Greg Donaldson: Welcome, and thank you for joining us for this podcast brought to you by the American heart association. This podcast is part of the series focused on the consensus conference report on professionalism and ethics released jointly by the American heart Association and the American College of Cardiology. The goal of this series is to amplify the reports details and actionable steps for healthcare professionals, researchers, and educators.

Ivor Benjamin: Hi I'm Dr Ivor Benjamin conference co-Chair of the 2020 AHA / ACC consensus conference on professionalism and ethics consensus conference report. Diversity equity and inclusion is about excellence in everything we do patient care team science, as well as, of course, the whole swath of research. And last but not least, in order for us to really be able to treat diversity equity inclusion and belonging, commitment to diversity metrics both qualitative and quantitative in all aspects of healthcare clinical research and education

I'm joined today by Dr. Emelia Benjamin, who was a lead author of this paper and specific task force on diversity, equity, inclusion and belonging. I consider Dr. Benjamin an esteemed colleague and friend. Dr. Benjamin is associate provost of faculty development for Boston University, vice chair faculty development and diversity in the Department of Medicine and professor of medicine and epidemiology at Boston University Schools of Medicine and Public Health.

Emelia Benjamin: Thank you. Well, first I want to just say that it's an incredible honor to be part of this task force and also to have the opportunity to share with you and your listeners the outcomes of the task force. This task force was a task force of the who's who of diversity, equity, inclusion and belonging and it was extraordinarily well led by Pam Douglas from the ACC and Ileana Pena from the American Heart Association and all of us learned a lot from each other, and I think came up with. Big picture concepts, as well as robust practical tips that organizations can embrace to advance the culture and the practice.

This is an issue that is so important to academic health sciences and particularly cardiovascular health sciences. The writing group was focused on diversity, equity, inclusion, and belonging, and included topics such as how do we optimize cardiovascular health care research and education with an equity lens, so that we can ensure respect, eliminate bias, discrimination, harassment, and all the isms, including racism and sexism, so that we can have a more vibrant workforce, and we can have a more effective workforce.

Ivor Benjamin: Can you go on and explain a little further to our listeners why diversity, equity, inclusion and belonging have been included in this report on professionalism and consensus report?

Emelia Benjamin: Interestingly, it wasn't particularly directly addressed by the prior AHA/ACC consensus conference report on professionalism and ethics. Often when we think about medical ethics and professionalism, we focus on individual actions of healthcare professionals with patients. I think having been through the pandemic, all of us appreciate that health equity and social justice must be addressed by our professional societies, such as the American Heart Association, in order to effectively advance cardiovascular health. I want to mention that one of the other task forces is going to be focuses entirely on health and social justice from a structural standpoint. Our task force in particular address professional and career aspects of diversity, equity inclusion and belonging. We know that individual and systemic injustices negatively affect our learners environment, our science, patient care, and ultimately public health. And hence, we have to address them in order to make the type of impact on death, disability from cardiovascular disease, and promoting cardiovascular health that is so central to the American Heart Association's mission.

I love the fact that you use the word excellence, Dr. Benjamin, because there's this weird concept among some people who haven't thought about it deeply that somehow diversity is in opposition to excellence. And I think you and I, and people that have thought through these issues deeply understand, we cannot be excellent unless we embrace diversity, equity, inclusion, and belonging. And this isn't a kind of fuzzy PC feel-good stuff, right? This is backed up by data, big data analytics and research science. So for instance, I started subscribing to the Harvard Business Review. The business literature every year comes out with more and more studies about having diverse workforces, improving the bottom line, improving the innovation of the discovery at parts of various business enterprises.

Similarly, the health literature is replete with descriptions of the fact that diverse workforces are essential to drive excellence. They come up with more innovative solutions, they have higher impact science. In fact, there's actually a bibliometric data study that looked at impact factor versus the diversity of the team. And lo and behold, the impact of the science was higher on diverse teams. And, interestingly enough, diverse workforces are more likely to address health inequities, which have to be

addressed if we're going to achieve the ambitious health goals in order to have a healthy society.

Ivor Benjamin: I am really so glad that you teased out the word excellence. And as a conference co-chair, I can attest to the outstanding as truly unextraordinary individuals who brought their talent as well as the kind of scholarship in really being able to express that excellence in this report. So Dr. Benjamin, what guidance then does the task force recommend with respect to diversity, equity, inclusion, and belonging?

Emelia Benjamin: One of the things that we have to address is that the cardiology work force does not look like the general population. That's incontrovertible. The portions of women, of blacks, Hispanics, indigenous peoples that are in cardiovascular health, sciences, and cardiovascular clinical care don't look like the US population. And what's disturbing is that really hasn't changed over the last decade. So what are the immediate goals? The immediate goals, we'll start from the converse, which is we've got to eliminate structural racism and sexism. We must achieve a freedom from bias, discrimination, and harassment. But I want to focus on the positive aspects. We also need to ensure equity, inclusion, and belonging in order to drive diversity in our trainees, our workforce, and our leadership. Now, if you talk to trainees, residents, who are making the rounds of cardiology interviews for fellowship, not infrequently, they are the only woman in the room.

