Chapter 3
Orientation: Looking at Strategies Utilized by Other Health Professions for Increasing Diversity

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Orientation is the process of establishing a correct directional path by referencing the points of a compass (Maps for America).

In chapters 1 and 2, we explored the lack of diversity in the STEM disciplines at the undergraduate level, and corresponding serious implications for the DVM applicant pool. Many other professions have a long history of utilizing various strategies in an attempt to increase diversity within their academic programs. This chapter presents an overview of a select group of these strategies; this list is by no means exhaustive. Academic veterinary medicine can certainly benefit from the body of knowledge that exists around what strategies have and have not worked, particularly with regard to other health professions, whose curricula and potential applicant pools are similar to those in veterinary medicine.

A 2004 Institute of Medicine report states that it is in the nation’s compelling interest to increase diversity in the health care professions, since this will support greater access to care for diverse racial/ethnic patients, increased patient choice and greater patient satisfaction, and better quality patient/provider communication (Smedley, Butler, and Bristow 2004). Racial and ethnic minority health care professionals are significantly more likely than nonminorities to serve minority
and other medically underserved communities, thus increasing access to health care (Cantor et al. 1996; Komaromy et al. 1996; Turner and Turner 1996). In addition, minority patients rate the quality of their health care higher when it occurs in a racially concordant environment as opposed to a racially discordant one (Cooper-Patrick et al. 1999).

Cohen et al. (2002) outlined four practical reasons for specifically promoting diversity in the health professions. They argued that diversity in the classrooms of health professional schools: 1) helps provide a better quality education for all students; 2) increases access to health care in the US where serious racial and ethnic health care disparities exist; 3) leads to accelerated advances in both medical and public health research, since research programs are greatly influenced by the backgrounds of researchers; and 4) makes good business sense. Diversity in the classroom encourages learning skills (active thinking, intellectual and civic engagement, etc.) that help these students become more culturally competent professionals, while diversity among health care managers will improve business performance, since a management team that reflects the racial and ethnic composition of their clientele is best able to anticipate their needs (Cohen et al. 2002).

**Dental Schools**

In 2000, the Robert Wood Johnson Foundation, the California Endowment, and the W. K. Kellogg Foundation launched an initiative entitled “Pipeline, Profession, and Practice: Community-Based Dental Education Program” (Formicola et al. 2010). This program was designed to work with the schools and colleges of dental education to both facilitate an increase in enrollment of underrepresented minority (URM) students, and to address lack of access to dental care. In phase 1 of the program, there was a 54.4 percent increase in first-year URM student enrollment at thirteen participating Pipeline schools/colleges, compared to a 16 percent increase in enrollment at nonparticipating schools. The analysis did not include data from College of Dentistry at Howard University, Meharry Medical College, and the University of Puerto Rico, due to their already diverse student bodies. In order to achieve this increase, the participating institutions have: 1) increased outreach and recruitment; 2) adjusted admissions practices; 3) examined school/college climate; and 4) used enrichment programs to strengthen the academic pipeline (Formicola et al. 2010).

During the early phase of the Pipeline program, in 2003, a focus group study of ninety-two URM college or dental students provided new information regarding the perceptions of this group to dentistry. From the focus group it was dis-
covered that early exposure to dentistry and dentists is essential in order to ensure more of these students choose dentistry as a profession. Many students shared that there was little to no dental school outreach to them, and that their advising at the predental level lacked enough information to properly prepare them for the application process. Currently enrolled URM dental students (particularly African American/Black students) reported their educational experience as being isolating and difficult, but some students did praise summer school enrichment programs and peer mentoring programs. Dental school faculty members who were interviewed as a part of this focus group reported that losing an URM student because of academic reasons is rare, despite the fact that many of these students graduated from small colleges with less academic rigor and did experience quite a shock during the transition to the intense dental school curriculum (Veal et al. 2004). The information in this focus study was shared with the Pipeline dental schools, and these schools in turn improved or began summer enrichment programs, and began or expanded outreach to URM college undergraduates. These Pipeline institutions also examined climate issues, such as presence/absence of a critical mass of URM students and faculty, and providing adequate mentoring to URM students.

A follow-up study was performed in 2006, during the last year of phase 1 of the Pipeline program. All the individuals interviewed for this study came from four Pipeline schools/colleges and included thirty-one individuals, including URM and non-URM students, predental students, recent graduates in practice, deans, and faculty members. In general, participants believed that increased recruitment and enrollment efforts at the schools and colleges were resulting in increased numbers of URM students entering dental schools. While the Pipeline program was given credit for achieving these goals, many wondered about the feasibility of the dental schools sustaining these efforts beyond the Pipeline funding. Students reported three significant barriers to overcome to get to dental school. These were: 1) the debt incurred; 2) lack of support from family, friends, peers, and teachers/mentors/advisors for their career choice; and 3) inadequate exposure to this profession on their undergraduate campuses (Formicola et al. 2010).

