

# A Diversity 3.0 Update: Are We Moving the Needle Enough?

Marc A. Nivet, EdD, MBA

## Abstract

Five years ago, in a previous *Academic Medicine* Commentary, the author asserted that the move toward health reform and a more equitable health system required a transformation of more than how we finance, deliver, and evaluate health care. It also required a new role for diversity and inclusion as a solution to our problems, rather than continuing to see it as just another problem to be fixed. In this update, the author assesses the collective progress made by the nation's medical schools and teaching hospitals in integrating diversity into their core strategic

activities, as well as highlighting areas for continued improvement.

The author identifies five new trends in diversity and inclusion within academic medicine: broader definitions of diversity to include lesbian, gay, bisexual, and transgender people and those who have disabilities; elevated roles for diversity leaders in medical school administration; growing use of a holistic approach to evaluating medical school applicants; recognition of diversity and inclusion as a core marker of excellence; and appreciation of the

significance of subpopulations within minority and underrepresented groups.

More work remains to be done, but institutional initiatives to foster and prioritize diversity and inclusion coupled with national efforts by organizations such as the Association of American Medical Colleges are working to build the capacity of U.S. medical schools and teaching hospitals to move diversity from a peripheral initiative to a core strategy for improving the education of medical students and, ultimately, the care delivered to all of our nation's people.

It has been five years since I stepped into the role of chief diversity officer at the Association of American Medical Colleges (AAMC). In that time, I have visited more than 100 of the nation's medical schools and teaching hospitals, and I have seen firsthand the high level of interest and commitment to diversity and inclusion across the medical education continuum.

Shortly after I came on board at the AAMC, I began working on a Commentary entitled "Diversity 3.0: A Necessary Systems Upgrade," which was published in *Academic Medicine* in December 2011.<sup>1</sup> In it, I asserted that the move toward health reform and a more equitable health system requires a transformation of more than how we finance, deliver, and evaluate health care. It also requires us to view diversity and inclusion as a solution to our problems, rather than continuing to see it as just another problem to be fixed.

**M.A. Nivet** is chief diversity officer, Diversity Policy and Programs, Association of American Medical Colleges, Washington, DC.

Correspondence should be addressed to Marc A. Nivet, Association of American Medical Colleges, 655 K St. NW, Suite 100, Washington, DC 20001-2399; telephone: (202) 862-6022; e-mail: mnivet@aamc.org.

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I referred to IBM's diversity framework to outline three phases in the evolution of thinking about diversity and inclusion within the academic medicine community. The first phase included peripheral efforts aimed at removing social and legal barriers to access and equality. During this phase, most institutions perceived excellence and diversity as being mutually exclusive. In the second phase, a growing awareness that diversity benefits everyone allowed diversity and excellence to exist as parallel entities. The third phase was in its nascent stages at the time of the article. Known as "Diversity 3.0," this phase reflects an increasingly widespread understanding that diversity and inclusivity are broadly and fundamentally relevant to institutions and societal systems. In other words, institutions that wish to achieve excellence must integrate diversity and inclusion into their core workings.

Now, five years after taking on my current role and four years after proposing the Diversity 3.0 framework for academic medicine, it is a good time to look back and reflect on successes and failures as well as progress toward our goals. To put it bluntly, is academic medicine improving quickly enough? Are diversity and inclusion universally perceived within academic medicine to be vital metrics as fundamental to measuring institutional

success as, say, graduation rates, residency placements, research grant awards, or 30-day readmission rates?

Using the drive toward Diversity 3.0 as the benchmark of success, I see several areas in which we have made major strides and some where we have much more work to do. I also look forward to what I think will be the next big trends in diversity within academic medicine.

## Greater Inclusivity

I see evidence that we are moving toward a system that embraces the widespread diversity that exists in our institutions. We no longer limit our discourse and efforts to only achieving diversity in terms of racial composition, although this goal remains core to our work. We now look more broadly at becoming more inclusive by focusing on organizational culture and climate and recognizing the needs of other populations that suffer disproportionately from health disparities, including the lesbian, gay, bisexual, and transgender (LGBT) communities and individuals with disabilities.

Academic health centers (AHCs) understand more than ever that it is not enough to diversify the student body or the faculty. Equal weight must also be

given to how all community members—including students, faculty, clinical and nonclinical staff, and patients—experience the institution's culture: Do all community members feel welcome and valued, both as individuals and as members of the groups with which they identify? Institutions must develop new ways to assess their culture and climate, and to make improvements as warranted.

In the last five years, tools and resources have been developed to help AHCs assess the climate and culture of their institutions.<sup>2</sup> These include webinars and publications on the Diversity 3.0 framework and the assessment process, as well as the development of the Diversity Engagement Survey (DES)—a collaboration between the AAMC and the University of Massachusetts Medical School.<sup>3</sup> To date, hundreds of AHCs have relied on the available publications, webinars, and framework to guide their work, and more than 35 institutions have administered the DES survey to understand and improve their cultures of diversity and inclusion.

### **Elevated Role for Diversity Leaders**

There has been a rapid push within the medical education community to create leadership for diversity and inclusion efforts at the executive “C-suite” level. Five years ago when I began at the AAMC, three AHCs had diversity leaders who could be considered C-suite executives. Today more than 20 medical schools include diversity officers at the executive level, and several medical schools are in the planning or hiring phase for a chief diversity officer. Any widespread institutional improvement requires one or more agents of change to succeed. The most progressive AHCs have found the creation of a chief diversity officer role to be a necessary catalyst to move diversity from the periphery to a central role in the drive toward excellence.

