The Benefits of Diversity: An Exploratory Study

By

Kira Foster, PhD
Yolanda Jenkins, PhD
Jeff Oxendine, MPH, MBA
Denise Herd, PhD

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The Connecting the Dots Initiative
A Comprehensive Approach to
Increase Health Professions Workforce Diversity in California

Produced by:
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Written by:
Kira E. Foster, PhD
Yolanda Jenkins, PhD
Jeff Oxendine, MPH MBA
Denise Herd, PhD
ABOUT THE INITIATIVE

The Connecting the Dots Initiative: 
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This is one of seven reports that share findings from a coordinated set of inquiries commissioned by The California Endowment. The purpose is to foster a more comprehensive, evidenced-based understanding of the issues, challenges, and opportunities associated with efforts to increase health professions workforce diversity. Each report includes a set of targeted recommendations to increase health professions workforce diversity in California. The basic theme and title of the initiative is “Connecting the Dots,” reflecting an understanding of the need for a thoughtful, deliberate, and sustained commitment by the full spectrum of educational institutions, health professions employers, businesses, community stakeholders, and other leaders in the public and private sectors. The Public Health Institute and UC Berkeley School of Public Health formed a partnership to conduct the research and take action as part of The Connecting the Dots Initiative, and worked in collaboration with UCSF Center for Health Professions, Gibson and Associates, and The Praxis Project.

Impetus for the Connecting the Dots (CTD) Initiative was provided by earlier reports from the Institute of Medicine, The Sullivan Commission, and The UCSF Center for Health Professions. These reports documented the dramatic under-representation of many racial and ethnic groups in the health professions and provided evidence that a more diverse health workforce can contribute to improved access and quality for health status for all Americans. They also made the case that increased representation is essential to our future health workforce and economy. The Connecting the Dots Initiative builds on those earlier reports by documenting the current state of affairs in California and developing an evidence-based, comprehensive strategy to increase health workforce diversity. The Connecting the Dots Initiative reports include:

• A quantitative assessment of the current level of diversity in CA health professions education institutions and among practicing professionals.
• A qualitative assessment of issues, challenges, and opportunities based on key informant interviews with the leadership of health professions education institutions, health professions employers, and state regulatory agencies.
• Profiles of over 30 exemplary practices to enhance health professions diversity
• An analysis of how the issue of diversity is framed in the California media, and strategies to re-frame the public dialogue.
• Qualitative and quantitative research with health professions students, faculty and alumni to explore the benefits of diversity in the educational environment.
• A comprehensive annotated bibliography and literature review of diversity-related research to date.
• A qualitative assessment of K-12 networks of support to strengthen the health career pipeline in four CA communities.

All seven reports can be found at http://www.calendow.org/Article.aspx?id=2290. The Connecting the Dots Initiative is in its next phase to support the implementation of the targeted recommendations. For more information, please contact Shelly Skillern at sskillern@phi.org

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1.0 Executive Summary

1.1 Purpose of Study

The purpose of the *Benefits of Diversity Exploratory Study* was to explore the benefits and challenges of racial, ethnic, and cultural diversity as experienced at selected California schools of medicine and public health. More specifically, we sought to gain a detailed and holistic understanding of whether, how, and under what conditions diversity in medical and public health training enhances:

1. the education and practical training of medical and public health students;
2. the later professional practice of medical and public health students;
3. the research and teaching practices of medical and public health faculty; and
4. the ability of schools of medicine and public health to meet their major goals and responsibilities.

1.2 Study Design and Methods

The study utilized a limited case-study design. Study sites included three schools of medicine and three schools/programs of public health in California. Sites were selected primarily for the level of racial/ethnic diversity among students, but also with an eye to regional variation, public/private status, and selectivity in admissions. The study team collected data through key informant interviews, focus groups, and online surveys. Interview, focus group, and survey questions were based on a conceptual framework derived from recent work in the field of diversity research. In brief, this framework conceptualizes the benefits of diversity in educational settings as derived from three interrelated features of the institutional landscape: the racial/ethnic makeup of students, faculty and staff; the frequency and quality of interaction among diverse groups, and institutional efforts to promote compositional and interactional diversity.

1.3 Study Participants

Altogether, over 1200 respondents contributed their views and experiences to this study. About one-third (34%) were faculty or teaching staff members, close to half (45%) were students, and about one-fifth (21%) were alumni. Just over half were from public health (55%) and just under half were from medicine (45%).

From February to June of 2007, the study team conducted forty-nine individual interviews with diversity-engaged faculty and teaching staff, students, and alumni from six study sites. Of these respondents, 59% were from racial/ethnic groups that are underrepresented in public health and medicine. A similar proportion (57%) was

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1 For the purposes of this study, “well-represented” racial/ethnic groups include Asian Indian, Chinese, Japanese, Korean, Taiwanese, White, or some combination of those. “Underrepresented” groups include African American, Alaskan Native, American Indian, Chicano/a, Filipino/a, Hmong, Lao, Mexican
women. Among sixty-one student focus group participants, about half (52%) were from underrepresented groups and 90% were female.

Between June and October of 2007, over 6200 faculty, teaching staff, students, and alumni were invited to complete an online survey about diversity. About one in five (19%) responded. Two-thirds (67%) identified themselves as being from well-represented racial/ethnic groups, and one in five (20%) from underrepresented groups.2 About 59% of survey respondents identified themselves as female, 35% as male, and 7% did not state their sex.

1.4 Summary of Key Findings

Finding 1: The benefits/challenges of diversity arise from a complex web of factors. The benefits and challenges of diversity in schools of medicine and public health are produced through a complex web of interrelated factors and conditions (see Figure 1). Increasing diversity and its benefits requires the coordinated development of compositional, interactional, and institutional factors. If one factor is overlooked or lags behind, it will constrain the realization of benefits throughout the “diversity web”.

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2 Approx. 5% indicated a race/ethnicity whose representation is unknown, and 8% did not indicate race/ethnicity.
Finding 2: Community context and community relations play a role. The racial, ethnic, and cultural diversity of an institution’s regional, patient, and community practitioner populations are part of an institution’s diversity profile and can contribute significantly to the benefits of diversity realized within the institution.

Finding 3: Traditional admissions criteria are under debate. Admissions committee members at schools of medicine and public health are debating how well certain traditional admissions criteria (such as MCATs, GREs, and GPAs) predict long-term academic or professional success. Most recognize that these measures do not predict a student’s commitment to primary care, serving the underserved or reducing health disparities. Opinions differ as to whether and how to strike a fair and legal balance between traditional and non-traditional criteria such as life experience, cultural and linguistic competency, and “distance traveled” in student admissions.
Finding 4: Numbers matter.
Student respondents from underrepresented groups reported that it was easier to feel isolated within a small health professions cohort than within larger undergraduate cohorts, even if the percentage of students from their racial/ethnic group was the same. Many often experienced being the only person of their ethnicity, or even of any underrepresented ethnicity, in classroom and small group settings. Negative effects of these conditions included:

a. feeling like and/or being treated as a “token”
b. being expected to “represent my race”
c. being the only one expected to or willing to raise racial/ethnic issues in class
d. feeling alone to face negative social consequences of raising racial/ethnic issues

To combat the pressures of cultural isolation, students from underrepresented groups create formal and informal networks of solidarity and support within the broader institution. However, the work required to maintain these networks also constitutes a burden not carried by students from well-represented groups. Enrolling a critical mass of students from underrepresented groups helps combat day-to-day isolation and spreads the work of intragroup support more widely. This allows such students more time and energy for participation in the broader institution, making their insights and perspectives more available to their well-represented peers.

Finding 5: Numbers are not everything. Students also need a variety of ways to connect. Racial/ethnic diversity among students is necessary but not sufficient to realizing the potential benefits of diversity in educational settings. Other factors, such as faculty diversity, curricular diversity, and institutional support for cross-cultural dialogue, are also crucial. Each student needs a supportive social niche, opportunities to safely explore personal motivations and concerns in relation to professional goals, and opportunities to learn from the professional choices of others like and unlike themselves. Institutional features that help meet these needs include diversity-related student orientation events, ethnic student organizations, multiethnic student groups formed around diversity-related issues, race-concordant mentors and role-models, diversity-related courses, community-based training, and “safe spaces” for sharing personal perspectives on racial, ethnic, and cultural issues. No one of these avenues will work for all students, so a variety of ongoing opportunities is needed.

Finding 6: Race-concordant mentors are best equipped to meet certain needs of students from underrepresented racial/ethnic groups. Diversity-engaged faculty suggest that students from underrepresented groups communicate more freely with, and are therefore better known, assessed, advised, and championed by race-concordant mentors. Students from both underrepresented and well-represented groups confirmed that they felt more comfortable with advisers “like themselves”. Those from underrepresented groups particularly mentioned the importance of hearing about the educational and professional paths taken by race- and gender-concordant mentors, as a guide to their own life plans and considerations.
Finding 7: Sharing “multiple perspectives” is central to the benefits and challenges of diversity. Such sharing is most successful when pedagogical approaches create a safe space for relating personal experiences to academic and professional frameworks. In less appropriate pedagogical contexts, the sharing of multiple perspectives can still occur, but the emotional costs are likely to fall most heavily on those students whose perspectives are the most at odds with the dominant assumptions of the group.

Finding 8: Public health students feel that diversity-related learning opportunities are too few and far between. Respondents at schools of public health and medicine shared a desire for a more cohesive and well-integrated approaches to teaching cultural competency, health disparities, and other diversity-related material. Public health students praised the content of diversity-focused courses, which were usually offered by diversity-engaged faculty using appropriate pedagogy. However, they felt that such courses were offered too rarely and that diversity-related issues were poorly integrated into the broader public health curriculum.

Finding 9: Medical students warn that a shallow cultural competency curriculum can undermine diversity goals. Many medical student respondents experienced didactic approaches to teaching cultural competency as shallow, ineffective, and lacking in follow up. They reported that such curricula could even become a source of racial tension because they prompted resentment, avoidance, or dismissiveness among students uninterested in diversity-related issues, while putting diversity-concerned students in the position of defending, in principle, something that they found lacking in reality.

Finding 10: Cultural sensitivity can be taught, but not in the abstract. Both faculty and student respondents felt that cultural sensitivity is best learned through direct interactions with culturally different patients and clients, especially when such experiences are discussed and reviewed with culturally diverse peers and teachers. Students noted that interactions with culturally different peers, patients, and teachers each allow for different kinds of cross-cultural learning. The common ground and relative equality of peer relationships allow for trust and cultural translation, while interactions with patients or clients provide practice in combining cultural sensitivity with professional confidence and authority. Most students did not find didactic courses on “diversity” very helpful, but were highly appreciative of teachers and supervisors who honestly shared their own experiences with issues of race, ethnicity, and cultural in professional and personal life.

