

Building Institutional Capacity for Diversity and Inclusion in Academic Medicine

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Abstract

Today, most agree that the health care system in the United States is in need of reform and that existing health disparities have huge implications for both that system and society as a whole. As a result, academic medicine has come to play a central role in addressing health disparities in a pluralistic society. Today, diversity is no longer a projection; it is a reality. Yet, most diversity efforts continue to run parallel to core institutional processes, rather than as part of the

mission of the institution. Researchers agree that, to promote a healthy and vital society, leaders in academic medicine must create institutions that can serve diverse populations. To do so, they must first increase their institutional capacity for diversity. This article outlines the next generation of work on diversity and inclusion, drawing on a broad body of research and practice to identify some of the key elements for building the kind of institutional capacity necessary for

sustained change in academic medicine, including a deeper engagement of mission, one that considers diversity as core to excellence; an inclusive and differentiated understanding of diversity institutionally; alignment and intentionality with respect to key institutional elements; key metrics associated with success and a serious process to monitor progress; and the identification of diverse talent for leadership at all levels.

Most discussions about health and health care systems in the United States acknowledge that addressing health care disparities represents one of the major strategic objectives for our health care system in the foreseeable future and has huge implications for the health of our society more generally. In part, this is a function of the dramatic diversification of our society and the recognition that the fastest-growing populations are often those with less access to quality care. Dr. Darrell G. Kirch,¹ president of the Association of American Medical Colleges, noted that “reducing health disparities is more than just the right thing to do—it is a critical component of improving health care quality.” In addressing disparities, he outlined a series of initiatives that focus on collecting improved data on race, ethnicity, and language from all patients, increasing the ability of all health care providers to competently address the diversity of communities and patients, and increasing the diversity of the leadership within health care and,

indeed, the entire workforce. These goals represent a paradigm shift away from simply increasing the diversity of medical students, residents, and practicing physicians in the pipeline. Indeed, they suggest that excellence in academic medicine is related to institutional transformation to better serve the diversity of all populations throughout the United States. Thus, diversity is now a strategic imperative for excellence. Dr. Marc A. Nivet² described this as a paradigm shift to Diversity 3.0, for which achieving excellence will “depend on the appropriate leadership, management, adaptive, and technical capacities.” Significantly, excellence today relates not only to addressing health care disparities¹ but also to recognizing that the identity of the patient plays a role both in terms of obvious factors, such as economics and access to quality care, and in how these identities are related to responses to care, reactions to medical interventions, including drugs, and openness to behavioral changes underlying health.

The research from a broad range of fields, including management and higher education, is reasonably clear, however, that the kind of institutional change that leaders in health care are envisioning requires increasing institutional capacity for diversity. Toma³ emphasized the strategic role of capacity building in creating sustained change. He noted that “capacity building is the administrative foundation of an institution, which is

essential for establishing and sustaining initiatives intended to realize its vision.”³ Thus, to actually create change requires a process that involves core institutional functions, which he lists as attention to mission, institutional structures, policies, decision making, information, infrastructure (human, physical, technological, financial), and culture. In reviewing the elements related to institutional capacity, virtually all authors underscored the need for alignment and intentionality.^{3–5} That is, central to building capacity is the alignment of key components so they can be mobilized for change.

Yet today, most diversity efforts run parallel to core institutional processes, focus on the physician pipeline, and result in growing numbers of programs and projects.⁴ Indeed, because creating programs does not require addressing institutional change, the proliferation of programs is leading to “projectitis” rather than strategic change.⁶ Reframing our ways of thinking about diversity on an institutional level provides an opportunity to confront the unfinished business of the past even as we address the newer issues of today.

Building Institutional Capacity

Reframing diversity to focus on building institutional capacity is not an easy transition. Understanding the notion of “building capacity” requires a clear

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picture of the stakes for institutions concerning diversity and the alignment of key elements that can produce change in complex institutions. A useful parallel can be seen with institutions' efforts to build capacity for technology. Several decades ago, institutions across the country understood that their viability as institutions relied on their ability to build capacity for technology.⁴

Administrators understood technology to be central, not marginal, to teaching and research. But, most critically, they also saw technology as central to the viability and excellence of every facet of the institution—for example, how the institution communicated, built infrastructure, spent money, and went about hiring. Although the imperative of technology has touched all institutions, different strategies and approaches have evolved as a function of each institution's mission and other characteristics. As technology is dynamic and continually changing, institutions have adapted as new technologies have been introduced.

