Speaker 1 (00:16):

Welcome, and thank you for joining us for this podcast brought to you by the American Heart Association. This podcast is part of a series focused on the 2020 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, MD (00:44):

Welcome to this podcast on the 2020 AHA/ACC consensus conference report on professionalism and ethics, with a specific focus on modern healthcare delivery. My name is Dr. Ivor Benjamin, I'm a past president of the American Heart Association. I was privileged to co- chair this conference report with Dr. Mike Valentine, past president of the American College of Cardiology. I also serve as a Director of the Cardiovascular Center at the Medical College of Wisconsin. For a bit of program overview, delivery of cardiovascular care to people in communities continue to evolve rapidly, whereas professional obligations to patient centricity must remain consistent. The transformation of care delivery models and the complexities of new technologies mandate increased attention and careful introspection in relationship to professionalism and ethics. Evolving employment and payment models, rapidly changing delivery sites of care, and the documentation of care require maintenance of standards that are beyond reproach and representative of the trust placed in all physicians and clinicians.

Ivor Benjamin, MD (02:01):

It is a responsibility of each individual, as well as our professional communities to continually evaluate the degree to which such standards are maintained and met. I'm really excited to be joined today by Dr. Clyde Yancy, who was a lead author of the paper. Dr. Yancy is the Vice Dean of Diversity and Inclusion at Northwestern University in the Feinberg School of Medicine. He's also the Magerstadt Professor of Medicine, Professor of Medical Social Sciences, and Chief of the Division of Cardiology. Dr. Yancy is also a past president of the American Heart Association. He's been a long- time friend as well as colleague. Thank you, Dr. Yancy for joining us for this sixth and final podcast in our series, focusing on the 2020 AHA/ACC consensus conference report on professionalism and ethics. Please tell our listeners about your role on task force five.

Clyde Yancy, MD (03:13):

Well, Dr. Benjamin, thank you first of all, for the privilege of having this conversation with you.~ I really enjoyed listening to you articulate the program overview because you emphasized tier of the thoughts of those of us who participated in the deliberations specifically this. We have begun to understand that medicine has undergone a disruptive dramatic shift, particularly in healthcare delivery. I don't need to recite the external pressures that we have faced from 2020 and beyond. But if we try to be what we were pre 2020, there's no way we can accommodate the post 2020 world because of the necessity of doing research and the necessity of acquiring observational data. The necessity of being able to understand things quickly and deliver care rapidly and efficiently and correctly.

Clyde Yancy, MD (04:10):

What is at risk is in fact, that core ethos in medicine, where we work assiduously to protect the confidentiality of our patients. Where we work tirelessly to be absolutely correct in our assessments, in the way we use testing, in the way we evolve the diagnosis and to be unfailingly true to our interpretation of new science and the application of that science, and to do all of this in a way that

captures a sense of ethic. That is the one thing that doesn't change, no matter how disruptive medicine has been in the last 24 months, we're recording this now in the mid part of 2021. No matter how disruptive medicine has been, it's imperative that we are assiduous in our embrace of the core principles of ethics.

Clyde Yancy, MD (05:04):

I'm engaged in this as a member of the task force, the listening group, the writing group that uniquely carved out modern care delivery. Now, why do we opt to do that? We opted to do that because there's something about the way in which we are employed in systems. There's something about the way in which we use electronic health records, as it pertains to extracting data. There's something about the way in which individual physicians engage with outside parties, industry, third party contractors. These things are radically different than they were before, but nevertheless, they don't allow us to stray from our fundamental principle of being professional and being ethical. Before I yield back to you though Ivor, I want to articulate for those that are listening, what we as the aggregate writing group because it wasn't just us in our silos, and our task force, but it was our aggregate writing group that brought forward some incredibly important statements.