Finding 11: Institutional culture, traditions, and practices are not race neutral. Institutional and professional cultures affect different kinds of students in different ways. For example, longstanding traditions associated with medical school hierarchy and hazing have a stronger negative impact on students from underrepresented groups than on those from well-represented groups, due to their different relationships to hierarchy and oppression in the broader society.
Finding 12: In the absence of institutional support, faculty and students from underrepresented groups bear the costs of diversity-related education.

In the absence of strong institutional support for diversity and diversity-related education, faculty and students from underrepresented groups feel compelled to use personal time, energy, and resources to educate each other and members of well-represented groups. Both faculty and students contribute disproportionately to creating and sustaining diversity-related curricula. Faculty members take on extra student advising. They maintain ties and increase capacity for collaborative research with communities of color. Although these efforts benefit the institution as a whole, they often go unrecognized, particularly in promotion and tenure proceedings.

1.5 Summary of Key Recommendations

Recommendation 1: Site Assessment
In order to increase the educational, professional, and institutional benefits of diversity, institutional leadership should assess the interacting factors and conditions at their site, and identify nodal points where development is lagging, or where an investment of time, personnel and resources will most enhance the benefits of diversity-related efforts already in place. The conceptual framework, findings, and recommendations of this study can serve as a basis for institutional assessment.

Recommendation 2: Strategic Plan
Based on a site specific assessment of factors and conditions, all institutions should have an adequately funded strategic plan for increasing the benefits of diversity, and a high-ranking official designated to insure the implementation of this plan through its integration into the job requirements, performance evaluations, and incentives provided to faculty and staff. The conceptual framework, findings, and recommendations of this study can serve as a basis for strategic planning.

Recommendation 3: Sustainable Community Partnerships
Institutions seeking to increase the benefits of diversity should insure that faculty and students have the skills and resources to form mutually beneficial partnerships with diverse communities and community practitioners in the surrounding region. Caveat: The tendency of some institutions to value and privilege research over practice can work against the formation of sustainable community partnerships.

Recommendation 4: Evidence-based Admissions
Admissions committee members should be made aware of existing evidence concerning the predictive value and compositional effects of both traditional and non-traditional admissions criteria (see Annotated Bibliography for references). Institutions should consider implementation of some form of “whole file review” that takes both traditional and non-traditional factors into consideration. (See accompanying report on Exemplary Practices for successful examples of this approach).
Recommendation 5: Minority Representation on Admissions Committees
Admissions committees, like all decision making bodies in a diverse institution, should include members from underrepresented groups. Institutional leadership should periodically review admissions policy and practices to ensure that they support all aspects of the institution’s educational and public missions.

Recommendation 6: Culturally Aware and Sensitive Teaching Staff
Faculty members and teaching staff should be trained in classroom strategies that minimize the negative effects of isolation and difference on students from underrepresented groups. They should also be trained in pedagogical approaches that create safe spaces for interaction and learning across racial, ethnic, cultural and class lines.

Recommendation 7: Consultation with Minority Students
Students from underrepresented and minority groups should be periodically consulted as to their experiences of institutional culture, particularly as manifested in traditional rites of professional initiation and enculturation. Traditional practices should be altered, adapted, or abolished as appropriate to the changing makeup and sensibilities of the student body.

Recommendation 8: Diversity-Related Student Organizations and Events
Schools should provide financial and organizational support for a variety of ethnic and multiethnic student organizations and events that help underrepresented and diversity-concerned students create informal networks of solidarity and support. In addition, schools and departments should host regular events that promote exchange and understanding across racial, ethnic, cultural and class lines.

Recommendation 9: Integrated and Effective Diversity Curricula.
Institutional leaders should commit the resources and personnel necessary to develop and implement a coherent approach to diversity curriculum integrated across each year of training and across classroom and clinical/practical learning. Diversity-related curriculum should mesh with the broader educational goals and focus for each year of training. Students and faculty working to develop such curricula should be formally supported (through stipends, academic credits, time out from other duties, etc.) in their efforts.

Recommendation 10: Collaboration on Model Curricula and Pedagogies.
Innovative approaches to teaching cultural awareness and sensitivity should be shared across institutions. Each site in our study demonstrated different strengths in this area. Faculty and students spearheading these efforts were interested in the experiences of others, but limited time and resources often meant that they worked in relative isolation.

Recommendation 11: Modeling Culturally Competent Professional Practices
An excellent diversity curriculum can be undermined if faculty and staff do not model cultural awareness and sensitivity in their own professional practice. Training should be required for those who teach or supervise students in clinical care, community
intervention, and research. Such training should, itself, be culturally sensitive to the institutional context and status of trainees—be they residents, faculty, or staff.

**Recommendation 12: Faculty-wide Commitment to Diversity**
All faculty members should be responsible for considering how racial, ethnic, and cultural issues are relevant to their teaching and research. Institutions and accrediting organizations should provide training and resources to support faculty efforts in this area. Faculty members’ diversity-related contributions should be fully and fairly recognized in appointment, workload, and promotion procedures of the institution.

**Recommendation 13: Reassess Criteria for Faculty Hiring and Promotion**
Traditional criteria undervalue teaching and service relative to research. At the same time, institutions rely disproportionately on their few minority faculty members to sustain diversity-related courses, advise minority students, and represent the university to minority communities. Traditional criteria also tend to discriminate against those doing research on underrepresented groups because such research takes longer, has lower response rates, and is published in less prestigious journals.

**Recommendation 14: Areas for Further Investigation**
Further research is required to understand how specific elements of the diversity web contribute to maximizing or limiting the benefits of diversity for all students, for institutions, and for society. For example, research into the academic and workforce consequences of various approaches to student admissions and faculty hiring would support evidence-based policies in those areas. Evaluation of innovative diversity curricula would guide the spread of best practices. Further analysis of the data from this study would provide more specific information on the relationship between the conditions for and benefits of diversity at particular sites.
2.0 Introduction

The United States is a nation of citizens differentiated by their cultural traditions, by the particular historical processes that brought them or their forebears to this continent, and by the differing obstacles and opportunities they encounter within American society. In this context, the term ‘diversity’ has become a shorthand for the opportunities and challenges associated with seeking to respect, appreciate, and benefit from the varied experiences and perspectives found within such a heterogeneous citizenry.

Among the differences commonly associated with the idea of diversity are those of race, ethnicity, socioeconomic status, gender, age, religious belief, sexual orientation and physical ability. Most, if not all, these differences exist within and are relevant to the health care and health outcomes of any American community. While recognizing this, the primary focus of this study is on the benefits and challenges related to increasing racial, ethnic, and cultural diversity in California’s health professions educational institutions (HPEIs).

This emphasis on racial/ethnic diversity is due to the serious health disparities currently associated with racial and ethnic difference, coupled with the severe under-representation of certain racial, ethnic, and linguistic groups within the health professions workforce. Data from professional and academic sources show that in California, and in the nation as a whole, the representation of African Americans, Hispanic/Latino Americans, and Native Americans in the health professions lags far behind their representation in the population as a whole [1-3]. In addition, certain Asian, Pacific Islander, and other racial/ethnic groups are underrepresented in specific health professions and regions of California, relative to the proportion of state and regional populations that they represent (see accompanying Inquiry 1 report on workforce diversity).

The purpose of the Benefits of Diversity Exploratory Study was to explore the benefits and challenges of racial, ethnic, and cultural diversity as experienced at selected California schools of medicine and public health. Through interviews, focus groups, and online surveys with students, faculty, and alumni, we sought to gain a detailed and holistic understanding of whether, how, and under what conditions diversity in medical and public health training enhances:

1. the education and practical training of medical and public health students;
2. the later professional practice of medical and public health students;
3. the research and teaching practices of medical and public health faculty; and
4. the ability of schools of medicine and public health to meet their major goals and responsibilities.

Respondents to this study associated the term “diversity” with two related but distinct kinds of benefits: those arising from the fairness of inclusion and those arising from the advantages of cross-cultural exchange. While respondents from both underrepresented and well-represented racial/ethnic groups valued these benefits, their lived experience of inclusion and of cross-cultural exchange often differed, as will be discussed below.
Overall, we found that many of the study’s 110 diversity-engaged interviewees and focus group respondents had experienced and could provide examples of educational, professional, scientific, or institutional benefits of diversity. Most also felt that the compositional, interactional, or institutional conditions for realizing such benefits could be improved. Some respondents suggested improvements that would increase the number of people experiencing the benefits of diversity. Others suggested changes that would deepen the quality and professional relevance of diversity-related learning and exchange.

On-line survey responses from 1,124 faculty and teaching staff, students, and alumni also indicated broad recognition of the importance of compositional and interactional diversity for health professions education. As will be discussed below, the surveys also provided insight into how perspectives and experiences differed across various respondent groups and across institutions with differing conditions for diversity.
3.0 Background: From Affirmative Action to the Benefits of Diversity

In 1961, John F. Kennedy’s Executive Order 10925\(^3\) introduced the term “affirmative action” into American politics as a shorthand for proactive efforts to “realize more fully the national policy of nondiscrimination” [4]. The landmark Civil Rights Act of 1964 and its implementation under Lyndon Johnson solidified the legislative and executive power of the term. In a 1965 commencement speech at Howard University, President Johnson described this proactive approach as “the next and the more profound stage of the battle for civil rights” in which the government sought “not just equality as a right and a theory but equality as a fact and equality as a result” [5].

In this spirit, and in keeping with the legislative and executive mandates of the day, many institutions of higher education began to consider race, ethnicity, and gender more explicitly and more equitably in their admissions policies. The result was an increase in the numbers of women and minorities attending college and subsequently, graduate and professional school. As their numbers grew, students from these groups questioned many of the assumptions, beliefs, and practices that they found in higher education. Rather than assimilating to the established academic culture, they sought recognition and legitimacy for their own perspectives. Their efforts gave birth to ethnic and women’s studies programs. The terms multiculturalism and diversity, rather than “integration”, best captured their visions for a context in which different perspectives are recognized and valued, rather than suppressed.

In the early 1970’s, the legality of race-conscious admissions practices was called into question by Alan Bakke. A White applicant, Mr. Bakke was twice refused admission at the UC Davis Medical School while others with lower overall admissions scores were admitted through a program that reserved some seats for disadvantaged minority applicants. In 1978, the U.S. Supreme Court ruled that while the goal of achieving a racially and ethnically diverse student body justified “consideration of race in admissions decisions”, the UC Davis method of achieving this goal was too mechanistic and inflexible and impinged unnecessarily on the rights of majority applicants to equal protection under the Civil Rights Act of 1964 [6].

While this ruling upheld the legality of race-conscious admissions practices, it subtly shifted the legal basis for such practices. When implementing the Civil Rights Act, Lyndon Johnson viewed affirmative action as a remedy for both historical and ongoing discrimination against certain groups. In the Bakke decision, the Supreme Court allowed that affirmative action could serve as a remedy for specific legal wrongs, but not for broad socio-historical ones.