Building technological capacity required that institutions develop the human, physical, fiscal, knowledge, and cultural resources to respond effectively in a technologically advanced society. Significantly, there was and has been skepticism and even hostility regarding technology's impact on society and institutions. Although many of these fears have not come to pass, no one has waited for skeptics to be satisfied. Like any deep change, developing the infrastructure has not been easy, and resources have had to be allocated to continue the process of change.

Today, we must understand that diversity, like technology, is a powerful presence. Reframing diversity as central to institutional effectiveness, excellence, and viability is required for academic health centers. The issue today is fundamentally about whether and how academic medicine is building its capacity to function in a diverse society and to address issues related to access to health care, health outcomes, and health disparities in society. It is also about how the field builds its capacity to harness the talent and full participation of diverse groups of people to address the compelling challenges it faces.

A growing consensus^{4,5} is emerging that the next generation of diversity efforts will take a more "systems approach" that will focus on building capacity in all sectors by identifying talent, building the knowledge and research base, and even engaging in difficult dialogues that inevitably emerge. This article outlines the next generation of work on diversity and inclusion, drawing on a broad body of research and practice to identify some of the key elements for building the kind of institutional capacity necessary for sustained change in academic medicine, including a deeper engagement of mission, one that considers diversity as core to excellence; an inclusive and differentiated understanding of diversity institutionally; alignment and intentionality with respect to key institutional elements; key metrics associated with success and a serious process to monitor progress; and the identification of diverse talent for leadership at all levels.

Setting diversity as core to the mission

A key lever for change is the degree to which leaders understand diversity to be an imperative for the institution,^{4,7-9} an imperative that goes beyond simply serving students or creating pipeline diversity programs with an attendant focus on admissions criteria. Is diversity a strategic imperative for a hospital, a research-focused academic medical center, or a clinically oriented program? How diversity is critical to a high-quality medical education in the 21st century at a particular medical school requires engaging the mission and culture of that institution and addressing how standards of professional preparation in medicine inform medical practice and diversity. For example, whereas some institutions may see social justice as a core value, others may not. In contrast to seeing the mission as a static statement on a Web site, much of the literature on change suggests that a mission related to a compelling vision is central to creating change.¹⁰

Conceptualizing an inclusive and differentiated institutional framework

Defining diversity today is challenging. The beginning of most institutional statements on diversity now includes, appropriately, a list of salient identities that are relevant, from race/ethnicity to gender, sexual orientation, social class, religion, disability, etc. Increasingly,

these diversity statements also include some aspiration for *inclusion* in which individuals from diverse backgrounds feel valued and part of the work of the institution. The challenge with simply listing identities is that some of the inequities that emerge in terms of health disparities do center on historically underrepresented racial and ethnic groups, whereas others center on social class. How, then, do leaders in academic medicine think about diversity and inclusion? Do they focus on inclusion or on only one form of inequity?

Smith⁴ suggests that we can understand diversity to be both inclusive and differentiated. In this conceptualization, access and success of historically underrepresented populations remains the legacy of diversity work in general. Diversity initiatives, then, must continue to address historic and largely unfinished efforts related to race, social class, and gender. However, we must also differentiate and engage other concerns related to disability, sexual orientation, gender identity, immigration, and religion, among others. We then must move forward on multiple fronts. We need to address more urgently both the intersections of identities and multiplicity of identities for traditionally underrepresented populations while also addressing other identities, such as gender and social class, that are gaining in significance.⁴ Most research^{1,11} on health disparities, for example, reveals significant intersections between race, gender, and social class. Today we must acknowledge that we are dealing with a multiplicity of identities, that we are dealing with the intersections of identities, and that what will emerge as critical will depend in part on the context in which we engage issues. How we address these identities will also depend on institutional contexts, mission, and the ethics of providing health care for diverse communities.

