September 1, 2023

From: The Dialogues Group

The Dialogues Group is a coordinated movement across the fields of hearing science and hearing healthcare that aims to improve diversity, inclusion, equity, and access within its professions. Our goal is to continue inter-organizational conversations that lead to a tangible action plan.

Dear Colleagues,

We, the members of the Dialogues group, believe that it is imperative that the disciplines of audiology, hearing science, otolaryngology-head and neck surgery, and related fields take bolder actions to highlight and develop sustainable solutions to transform organizational systems that enable racism and inequity within our professions. We take this stand because:

1) The professions overwhelmingly lack diversity and do not represent the larger U.S. population.

The demographic profile in the professions of audiology and otolaryngology-head and neck surgery continues to under-represent the growing diversity of the U.S. population. Demographic data on race and ethnicity are also not readily available across our member organizations. The table below partially illustrates the problem with the most recent data from our national organizations, including the U.S. Census:

Race Category (%)	ASHA[1]	AAA[2]	AAO-HNS[3]	US Census[4]
American Indian or Alaska Native	0.3	0.3	<0.5	1.3
Asian	3.2	6.0	13.0	6.3
Black/African American	3.6	2.8	2.5	13.6
Native Hawaiian or Other Pacific Islander	0.1	0.1	<0.5	0.3
Multiracial	1.5	1.4	<2.0	3.0
White/Caucasian	91.1	79.9	72.0	58.9
Ethnicity Category (%)				
Hispanic or Latino/a	3.3	5.7	3.4	19.1
Not Hispanic or Latino/a	96.7	94.3	96.6	80.9

[1] Data from 2022 https://www.asha.org/siteassets/surveys/2022-member-affiliate-profile.pdf

[2] Data from 2021 American Academy of Audiology members based on voluntarily provided information when members join, renew or update their member profile.

[3] Data from American Academy of Otolaryngology-Head and Neck Surgery (AAO-HNS), July 20, 2023, The 2022 Otolaryngology Workforce, www.entnet.org/advocacy/health-policy-advocacy/socioeconomic-data

[4] *Data from the US Census Bureau, July 2022, https://www.census.gov/quickfacts/fact/table/US/PST045221)*

2) Health disparities and healthcare access disparities persist.

Irrespective of insurance status, access to hearing healthcare is not equitable across the U.S. population. The evidence that this disparity exists highlights the notion that even within the same healthcare system structural and implicit biases may influence the quality of care minoritized racial and ethnic groups receive. In part, this is likely due to the lack of diversity within the professions of audiology and otolaryngology-head and neck surgery as shown above. The availability, accessibility, and quality of healthcare are influenced by the effects of racism, discrimination, and socio-cultural factors. The factors that produce this remarkable disparity in our professions are multifaceted. However, addressing the lack of diversity, with the goal of improving representation in the clinic, academic, and research workforce, may offer one viable solution for a very complex problem. From the literature, examples of these disparities include:

- In hearing healthcare, there is evidence of racial disparity in the management of a variety of clinical conditions including hearing loss (Nieman et al., 2016; Reed et al., 2021) and vestibular schwannoma (Babu et al., 2013; Pandrangi et al., 2020).
- The utilization of pediatric cochlear implantation in the United States differs based on race and ethnicity (Jabbour et al., 2017). Black, Indigenous, and People of Color (BIPOC) pediatric patients with hearing loss who are candidates for cochlear implantation are half as likely to receive a cochlear implant compared to White patients (Tolisano et al., 2019).
- Additionally, the timing of implantation differs based on race and ethnicity: Black children in the U.S. were 56% less likely, and Hispanic children were 30% less likely to be implanted prior to the age of 2 years compared with White children, regardless of insurance status (Liu et al., 2021).
- Likewise, for minoritized racial or ethnic groups timing of hearing aid adoption is delayed. In an ongoing longitudinal study on age-related hearing loss, the average time between hearing aid candidacy and hearing aid adoption for non-White adults was 15.2 years as compared to 8.6 years for older White adults (Simpson et al. 2019). Hearing aid use among Hispanic/Latino adults is estimated to be under 5% (Arnold et al., 2019).
- Dual-eligible older adults with Medicare and Medicaid coverage who already own or use hearing aids are less likely to receive hearing care services and are more likely to report persistent trouble hearing despite using hearing aids as compared to higher-income older adults on Medicare alone (Willink et al., 2019).

Existing health and healthcare disparities have been exacerbated due to the COVID-19 pandemic, which disproportionately affected individuals from marginalized communities (Andrasfay et al., 2021; Shiels et al., 2021; Parcha et al., 2020). These data underline the importance of addressing equity in hearing healthcare to prevent deepening inequities.

3) The lack of diversity and inclusion in research studies leaves the clinical science of hearing health biased.

As a result, it is unethical and inappropriate to apply biased evidence to clinical practice when underrepresented groups have not been adequately sampled in research studies. In clinical research, the underrepresentation of racial and ethnic populations leads to reduced sensitivity and specificity of

outcomes that are important for reducing disparities in hearing healthcare access. The under-representation of diverse communities in clinical research contributes to the limited generalizability of scientific advances, which can perpetuate existing disparities through a lack of evidence-based approaches to address them. Some recent examples include:

- Race and ethnicity are under-reported in hearing-related clinical trials: Only 16 of 125 clinical trials on hearing loss management performed between 1990-2020 reported race and/or ethnicity outcomes (Pittman et al., 2021).
- Increased inclusion is needed in hearing-related clinical trials: Of the 125 clinical trials on hearing loss management systematically reviewed by Pittman et al. (2021), only 5 trials included greater than 30% non-White representation. Most of what we know about Alzheimer's disease biomarkers and pathological changes comes almost exclusively from research studies of Caucasians, although studies suggest that Black Americans may be more at risk for Alzheimer's disease and dementia (Shin & Doraiswamy, 2017).

Overall, inattention to these problems is a threat to the health of millions of people as well as a threat to the very foundation of our clinical sciences. According to Polite, Gluck, and Brawley (2019), "In 1966, Rev. Dr. Martin Luther King Jr. told the Medical Committee for Human Rights, 'Of all the forms of inequality, injustice in health is the most shocking and the most inhuman'…." Hence, diversification of the professions is not optional but is necessary as a next step to protecting both the public and our disciplines.

We recognize and applaud the many ongoing discussions and initiatives that aim to address the issues described above and call for dialogues to be elevated among the leaders and members of the hearing professions. To this end, we are working to coordinate a conference that will engage stakeholders to develop an awareness of and solutions to the lack of diversity, equity, inclusion, and access in the hearing health fields to face our challenges together and hold one another accountable to remediate them. We invite all members of the hearing professions to join us and RISE together!

1) ***R**ecognize that our lack of attention to diversity and inclusion within our professions has led to severe threats to inclusive patient care, equitable clinical outcomes, and research that is generalizable across populations*

2) ***I**mprove access, retention, and empowerment of underrepresented racial and ethnic minorities pursuing advanced training in hearing, hearing healthcare, and related professions*

3) ***S**upport all members of the community in becoming allies through education in appropriate mentorship, sponsorship, and anti-racism action*

4) ***E**valuate our success regularly and hold ourselves accountable for affecting real change*.

Signed by the following members of the Dialogues Group:

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