\(^{3}\) The order that established the President’s Committee on Equal Employment.
Race could be considered in medical school admissions, but not as redress for past exclusionary practices, nor as a means of achieving “the admittedly compelling state interests of integrating the medical profession and increasing the number of doctors willing to serve minority patients.” Rather, the Supreme Court recognized only the direct educational benefits of a diverse student body as provably relevant to the case.

When the Supreme Court recognized the benefits of diversity in education in 1978, little systematic research had been carried out on the topic. The 1980’s and 1990’s saw the development of a body of literature seeking to explore and document the consequences, benefits, and challenges of affirmative action and diversity in undergraduate settings. See section three for a brief review of this literature [7].

In 2003, two University of Michigan cases brought the question of race-conscious admissions before the U.S. Supreme Court once again. In Gratz v. Bollinger and Grutter v. Bollinger, the Court rejected the University’s “mechanistic” use of race in undergraduate admissions, but affirmed the legality of a “narrowly tailored” case-by-case consideration of race in the pursuit of the educational benefits of diversity at the University’s Law School. The case notes that “[t]he Law School’s claim is further bolstered by numerous expert studies and reports showing that such diversity promotes learning outcomes and better prepares students for an increasingly diverse workforce, for society, and for the legal profession” [8].

Having won only half their battle in the courts, opponents of affirmative action have successfully advanced their cause through ballot initiatives in several states, including Proposition 209 in California (1996), Initiative 200 in Washington (1998), and, most recently, Proposal 2 in Michigan (2006). While the “benefits of diversity” won the day in the more measured context of judicial review, it remains to be seen whether and how they can hold their own in the rough-and-tumble realm of popular opinion.
4.0 Researching the Benefits of Diversity

Research conducted primarily in undergraduate settings demonstrates that adequately realized diversity within institutions of higher education yields significant intellectual and interpersonal benefits for students (see, for example, [9-11]. These benefits include:

- More active, critical, and complex thinking
- Improved intellectual engagement and motivation
- Improved capacity to identify and question own assumptions
- Improved capacity to see commonalities across difference
- Improved capacity to consider multiple perspectives
- An increased awareness and understanding of other social and cultural groups

In addition, diversity in undergraduate education yields social benefits that include:

- An increased ability to relate to and work with diverse populations
- A more engaged citizenship
- A greater belief in the value and potential of a diverse, democratic society

Studies conducted in health professions educational settings indicate that a diverse student body may confer similar intellectual, interpersonal, and social benefits for students across racial and ethnic backgrounds. These benefits are often linked to the development of key professional competencies, such as the ability to gain trust and collaborate successfully with patients or community groups to manage or solve health problems. When directed toward research design and administrative leadership, the benefits of diversity help to insure the provision of effective, high quality health care to all segments of the population.

In a survey of student’s perceptions of the educational benefits of diversity in medical school, Whitla et al (2003) found that exposure to a diverse student body improved students’ ability to consider multiple perspectives and work with others from different backgrounds. Moreover, the experience increased students’ concerns about equity within the health care system, access to care for the medically underserved, and cultural competency in the treatment of diverse patient populations [12].

A survey study by Novak et al (2004) found that students who perceived their dental school environment as diverse also felt more competent to work with multicultural and economically disadvantaged populations [13]. Two other studies also found that exposure to diverse patients and colleagues during training can enhance health professionals’ ability to work with increasingly diverse patient populations [14, 15].

As Lisa Tedesco (2001) argued, these studies indicate that health professions educational institutions have the opportunity to continue the educational, interpersonal, and citizenship benefits of diversity that students gain in their undergraduate years and to
channel those benefits toward the enhancement of professional competence and professional citizenship [16].

4.1 Conceptualizing Diversity in Educational Settings

One empirical finding of “benefits of diversity” research has been that achieving the educational benefits of diversity requires more than simply admitting a diverse student body, or even hiring a diverse faculty. Attention must also be paid to the interactions among diverse actors and the institutional context in which they operate. For example, Lee and Coulehan (2006) and Coulehan and Williams (2001) discuss the effects of an implicit “hidden curriculum” that tends to undermine explicit cultural competency education in medical schools [17, 18].

The conceptual framework utilized by this study represents a synthesis of various efforts to create models that capture the complex dynamics of diversity in educational settings. We have drawn on the definition of diversity put forward by the Sullivan Commission on Diversity in the Healthcare Workforce; a conceptual framework developed by Hurtado, Milem, Clayton-Peterson, Allen, and others; and work by Gurin and Nagda on intergroup interaction [3, 7, 19-21].

In keeping with this work, we define diversity within health professions educational institutions as a dynamic, multifaceted process. This process is shaped by historical and political forces external to the institution and by several mutually interrelated features of the institution itself—its demographic composition, its social interactions, and its institutional culture, climate, and practices.

In Figure 2, compositional diversity (sometimes termed “structural diversity”) refers to the numerical and proportional representation of individuals from diverse backgrounds and population groups. Interactional diversity refers to the quality and frequency of interactions, both formal and informal, within and between groups and individuals as participants in the institution. Formal interactions include classroom and practical training interactions, while informal interactions are those associated with school-sponsored or student-led social and extracurricular activities.
The arrows in Figure 2 illustrate interactions between institutional, compositional, and interactive aspects of diversity in educational settings. For example, formal classroom interactions can affect informal interactions among students which can affect the institutional climate and student recruitment. Student recruitment affects the makeup of the student body, which in turn affects classroom interactions. As described in our findings, this complex web of influences makes institutional change a challenging juggling act, in which success depends not only on what is done, but on how it is done and in concert with what other efforts.

4.2 Study Design and Methods

The methodology most suited to the purpose, conceptual framework, timeline, and resources of this study was that of the limited case study. Of fourteen California schools of medicine and public health, six were selected. The primary selection criterion was that the institutions have enough compositional diversity to allow any potential benefits and challenges of diversity to emerge. Beyond that, sites were selected with an eye to variation in regional location, public/private status, and degree of “selectivity” in student admissions. In practice, five of our six selected sites were able to accommodate the study during the available time frame. We were able to meet all selection criteria as planned, except for some lack of regional variation among medical schools.

Interview instruments, focus group guides, and online surveys were developed based on the conceptual model described above. In general, interviewees and focus group
participants were asked to reflect on the current climate for diversity at their institutions; on diversity-related efforts that they were engaged in or affected by; and on the benefits and challenges of student diversity, faculty diversity, and diversity-related curricula as they had experienced them. Finally, respondents were asked for recommended changes that might better prepare students at their institutions for work in diverse communities and in communities of color.

At each site administrative approval was obtained and a key contact was identified. Usually this person was actively engaged in diversity-related efforts at the institution. Through this contact, other diversity-engaged faculty and students were invited to participate in individual interviews. Potential alumni interviewees were identified either by the key contact or by faculty respondents at each site. Thus, interview respondents were selected using purposive snowball sampling and do not represent a random sample. We sought to interview at least three faculty members, two students, and two alumni from each institution. As is detailed below in the section on data collection, these goals were met, except at one site where only one alumnus was interviewed.

Focus group respondents were selected through opportunity sampling. While not necessarily diversity-engaged, they were likely concerned enough about issues of diversity to respond to our invitations, which were issued via student listservs and through word-of-mouth efforts by faculty and student interviewees. We aimed to conduct two focus groups at each site—one for students from well-represented racial/ethnic groups and one for students from underrepresented groups. This goal was met at four of the six sites. However, we were unable to gather enough volunteers to hold a “well-represented” focus group at two sites.

Through online surveys, we sought to gather the views of a broader range of faculty, teaching staff, current students, and alumni. In keeping with the conceptual framework, the survey instruments addressed perceived compositional diversity; perceived benefits and challenges of diversity; issues of formal and informal interactions across racial, ethnic, and cultural lines; and perceptions about the institution’s commitment to racial/ethnic equity and inclusion. Faculty, teaching staff, students, and alumni from each site received invitations via email to complete an online survey. Those who responded likely included faculty, students, and alumni most likely to answer an online survey, and those most motivated to express an opinion—either positive or negative—about the role of diversity in public health or medical education.
4.3 Data Collection

Interviews and focus groups took place from February to June of 2007. During that time, forty-nine individual interviews were conducted with diversity-engaged faculty, students, and alumni from three schools of medicine and three schools of public health. Twenty-five of these respondents were from medical schools and twenty-four from schools of public health. Of the 49 respondents, 59% were from underrepresented racial and ethnic groups\(^4\), and 57% were women.

Ten focus groups were conducted with a total of 61 participants. At the three schools of public health, six focus groups explored the views and experiences of 19 students from well-represented racial/ethnic groups and 20 students from underrepresented groups. At the three medical schools, because we sought to include 3rd and 4th year students with some exposure to clinical training, focus groups were smaller and more difficult to arrange. In all, 13 medical students attended three focus groups for students from underrepresented groups. Only one focus group for medical students from well-represented groups was successfully conducted. It was attended by 9 students. At one school, in lieu of a focus group, three students from well-represented groups were interviewed individually. It is worth noting that 90% of focus group participants were female, a significant overrepresentation given that approximately 72% of public health students and 53% of medical students at the study sites were female in 2006.

During June, July, and August of 2007, invitations to complete online surveys were sent to faculty and student listservs at five of the six study sites. Between August and October, invitations were sent to alumni from selected years (before and after 1996) at the same five sites. Medical school faculties provided the largest pool of potential respondents (1,866) while public health faculties totaled only 430. On the other hand, there were many more potential respondents among current public health students (1,314) than medical students (784), and more public health alumni (1,436) than medical alumni (404). Of the 6,234 people invited to complete a survey, 1185 (19%) responded, yielding 1,124 responses for analysis.\(^5\) Discussion henceforth refers only to respondents whose responses were retained for analysis.

Response rates varied across medicine and public health, and across the three constituent groups—faculty, students, and alumni. Overall, those affiliated with schools of public health had a slightly higher valid response rate (19%) than those affiliated with schools of medicine (17%). This difference was also true for each public health group (faculty, students, and alumni) as compared to their medical counterparts. Overall, students had a higher valid response rate (23%) than faculty (17%) and alumni (13%). As mentioned

\(^4\) As mentioned above, the underrepresented group included respondents who identified as African American, Hispanic or Latino, Native American, Alaska Native, Native Hawaiian, Vietnamese, or Filipino. The well-represented group included respondents who identified as Chinese, Asian Indian, or White.