When we begin to think about an institution's mission and building capacity for excellence in medical education, research, and health care, our list of projects grows. Because building capacity requires a coherent systems orientation to the varied and complex domains of diversity, I developed a visual representation of the four domains of diversity (see Figure 1).⁴ Each of these domains engages different aspects of the

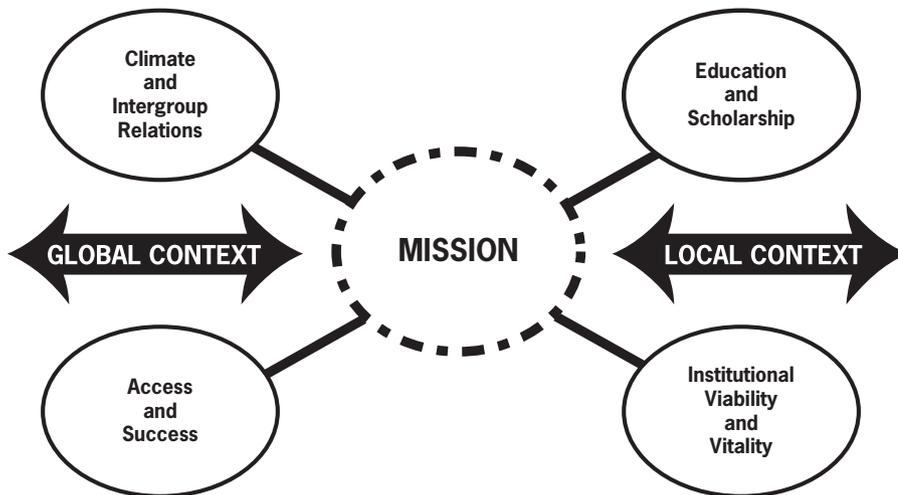


Figure 1 Framework, including the four domains, for building institutional capacity for diversity and inclusion.⁴

institution and addresses key dimensions related to the mission. Each domain also clearly connects to the others. Together they frame a way to think about an operational approach to diversity that is both inclusive and differentiated. Although I designed this figure to think about diversity institutionally, these four dimensions may also be useful in thinking about the larger task of systemic change related to societal concerns about health and health care.

The *institutional viability and vitality* domain, in particular, addresses institutional-level concerns about capacity, including a mission statement that engages diversity deeply, not superficially. It suggests that core indicators of excellence and priorities for strategic planning are directly linked to diversity, not parallel to diversity efforts. Interrupting parallel conversations between excellence and diversity and instead integrating them is an important step in building capacity. Indeed, the Liaison Committee on Medical Education (LCME) standards explicitly reference diversity indicators. This domain also includes how the institution is viewed by diverse communities and whether it has the leadership capacity with the requisite expertise to meet the demands of serving a pluralistic society. Indeed, faculty diversity is especially significant because faculty in the health professions are teachers, researchers, and clinicians.¹¹ Physicians' relationships with communities, trust with patients, and standards of excellence are directly linked to diversity.

The second domain for diversity, *education and scholarship*, goes to the academic core. It addresses the question of the knowledge that all medical students and physicians need in a pluralistic society and the capacity of faculty to provide the research and curricular bases. It also addresses the core competencies in research and scholarship. What are the core competencies essential to medical education? Do all physicians need to understand the role of race/ethnicity and gender, for example, in thinking about the patient and his or her pharmacology and disease? A growing literature^{12,13} also underscores the importance of cultural competence in engaging the diversity of patients and how health outcomes are influenced by patients' relationships with health care providers. Significantly, cultural competence has now developed into a field that is more about patient care than about diverse groups. As Betancourt and colleagues¹² noted:

Cultural competence has thus evolved from the making of assumptions about patients on the basis of their background to the implementation of the principles of patient-centered care, including exploration, empathy, and responsiveness to patients' needs, values, preferences. Culturally competent providers expand this repertoire to include skills that are especially useful in cross-cultural interactions.

