

Chapter 52

Diversity in Undergraduate Medical Education: An Examination of Organizational Culture and Climate in Medical Schools

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ABSTRACT

The Association of American Medical Colleges (AAMC) developed the Diversity 3.0 framework to reflect this current, evolving literature on diversity and inclusion, as well as the increasing need to broaden the scope of diversity work. This framework illustrates the major components of organizational culture and climate: Institutional and social context, institutional structures and policies, and the key groups of people within the institution: administrators, professional staff/non-faculty, faculty and students. This chapter will explore various aspects of the Diversity 3.0 framework, presented by experts in the field of institutional culture and climate. Additionally, the chapter will provide information on how institutions can engage their surrounding community, what metrics to consider when assessing organizational culture and climate, and how to best leverage data and findings once they are obtained.

INTRODUCTION

Beginning in the mid-1960s, following the general trends in higher education, medical schools began working to increase the number of women and racial and ethnic minorities in their student bodies. These initial diversity efforts, which were fomented by a larger social justice movement, focused on alleviating the societal effects of institutionalized racism and sexism by increasing the numbers of underrepresented racial and ethnic minority and female healthcare providers (Nivet, 2011). Given this orientation, the focus of early diversity efforts were measured by medical student enrollment and retention rates.

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This focus evolved beginning in the 1990s, due in part to the robust scholarship of higher education researchers. The creation of diverse educational environments began to be viewed as fundamental to the goals of higher education rather than being viewed as an issue of social justice. When implemented in a thoughtful, comprehensive manner (Gurin, Dey, Hurtado, & Gurin, 2002; Milem, 2003) diversity initiatives can challenge individuals to engaged with problems in new and creative ways. The improved cognitive and social outcomes that result from being educated in diverse contexts have been well documented (Antonio, et al., 2004; Astin, 1993; Chang, Witt, Jones, & Hakuta, 2003; Gurin, et al., 2002; Nemeth & Wachtler, 1983; Smith, 2009). More recent scholarship shows that there are long-term effects of being educated in diverse environments on “personal growth, purpose in life, recognition of racism, and volunteering behavior among college graduates” (Bowman, Brandenberger, Hill, & Lapsley, 2011). Members of diverse organizations experience professional and personal benefits from inclusive environments that result in enhanced learning, understanding, and performance (Avery & McKay, 2006; Hicks-Clark & Iles, 2000; Miner-Rubino & Reed, 2010; Page, 2007; Volpone, Avery, & McKay, 2012). Specifically, in medical education, studies have found that medical students perceive that diversity in the student body will improve their ability to treat a diverse patient population (Guiton, Chang, & Wilkerson, 2007; Saha, Guiton, Wimmers, & Wilkerson, 2008; Whitla, et al., 2003).

This shift from a social justice argument for diversity to an examination of how diversity contributes to an institution’s educational environment accelerated due to legal challenges to practices designed to diversify the medical student body (Nivet, 2012). This new wave of diversity research posited that exposure to diverse populations improved students’ perception of the quality of medical education, reinforced the value of diversity for the health of the underserved populations (Cohen, 2003; Saha et al., 2008). Furthermore, the value and benefit to diversity in the scientific research workforce may accelerates new and varied advances in medical research (Cohen, 2003). The mission of academic health centers is now being considered through the business case frame of diversity initiatives as a return on a financial investment (Cohen, 2003).

Over time the rationale for diversity efforts in academic medicine, while still being informed by social justice and the value of diverse education environments, evolved to consider how diversity can eliminate health disparities. Supporting this shift was a body of research demonstrating the propensity of racial and ethnic minority physicians to practice in medically underserved communities and to treat racial and ethnic minority and uninsured patients (Brotherton, Stoddard, & Tang, 2000; Cantor, 1996; Grumbach, Vranizan, & Bindman, 1997; Komaromy, 1996; Moy, 1995; Stinson & Thurston, 2002) as well as patients’ desires to select health care providers with similar backgrounds and their increased levels of comfort with providers who share such backgrounds (Bach, Pham, Schrag, Tate, & Hargaves, 2004; Cooper-Patrick et al., 1999; Laveist, 2002; Saha, Taggard, Komromy, & Bindman., 2000; Tarn et al., 2005).

During the past decade, the diversity narrative in academic medicine has continued to shift in reaction to new research which builds upon these previous generations of work. The current diversity and inclusion focus recognizes the role that diversity plays in improving the intellectual and social functioning of learners (Antonio 2001; Milem, 2003). It further acknowledges the role diversity plays in enhancing the educational experience of learners is critical in the training of culturally competent physicians. Without this knowledge and exposure, future physicians are unequipped to practice in and care for a diverse society (Nivet, 2012). Additionally, research now shows that diverse groups consistently outperform homogenous groups in solving complex issues (Page, 2007). Academic medicine and other fields have also drawn from organizational psychologists who have demonstrated that when managers and employees perceive

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