\(^5\) About 5% of responses were excluded from analysis, including those from 16 respondents who declined consent, 14 who were not members of the surveyed groups, 26 who broke off the survey without providing substantive data, and second responses from 5 respondents who filled out the survey twice.
above, a random-sample methodology was not employed, so—regardless of response rate—the survey findings cannot be generalized to the entire faculty, student, or alumni populations of the study sites. Instead, the surveys serve as a source of information about the views and experiences of a broader group of faculty and students than was possible to interview in person.

About 45% of survey respondents were affiliated with a school of medicine and about 55% with a school of public health. About 59% identified themselves as female, 35% as male, and 7% did not state their sex. One in five survey respondents (20%) identified themselves as being from a racial/ethnic group that is underrepresented (UR) in medicine and public health, while 67% identified with a racial/ethnic group that is well-represented (WR). About 5% identified with various Middle Eastern, “Other Asian”, or “Other” groups whose degree of representation is not known. The remaining 8% of respondents did not select a racial/ethnic category.

For the purposes of this study, WR refers to respondents who identified as Asian Indian, Chinese, Japanese, Korean, Taiwanese, White, or some combination of those. UR respondents are those who identified as African American, Alaskan Native, American Indian, Chicano/a, Filipino/a, Hmong, Lao, Mexican American, Native Hawaiian, Other Latino/Hispanic, Other Pacific Islander, Puerto Rican, Thai, Vietnamese, or any combination including one or more of those groups.

Comparing survey data to student data available for the study sites, it appears that female students and students from underrepresented groups are somewhat overrepresented in the survey while male students and those from well-represented groups are underrepresented and, perhaps, more likely not to state their sex or race/ethnicity. It is likely that men and those from well-represented groups are also underrepresented among faculty and alumni respondents, but institutional data are not available for comparison. Table 1 provides a brief profile of the participants in this study.

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7. For example, 67% of respondents to the student surveys identified as female, compared to an estimated 63% female students at the sites. However, only 25% identified as male, compared to an estimated 37% male students across the study sites. Eight percent of student survey respondents did not state their sex.
Table 1: Profile of Study Participants

<table>
<thead>
<tr>
<th></th>
<th>Individual Interviews</th>
<th>Focus Groups</th>
<th>Online Surveys</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>Percent</td>
<td>N</td>
</tr>
<tr>
<td>Respondents</td>
<td>49</td>
<td></td>
<td>61</td>
</tr>
<tr>
<td>Faculty/Teaching Staff</td>
<td>22</td>
<td>45%</td>
<td>-</td>
</tr>
<tr>
<td>Students</td>
<td>16</td>
<td>33%</td>
<td>61</td>
</tr>
<tr>
<td>Alumni</td>
<td>11</td>
<td>22%</td>
<td>-</td>
</tr>
<tr>
<td>Medicine</td>
<td>25</td>
<td>51%</td>
<td>22</td>
</tr>
<tr>
<td>Public Health</td>
<td>24</td>
<td>49%</td>
<td>39</td>
</tr>
<tr>
<td>Underrepresented (UR)</td>
<td>29</td>
<td>59%</td>
<td>32</td>
</tr>
<tr>
<td>Well-represented (WR)</td>
<td>20</td>
<td>41%</td>
<td>29</td>
</tr>
<tr>
<td>Unknown</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Female</td>
<td>28</td>
<td>57%</td>
<td>55</td>
</tr>
<tr>
<td>Male</td>
<td>21</td>
<td>43%</td>
<td>6</td>
</tr>
<tr>
<td>Unknown</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>
5.0 Main Findings

5.0.1 Shared Values, Different Priorities

Study interviewees and focus group participants associated racial/ethnic diversity in the health professions with three closely related kinds of benefits—the benefits of achieving a fairer, more inclusive society; the benefits of minority participation in professional practice, research, and education; and the benefits of cross-cultural exchange. While respondents from both underrepresented (UR) and well-represented (WR) groups valued all three types of benefits, they tended to experience them differently. Respondents from WR groups tended to speak most animatedly about the benefits of cross-cultural exchange, while those from UR groups spoke more passionately about institutional inclusion, as in the integration of diversity-related issues into the curriculum or the importance of minority professionals “being at the table” in order to improve the health and well-being of their communities.

This is not to say that the two groups did not empathize with and respect each others’ perspectives. Respondents from well-represented groups valued fairness and inclusion, but tended to see the benefits of greater institutional inclusion as accruing primarily to minority students and faculty and, through them, minority communities. For many WR respondents, particularly those in medicine, an increase in the number and standing of minority professionals was also seen as primarily benefiting minority patients. WR respondents in public health were more likely to see minority participation in the profession as making all public health efforts more efficacious.

For their part, respondents from underrepresented groups valued direct cross-cultural exchange, but tended to see the benefits as accruing primarily—though not exclusively—to those from well-represented groups. While cross-cultural exchange can be an exceptional, illuminating experience for those in the majority, it is a daily necessity—even an exhausting burden—for those representing racial, ethnic, and cultural minorities. For UR students, the institutionalization of diversity education, awareness, and sensitivity represents, in part, a chance to feel less constantly and personally responsible for the cultural education of peers and colleagues.
5.0.2 ... All Caught in the Same Web

It is not surprising that members of well-represented and underrepresented groups have differing perspectives on the benefits of diversity and how to achieve them. In fact, this finding is similar to that of *The Diversity Project* (1991), a study of UC Berkeley undergraduates’ attitudes towards diversity. This study found that:

> “While *both* African American and white freshman students want more interracial experiences and contacts, *they want them on different terms*. African Americans want more classes and programs and institutional commitments and responses. Whites want more individual, personal contacts developed at their own time and leisure” [23, p. 14 (emphasis in original)]

Among our survey respondents, men and women also tended to have significantly different views on diversity, as did faculty and students on some issues. In general, the respondents to this study indicated that the benefits of diversity (or lack thereof) are produced and experienced through a complex web of interrelated factors and conditions that affects differently positioned actors uniquely. While the elements of this web are similar from school to school, the overall configuration is site specific.

Historical accounts obtained from senior faculty and older alumni suggest that compositional diversity among students and faculty is fundamental to the dynamics of the web over time. To put it briefly (and somewhat simplistically), when racial/ethnic compositional diversity is low, both minority influence and cross-cultural exchange usually become limited as well. Students and faculty from underrepresented groups tend to feel marginalized and isolated. Consequently, their priorities are to increase their representation (both numerical and hierarchical) and improve their support systems within the institution. In graphic terms, the “diversity web” of a newly diversifying institution can be represented as in Figure 3 below, where the shaded areas represent the presence and positioning of underrepresented groups within the institution.
Those from well-represented groups (again in oversimplified terms) often expect that numerical inclusion is enough and that those from underrepresented groups will not require further adaptation from the institution. Most think of their institution’s conventional practices as inherently fair. Their priority, therefore, is to treat everyone equally within that framework. As minority participants seek to make the institution more comfortable and less alien, majority participants can begin to see them as demanding and/or receiving “special treatment”. Often, confrontations occur.

Commenting on this dynamic in her article, “What can White faculty do?”, Jill Gordon urges readers to consider, “What are the preexisting institutional and social conditions that place one group in the position of having to ask consistently for certain considerations in the first place?” Gordon also recommends that, “Activities intended to change the institution, which are taken up by minority students, faculty, and staff, need to be recognized as demonstrations of their commitment to and/or engagement with the institution” [24, p. 344-345].
Although confrontations over diversity-driven change can be difficult, it seems that they can also move the institution toward increased intergroup communication and institutional change. This occurred at one of the sites in this study. An African American alumnus, whom I will call Daniel, recounted how he and his peers responded to the low number of African-Americans at the school by becoming involved in the recruitment and admissions process—seeking to make it more receptive and welcoming to African American applicants. By the time Daniel graduated, the number of African Americans in the incoming class had nearly tripled from the number in Daniel’s own cohort. This success, however, also focused institutional scrutiny on African Americans as a group:

“Once we got the numbers up … That’s when the backlash came … the perception was that there were more students from the African-Americans that were having to take [a certain] makeup exam. They all subsequently passed and moved on but there were some people in the administration who … didn’t like that effect so they changed and [tightened] the criteria for allowing these students … that backlash resulted in a decrease in the number of African-Americans that were admitted.”

Rather than examining traditional practices—in the areas of classroom pedagogy, exam preparation, or exam administration—for possible shortcomings in the face of new conditions, the institution’s leadership located the problem with the minority students and tightened admissions standards. This choice, as the rest of the story bears out, represented a missed opportunity for institutional self-reflection and reform that might have improved educational success and support for students from all groups.

Despite the setback in admissions policy, many of the gains made by Daniel’s cohort remained in place to benefit those who came after. “Alicia”, a Latina alumna, entered school just after Daniel graduated. Her cohort was one-third racial and ethnic minorities—“a record number for the university”. These students were offered a pre-matriculation summer program to provide both social and academic orientation. Because of their racial/ethnic exclusivity, such programs can seem “unfair” to majority group students. Alicia recounts:

“Some of the second-years were a little curious as to why we were there. So I remember there was … a Caucasian gal who came by and invited us to participate in [a student organization] and to come to a social that evening … So we got to the meeting and it turns out that it’s at a café … So then they proceeded to interrogate us about what we were doing there, why we were there early … and it turned out that there was no meeting at all, they just wanted to find out what we were up to.”

One of Alicia’s companions was very upset by this encounter and news of it soon spread. Students who had arranged the false meeting were berated by their classmates, and “everybody was crying and upset”. Alicia and others met with the dean, who agreed to put a diversity training program into place.
Staff members (funded through now severely reduced federal grants to support the development of minority health professionals) identified materials for a series of diversity seminars that, according to Alicia, was very successful on a number of levels. Apologies were made and some students gained greater awareness of the historical inequities in health professions education. Role playing scenarios educated students about the importance of cross-cultural communication in their future practice. Most strikingly, ongoing communication between UR and WR students was increased to the extent that long-standing, but hidden, discriminatory practices were exposed. Alicia explains:

“… because we were now talking to each other—everybody—we were able to find out that certain students were treated differently based on what appeared to be their ethnicity and race. They’d get the same grades, had the same profile, but certain of them would be put on academic probation or kicked out of the school whereas their White counterparts with similar situations were maintained … So then even the majority students were like ‘Hey, I’m still here. What’s the deal?’”

Eventually, as a result of the students’ discoveries, legal action was brought against a member of the administration who had, according to Alicia, been discriminating based on racial/ethnic identity for many years. In this example, students from all groups benefited educationally, interpersonally, and professionally from working through the issues raised by diversity on their campus. Beyond that, the institution benefited from the exposure of a longstanding injustice hidden within purportedly fair and merit-based procedures.

Is this series of events unusual? Interestingly, a White alumna from another site related a similar story in which increased diversity was followed by the establishment of a summer pre-matriculation program that became a bone of racial/ethnic contention. Again, diversity workshops were held, but this time by an outside agency for only a day or two. These workshops also “opened lines of communication” but, according to the alumna, did not create ongoing interaction and social ties across racial and ethnic lines.