Clyde Yancy, MD (06:04):

Let me share with you very quickly the principles of professionalism upon which we all agree. The primacy of patient welfare, that everything we do is in the best interest of the patient. Ivor, in your opening comments you used the phrase "Patient centricity", but let's just remember that the number one principle is the patients welfare the patient is first. The second principle is that the patients have earned, deserve, and should be offered, complete autonomy with complete respect for their volitional will in how we make decisions. And the third part that we declared was a principle of professionalism, and this I think is a shift from what it was before but an appropriate one, investing in grace of social justice. There should be some space Ivor, some space in the totality of life and living. Where , once you enter that space, the only thing that's important is doing the right thing, for the right person, at the right time, in the right way. No modifiers, no additives, no qualifiers.

Clyde Yancy, MD (07:07):

We believe, as leaders in cardiovascular medicine, the American College of Cardiology and American Heart Association, that that space is in the way in which we engage with patients. And so we elevated social justice to one of the principles of professionalism. We then went on to make a couple of commitments and I'll just articulate these so we can all be on the same page. Professional competency, be certain your skilled at what it is you determine is your particular focus work. Honesty with patients. Where this is most important is a simple phrase, "I don't know, but I'll find out." That is incredibly important. Patient confidentiality, not just now, but perpetually. We owe it to our patients to respect what they share with us in confidence and keep it that way regardless. And you know what? That's in the Hippocratic oath. Maintaining appropriate relation with patients being professional at all times. It's very easy to blur the lines, but be professional at all times.

Clyde Yancy, MD (08:05):

Improving quality of care. We know what we need to do. Ivor, you and I have passed so many tests we've even written tests, but we have to be certain that executing on our knowledge is important, improving access to care, removing barriers, making certain those barriers touch on this one important concept. Equity is a key consideration. Understanding that our reality is that we have finite resources

make certain that the way we distribute those resources to our patients represents a just distribution. Scientific knowledge, we can not walk away from what you and I, and the overarching focus on American Heart Association promulgates. We are better through science. Discovery science is key in helping us unravel the mysteries of heart disease and helping people live longer, happier, healthier lives, free of heart disease and stroke.

Clyde Yancy, MD (08:58):

Have you heard that somewhere before Ivor? And then maintaining trust by managing conflicts of interest. Don't let some undercurrent of influence stray you away from making the best decision for your patients. And then at all times, to whatever extent we acknowledged certain professional responsibilities, execute those as carefully and as best as we can. So, that really is a set of opening comments that I hope captures the spirit of the five preceding podcasts and gets us up to where we are today to spend the rest of this time, thinking about modern healthcare delivery and how that touches professionalism and ethics. Thanks Ivor.

Ivor Benjamin, MD (09:41):

Thank you Clyde, for not only that articulate, but for so succinctly placing your hands on some important issues that resonate so well with me. Patient centricity, social justice, access to quality health care. These are just so critical and I'm sure you will join me in encouraging everyone who's listening to this podcast to take a deeper dive in the many other aspects of I think, this so well-written report. So let's talk a little bit more Clyde about other areas of recommendations put forth by the task force. What are areas of guidance? Perhaps you may want to get into medical professionalism, maybe relationship to the employed clinician. There are other areas that we can get into and perhaps you might even want to touch on the Quadruple Aim.

Clyde Yancy, MD (10:46):

So, let's start with one of the most important areas that's so obvious that it really merits our immediate attention. In today's world, transparency is so important and understanding what is a conflict of interest, and in particular understanding how conflicts of interests have varied over time. Ivor there was a time where a conflict of interest meant you received an honorarium from a company for being on a speaker's Bureau. Conflict of interest might've meant that you were a paid consultant for a company. Those are straightforward. Those are transparent. Those are reportable. Those are easy to access. But what happens when you're employed by a hospital corporation and you're on a performance contract? Is that not a conflict of interest? What happens when you, or offering CME and you receive a nudge from a sponsor, "To be certain to focus on this technology, please." Should you expose that? Should you divulge that?

Clyde Yancy, MD (11:46):

These are the kinds of nuance conflicts, that now enter the workspace and what we believe is important is that through transparency and being driven by equality initiative, that is patient-centric as you've articulated, we can avoid some of the inevitable entanglements, that ultimately, "Unfortunately, compromise our works". We can't allow that to happen. One of the other things to keep in mind is that as we have transitioned from the traditional fee for service model, which was appropriate to a value-based model, we can't allow ourselves to de-select higher risk patients so we can have best possible outcomes. Because you and I both know that when we de-select high risk patients, it's the old patient. It's the patient with multiple comorbidities. It's the poor patient. It's the patient that's been

marginalized, minoritized. We can't allow those things to happen. We have to also recognize that when we worked in multi-dimensional corporations, some of those corporations reap a financial return on tests that we order, on procedures that we order.