A survey sent to US dental schools indicated that there was little if any support services for LGBT students at the forty-seven US dental schools that responded to the survey. Because of this, LGBT students and faculty may not feel safe enough to reveal their sexual identity (and thus live “openly”) to their peers and teachers. Although all of these schools had nondiscrimination policies, only 75 percent of these contained language that specifically included “sexual orientation.” Given the fact that 62 percent of respondents said they were aware of
LGBT dental students at their school, and 45 percent of dental schools reported having treated LGBT clients in their clinics, dental schools should be compelled to provide safe and hospitable environments for members of the LGBT community (More et al. 2004).

The Commission on Dental Accreditation revised accreditation standards in 2010 to reflect the need for diversity in dental medical education. Standards now state that dental schools “must have policies and practices to: a. achieve appropriate levels of diversity among its students, faculty and staff; b. engage in ongoing systematic and focused efforts to attract and retain students, faculty and staff from diverse backgrounds; and, c. systematically evaluate comprehensive strategies to improve the institutional climate for diversity” (Commission on Dental Accreditation 2010, 18).

In 2002, the American Dental Association published its report, “Future of Dentistry: Today’s Vision, Tomorrow’s Reality” (Health Policy Resource Center 2002). In this document, it is stated that a primary goal of the profession is to improve the health of the public in a culturally competent manner.

Pharmacy Schools

Colleges and schools of pharmacy have also been focusing on increasing diversity within their organizations. In 2008, the American Association of Health-System Pharmacists (ASHP) released a statement on racial and ethnic disparities in health care, which outlines three general principles to guide the actions of health-system pharmacists (who work in hospitals and other health-systems). These are: “(1) all patients have the right to high-quality care; (2) medication-use practices should reflect knowledge of, sensitivity to, and respect for the race and culture of the patient, and (3) health-system pharmacists have a vital role to play in eliminating racial and ethnic disparities in health care” (American Association of Health-System Pharmacists 2008, 287).

Chisholm (2004) argues that diversity is the missing link to professionalism in the pharmacy school curriculum. She believes that when pharmacy schools fail to provide a diverse academic environment for their students, the pharmacy education these students receive is a “culturally repetitive” one, which is more likely to foster narrow values and beliefs. This can translate into a pharmacist who cannot effectively understand, communicate, or empathize with a diverse group of patients, and can thus be viewed as lacking in professionalism (Chisholm 2004).

Using best practices from a number of resources specific to health care, business, and/or higher education settings, Nkansah et al. (2009) offer a list of practi-
cal steps for the pharmacy schools to consider when designing a diversity program. These are as follows:

1. Ensure academic leadership. Diversity programs can only be successful if the deans, department heads, and key academic leaders support them. This support is actualized in allocation of monetary and human resources for program design, implementation, and ongoing maintenance. In addition, diversity should be addressed in the schools’ mission and vision statements, and in the strategic plans.

2. Create a committee that will function as the governing body. This committee is most effective when its authority comes directly from the dean, both in the development and the implementation of the diversity plan. The committee should be a model for inclusiveness and should be open to objective feedback during the entire process.

3. Perform a baseline needs assessment. The committee will create the definition of diversity and be responsible for baseline assessment that will be important in the design and implementation of a program. Assessment can include information from a variety of sources, such as demographic information on students, faculty, and staff; academic climate surveys; exit interview results; focus groups; and retention and graduation data. Utilization of this information will allow for a diversity program designed specifically to meet the strategic goals and needs of individual institutions.

4. Create a strategic plan. This plan will guide the school/college/committee in terms of having solid goals, objectives, and initiatives that can be systematically pursued.

5. Systematically implement the strategic plan. Resources (financial and otherwise) should be allocated to ensure the strategic plan can be successfully applied.

6. Ensure accountability and communicate often with multiple stakeholders. Metrics for measuring the success of various initiatives and progress of the overall plan must be designed and routinely evaluated for both reliability and validity. Progress of the strategic plan should be regularly reported to both internal and external stakeholders, as well as shared with other institutions in a “best practices” format.

Diversity programs should have a solid focus on building and maintaining a diverse academic environment. Efforts should be made to resolve issues of dispar-
ity (such as in promotion and salary) unveiled by the baseline needs assessment. Committees should be open to networking with other academic institutions, to discuss successes and challenges of established programs.

Diversity initiatives and activities should be systematically implemented according to allocated budget/resources. Activities can include innovative outreach programs to build a diverse pipeline of students to the pharmacy profession, and a variety of sessions (workshops, roundtables, lectures) designed to increase awareness and understanding of diversity-related issues.

