Diversity and Inclusion—Why Does It Matter

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KEYWORDS

• Medical education • Diversity • Inclusion • Underrepresented in medicine

KEY POINTS

- The US population is becoming increasingly diverse. In otolaryngology, racial, ethnic, and socioeconomic disparities have been identified in adult and pediatric populations.
- Competent health care systems can improve the efficiency of staff, patient satisfaction, and outcomes of care like unnecessary testing or differences in referral patterns.
- Otolaryngology has historically lagged behind other specialties with respect to diversity, equity and inclusion and remains one of the least diverse specialties as it relates to gender, race, ethnicity and other identities.

The US population is becoming increasingly diverse. Such a nation requires a culturally competent and diverse physician workforce.[1] Minoritized communities have higher rates of disease and receive lower quality care than White people. Women of color have staggering infant mortality rates compared with their white counterparts. In otolaryngology, racial, ethnic, and socioeconomic disparities have been identified in adult and pediatric populations.[2–6] Cultural competence, diversity, equity and inclusion (DEI) alone may not be enough. Without a critical lens toward structural racism sociodemographic-based health disparities will become more pronounced.[7–9] Cultural competence values equality, acknowledges historical injustice and incorporates culture into communication, relationship buildling, and adaptation to meet unique needs.[7,10]. Structural competence values equity and focuses on the elements of health influenced by systems and policy.[8,9] Additionally, there is a growing recognition that structural competence is essential to the practice of high-quality medicine.[8,9]

Structurally competent health care systems can improve the efficiency of staff, patient satisfaction, and outcomes of care, like unnecessary testing or differences in referral or treatment patterns. The presence of cross-cultural issues, political and socioeconomic forces highlight the need to be aware of the diverse experiences of patients and how these have an impact on how care is rendered and received.[11] Concordance in racial or ethnic patient-physician relationships result in improved

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perception of communication, increased patient satisfaction, and improved appropriate health care utilization.[12] Conversely, poorly handled cross-cultural issues can result in patient noncompliance, delays in obtaining consent, unnecessary tests, and lower quality of care.[13] The American College of Surgeons Code of Professional Conduct states that "a good surgeon is more than a technician," with the possession of an "altruistic commitment to each patient's unique biologic, psychological, social, cultural, and spiritual needs" a critical component of good surgical practice. The Medical Professionalism Project—initiated by the American Board of Internal Medicine Foundation, American College of Physicians Foundation, and European Federation of Internal Medicine—also includes a commitment to social justice among baseline characteristics of professionalism.[14]

Attaining diversity, equity and inclusivity (DEI) is not always instinctive. It requires careful thought so that potential biases can be addressed. A commonly heard challenge to DEI is that it is hard to define diversity in objective and easily quantifiable terms. Additionally, many aspects of diversity are closely tied to identities. Thus, prioritizing certain components of diversity can be inherently threatening if it is perceived that some aspects of identity are more worthy than others. It also challenges deeply ingrained beliefs in meritocracy. Just as no one wants their hard work and resultant achievements negated by the belief that successes are because they are the token other, no one wants to believe that their accomplishments are secondary to their privilege. Yet, studies have shown that rigid beliefs in meritocracy can exacerbate inequality—the paradox of meritocracy.[15,16] In environments that prioritize meritocracy, it is easy to prioritize the belief that one is impartial. This can lead to lack of monitoring or scrutinizing behavior—creating an environment where there is disadvantage among underrepresented groups and unfair advantage among traditionally dominant groups. This is complicated further by the fact that ideals, such as diversity and meritocracy, may be nested in broader institutional or cultural environments simultaneously characterized with bias.[17] Additionally, progress in DEI requires something that cannot be mandated: buy-in.[18] This can be difficult to achieve because it relates to the challenges, discussed previously, and more. Simply creating requirements or mandatory training will not suffice and can be counterproductive. Diversity projects devoid of practical benefits are unlikely to gain support.[19] Top-down leadership is a must. Enlist broadly, listen, be transparent and accountable, and empower with recognition and support. Those involved must understand the importance of DEI for the specialty as well as its direct link to the quality of health care otolaryngologists provide.[20]