Clyde Yancy, MD (12:58):

Why does one group of physicians rely on stress echo, another group of physicians around rely on nuclear imaging? We have to be careful that we're not nudged in decisions that we make about patients that are driven by other motives. And as we think about our peers in the ACC, who really came up with this important vernacular of appropriate use criteria, it really helps us guide our decisions about what we do for which patient when and why. And I think that ends up being a good first step in this conversation. So let's say this first pillar is thinking about conflicts of interest. Would love to know your thoughts there.

Ivor Benjamin, MD (13:41):

Well, absolutely Clyde. And I think you have so appropriately placed your finger on the pulse as we discuss, of course, the modern healthcare delivery system. Now talk a little bit more about recommendations that clinicians, educators, and researchers can and should immediately put into practice.

Clyde Yancy, MD (14:06):

So several things, and this is really straight forward on the issue that we just discussed. Just transparency, and physicians are intuitively so bright that it should be relatively easy to understand when there's a need to let others know where you are. The second thing though that we can't overlook is evidence-based medicine. That's guideline driven. We have invested so much of our brand equity forgetting about costs, forgetting about the very important in kind contributions to staff for the ACC and AHA, our brand equity is on these guidelines statements. We need to utilize those statements as a guidepost and say, "As long as we're adhering to a standard, like an evidence-based guideline, we will practice medicine that will be reasonably high quality if not explicitly so." So, I think those are the first two things transparency, adhering to guidelines and the third thing, is think very carefully when you order a test.

Clyde Yancy, MD (15:08):

Are you ordering the test to make a diagnosis? To resolve uncertainty or just in case? And understand, if the test is not ultimately going to change the way you think about things, the test is not ultimately going to change your decision, is that the right strategy to do at this point in time? I think those are three things that are very important, but here's the fourth thing. So I've already said, be transparent. I've already said, adhere to guidelines because they're evidence-based and quality focused. I've already talked to you about understanding the necessity to work assiduously, to really provide best care in all circumstances.

Clyde Yancy, MD (15:51):

But the other part of this I really want to emphasize is we need to understand the power and the peril P-E-R-I-L in the electronic health record. If we immerse ourselves in electronic health record for the good then it is a reasonable tool. But if we leave charts open on computer screens, if we look at other patient's record without their consent, as a friendly gesture, that's not a friendly gesture. That's a violation of someone's privacy. If we make an entry into a chart that was not invited, that again is

untoward. That is an affront to a patient. And so we have to really respect that entirety of access to records is something that is very, very important. And I think if we do such, we will be in the right place in the right place. [crosstalk 00:16:51]

Clyde Yancy, MD (16:53):

We have to remember that the Triple Aim really says let's improve the health of the population, enhance patient satisfaction and reduce the cost of the care. And then when we go to a fourth aim where now we're thinking about how systems function, we really are in a very, very different place. You think about the things I've just said, we are right in the center of that whole experience. We've got to find a way to be certain that we improve the care of the population, we do so at a reasonable cost, that we consider how we interface with systems, and here is the other part that's very important. That we understand and finally, it's made an entire vernacular, the importance of provider wellness. That's a really key consideration.

Ivor Benjamin, MD (17:52):

And in an earlier podcast, Clyde, we specifically looked at the relationship, for example, even in the context of clinician wellbeing, how interface with the medical record. But Clyde, you mentioned earlier that you and I have known each other for a few decades and I cannot help, but get your perspective. We are just, of course, wrote this amazing document that would be etched in the annals of a history, linked to a pandemic. And you talked about de-selecting the high risk patient, and we know, how particularly in communities of color, there were some disproportionate outcomes that was associated. Without recognizing and perhaps recognize that that's a separate podcast, why not take a few moments, Clyde put in perspective this whole podcast, in the context of the modern healthcare deliveries.