When increased compositional diversity brings greater visibility to minority students and the programs designed to support them, institutional support for ongoing intergroup, as well as intragroup, interaction can be crucial. Staff with diversity-related expertise can transform a distressing confrontation into a teachable moment. If these efforts are sustained, mutual suspicion and division can become mutual respect and cohesion. Figure 4 represents the “diversity web” in an institution engaged in concurrent diversity efforts on a variety of fronts.
These stories illustrate the complex interactions of compositional, interactional, and institutional factors that make a campus more or less conducive to the benefits of diversity. The following sections examine the benefits of diversity as experienced by respondents to this study. Following sections explore, in general, the conditions that produced those benefits. Further analysis, beyond the scope of the present report, are required to determine whether and how conditions at each site relate to the benefits experienced by respondents at that site.
5.1 The Benefits of Diversity

5.1.1 Benefits of Interaction among Diverse Students

Once a degree of compositional diversity is attained, the benefits of diversity are all about interaction. Among interview and focus group respondents in this study, the most commonly mentioned educational benefit of diversity was the sharing of “multiple perspectives”. Such sharing made discussions more interesting and intellectually challenging, bringing greater richness and depth to classroom learning. As one faculty member noted, the best teaching situations are those in which contrasting views provide creative tension and spark student engagement. Respondents also felt that the sharing of multiple perspectives has psychosocial benefits for all students. These benefits include a reduced reliance on social stereotypes, a clearer understanding of one’s own cultural identity and positioning, and an increased sense of confidence and ease in multicultural settings.

Interviewees and focus group participants saw interactions among diverse students as contributing to the professional competency of all students, although this differed across public health and medicine. Public health interviewees often viewed a sophisticated understanding of racial, ethnic, and cultural differences as essential to solving pressing problems in their field. Several public health faculty members remarked that they had a lot to learn from students with varied racial, ethnic, and socioeconomic backgrounds, describing these students’ contributions as “eye-opening”. For most medical interviewees, bioscientific competency remained paramount, but cultural competency was viewed as an essential secondary tool that today’s physician should not be without.

Of the various benefits of diversity discussed above, most were mentioned by interviewees and focus group participants from both well-represented (WR) and underrepresented (UR) groups. However, respondents from UR groups described educational and professional benefits of diversity much more often than those from WR groups. Comments regarding the interpersonal, research-related, and social benefits of diversity were more evenly distributed across UR and WR groups. Box 1 illustrates the kinds of educational and professional benefits that WR students from both public health and medicine described:
5.1.1a Survey Respondents on Educational Benefits of Interaction

Nine survey questions elicited respondent views on the educational and professional benefits of diversity. Overall, survey results found that, on most questions, UR respondents, women, and public health respondents were significantly more likely than their WR, male and medical school counterparts to see strong educational and professional advantages to interaction among diverse students.

To address educational benefits of interaction among diverse students, respondents were asked how often such interactions “enrich or enliven classroom discussions”, “challenge students to rethink assumptions and biases”, and “bring out differing interpretations of the same data”. Public health respondents were significantly more likely than medical respondents to report that diverse interactions generate these benefits often or all the time (chi2 p=.000). Given similar levels of compositional diversity, this difference is perhaps due to the greater social science content in public health curricula. Public health courses may be more likely to raise issues and facts about which students have differing perspectives, assumptions, biases, and interpretations.
“Enriched classroom discussion” was the most frequently experienced of the three educational benefits. Nearly three-quarters (72%) of public health respondents and just over half (53%) of medical respondents felt that interactions among diverse students enrich or enliven classroom discussions often or all the time. More than half (55%) of public health respondents and one-third (37%) of medical respondents saw students challenged to “rethink assumptions and biases” with high frequency. Finally, 45% of public health respondents and 27% of medical respondents reported that interactions among diverse students bring out “differing interpretations of the same data” often or all the time.

Among medical respondents, UR participants were much more likely to perceive these educational benefits of diversity occurring “often” or “all the time” than were their WR counterparts (chi2 p<.002). Women and students were also significantly more likely to report frequent benefits than their male and faculty counterparts (chi2 p=.000 to .052). Such variation was less evident among public health respondents. UR respondents were more likely to perceive “rethinking of biases” and “differing interpretations of data” than were their WR counterparts (chi2 p<.030), but not more likely to perceive enriched or enlivened classroom discussion. Differences in student and faculty responses were of marginal significance (chi2 p=.055), and differences between men’s and women’s perceptions were not statistically significant (chi2 p>.332).

The tendency of faculty and teaching staff to perceive classroom benefits of diverse interaction less frequently than students may be due to their greater distance from student discussions, or their own familiarity with the materials being discussed. The tendency of WR and male medical respondents to experience classroom benefits less frequently than their UR and female counterparts could relate to a variety of conditions within the diversity web. In qualitative interviews, respondents frequently noted that while some WR students were aware of and interested in the role of racial/ethnic differences in medicine, the majority were not.

Lack of awareness implies that diversity issues have not been adequately addressed in a school’s pedagogy and curriculum, while lack of interest would imply that concern about racial/ethnic health disparities is not a significant factor in student admissions. Nevertheless, it is important to note that a solid percentage of WR male medical students do perceive frequent classroom benefits of diversity (see Table 2):
Table 2: Percent of medical respondents perceiving frequent benefits of interaction among diverse students, by sex and racial/ethnic representation

<table>
<thead>
<tr>
<th>Benefits of interaction among diverse students:</th>
<th>Discussions enriched often or all the time</th>
<th>Biases challenged often or all the time</th>
<th>Data differently interpreted often or all the time</th>
</tr>
</thead>
<tbody>
<tr>
<td>WR male med students</td>
<td>42%</td>
<td>30%</td>
<td>21%</td>
</tr>
<tr>
<td>WR female med students</td>
<td>58%</td>
<td>36%</td>
<td>28%</td>
</tr>
<tr>
<td>UR male med students</td>
<td>60%</td>
<td>44%</td>
<td>35%</td>
</tr>
<tr>
<td>UR female med students</td>
<td>78%</td>
<td>73%</td>
<td>51%</td>
</tr>
</tbody>
</table>

5.1.1b Survey Respondents on Professional Benefits of Interaction

With regard to potential professional benefits derived from interaction among diverse students, public health and medical responses were more similar. Proportions seeing diverse interactions as contributing “a lot” or “a great deal” to students’ “readiness to practice in diverse communities” (45% for public health & 41% for medicine) and “ability to communicate across racial/ethnic lines” (44% for both) did not differ significantly across professions. A somewhat larger proportion of public health respondents (55%) than medical respondents (45%) felt that interactions among diverse students contributed strongly to students’ “understanding of barriers and obstacles faced by certain populations” (chi2 p=.007).

Among medical respondents, female participants were significantly more likely to see diverse interactions as contributing “a lot” or “a great deal” to these professional skills than were their male counterparts (chi2 p<.004). UR respondents were significantly more likely to report a strong contribution to “understanding of obstacles” and “readiness to practice” than their WR counterparts (chi2 p<.004). In public health, such variations were more limited. UR respondents were somewhat more likely to see diverse interactions as contributing strongly to “ability to communicate across racial/ethnic lines” and “readiness to practice in diverse communities” than were their WR counterparts (chi2 p<.050). Variation by sex was not significant among public health respondents (chi2 p>.192) and faculty and student responses did not differ significantly in either profession (chi2 p>.173).

A more general triad of questions probed respondent views about how much interactions among diverse students help improve their academic, professional, and interpersonal skills. About half of respondents in each profession (from 51% to 56%) felt that diverse interactions help “a lot” or “a great deal” to improve students’ professional and interpersonal skills, while another 25% to 31% saw such interactions helping “a moderate amount”. By contrast, only 25% of medical respondents and 35% of public health respondents felt that diverse interactions help “a lot” or “a great deal” to improve academic skills, with a comparable 25% to 29% indicating that they help a “moderate amount”.

As with earlier findings, WR and male medical respondents were less likely to perceive a strong relationship between diverse interactions and improved skills than their UR and
female counterparts (chi2 p=.003 to .054). In public health, UR respondents were more likely than WR respondents to perceive a strong effect on academic and professional skills (chi2 p<.02), but not interpersonal skills. Male and female responses did not differ significantly.

A significantly larger proportion (68%) of public health faculty than of medical faculty (50%) or public health students (47%) felt that interactions among diverse students help “a lot” or “a great deal” to improve students’ professional skills (chi2 p<.011). About one in five (21%) medical faculty felt that interactions among diverse students help only “a little” or “not at all” to improve professional skills, compared to 6% among public health faculty [chi2 p=.008].

5.1.2 Benefits of Minority Participation in Professional Practice and Research

Interview respondents from both medicine and public health cited the reduction of racial/ethnic health disparities as a major benefit expected from the greater participation of African Americans, Latinos, Native Americans and other underrepresented groups in professional practice, research, and teaching. Diversity-engaged medical faculty often cited research showing that students from minority and low-income backgrounds are more likely to practice in underserved communities and indicated that minority patients and community members are more likely to trust, listen to, and maintain contact with health professionals from their own racial/ethnic backgrounds. Many public health respondents—faculty, students, and alumni expressed the strong conviction that public health efforts would be more effective if more public health professionals came from the communities most often targeted for interventions.

With regard to basic and applied research, faculty interviewees felt that greater diversity and multicultural awareness among researchers would broaden research agendas through the introduction of new questions and methods, as well as new interpretations of existing data. Medical faculty felt that greater diversity among researchers would aid in the recruitment of diverse participants for clinical trials and win wider patient and community acceptance of new and existing clinical protocols. Public health faculty mentioned an enhanced capacity for collaborative research, intervention, and program implementation in diverse communities. Overall, both faculty and student interviewees felt that greater inclusion of Latinos, African Americans, Native Americans and other underrepresented groups was also crucial to the educational efficacy and social relevance of their institutions.

Among survey respondents, 72% saw it as “very” or “extremely” important to increase the number of physicians or public health professionals from underrepresented groups. Men, WR respondents, faculty and alumni were less likely than women, UR respondents, and students to select these high-value responses (chi2 p ≤ .003). However, even among WR male faculty and alumni respondents, 60% indicated that increasing the number of UR professionals is “very” or “extremely” important.
5.2 Conditions for Diversity

5.2.1 Compositional Diversity

In the conceptual framework of this study, compositional diversity refers to the numerical and proportional representation of diverse population groups at all levels within an educational institution. Data from the Association of American Medical Colleges showed that African American, Latino, and Native American students made up from 16% to 28% of the 2004 entering class at the three medical schools studied. White students made up about half (46% to 50%) and Asian students represented from 20% to 45% of each entering class. At one site, a significant proportion of Asian students identified as Filipino or Vietnamese, groups that are generally underrepresented in medicine and public health relative to their presence in the California population [1].

