

## Commentary: **Diversity 3.0: A Necessary Systems Upgrade**

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### Abstract

This is a defining moment for health and health care in the United States, and medical schools and teaching hospitals have a critical role to play. The combined forces of health care reform, demographic shifts, continued economic woes, and the projected worsening of physician shortages portend major challenges for the health care enterprise in the near future. In this commentary, the author employs a diversity framework implemented by IBM and argues that this framework should be adapted to an academic medicine setting to meet

the challenges to the health care enterprise. Using IBM's diversity framework, the author explores three distinct phases in the evolution of diversity thinking within the academic medicine community. The first phase included isolated efforts aimed at removing social and legal barriers to access and equality, with institutional excellence and diversity as competing ends. The second phase kept diversity on the periphery but raised awareness about how increasing diversity benefits everyone, allowing excellence and diversity to exist as parallel ends. In the

third phase, which is emerging today and reflects a growing understanding of diversity's broader relevance to institutions and systems, diversity and inclusion are integrated into the core workings of the institution and framed as integral for achieving excellence. The Association of American Medical Colleges, a leading voice and advocate for increased student and faculty diversity, is set to play a more active role in building the capacity of the nation's medical schools and teaching hospitals to move diversity from a periphery to a core strategy.

**T**his is a defining moment for health and health care in the United States, and our medical schools and teaching hospitals have a critical role to play. The combined forces of health care reform, demographic shifts, continued economic woes, and the projected worsening of physician shortages portend major challenges for the health care enterprise in the near future.

The federal government's reform package represents a major opportunity to transform the way we access, finance, deliver, and evaluate health care in pursuit of an equitable health system. As the country's population continues to change and as more people gain access to the health care system, medical schools and academic health centers must admit, train, and graduate physicians capable of providing high-quality, culturally responsive care to all patients. This requires strengthening the capacity to adapt and innovate in every aspect of

academic medicine. It also necessitates a reexamination of the role that diversity and inclusion play, not only in the classroom but in the core strategy and workings of our institutions.

The innovation that we need will not be developed just by calling on the traditional players. I believe that there is a central role for diversity in this process, if we can adopt the mind-set that diversity is a solution rather than a problem. Building the capacity for innovation relies on engaging people with different perspectives, skills sets, and experiences to create strategies and solve problems. This means viewing diversity and its value in a much broader sense.

There have been two distinct phases, or paradigms, in our understanding of diversity over the past five decades, and a third paradigm is emerging today that reflects a growing understanding of diversity's broader relevance to institutions and systems. Technology offers a helpful metaphor for this progression of diversity thinking, as each new wave builds on past accomplishments yet also requires new capacities and infrastructure to serve new or expanded functions. IBM, a corporate leader in diversity and inclusion, has a framework in place for its workforce that incorporates three distinct phases in the evolution of diversity: 1.0, 2.0, and 3.0.<sup>1</sup>

Therefore, I purposefully employ this notion of a 1.0, a 2.0, and a 3.0 version of the diversity operating system (DOS) at our medical schools and teaching hospitals. DOS 1.0 included somewhat isolated efforts aimed at removing social and legal barriers to access and equality, with institutional excellence and diversity as competing ends. DOS 2.0 kept diversity on the periphery but raised awareness about how increasing diversity benefits everyone, allowing excellence and diversity to exist as parallel ends. In the DOS 3.0 paradigm, diversity and inclusion are integrated into the core workings of the institution and framed as integral to achieving excellence. A more thorough description of this progression of diversity thinking follows.

### **Diversity 1.0**

Though the foundations were laid much earlier, diversity, as it is often understood, has its roots in the Civil Rights era. Advocates in identity-oriented and social justice movements fought to alleviate discrimination and institutionalized racism in pursuit of fairness, access, and equality primarily along gender, racial, and ethnic lines. Concomitant efforts at the federal level resulted in reforms such as the Civil Rights Act of 1964 and the Elementary and Secondary Education Act of 1965, both of which focused on removing

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some, though not all, structural barriers to access and equality.

Following a general trend in higher education, medical schools formed offices for minority affairs beginning in the mid- to late 1960s, often as siloed entities separate from the existing educational, research, and patient care missions. In addition to providing safe spaces that nurtured racial and ethnic minority students, these offices were tasked with ensuring compliance with civil rights legislation and affirmative action. As a result, their successes were often measured by institutional head counts and student retention rates. DOS 1.0 reflected the view that racial and ethnic diversity was important but not critical to an institution's primary functions.