A more advanced understanding of cultural competence avoids stereotyping specific groups and relies on notions of multiple and intersecting identities. Knowing a person's ethnicity, for

example, does not illuminate other issues, such as his or her primary language, social class, religion, sexual orientation, etc. All of these may be relevant not only to specific health issues but also to the relationship and trust that develops between a health care provider and patient.¹³

The third domain focuses on *climate and intergroup relations* for students, staff, and faculty at the institution. What are the climate, culture, and ultimate attractiveness of medicine or of specific subfields of medicine? A growing literature addresses climate and culture in medicine and their relation to faculty satisfaction and retention.^{14–18}

This domain also includes a concern for intergroup relationships. How do different groups engage? Although higher education has begun to address, quite formally, ways in which educational climate impacts intergroup relationships among students, there has been less facilitation of intergroup relationships among faculty and staff. What is the capacity of the leadership at an institution to address, in the context of the mission, difficult dialogues—whether about race, religion, or sexuality? What are the ethics of treatment standards when it comes to controversial issues? Nowhere are these difficult dialogues more likely to be found than in health-related contexts.

The fourth domain is really the historic root of diversity in higher education—the *access and success* of historically underrepresented individuals. This domain addresses not only admissions (who has access) but also who succeeds. The physician pipeline has been the starting and ending point of many discussions about diversity. It remains quite central to such discussions because the research is clear both that the current diversity of students in the pipeline will not provide the diverse talent that we need in medicine and that where students choose to practice is partially related to their identity.^{11,16,19–21} Moreover, although the graduation rates of all medical students are very high once they have been admitted to medical school,²² we now need to ask whether and how different groups are thriving and whether they are going into diverse fields of practice. In addition, in clinical and research contexts we also need to ask

which communities they are serving and how successful the institution has been in creating access and success for patients and research participants.

Each of these domains provides an *architecture* in Sturm's⁵ words that, when developed and coordinated, provides the framework for building institutional capacity.

Aligning key institutional elements

Sustaining change at a complex institution requires the alignment of disparate elements and efforts.^{7-9,23} Toma³ suggested that building capacity for change requires these elements to be "in sync." Hirschhorn and May²⁴ proposed that the key to strategic change is mobilizing resources from disparate parts of the institution in service of a vision that is shared, central to the mission, and communicated in powerful ways. They emphasized the need to take advantage of work already being done, engage passionate people, mobilize others to join, and develop an appropriate infrastructure. Their "campaign approach to change" is particularly relevant not only to the potential for building on current diversity efforts but also in mobilizing such efforts in service of excellence and mission. Wheatley¹⁰ cautioned, however, against a mission and vision that are merely words: "We must say what we mean and seek for a much deeper level of integrity in our words and acts than ever before." As Smith⁴ concluded: "With every diversity initiative, with every response to crisis, those who have been working on diversity for years inevitably hold their breath waiting to see if the effort is real, inclusive, and structured to ensure that a campus will 'walk the talk.'" Aligning institutional efforts and remaining intentional over time is a critical lever for change.

Developing key metrics and a process to monitor progress

The literature on change, capacity building, and organizational learning all conclude that monitoring progress is essential for change.^{3-5,25,26} Indeed, a coherent monitoring effort has the potential to facilitate the alignment that is normally a challenge for complex institutions. Nonetheless, using data effectively has in itself been a challenging task.^{26,27} To encourage the

use of data to monitor excellence and improvement, Kezar²⁶ emphasizes data in terms of organizational learning. The guiding questions now are, How can an institution or field know if it is making progress? If it is making progress, in what areas? And is it making progress in ways that are manageable and sustainable?