Data from the Association of Schools of Public Health indicated that African American, Latino, and Native American students comprised from 13% to 28% of students enrolled at the three public health study sites. Asian students represented from 18% to 23%, while White students made up from 38% to 48%. This data did not provide a breakdown of ethnicities within the Asian category [2].

Student diversity as perceived by respondents to this study corresponded, in a very rough way, to the picture painted by the institutional reports cited above. Overall, respondents tended to perceive those sites reporting higher percentages of African American, Latino, and Native American students as more diverse (in both survey and interview findings) and those reporting lower percentages as less diverse. However, perceptions sometimes contradicted the numbers. For example, of two schools reporting identical proportions of non-Asian UR students, one was perceived as more diverse by its well-represented students and faculty than the other.

Disaggregating the survey data showed that respondents from underrepresented groups (UR) were more likely to perceive a lack of diversity in their student body than were respondents from well-represented groups (WR). While 41% of UR student respondents perceived their student body to be minimally or not diverse, only 16% of WR student respondents shared that perception [chi-square p=.000]. Similarly, 34% of UR faculty perceived the student body to be minimally or not diverse, while 9% of WR faculty shared that perception [chi-square p=.000]. UR faculty and students did not differ significantly in their assessment of student diversity, but WR students were more likely than WR faculty to perceive a lack of diversity [chi-square p=.012].

5.2.1a Critical Mass

While it may not be surprising that UR and WR respondents perceive compositional diversity differently, it is still instructive to explore the specifics of why that might be.

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8 In the AAMC data, racial/ethnic percentages did not total to 100% because students were allowed to select more than one racial/ethnic category. Totals for the study sites ranged from 105% to 110%. Foreign students represented a separate category.
Interview discussions around the idea of “critical mass” were very helpful in elucidating this issue as well as other aspects of compositional diversity as lived experience.

Faculty and student interviewees were asked to consider the notion that the benefits of diversity increase dramatically when there is a “critical mass” of students from underrepresented groups. In response, interviewees consistently mentioned three kinds of benefits—the psychosocial benefits to UR students, the greater likelihood of institutional progress on diversity-related issues, and the educational and professional benefits to students and faculty from well-represented groups.

Many respondents—faculty and students, from medicine and public health—used the term “isolated” to describe situations in which UR students have too few socioculturally concordant peers. I say “socioculturally” concordant because respondents made it clear that compatibility was not always or only about race/ethnicity, but about the complex interaction of race, class, gender, sexual orientation, geographic origin, personal interests, and goals:

“There’s aspects of yourself that you don’t bring forth unless you’re around people you trust and I think that myself as a Black person, I am more comfortable when I’m around people who come from my background and that’s not actually racial. Like the Latino students, I feel at home with them because we understand where we’re coming from. It’s more an issue of class, social class.”

“The interesting thing about critical mass is that there are a lot of different communities all over the U.S. Latins from California are very different from the Latins in New Mexico. They’re different from Latins in New York … and then those that come in from other countries. So I think that a critical mass also has to be for the different kind of sections of the country, the different parts of the world”

“I was the only Black female in my class … there were three black males and then me. So I kind of felt like I’m their only reference point … and that’s not good. Because what if I do something stupid, right, [chuckle] and then everybody’s going to think, “Oh, Black women are stupid.”

The implication of these statements is not that schools should try to admit a “critical mass” of every possible identity configuration—a clear impossibility. Rather, it implies that one indicator of “critical mass” is that there are enough students from underrepresented groups such that any particular student has a hope of finding one or two highly compatible peers. As one student explained, the same percentage of African Americans felt much less like a critical mass in graduate school than it did in her undergraduate institution: “In just sheer numbers, if I have forty-nine people to draw from, that’s a lot more than four.”
For some UR students, close camaraderie with classmates is particularly crucial because higher education creates sociocultural distance within their existing networks of support. As one student recounted:

“I know I can do the work but I kind of don’t know why I’m here … a lot of times I think maybe I should have just got a job at Blockbuster, you know what I mean? [chuckle] I can’t even relate to my family, they don’t understand what I’m doing … my husband … I met him in church … his growing up was a lot similar to mine … But it was so hard for him to blend in to this academic side of me, and every day I wished I hadn’t done this, that I had just been like a normal person … I mean from where I come from this is not normal so why would I ruin my life like this?”

Emblematic of the isolation felt by UR students was the all too common experience of being “the only one in class”. This experience was strongly associated with problems of voice and authenticity. When the tacit understandings and assumptions of the majority shape the conversation, UR students can feel both inhibited from raising racial/ethnic issues when they do want to and obliged to speak on such issues when they don’t want to. One UR faculty member explained that sociocultural isolation creates a dilemma for UR students, who have to choose between downplaying their difference or being “the cultural guy” constantly expected to represent an entire category of people.

In contrast to the isolation and lack of support associated with having too few socioculturally concordant peers, UR respondents associated the idea of “critical mass” with feeling “comfortable” and “supported” and being able to “have a voice”, and “bring all aspects of themselves to the table”. Both UR and WR respondents noted that greater numbers and a stronger voice would allow UR students to have greater positive impact on their WR peers, on the institution, and on the efficacy of their chosen profession. These effects are explored in greater detail below under the topics of interactional, institutional, and professional diversity.

When asked what might constitute a critical mass many respondents hesitated to assign a precise number or percentage, saying “it’s more of a palpable presence and feeling” or “you know when you have it”. Others felt that it depends not only on the numbers but on the commitment and activism of those involved and on the context in which they are operating. Those who did venture to define a “critical mass” quantitatively fell into two groups—those who offered a simple percentage and those who felt that the proportions should reflect those of either the local, state, or national population (with state being the most common). Among those who offered a percentage, the most common (but also very tentative) estimate was that 20-25% of the student body should be students from underrepresented groups.

When asked if their institutions had achieved a critical mass of students from underrepresented groups, respondents from three of the six institutions responded in the affirmative. Two of these institutions reported that 28% of their 2004/05 students or enrollees were from non-Asian underrepresented groups, but one had reported only 13%.
5.2.1b Admissions

Admissions committees at schools of public health and medicine are clearly engaged in discussion and debate over how best to evaluate and select among applicants. This debate is partly about fairness, partly about diversity, and partly about the goals of the training process. With regard to fairness, respondents reported that some faculty and students see test scores and GPAs as fairly good indicators of academic ability, and as the fairest, most objective means for distinguishing among applicants. Others argue that these indicators are not objective or fair because 1) they fail to assess non-academic qualities crucial to both academic and professional settings—such as interpersonal skills, multicultural awareness, workplace experience, or professional goals—and 2) they tend to underestimate the academic potential of certain groups, such as older applicants, those who attended poor-performing high schools or second tier colleges, those from underrepresented racial/ethnic groups, those whose first language is not English, and those who are first-generation college students.

Of course, no study site relied entirely on test scores and GPAs to select its incoming students. Application processes involve personal statements, letters of recommendation, and, in the case of medical schools, personal interviews. Respondents from most sites noted broadening support for a “holistic” approach that allows a low test score to be counterbalanced by a well-written statement of purpose or a strong interview; or understands a lower GPA in the light of the student’s demanding work schedule or family obligations. One faculty member mentioned a shift, at his institution, from overall GPA to junior and senior year GPA, in order to deemphasize grades earned many years earlier or poor marks due to the initial adjustment to college.

At one study site, several respondents said that a more holistic approach had given way to increasing emphasis on test scores and GPA. It was suggested that this change was driven, in part, by the need to make a first cut among many applications received for few available slots. At sites where minimum test scores and/or GPAs were used as a first cut, faculty reported that there was also a committee to take a “second look” at applications that did not meet these minimums and to recommend “exceptions” when needed. The approval of such exceptions often depended on the inclinations of a single chair or administrator. Respondents at several sites noted that efforts to track the performance of those admitted with sub par test scores or GPAs had shown that these students graduated on time and at the same rate as students who did meet the usual requirements.

Beyond issues of fairness and diversity in the educational setting is the question of professional practice. The qualities that make someone a top student while in school may not be the same qualities that make them a top quality practitioner after graduation. Many public health respondents were concerned that a heavy reliance on test scores and GPAs favored the younger, less experienced applicant, while tending to exclude older applicants whose workplace and community experience better positions them to learn from and contribute to the graduate school experience, and to become leaders and innovators in public health. The following statements—from an alumna and an adjunct faculty member—were typical:
“When I was on the Admission Committee … we would look at professional experience, life experience, grades, … GRE scores, and … how they would do well as part of this cohort … And then it moved to GRE scores and grades … So they got a bunch of very, very young, inexperienced people …”

“In terms of selecting people … they need to dig a little deeper into some people who have actually done something before they get there … the year before [last] they were so young that … they had no practice to bring to the conversation … that for me is not what a graduate education is supposed to be about.”

Medical respondents were also concerned about qualities not captured, or even selected against, by a focus on high MCAT scores and GPAs. In general, student respondents felt that, given the rigors of medical school, some evidence of test-taking and academic skills was needed. However, top scores in these areas should not outweigh evidence of other qualities, such as communication skills, “emotional intelligence”, open-mindedness, and a passion for medicine and service.

Medical faculty members focused on their institutional responsibility to produce a cohort of physicians who would pursue a range of career paths, particularly those who would fill roles that are currently underserved:

“We have the responsibility to train a workforce that’s going to work in all segments of the community, … just as we look for the person who’s going to be a great academician, research scientist … we’re looking for that person who’s going to go start a community health center and we built the criteria that would help raise those. And those are not academic criteria, necessarily. That doesn't mean we discount the academic piece of it”

“We know right now what kind of students will go into underserved areas, will go into the inner city or go into the rural areas … I mean older students, students who’ve done a certain amount of volunteerism … part of it is race concordance but not all of it. Rural people tend to go back to rural places, that sort of thing. So we're not letting the right people into medical school.”

Diversity-engaged medical faculty seemed fairly optimistic about building consensus around a holistic, multifaceted approach to medical school admissions that would provide the needed diversity of talents, experiences, and professional goals among medical students. They were less sanguine about their ability to make progress at the levels beyond medical school—in residency programs and faculty hiring. While medical school admissions are fairly centralized, residents and faculty members are chosen by a multiplicity of departments with differing institutional and professional cultures. This was also true at schools of public health, where, for example, some departments made work experience a requirement of admission and others did not.
5.2.1c Faculty Diversity

A diverse faculty was seen as essential for attracting and supporting a diverse student body, and also valued for the broader range of experiences, concerns, interests, and activities that it can bring to an institution’s research and teaching portfolios. Among the study’s 1,124 survey respondents, 57% saw faculty diversity as “very” or “extremely” important and another 26% saw it as “moderately” important.