Ensure accountability by continuously defining metrics to measure program success and developing communication reports and vehicles. Metrics should be designed for each activity, and these metrics should be routinely reevaluated for reliability and validity. Communication reports should be developed that outline results of committee efforts and a mechanism of sharing those results with the college/school should be identified and utilized (Nkansah et al. 2009).

Medical Schools

A national campaign to enroll 3,000 underrepresented minority students (defined as Black/African American, Mexican American, mainland Puerto Ricans, and Native Americans) in medical schools by 2000 was launched by the Association of American Medical Colleges (AAMC) in 1991. The initiative was called Project 3000 by 2000 and focused on pipeline programs. Although the numeric goal was not met, there were many successful outcomes from this campaign and many important lessons to be learned by those interested in promoting diversity in health professional education (Terrell and Beaudreau 2003).

Prior to the late 1960s, the only two Historically Black Medical Schools in the United States (at Howard University and Meharry Medical College) trained 75 percent of the country’s African American physicians. During that time, the other eighty-one US medical schools enrolled approximately one African American/Black student every other year, with Hispanic/Latino and Native American students being admitted at even lower numbers (Cohen et al. 2002). In the 1960s, when US medical schools were overwhelmingly Caucasian/White and male, affirmative action was used to increase minority enrollment. This resulted in an increase of approximately 6 percent in minority student medical school enrollment between 1964 (about 2 percent) and 1971 (about 8 percent) (Cohen 2003). Project 3000 by 2000 was designed by the AAMC when the 1990 data on students matriculating to medical schools indicated that minority enrollment in medical schools was far behind the rapid growth in the country’s minority population (Terrell and Beaudreau 2003).
Chapter 3

Project 3000 by 2000 was shaped by two key concepts. The first concept was that medical schools should create a system to identify talented minority students who had an interest in becoming physicians, and the second concept was designing academic interventions that would influence students daily in their classrooms. Medical schools who participated in Project 3000 by 2000 assigned a coordinator on their campus to coordinate the programmatic requirements, which were: perform an assessment of the medical school’s past, current, and future potential for minority enrollment; provide students at magnet health professions high schools with high minority enrollment with academic enrichment opportunities; create partnerships with high schools and colleges to enhance student progression through the academic pipeline and to collectively identify and reduce barriers to continuous progression; reassess all aspects of medical school recruitment, admissions, financial aid, and academic support programs; and ensure an inclusive climate at the medical schools that would be hospitable to the increased racial and ethnic makeup of future medical school enrollees (Terrell and Beaudreau 2003).

To implement the above agenda, funding was provided by both foundations (such as the Robert Wood Johnson Foundation and W. K. Kellogg Foundation) and the AAMC to sponsor several programs and activities. Through Project 3000 by 2000, a public education campaign for medical school recruitment, retention, and academic achievement was created and launched. The initiative supported the creation of partnerships among K-12 school systems, colleges, the medical schools, other health professional schools, and even community-based organizations. These partnerships served as a catalyst for increasing the numbers of minority students in the pipeline to medical school. These efforts realized a 36.3 percent increase in minority matriculants to US medical schools from 1990 to 1994 (12.4 percent of all medical students) (Smedley et al. 2003).

Project 3000 by 2000 technically ended in the year 2000, but two major programs continue today. These are the Health Professions Partnership Initiative (HPPI) and the Minority Medical Education Program (MMEP), both are funded by the Robert Wood Johnson Foundation and the W. K. Kellogg Foundation. Through HPPI, medical schools work with local K-12 schools and undergraduate institutions to boost minority student academic preparedness for medical school by creating new curricula and providing multiple and diverse learning opportunities. Through MMEP, college students receive rigorous preparation for medical school as part of a six-week summer enrichment program on the campuses of participating medical schools (Terrell and Beaudreau 2003).

In 2010, a Diversity Research Forum was convened at the AAMC annual meeting. Entitled “Excellence and Capacity in Medical Education: The Diversity
Imperative,” the Diversity Research Forum provided medical school representatives with key principles designed to move diversity work into the core of the institutional mission. These principles were presented by keynote speaker Daryl G. Smith, PhD, from the School of Education Studies at Claremont Graduate University. She said that diversity should be defined as both inclusive and differentiated; diversity should be linked to the mission of the AAMC, medical schools, and nation; diversity should be part of the core indicators of success, and not parallel to them; diversity work needs to move beyond being a series of disconnected efforts (termed “projectitis”) toward synergy and coordination; and diversity work should be consistently monitored for progress (AAMC 2010).

Conclusion

This chapter provides a sample of the various approaches and strategies utilized by other health professions to address the lack of racial/ethnic diversity within their academic institutions and thus within their practicing professionals. There is general consensus that increasing the diversity among all the health professions is necessary to reduce health disparities, to meet the needs of a rapidly changing and increasingly diverse US population, and to graduate health professionals who are prepared to practice in their respective fields in a culturally competent manner.

References


