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EDITORIAL COMMENT

Increasing Diversity in Cardiology

It Will Take a Village*

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In the past 5 years, the need to increase the diversity of the cardiovascular workforce has become a prominent focus of the American College of Cardiology (ACC), along with several cardiovascular subspecialty societies. In doing so, the ACC seeks to "harness the power of the diversity of its members to advance patient care, spur innovation, and improve health equity among individual patients and populations" (1). Recent papers suggest that we have a long way to go. In 2016, just 12.8% of adult cardiology fellows met the Association of American Medical Colleges definition of under-represented minorities (URMs) (2), and representation in subspecialty fellowships was even worse: 9.2% of interventional, 10.3% of electrophysiology, and 15.7% of advanced heart failure transplant cardiology fellows. From 2006 to 2016, the percentage of URM adult cardiology fellows increased minimally (from 11.1% to 12.4%) albeit significantly (3). The outlook for attracting more women into cardiology is also grim. Although the proportion of fellows who were women doubled from 10.1% in 1991 to 21.3% in 2016, even the more recent "improved" number is lower than that for every other subspecialty in medicine back in 1991 except gastrointestinal and pulmonary/critical care (4). In 2019, the American College of Graduate Medical Education included work force diversity in its program evaluation requirements, a wakeup call for cardiology (5). The urgency to address diversity in cardiology is further heightened by the current dual crises of coronavirus disease-2019 and police brutality, which demonstrate in stark terms the glaring health disparities and structural racism endemic in the United States. Clearly, increasing female and URM trainees in cardiology is a critical part of the solution.

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In this setting, understanding the attitudes of cardiology program directors (PDs) and their efforts to increase diversity in their fellowships is timely and important. In this issue of the *Journal*, Damp et al. (6) present the results of an ACC survey offering a comprehensive picture of this important group of gatekeepers and leaders who have primary oversight of the recruitment and selection process, as well as responsibility for the fellowship experience. The top line result, that PDs overwhelmingly see a need to increase diversity (86%), is immensely reassuring. Indeed, the majority of programs (55%) report having none or only 1 URM fellow. However, there are some concerns. In total, 42% of PDs did not respond to the survey; although it is unclear whether this large minority feels similarly or if their nonresponse sends a message of disagreement, nonresponding programs are smaller and are more likely to be community-based. There is also a disconnect in translating the responding PDs enthusiasm for diversity into reality: most PDs (89%) have tried to increase diversity in recruitment, although only 70% thought training programs could help. Only one-third have a current plan in place to increase diversity, while another one-third feel unsure how to accomplish this. The existing strong will to change needs to be empowered by critically examining the barriers and developing a road map to improve.

Not surprisingly, most PDs focus on recruitment strategies (as these are under their control), prioritizing diversity when offering interview invitations, showcasing

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diversity of faculty or fellows during the interview day, and prioritizing diversity in developing the match list. These efforts are in line with and complement growing published data in this area (7). Further, the PDs also provided a list of needed resources, which represents a clear and actionable request to the ACC and cardiology specialty societies as they seek to support and encourage diversity in training programs. This is especially true for smaller programs, which report having access to fewer resources. However, while necessary, such efforts are not sufficient. Indeed, PDs identified the 3 most significant barriers to diversity in their fellowship program as all being outside their control, including lack of 'qualified' diverse candidates (as defined by the PD), overall culture of cardiology and lack of faculty diversity. The least significant barrier was the overall culture of their training program itself (6). Although this ranking represents the perceptions of the responding PDs, it suggests that our profession needs to take on the challenge of what is, in fact, a complex, multidimensional problem that can only be addressed broadly.

So, how do we tackle these larger issues? Although the data are insufficient, particularly as related to URMs, we do have some information to guide us. A survey of internal medicine residents' perceptions of cardiology provides clarity on why more women chose not to apply for cardiology fellowships: unlike men, whose choices were largely based on being attracted to cardiology (10 of 14 independent predictors), women's choices were based on deterrents, which represented 6 of 9 predictors (8). Both men and women found the culture of cardiology to be off-putting, with the 3 most prominent features all being negative: adverse job conditions, interference with family life, and lack of diversity of the field. We also have data on the professional experiences of female cardiologists that provide important reasons to avoid cardiology. Although overall satisfied with their careers, women experienced slower advancement, more harassment/discrimination (an eye popping 65% in a 2015 survey, 96% of which was gender-related), and more burnout than men, and received less compensation for the same work (9–11). These are deep systemic problems that cannot be addressed by PDs alone; they are the responsibility of all of us, including our institutions and the American College of Graduate Medical Education.

A first step toward remedying the situation is to acknowledge the problem, accept responsibility and commit to doing better. This applies not just to organizations like ACC and cardiology training program directors, but to all academic centers, community hospitals, and even individual cardiologists. We need to continue to listen to trainees in internal medicine and cardiology and, importantly, make sure that the voices of URMs, currently missing, are heard and attended to. There is no shortage of guidance as to what needs to be done, including a recent publication outlining a succinct list of 10 recommendations for career advancement of female cardiologists (12), and the ACC's first workforce Health Policy Statement on Compensation and Opportunity Equity (13). More data are always welcome, but the evidence base is robust enough to get started. All of us need to work harder toward a better professional experience for ourselves and the next generation, including work-life balance/integration, family-friendly schedules and leave policies, and zero tolerance for harassment and racism. We need to dismantle the structural racism inherent in our institutions and replace it with truly equitable environments. Cardiovascular leaders—division chiefs, practice managing partners, service line directors—need to own this problem and make themselves accountable for creating needed change. Program directors cannot do this alone, nor should they have to. Now is the time for all of us to engage.

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