It also is critical to keep in mind that outward appearance is not the sole component of diversity. Although minoritized groups certainly are underrepresented in medicine (URiM), so are individuals from rural backgrounds and disadvantaged backgrounds and first-in-family physicians. Otolaryngology historically has lagged behind other specialties with respect to DEI. Today, it remains one of the least diverse specialties, with women as well as racial and ethnic minorities significantly underrepresented.[12] Between 1975 and 2010, there was an increase in the number of female otolaryngology residents but minimal improvements in racially and ethnically underrepresented groups.[21] In the decade since, there have been no significant gains in gender representation, and Hispanics and African Americans continue to be the most underrepresented groups in the field.[12] In a 2020 study, women and nonwhite applicants prioritized program diversity and placed higher emphasis on racially and gender-congruent mentors compared with their white and male peers.[22] In this study, however, several subjects noted that few programs had substantial diversity, making diversity less of a consideration. Yet, would diversity be a larger

consideration in applicant decision making if diverse and inclusive programs were commonplace?

Application to the field of otolaryngology is a highly competitive process that seems to intensify every year.[23] Well-intentioned desires to select the best residents likely have created a hidden curriculum, similar to that seen in medical school, where certain backgrounds, activities, and histories carry different values. For example, during the selection process, a history of success in peer-reviewed research publications is likely viewed differently from similar success in financially necessitated work outside of medicine.[24,25] It is no surprise that successful applicants to medical school are coming from increasingly affluent backgrounds.[26,27] It has been postulated that the test preparation industry has transitioned medical education from a professional aspiration, earned through effort and study, to one that can be purchased with financial investment in test and application support services.[28] Additionally, the leadership and service activities that commonly populate resumes may better reflect the privilege of the applicants rather than their potential.[1,25]

It has been suggested that rather than a *glass ceiling*, a more apt term is *glass labyrinth*. Ceiling implies a linear trajectory with an assumed obvious solution: smash through the ceiling. Similar to a labyrinth, issues common for underrepresented groups in medicine are complex and multidimensional, requiring a variety of strategies to succeed. Many women report undercurrents of bias, difficulties in navigating professional life as the "other," special challenges in managing highly gendered doctor-nurse relationships, and struggles with work-life issues.[29] Workarounds include carefully constructed elements of self to be more well received by others, reliance on nonconfrontational strategies, keeping social distance, displaying professional symbols to overtly reinforce credibility and belonging, and downplaying otherness in appearance and voice. Creation of these dual identities may not resonate with true sense of self and lead to feelings of loss of authenticity.[29] Groups traditionally URiM, especially African Americans, remain less likely to be promoted even after controlling for percentage of time in clinical duties, years as a faculty member, and measures of academic productivity. Many have described these inequities as a minority tax, a considerable barrier that makes advancement in rank and leadership, among other successes, difficult to achieve.[30–32] Additionally, minority faculty are more likely to report feelings of loneliness and isolation, leading to lower levels of career satisfaction and job retention.[33] This has long-term ramifications in terms of role modeling, mentorship, sponsorship, and ability of individuals from underrepresented groups to have an impact on institutional culture. Health systems and departments with longitudinal DEI initiatives that include the stated efforts, as well as parity in pay, have made an impact on recruitment and retention.[34]

Some people argue that the moral or ethical framework for DEI is unnecessary because the business case for DEI is supported by a preponderance of evidence of improved outcomes with increased diversity. In fields that require complex thought and problem-solving, diversity leads to greater complexity of thought, improved troubleshooting abilities, and innovations.[19] Diverse educational environments allow for opportunities to challenge stereotypes and cultural assumptions.[35] As Columbia Business School Professor Dr. Katherine Phillips notes, "diversity jolts us into cognitive action in ways the homogeneity simply does not."[36,37] Simply interacting with individuals who are different forces the entire group to prepare more comprehensively, anticipate alternative viewpoints, and expect that reaching consensus will take effort. For example, elegant social science experiments investigating the impact of group composition on problem solving consistently demonstrate the benefits of diversity. When each group member is given unique information critical to solving a murder

