they see are the problems that might account for disparities—and addressing those things. Very exciting. Hopefully, we'll learn a lot from that, and some generalized principles will come from that.

Internally, Institute and Center Directors have, as part of their performance review, an expectation to address diversity and equity issues and to develop a plan to look systematically within their own Institutes to make sure there's equity for all. Externally, we have at least four new funding opportunities and one enhanced funding opportunity that will help to promote diverse perspectives. We also have other efforts to make it easier for people to report if there are issues with regards to discrimination, and training of NIH staff to be more inclusive of a broad range of perspectives. It's been very, very exciting. And it's just the start. These sorts of things take a long time to give definitive outcomes. But I am very pleased from a process perspective with what's developed thus far.

Shirko: That sounds like there's been some tangible progress so far, which is great. Is there anything else you'd like to discuss for the record in terms of your research, your experience, or your background? You've had quite

the career and a lot of accomplishments to be proud of, but is there anything that we missed or that you'd like to comment on?

Bernard: I would like to comment to early career scientists and clinicians who are wondering about how this woman, who is a clinician and a clinician researcher, ended up at NIH and why I would do that. This is a great place to be. I mean, if I didn't have a day job, I could hear so many superb lectures by Nobel laureates and near laureates. You're in the middle of all the knowledge generation. If, at any point, you've been thinking about the possibility of NIH, give it a careful look—it's really a great place to be.

Shirko: That is a great point for sure. Thank you very much for sharing your history with us and getting all this documented. We really appreciate the time you've taken and look forward to seeing where things go.