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The Importance of Diversity and Inclusion in the Healthcare Workforce

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Abstract

Diversity and inclusion are terms that have been used widely in a variety of contexts, but these concepts have only been intertwined into the discussion in healthcare in the recent past. It is important to have a healthcare workforce which represents the tapestry of our communities as it relates to race/ethnicity, gender, sexual orientation, immigration status, physical disability status, and socioeconomic level to render the best possible care to our diverse patient populations. We explore efforts by the Liaison Committee on Medical Education (LCME), the Institute of Medicine (IOM), and other medical organizations to improve diversity and inclusion in medicine. Finally, we report on best practices, frameworks, and strategies which have been utilized to improve diversity and inclusion in healthcare.

Keywords

diversity; inclusion; healthcare; workforce

In order to explain diversity and inclusion in healthcare and beyond, the popular colloquialism has been dispersed on social media outlets originally coined by diversity advocate, Verna Myers, "**Diversity** is being invited to the party; **Inclusion** is being asked to dance." While many believe this to be a gross oversimplification of these issues, it does provide context regarding how we can began to understand and address these issues in healthcare. Throughout all facets of healthcare, race/ethnicity, gender, sexual orientation,

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Compliance with Ethical Standards

The author has no conflicts of interest. There was no research conducted on either human participants or animals. As such, this work is exempt from ethical consideration. Additionally, no informed consent was necessary as there was no participation of human subjects.

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immigration status, physical disability status, socioeconomic level plays a role in representation, acceptance, and progress both within and outside of the healthcare setting. We will evaluate the current status of diversity and inclusion in healthcare and note strategies to achieve success in this domain.

The Liaison Committee on Medical Education (LCME) is the US Department of Education body which accredits programs leading to the M.D. degree in the U.S. and Canada, and it is jointly sponsored by the Association of American Medical Colleges (AAMC) and the American Medical Association (AMA).[1] In 2009, they developed 2 diversity accreditation standards which mandated that allopathic medical schools engage in systematic efforts to attract and retain students from diverse backgrounds and develop programs to broaden diversity amongst qualified applicants.[2] In a recent publication to evaluate the impact of these LCME diversity standards, Boatwright and colleagues conducted an observational study to examine the change in US medical school matriculant sex, race, and ethnicity after their implementation.[3] After implementation of the LCME diversity accreditation standards (2012–2017), there was an increase in female, black, and Hispanic matriculants in medical schools in the US. In 2017, 50.4% of matriculants identified as female, 7.3% as black, 8.9% as Hispanic, 24.6% as Asian, and 58.9% as white.[3] While there is some progress, the current number of medical school matriculants does not mirror the population of black and Hispanic persons in the US which is 14.1%[4] and 17%[5], respectively.

Within medical specialties, problems with diversity training emerge. Let's explore nuances regarding diversity in physician trainees from underrepresented minorities in medicine and the patients that they serve in several key specialties and subspecialties: internal medicine, pediatrics, and critical care. Cardinal and colleagues evaluated training of internal medicine residents with regard to the care of patients with limited English proficiency. They found that an effective training curriculum is necessary, but such a curriculum is not uniformly present.[6] In an evaluation on standards in pediatrics, Mendoza and colleagues distributed an 8-question survey to 131 US pediatric chairs to assess plans for diversity, targeted groups, departmental diversity, diversity measures, perceived success in diversity, and presence and type of cultural competency training. Approximately 50% of the chairs responded and approximately 75% reported having a plan for diversity, which targeted racial, ethnic, gender, lesbian, gay, bisexual, and transgender, disabled, and social class groups. Despite these assertions, racial and ethnic diversity was limited among trainees, faculty, and leaders; there was limited information about promotion success for minority groups; and information was even more sparse for lesbian, gay, bisexual, and transgender trainees and faculty.[7] Along similar lines, Lane-Fall and colleagues determined that the current critical care workforce in medicine has a low number of women and racial and ethnic minorities which has persisted for many years. They conclude that further research is needed to elucidate the reasons underlying persistent underrepresentation of racial and ethnic minorities in critical care fellowship programs.[8]

There is often malalignment with the perceptions and experiences of persons from racial and ethnic minority groups in academic medicine compared to majority groups with regard to their health system and its performance surrounding cultural competency. Aysola and colleagues surveyed ~3500 healthcare professionals to ascertain demographic

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characteristics, length of employment, position, and place of work and their reported perceptions of institutional culture. They found that minorities and women were less likely to rank their organization as culturally competent, and they concluded that organizational efforts to achieve cultural competency would benefit from measuring this factor to target their efforts.[9]

Just as medicine has sought to evaluate diversity, nursing has tackled the issue also. The Institute of Medicine released its landmark report, *The Future of Nursing: Leading Change, Advancing Health*, which called for more racial, ethnic, and gender diversity among nurses in order to improve quality of care and reduce health disparities.[10] In 2015, Villaruel and colleagues evaluated the impact of the 2010 report and determined that there is progress, but there are also challenges that remain.[11] There has been an increase in racial and ethnic groups in nursing to 20%, but this is still short of the 37% of the US population that are considered to be racial and ethnic minorities. Unfortunately, there continues to be barriers to diversity in nursing education.