mystery, the progress of homogenous groups is hindered by assumptions that everyone already holds the same information and shares the same perspective.[38] Additionally, simply adding social diversity makes people believe that differences in perspective might exist.[37] Simultaneously expanding and refining thought processes and taking into account diverse experiences and perspectives are critical to appropriately addressing many of the complex problems facing medicine and otolaryngology today, such as the opioid epidemic, issues of adherence to treatment recommendations, and enhanced, shared, decision-making processes between clinicians and patients. Yet, decades after the business case for DEI was made, great strides in diversity, equity, or inclusivity have not been made. There is a business case for DEI but let it not be forgotten that the lack of DEI is a moral wrong that should be addressed and eliminated. Many ethical models have been used to support the elimination of health disparity; these frameworks can be applied easily to the physician workforce. The lack of a diverse workforce can perpetuate disparity and have an impact on the health outcomes of minority groups but also decreases the health of society as a whole.[20,39]

When will we know that "enough" is being done to support and achieve DEI? Ruth Bader Ginsberg famously responded to the question of when there will be enough women on the supreme court with, "When there are nine."[40,41] The "Global Gender Gap Report 2020" by the World Economic Forum suggests that the global gender gap can be closed in just under 100 years. In North America, it is expected in 150 years.[42] Other scholars have found that racial discrimination in hiring practices has not changed in more than 25 years.[43] There continues to be work to do. Intention is only the beginning of outcomes in creating the desired outcomes—diversity, equity, and inclusion. In academic settings, to mitigate the impact of bias in hiring, it has been suggested that search committees be composed of at least 35% women.[44] All qualifications being equal, this is the threshold at which men and women are equally likely to be hired.[45] It stands to reason that similar thresholds are necessary for equity in selection of those URiM. Faculty development programs that foster mentorship facilitate a successful academic career. Additional efforts in undergraduate and graduate medical education also should be considered.[33,34] Similarly, in meta-analyses, the composition of review committees also had a significant impact on performance evaluations. When raters were all male, men were rated significantly more favorably than women. When evaluators were a mixed group of men and women, this gender bias was eliminated or women were rated more highly.[46–55] Ideally, efforts at increasing representation in decision making are paired with systematic efforts to increase awareness of the negative impact of unconscious bias on the advancement of women and other underrepresented groups.[44,45] Addressing the disparities of DEI is the responsibility of the whole. Culture change begins with leadership and progresses when a critical mass of those URiM, women and others, bring new perspectives that reshape strategy. Interventions begin by reassessing the value placed on DEI, frank communication, and the development of recruitment and retention strategies. Without responsibility and accountability for DEI efforts, it will be hard to develop and maintain a strategy. Maintaining the DEI strategy requires focusing on outcomes rather than activities. The number of DEI activities is less valuable than defining metrics that meaningfully measure progress and accountability in the achievement of these goals. Finally, know that the conversation around DEI will be ongoing. We should incorporate the same diligence and results-driven orientation to DEI that normally are reserved for daily clinical operations, research productivity, and program development.

In conclusion, a diverse nation requires a culturally competent and diverse physician workforce. Otolaryngology historically has lagged behind other specialties with

respect to DEI and remains one of the least diverse specialties, with women and racial/ethnic minorities significantly underrepresented. Without active discourse around DEI, there remains a barrier for URiM undergraduate and graduate students and URiM faculty development and achievement. Similar to a labyrinth, issues common for underrepresented groups in medicine are complex and multidimensional, requiring a variety of strategies to succeed. Strategies aimed at increasing DEI include programs designed to provide mentorship, coaching, and sponsorship. Pipeline efforts, inclusivity on committees, bidirectional communication, and equal pay are additional DEI inclusion efforts that have been successful in increasing URiM representation. Closing the diversity gap is a long-term process; although action should be taken daily and progress measured regularly, culture changes slowly. Focus on performance and promotion. Finally, accept feedback and use it to make refinements—opportunities exist to continually improve diversity, equity, and inclusion efforts.

DISCLOSURE

The authors have nothing to disclose.

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