They are the only person of color in the room. They are talking to people who are on the faculty who don't look like them. And if we want to drive excellence, if we want to drive diversity, we've got to be thinking deeply about what are the structures that are keeping in place the fact that for many women and people of color, they're concerned about joining a workforce that does not look like them. And how can we do better? Because we can do better, because both you and our cardiologists, we have great faith in our cardiovascular colleagues. We know that they can and want to do better.

Ivor Benjamin: Well, I certainly know the tremendous passion, as well as commitment that you bring to this space professionally and personally. What I want to do is just talk a little bit more about the long-term action items that have been developed by your task force.

Emelia Benjamin: I'm really glad that you asked that because it wasn't just sort of big concepts. There were very concrete next steps that can guide institutions that can and should be on this journey. So the

first thing is, everything in the academy that's valued is measured. How many patients you see, RBUs, it's measured. How many grants you have is measured. How many papers you write is measured. We know from the business and the quality literature that if you care about something, you have to measure it. So, we as leaders and as institutions have got to double down on our commitment to assessing diversity metrics. We need to be conducting robust qualitative climate surveys that are across domains in the educational space, in the clinical space, in the research space, so that we can understand current state, we can come up with plans to address it, we can enact it, we can study it, and then start the PDSA cycle all over again.

Because, we have to be able to figure out what the lesions are, embrace best practices, how do we have team membership? Do we have citizenship? Do we have cultures of mutual respect? Do we have effective allyship? Do we have anti-racist anti-sexist institutions? How can we support and promote others? So qualitative data has got to be a piece of it. Quantitative data has to be a piece of this, quantitative metrics. I talk to chairs of medicine, and I ask them, "By the way, when you have done analysis of metrics, compensation, mentorship, sponsorship, resource allocation, startup packages, space promotions, compensation, is it equitable? Virtually every chair of medicine I've ever spoken with says that they have to do the analysis. And every time they do it, and they do it, the ones that really care about this, do it on an annual or every other year basis. Every single year, they discover inequities. They have to be addressed.

So we've got to have quantitative metrics that measure the things that are necessary for people to be successful. Either in academia or in private practice. Similarly, do they have the same access to nursing, et cetera? The next thing is that we need to have trainings. And in the report, we include examples of trainings that are robust, and that have been effective that address individual structural, systemic racism, systemic sexism, homophobia, classism, prejudice against people with disabilities. We need to have more trainings, and we need to study them to figure out how do we generalize them into different practice settings, into private practices across institutions. There's some emerging literature, we need a lot more.

The next is a very painful topic to bring up because none of us want to think that this happens. We have to take on abuses of power. Sexual harassment, overt racial bias, we have to embrace that. We have to regard that with the same seriousness as we regard academic and scientific misconduct.

We would never tolerate academic misconduct, but somehow, well, there was just a misinterpretation, blah, blah, blah. We've got to have robust systems for destigmatizing reporting of harassment and racism. We need to have independent investigations. We need to hold our colleagues accountable. And then we need to disseminate summaries of actions and providing visible support to targets. Now, I want to be clear. I'm not talking about every time somebody says an insensitive comment, we're going to cancel them. I don't know many people who haven't said insensitive things. I personally have said insensitive things. I have a child with a disability. And the other day I heard myself talking about something being so lame. That's a microaggression. Now I caught it, but maybe I hadn't caught it.

I think that we need to have restorative justice. We need to have bystander training. We need to have effective allyship so that we can call our colleagues and to be their best selves, so that we can help people understand that their intentions may have been good, but their impact was not. This is probably the most important and probably central to what AHA does best, which is the American Heart Association is so deeply committed to science and evidence-based clinical care and research. So we need to similarly invest the same amount of energy funding and rigor into conducting and publishing the evaluation of programs, interventions to address bias, harassment, sexism, racism, and the converse, what are cultures that are creating cultures of diversity, equity, inclusion, and belonging. I think through the robust science, we can start to disseminate these across practices across institutions. And we can see the kind of acceleration of cardiovascular health equity that we all want to see.

Ivor Benjamin: Well, without a doubt, both the timeliness, as well as the comprehensive approach that was undertaken by your task force is clearly reflected in many of these issues that you've just outlined Dr. Benjamin. Overall, cardiovascular clinical academic organization and specialty and society leadership and organizations must be held accountable for institutional culture and for visibly championing, working toward and in achieving diversity, equity, inclusion, and belonging. Thanks to all our listeners for tuning in, we have three more podcasts planned. So please turn to Heartbeats series for additional podcasts in this series, covering clinician wellbeing, patient autonomy, privacy, and social justice in health care. And last but not least, the modern healthcare delivery. Also please visit the AHA Lifelong Learning platform the webinar recording of the roundtable discussion led by Dr. Bob Harrington, coauthor of

the consensus statement and past president of the American Heart Association. Dr. Benjamin, thank you so very much.