Creating an Effective, Culturally Diverse Work Environment

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Goals For Today

• Define diversity and organizational culture
• Highlight the benefits of diversity
• Identify barriers and challenges to organizational change
• Commitment to success
Defining Diversity

Cultivating the seeds of diversity means recognizing the value of expanding our recognition of traditional and emerging identities from solely a focus on race/ethnicity and gender to considerations of:

<table>
<thead>
<tr>
<th>Ability</th>
<th>Socio-economic student status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rural/Urban</td>
<td>Sexual orientation</td>
</tr>
<tr>
<td>Nationality</td>
<td>First-generation student status</td>
</tr>
<tr>
<td>Religion</td>
<td>Language</td>
</tr>
<tr>
<td>Culture</td>
<td>Working Styles</td>
</tr>
<tr>
<td>Age</td>
<td>Other</td>
</tr>
</tbody>
</table>
Figure 15: Number of U.S. Medical School Graduates by Race and Ethnicity, 1995-2007

*Hispanic or Latino includes Mexican American, Puerto Rican, and Other Hispanic or Latino.
**Prior to 1995 data is not available for Native Hawaiian and Other Pacific Islander.
Source: AAMC Data Warehouse: Student_JND, as of 10/8/2008.
Figure 18: Percentage and Number of U.S. Medical School Faculty by Race and Ethnicity, 2007

White 69.0% (86,039)

Asian 13.2% (16,458)

Hispanic or Latino* 4.2% (5,272)

Native Hawaiian and Other Pacific Islander 0.2% (217)

Other/Unknown 7.9% (9,872)

Multiple Race 2.4% (3,012)

Black or African American 3.0% (3,773)

American Indian and Alaska Native 0.1% (134)

Note: The race and ethnicity categories in this figure reflects how the data has been collected since 2002. Individuals have the option of reporting both their race and ethnicity alone or in combination with some other race or ethnicity. In this figure numbers are reported for race alone; those that reported more than one race and ethnicity are included under Multiple Race.

*Includes Mexican American, Puerto Rican, Cuban, Other Hispanic or Latino, and Multiple Hispanic.

Source: AAMC Faculty Roster, as of 3/3/2008.
Figure 26. US Physicians* by Race and Ethnicity, 2006

Source: 2006 American Community Survey Public Use Microdata Sample.
Note: *Includes DOs and IMGs.

Importance of Diversity

- Shapes education for all students
- Increases access to high-quality health care services
- Broadens the medical research agenda
- Advances cultural competence
- Ensures equal opportunity for all interested in a medical career
Diversity improves the quality of medical education for all students.
Positive Returns

Diversity helps increase access to medical care.
Positive Returns

Diversity in the medical research workforce leads to an acceleration of advances in medical and public health research.
Positive Returns

Diversity in the health care industry makes good business sense.
Positive Returns

Leadership studies in the corporate sector show that companies with diverse management teams outperform homogeneous ones.
Educational Benefits of a Diverse Faculty

“A diverse faculty could affect teaching and learning in a positive fashion...could reach all types of learners and provide respect for needs of diverse learners and respect for diverse scholarship, promote student creativity in scholarship, improve accessibility, provide flexibility such as responding to ‘teachable moments,’ and improve strategies of teaching.”
Benefits of a Diverse Faculty

• Faculty diversity and leadership is necessary to realize the full benefits of diversity (Milem, 2001)

• Increasing *structural diversity* is an important first step but when considered without other efforts can adversely affect the experience of students (Hurtado et al., 1998, 1999; Chang, 1999)
Barriers to Increasing a Diverse Faculty

- The “pool problem”
- The nature of faculty searches
- How job descriptions are written
- The “cultural tax” (Knowles & Harleston, 1997)
- Structural barriers (poor retention efforts and lack of mentorship) (Price et al., 2005)
- Lack of commitment from leadership (Knowles & Harleston; Price et al., 2005)
Dr. Edgar Schein’s definition of Culture

“A pattern of shared basic assumptions that the group learned as it solved it’s problems of external adaptation and internal integration, that has worked well enough to be considered valid and, therefore, to be taught to new member as the correct way to perceive, and feel in relation to those problems.”

Source: “Organizational Cultural and Leadership”, Edgar H. Schein
Lead efforts to increase diversity in medicine

Help our members identify, implement, and sustain organizational performance improvement
How Do We Begin?

Top Down

Bottom Up

Crisis (Demands us to explore solutions)
<table>
<thead>
<tr>
<th>Old Academic Culture</th>
<th>New Academic Culture</th>
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</thead>
<tbody>
<tr>
<td>Autonomy</td>
<td>Mutual goal-setting and shared accountability</td>
</tr>
<tr>
<td>Independence</td>
<td>Interdependence across individuals and systems</td>
</tr>
<tr>
<td>Individuality</td>
<td>Group process and consensus</td>
</tr>
<tr>
<td>Narrow, focused professional pathways</td>
<td>Professional diversity and adaptation</td>
</tr>
<tr>
<td>Predictable career trajectory</td>
<td>Creative pathways that balance service and scholarship</td>
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How Do We Access the Current Picture?

- Climate survey
- Focus Groups
- Promotion and Tenure Policies
- Salary Equity
- Talent Management
- Exit Surveys
On the Right Track!

- Mentoring Programs
- Orientation for new faculty
- Tasks forces
Process of Ambitious Work

• Start slow
• Identify group or individual as responsible party
• Tap into all levels of the organization
The Elephant in the Room

1. What do we tell others about us?
2. What do we tell ourselves, about ourselves?
3. What do we talk about only behind closed doors?
4. What don’t we talk about, but should?

Source: Jim Herman, M.D. and John Neely, M.D.
Commitment to Success

- Set goals (not about the #s)
- Create a platform to share good and not so good
- Communicate consistent messages often
Questions?

Thank you!