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Commentary: “What’s in your diversity toolkit? Get the C-suite support”

Virginia R. Litle, MD

The killing of George Floyd was the spark and coronavirus disease 2019 the fuel for a conflagration of social unrest. The injustice discussion has risen from the streets to the C-suites, and tangentially leaders across professional sectors are responding. Cardiothoracic surgery is not immune to this awakening. Until now, there have been few opportunities for underrepresented minorities and women to enter our specialty, be sponsored, and be promoted to leadership positions.¹⁻³ The lack of role models is one deterrent to a diverse workforce and diverse leadership, but institutional support compounds the racial and gender disparities by failing to appreciate the value to health care. Ortmeyer and colleagues⁴ propose timely modifications to the recruitment of trainees and the education of the program leaders about Diversity and Inclusion (D&I). In their “Checklist for Diversity & Inclusion in Cardiothoracic Surgery,” they provide action items to effect change.⁴ The checklist outlined in their article is actually more of a toolkit. The former category would be a highway, whereas the latter contains the instruments for repair. All the contents of their toolkit are essential for sustainability; however, a modest revision and a prioritization of organizational change is required.

First, to effect change, the institutional leadership, or “top-down support,” must commit to the change. Delete “ideally” from “...ideally compensation for invested effort” and remove “could” from “Faculty...could receive compensation for these actions.” The statement “Training programs and sponsoring programs must support and compensate

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CENTRAL MESSAGE

Establishment of a diversity training program must start with financial buy-in from the institutional leadership. Put your money where your mouth is. Commit to action and long-term change.

individuals demonstrating commitment to diversity” is spot on. Financial compensation allows the drivers of implementation to actually have the time to accomplish the G.O.A.L.S. of their program. Often surgical education and participation in hospital committees are deemed softer and less valuable than clinical time. Addressing diversity cannot fall into that bucket.

Establishing a D&I program also is an opportunity to implement health policy training to future cardiothoracic surgeons so they have the skillsets to effect health care equity.⁵ Given that health care outcomes improve with workforce equity,⁶ let’s cover all the bases.

Second, recognize a sea of change. Business, finance, and legal sectors are openly addressing the D&I problem: they appreciate the financial value to structural change^{7,8} and are investing appropriately. Editors and scientific researchers are demanding change. Kibbe and Freischlag⁹ banded together 108 journal editors to commit to metrics and transparency. Scientists have stated the importance of proactively placing disparities experts on National Institutes of Health study sections instead of a meritocracy for reviewers.¹⁰

Don’t make it a DIY toolkit. The leaders of health care systems need to put their money where their mouth is and provide the financial support for D&I programs. Start with appointing an underrepresented minority or woman to lead the charge. Compensate that individual and their team. Value their contributions with promotions. Since the

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C-suite is tasked with financial solvency, they should recognize a diverse workforce boosts the bottom line. Ultimately financial return may be the motivating factor but the true value is the human return.

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Commentary: We need diversity in cardiothoracic surgery

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There have been many appalling events this year that highlight the inequities faced by underrepresented communities. Many surgical specialties have struggled with a lack of diversity. Only 5% of general surgeons are African American,¹ and as of 2017, there were only 6 female African American cardiothoracic surgeons practicing in the United States.² In their article in this issue of the *Journal*, Ortmeyer and colleagues³ discuss strategies to improve the level of diversity in cardiothoracic programs. More diversity would bring such benefits as increased creativity and better ability to relate to a wider percentage of the population.⁴

Many institutions have created committees dedicated to improving diversity, equity, and inclusion in response to

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CENTRAL MESSAGE

Diversity in workforce increases creativity and broadens the community served. Specific goals and projects will improve the chance of increasing diversity in cardiothoracic surgery.

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national tragedies. Unfortunately, however, most diversity efforts do not succeed.⁵ Strategies with noble intentions, such as mandatory diversity training, actually have been associated with a decreased level of diversity.⁶ When evaluating the function of these diversity committees, there is one glaring observation: there is no standard among them.

The GOALS checklist presented by Ortmeyer and colleagues attempts to address this lack of consistency by creating a set of guidelines for institutions. The authors have created a useful starting point. Using their checklist