Unfortunately, this focus on recruitment, compliance, and retention was interpreted by many within and outside the academic health enterprise as contrary to the drive for excellence in the tripartite mission areas. Despite the best intentions of many, precious little headway was made toward sustainably diversifying the physician workforce. In DOS 1.0, increasing the compositional diversity of students was seen primarily as righting past wrongs and was disconnected from achieving excellence in patient care, education, and research.

### **Diversity 2.0**

Since the 1980s, diversity has continued to gain ground in higher education, as demonstrated by the proliferation of multicultural, ethnic, and gender studies curricula. Many of the nation's medical schools and teaching hospitals now offer some curricula focused on cultural competence; some institutions also include course work and research opportunities examining public health and health care disparities. The recognition of these evolving avenues of study, and closer attention to institutional climate and culture, have contributed to a sense of inclusiveness on campus and helped build awareness among members of the majority culture. Support continues to grow for the educational dividends of diversity, and evidence continues to show that increased diversity in the classroom coupled with the intentional integration of diversity as a teaching and learning

tool benefits the intellectual development, service orientation, self-awareness, and cultural competence of all students.<sup>2,3</sup>

As a result, a deeper, more nuanced view of diversity's role in academic medicine has emerged. In this paradigm, the potential value of diversity to the entire medical profession came into focus. To support this shifting sensibility, diversity offices expanded programming from a singular focus on student access to an emphasis on fostering the success of racial and ethnic minority and other underrepresented students, faculty, and staff. Structurally, however, diversity remained detached from the core mission. Minority affairs offices and activities remained largely parallel to that mission and often underresourced, despite a growing portfolio of work that included recruitment and retention of faculty members and a broadening conception of diversity. This transition to DOS 2.0 helped move us away from the diversity versus excellence model. Perhaps more importantly, it increased our openness to the notion that diversity and excellence are not only complementary but inextricably linked. However, because the 2.0 operating system is not fully networked into the larger cultural operating system of academic medicine, it is not yet able to make a greater impact, and diversity efforts are still too often viewed as parallel to the core institutional mission.

### **Diversity 3.0**

The drumbeat for a new paradigm is accelerating. Medical schools and teaching hospitals are shifting their strategies to better capture, leverage, and respond to the rich diversity of human talents and aptitudes. For example, efforts abound to reexamine prevailing assumptions about the competencies necessary for future physicians. In an attempt to more clearly connect medical school admissions criteria with future practice, initiatives are under way to integrate personal experiences and attributes into the existing metrics used to evaluate medical school applicants. Efforts to integrate a competency-based framework reflect our growing understanding of the individuality of learning styles.

In this era of transformation, the specific role of diversity efforts must also shift.

Diversity work must be seen as more than just solving the problem of inadequate representation and alleviating the barriers facing disadvantaged and marginalized populations. Promoting diversity must be tightly coupled with developing a culture of inclusion, one that fully appreciates the differences of perspective. Together, diversity and inclusion can become a powerful tool for leveraging those differences to build innovative, high-performing organizations.<sup>4-6</sup>

To fulfill the promise of this notion of diversity, medical schools and teaching hospitals must acknowledge diversity as a strategic imperative, reposition it across the institution and its functions, and move beyond the limiting DOS 2.0 mindset without abandoning programs that have been proven to eliminate enduring inequalities and injustices. It requires a focus on differences beyond race and ethnicity, with an attendant set of resources both financial and human. Fundamentally, it requires a mental shift that frames diversity as a means to address quality health outcomes for all, rather than an end goal in and of itself. As with all computer systems upgrades, the shift toward DOS 3.0 will depend on the appropriate leadership, management, adaptive, and technical capacities, and it will not be without its challenges.

The Association of American Medical Colleges has long been a leading voice and advocate for increased student and faculty diversity and will remain steadfast. However, going forward, we will also play a more active role in building the capacity of the nation's medical schools and teaching hospitals to move diversity from the periphery to a core strategy, thus shifting from DOS 2.0 to 3.0. This DOS 3.0 transformation will be a realization of an upgrade in our thinking, one that is not limited to compositional diversity but also incorporates diversity of thought, expression, desires, and goals and, ultimately, enhances the experience of all medical students, faculty, and, most important, patients.

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