Key indicators associated with each of the four domains of diversity are emerging in higher education more generally, and in academic medicine specifically, including in LCME accreditation standards.^{4,28,29} A key indicator in the institutional viability and vitality domain is faculty diversity. Faculty diversity that moves beyond representation will be essential for every element of capacity building, from research to clinical practice, teaching, decision making, external credibility, etc. Diversity on boards, in leadership, and on the faculty is critical, a point that will be further developed in the next section. Higher education in general is in the midst of hiring the next generation of faculty.^{4,27} Yet, I predict that there is only a 10- to 15-year window for this to occur. We must seize the opportunity, then, and hire diverse faculty now. Recent research also suggests that faculty turnover is an issue at institutions.^{4,27} At medical schools and teaching hospitals, institutional and national data support this statement, though less research has been done on hiring patterns. Hiring and turnover patterns, then, are important indicators of diversity that we must monitor more closely.^{16,18}

Metrics in the education and scholarship domain include the degree to which both medical schools include cultural competency in their curriculum and the LCME standards reference it. We should ask questions that include, Who is exposed to the curriculum? What about the content of continuing education for physicians? Where and how much research is addressing diversity in health care, medicine, pharmacology, etc.?

In the climate and intergroup relations domain, a number of key indicators could be used. For example, perceptions of commitment to diversity disaggregated by constituency and by race and gender and questions on overall satisfaction and whether one would choose the institution (or field) again are manageable and meaningful.⁴

With increasing attention paid to using evidence to guide decision making, the accreditation process could be an important tool for monitoring institutional change. Current medical school guidelines provide standards that speak to data in each of the domains above. Implementing accountability concerning standards and metrics and building the capacity of accreditation teams to monitor progress may create another lever for facilitating and maintaining capacity building.

Identifying diverse talent for leadership at all levels

Whereas virtually all capacity building, change, and diversity work emphasizes leadership,^{3-5,7,23} the rationale for diversity in leadership is much less developed. Researchers need to study the expertise and the talent that is needed for academic medicine and medicine in general to be credible, effective, and viable in a pluralistic society.

First, a diverse leadership represents the institution's, and the field's, values concerning equity in both hiring and retention. A gap between espoused values and actual practices opens up questions about an institution's commitment to its values.

Second, diversity is a central component to the academy's ability to develop diverse forms of knowledge. Diverse faculty and researchers play an important role in bringing diversity themes to scholarship, in increasing diversity in the curriculum, and in introducing more and different patterns of pedagogy.⁴ Both that diverse communities are more likely to be served by diverse health care providers and, in academic medicine, that a diverse faculty will impact both the physician pipeline and health care itself, are powerful reasons to promote diversity.^{11,14,16}

Third, a diverse leadership fosters the development of vital relationships between institutions and diverse communities. Indeed, addressing health disparities and health issues will require the involvement of diverse communities.

Fourth, diverse faculty and staff also enable institutions and policy groups to make fully informed decisions at all levels—what some have called the

“demography of decision-making.”²⁴ The participation of diverse faculty and staff in decision making not only increases the likelihood that more information will be considered when making the decision but also increases the credibility that the decision-making process has with diverse communities.

Fifth, a diverse faculty and staff are also essential for creating an environment where other diverse individuals will want to work. Until medical schools and teaching hospitals achieve sufficient diversity, underrepresented minorities will continue to struggle to find their place as individuals rather than as token representatives.

Sixth, the demographics of current faculty and staff are important predictors of the demographics of future faculty and staff. Because most academic administrators rise from the faculty ranks, a relatively homogenous faculty limits the potential for diversity in future leaders.^{4,27}

Finally, a diverse faculty and staff can act as role models for all. Seeing individuals from diverse backgrounds succeed as faculty and in other leadership roles provides positive examples of what is possible and demonstrates the degree to which talent from diverse communities is valued by institutional leaders. Conversely, the absence of diversity in so many departments and fields also sends strong signals about what is possible and the capacity of institutions to identify talent from diverse communities.

These seven reasons provide both broad and deep rationale for promoting a diverse leadership in academic medicine across the four domains. They illustrate why promoting a diverse leadership must be a central strategy for building institutional excellence in a pluralistic society, one that requires institutions to “interrupt the usual” to identify talent and excellence when hiring new faculty.

Conclusion

Building institutional capacity for diversity requires that academic health centers develop the infrastructure to mobilize change. A powerful vision and mission, an inclusive and differentiated

approach to diversity, the alignment of key elements, the development of metrics, and the creation of a diverse leadership together form a roadmap for addressing diversity in academic medicine in the future. These elements represent a paradigm shift for the next generation of diversity and inclusion efforts.

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