So, what are systematic strategies that have been developed to address diversity and inclusion in academic medicine? What is the dialogue surrounding creating change in diversity and inclusion in medicine? Smith noted that we must build institutional capacity for diversity and inclusion in academic medicine to achieve sustained change by including a "deeper engagement of mission, one that considers diversity as core to excellence" which aligns to key institutional elements and identifies diverse talent for leadership at all levels.[12] Since diversity and inclusion are such large tasks to evaluate comprehensively, there have been different strategies proposed to address disparities in different groups. Gillespie and colleagues developed 10 best practices to achieve gender parity in global health organizations which include the following: (1) make diversity and inclusion (D&I) an essential element of global strategy, (2) tailor global D&I to fit local needs, (3) embed D&I throughout organizations, (4) multiply D&I impact via external partnerships, (5) maximize the role of employee resource groups, (6) maximize the role of diversity councils, (7) leverage D&I for innovation, (8) leverage D&I for business development, (9) engage CEO, and (10) make sharing of D&I best practices a meta best practice.[13] As we evaluate the lesbian, gay, bisexual, and transgender community in medicine, Eckstrand and colleagues developed a framework with *elements* and *processes* for successful lesbian, gay, bisexual, and transgender organizational change. Their key *elements* for success are: organizational champions, organizational priority, depth of mission, commitment to continuous learning, commitment to diversity and inclusion, and organizational resources, and their key *processes* for success are: change management, information exchange, action research, relationship building, values in action, and leveraging resources.[14] Regardless of which framework or strategy is utilized to improve diversity and inclusion in healthcare, Gill and colleagues note: "there is a growing understanding of the relationship between the providers' work environments, patient outcomes, and organizational performance".[15]

Much of healthcare has jumped on the "diversity and inclusion bandwagon", but is the change actually making a difference in the experience of health care workers and the increasingly diverse patient population to whom we render care? Many would argue that much needs to be done. It is not enough for organizations to just add a person to oversee

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diversity efforts- the organization as a whole must value diversity and inclusion as central to their mission and consistently assess these diverse groups of their perception of progress. Perhaps, Dr. Martin Luther King, Jr. said it best when he stated: “Of all the forms of inequality, injustice in health care is the most shocking and inhumane.” We have much to do to truly ensure that diversity and inclusion in healthcare is the norm and not the exception.

Here are some tangible strategies to ensure diversity and inclusion in your organization: 1) Ensure that diversity and inclusion is ingrained within the culture by making it integral to the mission and outputs within the organization, 2) Integrate stakeholders from all levels of the organization and ensure that all groups are included in discussions to enact and maintain diversity and inclusion efforts, 3) Share successes and failures with similar organizations as it is this discourse that will allow the organization to reflect on strengths and weaknesses in previous diversity and inclusion strategies, and 4) Start young- engage with local communities and schools to ensure that persons from underrepresented groups get early exposure to fields in medicine. While these are only a few steps, any step forward is a step in the right direction to improve diversity and inclusion in medicine.

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References:

1. Liaison Committee on Medical Education (LCME). 2019 (Accessed January 21, 2019, at https://www.aamc.org/members/osr/committees/48814/reports_lcme.html.)
2. Liaison Committee on MedicalEducation (LCME) Standards on Diversity. 2009 (Accessed January 21, 2019, at https://health.usf.edu/~/media/Files/Medicine/MD%20Program/Diversity/LCMEStandardsonDiversity1.ashx?la=en)
3. Boatright DH, Samuels EA, Cramer L, et al. Association Between the Liaison Committee on Medical Education’s Diversity Standards and Changes in Percentage of Medical Student Sex, Race, and Ethnicity. JAMA 2018;320:2267–9. [PubMed: 30512090]
4. American Community Survey (ACS) DEMOGRAPHIC AND HOUSING ESTIMATES 2015 American Community Survey 1-Year Estimates. 2015 (Accessed January 21, 2019, at https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS_15_1YR_DP05&prodType=table=American.)
5. Bureau USC. HISPANIC OR LATINO ORIGIN Population 2013–2017 American Community Survey 5-Year Estimates. American Fact Finder 2017.
6. Cardinal LJ, Maldonado M, Fried ED. A National Survey to Evaluate Graduate Medical Education in Disparities and Limited English Proficiency: A Report From the AAIM Diversity and Inclusion Committee. Am J Med 2016;129:117–25. [PubMed: 26453990]
7. Mendoza FS, Walker LR, Stoll BJ, et al. Diversity and inclusion training in pediatric departments. Pediatrics 2015;135:707–13. [PubMed: 25755235]
8. Lane-Fall MB, Miano TA, Aysola J, Augoustides JGT. Diversity in the Emerging Critical Care Workforce: Analysis of Demographic Trends in Critical Care Fellows From 2004 to 2014. Crit Care Med 2017;45:822–7. [PubMed: 28282303]
9. Aysola J, Harris D, Huo H, Wright CS, Higginbotham E. Measuring Organizational Cultural Competence to Promote Diversity in Academic Healthcare Organizations. Health Equity 2018;2:316–20. [PubMed: 30426110]

Author Manuscript Author Manuscript Author Manuscript Author Manuscript

10. Committee on the Robert Wood Johnson Foundation Initiative on the Future of Nursing atIoM. The future of nursing: leading change, advancing health. Washington, DC: The National Academies of Medicine; 2010.
11. Villarruel A, Washington D, Lecher WT, Carver NA. A more diverse nursing workforce. Am J Nurs 2015;115:57–62.
12. Smith DG. Building institutional capacity for diversity and inclusion in academic medicine. Acad Med 2012;87:1511–5. [PubMed: 23018326]
13. Gillespie JJ, Dunsire D, Luce CB. Attaining Gender Parity: Diversity 5.0 and 10 Best Practices for Global Health Care Organizations. Health Care Manag (Frederick) 2018;37:195–204. [PubMed: 29957659]
14. Eckstrand KL, Lunn MR, Yehia BR. Applying Organizational Change to Promote Lesbian, Gay, Bisexual, and Transgender Inclusion and Reduce Health Disparities. LGBT Health 2017;4:174–80. [PubMed: 28296563]
15. Gill GK, McNally MJ, Berman V. Effective diversity, equity, and inclusion practices. Healthc Manage Forum 2018;31:196–9. [PubMed: 30114938]