Several respondents mentioned that achieving the sense of a “critical mass” among students was linked to achieving a critical mass of UR faculty. For one thing, they noted, it is easier to recruit UR students when they see socioculturally concordant mentors, role models, advocates, and protectors among the faculty. In addition, UR faculty are often—though not exclusively—the ones to provide courses, conduct research, and nurture community ties that help students explore health disparities, multicultural issues, and other issues of concern to UR students (and to diversity-engaged WR students).

Survey questions about faculty diversity produced two different pictures for schools of medicine and public health. Nearly one in four (23%) public health students surveyed reported that they had encountered no instructors from underrepresented groups in their public health courses, while another 62% reported having encountered from one to three. By contrast, only 1% of medical students had encountered no UR instructors in their preclinical courses, and nearly three-quarters reported having had more than three.

In interviews and focus groups, both medical and public health respondents acknowledged the need for greater racial/ethnic diversity among faculty members. However, medical respondents seemed more assured that their institutions were making good faith efforts in this area, while public health respondents communicated stronger doubts about institutional and faculty commitment to increasing faculty diversity.

At public health sites where the faculty lacked compositional diversity but was perceived to have multicultural expertise, WR respondents seemed to feel that students’ need for basic multicultural skills were being met. These respondents still supported goals to increase faculty diversity, but primarily for the purposes of attracting and mentoring UR students. By contrast, UR respondents—although appreciative of diversity-engaged WR faculty members—felt that UR faculty contribute insider understandings of the concerns of people of color that WR faculty can only rarely provide.

In addition to voicing more urgent concerns over faculty racial/ethnic diversity, public health students were also more likely to mention that their faculty lacked diversity in terms of gender, age, and professional experience. At public health sites where the faculty lacked compositional diversity but was perceived to have multicultural expertise, WR respondents were more satisfied that students were getting the multicultural skills and awareness they needed. These respondents still supported goals to increase faculty diversity, but primarily for purposes of attracting and mentoring UR students. UR respondents appreciated WR faculty members with multicultural expertise, but felt that UR faculty often contribute insider perspectives on certain public health issues that even the most culturally aware WR faculty may not provide.
At sites where the faculty was viewed as lacking both racial/ethnic diversity and multicultural expertise, UR and WR students complained that the diversity-related curriculum was too thin. They felt that most faculty members failed to address the historical and institutional causes of health disparities and tended to discuss minority communities through an outsider’s “how-can-we-help-them” framework. UR students evinced frustration at being taught primarily by professors with less multicultural sensitivity and expertise than themselves. They also expressed concern that many WR students were graduating without the level of multicultural expertise necessary to operate effectively in community settings.

Just as low GRE scores can hinder the admission of promising UR students, the lack of peer-reviewed publications clearly hinders the hiring of UR faculty candidates. Some public health faculty respondents seemed more accepting of this situation, while others felt that the need for UR faculty was urgent enough to justify changes in, or at least exceptions to, conventional hiring criteria. However, such exceptions raised objections concerning the ultimate “tenurability” of people hired as “exceptions.”

One WR faculty member felt that the conventional “publish or perish” criteria are biased against people of color trying to do community-based, participatory research in their own communities:

“When you do community-based research it can take a lot of time for a new young faculty member because there’s a lot of community contact time and participation and often that’s tough for someone going through the tenure process. A lot of the research ends up with smaller numbers of subjects and it can be tough to get some of that published. So it’s sort of a bad spiral … and so then you're going to have faculty saying diversity impedes scholarship when I think the mechanisms of scholarship in this country impede diversity.”

Another faculty member suggested that schools of public health might adopt the medical school practice of hiring research-focused and practice-focused (clinical) faculty on separate tracks, so as to better meet all research, teaching, and service goals.

5.2.1d Lack of Faculty Diversity Impoverishes Pedagogy and Mentoring

Much of the discussion on faculty diversity overlapped with respondent comments about pedagogy and mentoring. On the issue of pedagogy, public health students were the most vocal. Both UR and WR students mentioned feeling uncomfortable with the way communities of color and poor communities were discussed or represented by predominantly older, white, male professors. While respecting these professors’ expertise in other areas, students felt a generation gap in the area of cross-cultural awareness and sensitivity. They were also concerned that learning about public health problems through a predominantly white, middle-class lens would not adequately prepare them for today’s workplace and community environments.
Noting that increased faculty diversity was not likely to happen soon, public health students felt strongly that existing faculty should incorporate a wider range of voices and perspectives by drawing on a broader repertoire of course readings and guest lectures. Many felt that existing faculty might also require support and resources to better integrate diversity-related topics into core courses in all program areas.

Students also suggested that, with training in more interactive and inclusive pedagogical approaches, faculty could make better use of the experiences and expertise existing among the students themselves. At both sites where faculty were viewed as lacking in multicultural expertise, they were also seen to hurry past or fail to acknowledge student contributions when they did not fit squarely within the existing course framework and agenda. Both UR and WR students experienced this reluctance to engage as personally disappointing and educationally limiting.

For their part, diversity-engaged public health faculty acknowledged that many of their colleagues were probably not particularly comfortable leading or facilitating discussions of racial privilege and disadvantage. However, they noted, efforts to educate faculty in this area could only be done on a voluntary basis, through collegial suggestion, or through strong leadership from deans.

Both public health and medical students expressed strong appreciation for professors who went beyond acknowledging health disparities to explore the historical, social, and institutional factors that produce them. Public health students valued faculty with strong community involvement and experience, as well as those who could create “safe spaces” for discussing, debating, and problem-solving about, as one student put it, “privilege, disadvantage, and the relationship between the two.” An important element in creating such a “safe place” seemed to be the professor’s willingness to share aspects of his or her own experiences with privilege and/or disadvantage.

Medical students valued faculty who modeled good clinical skills, but noted that the most experienced clinicians were not always the most culturally sensitive. Many white students tended to take this in stride, simply looking to different role models for different skills. Students of color found cultural insensitivity harder to overlook, but also felt that it was very risky to question or criticize such failings in the residents and attendings who would eventually evaluate their work.

Recognizing the stereotyping and poor doctor-patient interactions that medical students witness on the wards, diversity-engaged medical faculty sought to provide students with more time to talk through patient interactions and clinic experiences with peers and with culturally competent instructors. At one site, this was accomplished through the use of “standardized” patient scenarios in which actors play the role of patient in a script designed to teach the relationship between culturally and linguistically appropriate care and improved medical outcomes.

On the topic of mentoring, both medical and public health respondents, UR and WR, emphasized the crucial importance of student access to socioculturally concordant
mentors. One white female medical student noted that, just as she wanted female role models to talk to about gendered issues of trying to pursue both career and family, she could understand how students of color would want ethnically concordant mentors to talk about life choices as they play out for a person of color. A Latino medical student echoed this view, saying, “I don’t need ethnic concordance to choose classes or residency, but I do need ethnic concordance to make life choices.”

5.2.2 Diversity in the Curriculum

For the schools of medicine and public health in this study, diversity-focused courses and components seemed to have two main goals: (1) to increase the cultural awareness, cultural sensitivity, and cross-cultural skills of future practitioners; and (2) to educate students about the existence and causes of population-specific health disparities. Medical faculty tended to emphasize the first of these goals, while public health faculty tended to emphasize the second.

Medical faculty and students valued these curricula, in part, because they were among the few opportunities to discuss social and cultural issues within a curriculum dominated by bioscience. In public health, where the standard curriculum does embrace certain social scientific approaches (such as behavioral and social psychology), diversity-related courses provide an opportunity to assess the cross-cultural applicability of findings from such disciplines. They also introduce historical, sociological, political economic and anthropological perspectives on health and health disparities. As one public health faculty member put it, her course caused students to “start thinking about the impact of social structural factors like racism and poverty in ways that they hadn’t thought about it before.”

Students and faculty noted that, if well-facilitated by “the right instructor”, diversity-related curricula can offer psychosocial, as well as educational benefits. While enhancing cultural sensitivity, the sharing of personal experiences across racial, ethnic, and cultural lines can also foster peer support, understanding, and respect throughout a student cohort. The “right instructor” in this case seemed to mean someone familiar and comfortable with the emotions associated with experiences of both privilege and disadvantage.

Respondents from both schools of medicine and schools of public health recognized that cultural sensitivity is best learned through real-world interactions. Small group learning was viewed as an effective pedagogical approach that encouraged the “sharing of multiple perspectives” among culturally different but educationally “equal” peers. Some viewed these interactions among “equals” as good preparation for later interactions with patients or community members, in which cross-cultural communication is further complicated by differentials of power and status.

5.2.2a Diversity-related Learning in Medical Schools

The six medical school alumni interviewed had graduation dates ranging from 1992 to 2006. The earliest graduates reported little or no attention to issues of race, ethnicity, and culture in the formal curriculum. Medical alumni of the period 1997 to 2001 encountered
a nascent diversity-related curriculum, but said that it was unsophisticated and poorly integrated into their overall curriculum. Graduates of the medical school classes of 2004 and 2006 encountered more developed diversity-related curricula, but still reported the need for greater cultural and sociological depth and greater integration with scientific and clinical concerns. Three alumni independently mentioned the well-known book, *The Spirit Catches You and You Fall Down*, by Ann Fadiman, as an example of an effective and memorable approach to the importance of cultural understanding in medical practice.

From current medical students, the strongest messages were that: (1) curricula addressing issues of race, ethnicity, and culture lack sophistication, depth, and follow up, and (2) were not well-integrated across all four years of medical school training. It was, they said, often not taken seriously by the students who needed it most—i.e. those least aware of their effects on culturally different peers or patients. When diversity-related topics are addressed in superficial or unsophisticated ways, students from underrepresented groups find themselves forced to defend, in principle, something that they too find inadequate in actuality.

While some medical students need to be convinced that cultural sensitivity requires skills beyond common sense and civility, others—more aware of the complexities of cross-cultural interaction—are impatient to explore cutting-edge approaches to providing culturally sensitive care and reducing health disparities. Students in the latter group (often but not always those from underrepresented groups) described seeking out and even creating learning opportunities for themselves. While such elective and extracurricular opportunities are generally open to all, underrepresented students worry that they primarily “preach to the choir”, while a large swath of students goes on to clinical rotations in medicine or field practica in public health without having considered how their cultural background and biases may compromise the work they do.

Medical student respondents from well-represented groups noted some types of educational experiences that were more likely to be valued even by their less diversity-sensitive peers. These included training on how to work with linguistic interpreters, occasional lectures by community practitioners, exposure to diverse patients in community clinics, and carefully crafted videos or simulations of clinical encounters with patients from various social and cultural backgrounds. Not surprisingly, the more clearly tied to actual clinical situations, the more likely diversity-related material is to capture the serious attention of the skeptical student. Alumni and faculty from well-represented groups noted that cultural sensitivity is best taught by faculty from underrepresented groups or those with extensive clinical experience with diverse patients.