### **Measuring Outcomes, Not Just Inputs**

Historically, the marker of a school's attractiveness and competitiveness has been the average grade point average and Medical College Admission Test score of an entering class. Now, there is increasing awareness that academic achievement

is just one aspect of qualified medical school applicants; both schools and students are more than the product of their test scores. A growing number of medical schools are using holistic review,<sup>4</sup> a new approach to admissions that integrates applicants' personal experiences and attributes into existing admissions metrics to get a fuller picture of each applicant's capabilities.

At the same time, schools are determined to better articulate their specific missions so that applicants and students understand their institution's philosophy and approach to training health care professionals. This emphasis on vision and purpose enables schools to attract applicants and students who share their ideals and will help them fulfill their missions. It also helps ensure that schools train health care professionals who will meet the community's needs in certain specialties and geographic areas.

Increasingly, AHCs are holding themselves to a higher standard for outcomes that are meaningful to their local communities and to society as a whole. AAMC's Missions Management Tool assists institutions in measuring their progress toward producing a diverse workforce to address the high-priority health needs of the nation. Unfortunately, a presumed dichotomy exists between socially conscious medical schools and research-intensive medical schools—as if institutions have to choose one path or the other.<sup>5</sup> In reality, all of our medical schools have a common tripartite mission, and leaders must ensure that we are leveraging the unique talents of all minorities in the functions of research, education, and patient care. AHCs graduate not only primary care and specialist physicians who serve the underserved but also MD/PhD clinician–researchers and numerous PhD researchers who are investigating and developing solutions to the health disparities that continue to plague the health care system. The research performed at these institutions is nothing short of amazing and contributes to the nation's health in measurable ways.

In the last five years the conversation has shifted to a greater appreciation for the value of unique missions and expectations for medical schools based on history, geography, structure, and

character. I see this trend accelerating in the next five years as data analysis allows us to distinguish those schools that are meeting their stated missions from those that have had less success toward their goals.

### **Diversity Stewardship and Accountability**

Boards, CEOs, and deans are becoming more convinced of the need for diversity and inclusion as a core marker of excellence. Mounting evidence from inside and outside medicine shows that diversity and inclusion lead organizations to perform better on quality, financial, and other measures.<sup>6</sup>

Leaders are becoming more sophisticated in the questions they ask about diversity efforts. They are no longer looking only at the number of minorities recruited but are also looking inward to ask tough, but essential, questions such as

- Why are we not attracting the diverse talent we desire?
- What is the risk of being perceived as a chilly climate for minorities, women, or individuals who are LGBT?
- Are we a provider of choice for all community members? If not, why?
- How can we begin to ensure equitable care for all patients, given the universal tendency toward unconscious bias?

### **Greater Understanding of Subpopulations**

This growing appreciation for diversity opens the door to a greater understanding of more subtle details and differences among our students, employees, and patients, enabling us to create a more inclusive climate. Although it is important to recognize that we are ultimately one species and to work toward a world in which no one feels like “the other,” it is also important to understand where people come from, the experiences they bring, and the experiences they expect to have. We take important steps to understanding how individuality influences health care needs when we take time to recognize subtle differences among us. For example, we can better meet the needs of all people when we do not lump all Asians, all Latinos, or all LGBT individuals into one category.

These distinctions are made possible by better data collection strategies and a rising comfort with asking (and answering) more informative questions on patient forms, on medical school admission applications, and during the hiring process. While many legal and political constraints remain on what might be asked of individuals in terms of how they define themselves, there has been a rapid rise in comfort levels with certain questions.

For example, the AAMC recently added a question about sexual orientation to the Medical School Year Two Questionnaire. This move has attracted widespread support as a step toward more inclusion and social acceptance; institutions realize that measurement is integral to performance improvement.

But people are more than the boxes they check or the answers they give on a survey. As our society blends and melds together, more people carry multifaceted identities, such as their ethnicity or racial identity as well as their sexual orientation or gender identity. We must appreciate the combined experiences all people bring to our institutions in order to increase and refine our ability to improve health care equity.<sup>7,8</sup>

### The Work That Remains to Be Done

These are just snapshots of current trends, but I believe they are positive signs for the future of academic medicine. Would I like to see us progress faster? Of course. Much more work remains to be done. One area where we have

lost ground over the years is with black male applicants to medical school. In 1978 we had 1,410 black males apply to medical school; in 2014 there were just 1,337.<sup>9</sup> But as I have visited the nation's AHCs during the past five years, I know that this decline is not for a lack of trying or commitment to increasing diversity—it is more due to our inability to effectively reach deeper down into our K–12 education system and partner with schools to alter the course of our black male students. Many medical schools are indeed partnering with their local K–12 education systems, but the time has come for us to redouble our effort to help all minority males with a specific focus on black males.

During the last five years I have been welcomed by the brightest minds and exceptional leaders in medicine, and I have witnessed firsthand the work to ensure that the next generation of health care professionals will be just as talented as previous generations, yet even more diverse, culturally and linguistically competent, and committed to improving the lives of all members of society. As the shift in our health care system continues and our business models adapt, we must remain dedicated to innovation. We must leverage and increase the diversity of health care professionals and continually improve academic medicine for all who work, learn, or are in need of care.

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