Clyde Yancy, MD (18:54):

There are a couple of things that are important when we consider this podcast. Let's do a little bit of a history walk in the beginning of the document, we point out the difference between the first iteration of this document and the recent iteration of the document. First iteration of the document was in the '90s, '97 and '98 a Bethesda conference with fewer than 100 people, actually fewer than 75 people participating. You and I can both imagine the demographics of that group, I don't need to articulate that in particular. Think about how much has happened in 20 years, not just 2020. Think about how much has happened in 20 years. You and I both know the American Heart Association convened its first ever Health Disparities Conference in 2005. You know that we began to embrace health equity in 2010-2011. You know that this has been a platform at the American Heart Association on an annual basis now, at least for the last five years. And in fact for the 2020 goal that we articulated in 2010, we made an emphasis on improved outcomes for all Americans, for all persons living in the United States.

Clyde Yancy, MD (20:18):

And so there've been some major shifts and focus, but importantly, there've been some major shifts in the population since we were here before. So I think everyone hearing this or listening to this, needs to understand where we were with the first or earlier iterations of this in the 2000s and late '90s and where we are now. But I want to get very specific now because you put out an important question. When we think about this current iteration of a statement on professionalism and ethics, we have to be willing to accept that even though it might be etched in the annals of medical history because it's aligned with the pandemic of 2020, I hope that etching is soft clay.

Clyde Yancy, MD (21:03):

I say that because it needs to be dynamic. We need to be able to accommodate changing environmental circumstances that require that we consistently reevaluate professionalism and ethics. It would be a disappointment if we don't have standardized conversations about professionalism, ethics, not for another 20 years. And here is the thing that I believe should be front and center, and I've begun to espouse this in a number of keynote addresses to which I've been invited to provide. And that is the importance of equity as a new tenant of professionalism. When you understand what the corporate world thinks about professionalism, equity is missing in action. When you understand what the healthcare community thinks about professionalism, you find very little mention of equity. And point of fact, this is an evolving concept that we have a responsibility to practice medicine, to conduct science, to train practitioners in a race blind, age blind, color blind, sexual orientation blind, disability blind way.

Clyde Yancy, MD (22:15):

Why? Because we are approaching a populace where there's no longer majority anything. It's got to be a multi-faceted approach if we are to accommodate the bulk of the people who live in this country now. It is diversity with a very large deep, because of many, many different cohorts living in this country, not simply defined by race or ethnicity, but by a number of parameters. So to answer your question with clarity, yes, we participated in a very meaningful exercise generating stock from it, but the document needs to be dynamic. And one of the next steps that needs to be incorporated in a document like this is a profound embrace of equity as a platform of professionalism.

Ivor Benjamin, MD (23:03):

Thank you, Dr. Yancy for this truly impactful and inciting recap, not only of the work from you and task force five, but actually putting in context, the essentiality of having a dynamic living document, whereas it pertains to professionalism and ethics. The altruistic behaviors, the dedication to honesty and transparency, the avoidance of conflict of interest, the focus on patient centeredness, the commitment to equity and fairness and the efforts to dismantle healthcare disparities. All of which, to which you so eloquently, Dr. Yancy, must underlie the ethical care of professionalism as they imply to the individual and it must be expected of all healthcare systems. Some final thoughts.

Ivor Benjamin, MD (24:01):

Thanks to all our listeners for tuning in. We have five more podcasts of this series so please tune in to heartbeats series for additional podcasts in this series covering not only the introduction and historical perspective, there have been of course, podcasts on conflict of interests, relationships with industry and expert testimony. Other aspects that were embellished by Dr. Yancy, that address diversity, equity, inclusion, belonging, the clinician wellbeing, and finally patient autonomy, privacy, social justice, and healthcare. Also, please visit the AHA's lifelong learning platform @learn.heart.org for the webinar recording of the round table discussion of this paper, led by Dr. Bob Harrington, a co-author of the consensus statement and past president of the American Heart Association. Thank you very much.

Clyde Yancy, MD (25:04):

Thank you, Ivor.