In medical schools, diversity-engaged faculty were aware of many of the curricular shortcomings noted by students, and were working on substantially more integrated and sophisticated approaches. These included more clinically based approaches to teaching cultural competency. Along with alumni, some faculty advocated more sociological, historical, and literary content to counter the objectifying effects of statistical and clinical approaches. One faculty member noted that cultural sensitivity must, itself, be taught in a
way that is sensitive to the developmental stages of medical students and the professional culture into which they are being socialized.

Most faculty members agreed that diversity-related learning needed to be better integrated throughout the four-year curriculum, particularly in the clinical years. For most students, clinical rotations provided the most vivid, challenging, and memorable exposure to racial, ethnic, and cultural issues in medicine. Consequently, many faculty, student and alumni respondents felt it important that all students be exposed to ethnically, linguistically, and socio-economically diverse patient populations during their clinical rotations.

At the same time, most interviewees warned that many of the principles of cultural sensitivity were often violated on the ward floor. Because most medical students hesitate to challenge residents and attendings, racial stereotyping and cultural insensitivity on the part of such authority figures poses a moral dilemma for diversity-aware students, many of whom are students from underrepresented groups. Student, faculty, and alumni respondents all suggested that residents and attendings receive diversity training to limit their tendency to contradict in practice the culturally aware principles medical students were learning in theory.

While respondents of all types agreed that more and better diversity-related curriculum is needed, many also feared that the medical school curriculum is already filled to capacity. Some faculty and alumni recommended, therefore, that diversity-related teaching be integrated into the existing required curriculum. One alum suggested that basic science courses could devote some time to examining the history and validity of race as a biological construct. Several others suggested that racial, ethnic, and cultural topics would fit well into existing ‘clinical’ or ‘doctoring’ courses in which students learn about taking patient histories, doing physical exams, communicating difficult prognoses, and other aspects of interacting with patients.

5.2.2b Diversity-related Learning in Schools of Public Health

The five public health alumni we interviewed graduated between 1991 and 2006. The earliest graduate, who was a mid-career professional, reported that courses taught by faculty from underrepresented groups had profound effects on her understanding and career path. However, she noted that younger, less experienced students might have had more difficulty engaging with such advanced courses. A 1998 alum felt that while the effects of socioeconomic difference on health status were addressed, core courses offered little discussion of the role of culture in health behavior, health planning, and health interventions.

In the experience of more recent public health graduates, racial, ethnic, and cultural issues were more evident in the broader curriculum, although the presentation differed by study site. At one institution, special courses offered in-depth socio-historical examination of racial, ethnic, cultural, and class dynamics in health care, appealing primarily to those students already interested in such topics. At two other institutions, most students encountered some discussion of racial, ethnic, and cultural issues, primarily
when faculty from well-represented groups drew on their own community-based research experiences to describe the challenges and strategies of cross-cultural public health work. However, a deeper socio-historical framework and more challenging curricula for more advanced students were less evident.

Although current public health students made fewer comments about diversity-related curriculum, they touched on many of the same issues as medical respondents. Along with faculty and alumni, public health student respondents felt that there was no cohesive cultural competency or health disparities curriculum. At some sites, students felt that they had to piece together such a curriculum for themselves. The diversity-related courses that did exist were too few, offered too intermittently, and overenrolled. Faculty respondents recognized this “thinness” in the curriculum, and both students and faculty recommended increasing the number of diversity-engaged faculty—especially those from underrepresented groups—to support a more substantial, consistent diversity-related curriculum.

Student respondents from underrepresented groups noted that faculty members were sometimes dismissive of diversity-related questions or clarifications, especially when trying to work through an already thick syllabus. Several students from well-represented groups commented that community practitioners (acting as lecturers or guest speakers) were more effective at conveying the importance of racial, ethnic, and cultural issues than many (predominantly White, often male) academic faculty members. As one White public health student said, “I want to hear other perspectives … I get tired of listening to White people talk all the time.”

With regard to the integration of racial, ethnic, and cultural issues into the broader public health curriculum, the picture was very unclear. Even more than medical faculty, public health faculty members were often not sure whether or how fellow faculty might be addressing such issues. Nevertheless, diversity-engaged faculty felt that they were in a positive period. The debate is no longer about whether such concerns should be part of the curriculum, but how they should be incorporated and who is responsible. For example, should diversity-related curricula be carried by a few diversity-engaged faculty members, or do all faculty members have a responsibility to learn how racial, ethnic, and cultural issues impinge on their work? Are cultural sensitivity and an understanding of the social determinants of health relevant to all or only to some medical and public health specialties?

Respondents from both medicine and public health agreed that, in the absence of a well-conceived and required diversity curriculum, the benefits of student diversity are much less likely to be realized on a large scale. Those students already sensitive to the topic will seek out or create diversity-related learning opportunities for themselves, but the majority (including primarily students from well-represented groups) will not. Upon graduation, their opportunities to reflect upon and learn more about cross-cultural interactions and the dynamics of racial privilege and disadvantage will have been limited, and they will carry these limitations into their future work.
6.0 Conclusions and Recommendations

A significant proportion of faculty, teaching staff, and students at California schools of medicine and public health value, experience, and promote the benefits of diversity in their field. However, a lack of institutionalization means that the realization of these benefits is uneven and dependent on the constant efforts of a small minority. As cultural and linguistic diversity become more prevalent in the population, and as racial/ethnic health disparities increase, the need to train an ethnically diverse and culturally competent public health and physician workforce only becomes more urgent.

Greater efforts must be made to maximize the educational, scientific, and professional benefits of diversity in health professions education so that these benefits can be more fully realized in health services and health outcomes for all Californians. True institutionalization of diversity in health professions education will involve attention and resources devoted to each factor in the diversity web. The following are our recommendations based on the findings of this inquiry.

6.1 Key Recommendations from this Study

Recommendation 1: Site Assessment
In order to increase the educational, professional, and institutional benefits of diversity, institutional leadership should assess the interacting factors and conditions at their site, and identify nodal points where development is lagging, or where an investment of time, personnel and resources will most enhance the benefits of diversity-related efforts already in place. The conceptual framework, findings, and recommendations of this study can serve as a basis for institutional assessment.

Recommendation 2: Strategic Plan
Based on a site specific assessment of factors and conditions, all institutions should have an adequately funded strategic plan for increasing the benefits of diversity, and a high-ranking official designated to insure the implementation of this plan through its integration into the job requirements, performance evaluations, and incentives provided to faculty and staff. The conceptual framework, findings, and recommendations of this study can serve as a basis for strategic planning.

Recommendation 3: Sustainable Community Partnerships
Institutions seeking to increase the benefits of diversity should insure that faculty and students have the skills and resources to form mutually beneficial partnerships with diverse communities and community practitioners in the surrounding region. Caveat: The tendency of some institutions to value and privilege research over practice can work against the formation of sustainable community partnerships.
Recommendation 4: Evidence-based Admissions
Admissions committee members should be made aware of existing evidence concerning the predictive value and compositional effects of both traditional and non-traditional admissions criteria (see Annotated Bibliography for references). Institutions should consider implementation of some form of “whole file review” that takes both traditional and non-traditional factors into consideration. (See accompanying report on Exemplary Practices for successful examples of this approach).

Recommendation 5: Minority Representation on Admissions Committees
Admissions committees, like all decision making bodies in a diverse institution, should include members from underrepresented groups. Institutional leadership should periodically review admissions policy and practices to ensure that they support all aspects of the institution’s educational and public missions.

Recommendation 6: Culturally Aware and Sensitive Teaching Staff
Faculty members and teaching staff should be trained in classroom strategies that minimize the negative effects of isolation and difference on students from underrepresented groups. They should also be trained in pedagogical approaches that create safe spaces for interaction and learning across racial, ethnic, cultural and class lines.

Recommendation 7: Consultation with Minority Students
Students from underrepresented and minority groups should be periodically consulted as to their experiences of institutional culture, particularly as manifested in traditional rites of professional initiation and enculturation. Traditional practices should be altered, adapted, or abolished as appropriate to the changing makeup and sensibilities of the student body.

Recommendation 8: Diversity-Related Student Organizations and Events
Schools should provide financial and organizational support for a variety of ethnic and multiethnic student organizations and events that help underrepresented and diversity-concerned students create informal networks of solidarity and support. In addition, schools and departments should host regular events that promote exchange and understanding across racial, ethnic, cultural and class lines.

Recommendation 9: Integrated and Effective Diversity Curricula.
Institutional leaders should commit the resources and personnel necessary to develop and implement a coherent approach to diversity curriculum integrated across each year of training and across classroom and clinical/practical learning. Diversity-related curriculum should mesh with the broader educational goals and focus for each year of training. Students and faculty working to develop such curricula should be formally supported (through stipends, academic credits, time out from other duties, etc.) in their efforts.
Recommendation 10: Collaboration on Model Curricula and Pedagogies. 
Innovative approaches to teaching cultural awareness and sensitivity should be shared across institutions. Each site in our study demonstrated different strengths in this area. Faculty and students spearheading these efforts were interested in the experiences of others, but limited time and resources often meant that they worked in relative isolation.

Recommendation 11: Modeling Culturally Competent Professional Practices 
An excellent diversity curriculum can be undermined if faculty and staff do not model cultural awareness and sensitivity in their own professional practice. Training should be required for those who teach or supervise students in clinical care, community intervention, and research. Such training should, itself, be culturally sensitive to the institutional context and status of trainees—be they residents, faculty, or staff.

Recommendation 12: Faculty-wide Commitment to Diversity 
All faculty members should be responsible for considering how racial, ethnic, and cultural issues are relevant to their teaching and research. Institutions and accrediting organizations should provide training and resources to support faculty efforts in this area. Faculty members’ diversity-related contributions should be fully and fairly recognized in appointment, workload, and promotion procedures of the institution.

Recommendation 13: Reassess Criteria for Faculty Hiring and Promotion 
Traditional criteria undervalue teaching and service relative to research. At the same time, institutions rely disproportionately on their few minority faculty members to sustain diversity-related courses, advise minority students, and represent the university to minority communities. Traditional criteria also tend to discriminate against those doing research on underrepresented groups because such research takes longer, has lower response rates, and is published in less prestigious journals.

Recommendation 14: Areas for Further Investigation 
Further research is required to understand how specific elements of the diversity web contribute to maximizing or limiting the benefits of diversity for all students, for institutions, and for society. For example, research into the academic and workforce consequences of various approaches to student admissions and faculty hiring would support evidence-based policies in those areas. Evaluation of innovative diversity curricula would guide the spread of best practices. Further analysis of the data from this study would provide more specific information on the relationship between the conditions for and benefits of diversity at particular sites.
References


