Lack of diversity among cardiovascular health-care professionals continues

October 13 2020

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Despite working for more than two decades to address underrepresentation of women in cardiology, disparities among cardiovascular professionals continue to exist. Profound inequities also exist for individuals underrepresented in medicine, such as African Americans, Hispanic Americans and Native Americans, who constitute 32 percent of the U.S. population but only eight percent of practicing cardiologists.

"The disparities amplified by the COVID-19 pandemic present

disturbing evidence that we are far from cardiovascular healthcare equity in the work place," says Emelia J. Benjamin, MD, ScM, professor of medicine at Boston University School of Medicine (BUSM) and corresponding author of a Comment in the journal *Nature Reviews Cardiology*. "Individuals, leaders and institutions must prioritize research, policies, and structures to advance diversity, equity, inclusion, and belonging that is essential to advancing workforce excellence and cardiovascular health."

Diversity and equity in the health-care workforce have been shown to benefit patients and increase access to health care for underserved populations. Data also support that diverse organizations perform better and show more innovative thinking and problem-solving. In science, diverse teams by race, ethnicity and gender on average publish in higher impact journals than non-diverse teams; ethnically diverse teams on average had 10 percent more impact for papers and almost 50 percent higher impact for authors.

In the U.S. as well as in England and Australia, women constitute only a quarter of cardiology trainees, 15 percent of cardiologists and 4.8 percent of the interventional cardiologist workforce. According to Benjamin, over the past decade the number of female cardiology trainees has hardly increased and socioeconomic disparities between women and men cardiologists persists.

On average, women cardiologist still earn only approximately 92 percent of their male counterparts, translating to $2.5 million less over a 35-year career. In addition, Benjamin points to evidence of structural sexism persists such as a lack of sufficient childcare, adequate family leave policies, designation of endowed chairs and institutional responses to sexual harassment.

Evidence of structural racism includes an over reliance on board scores

and rank of institutions.

Benjamin calls upon academic health sciences to engage in transformative personal and structural anti-racist, anti-sexist and anti-classist work to promote diversity, equity, inclusion and belonging (DEIB). "A DEIB commitment will harness the innovation of all voices in the academic field to collectively address profound, persistent global structural healthcare and workforce inequities."

To achieve equity in the cardiovascular workforce and health-care delivery, Benjamin believes DEIB must be explicitly addressed, funded, prioritized and quantified over time at the personal, local and health-care system level. "Only through establishing equity in the health-care workforce we can achieve global health-care equity."

More information: Renate B. Schnabel et al. Diversity 4.0 in the cardiovascular health-care workforce, *Nature Reviews Cardiology* (2020). DOI: 10.1038/s41569-020-00462-8

Provided by Boston University School of Medicine