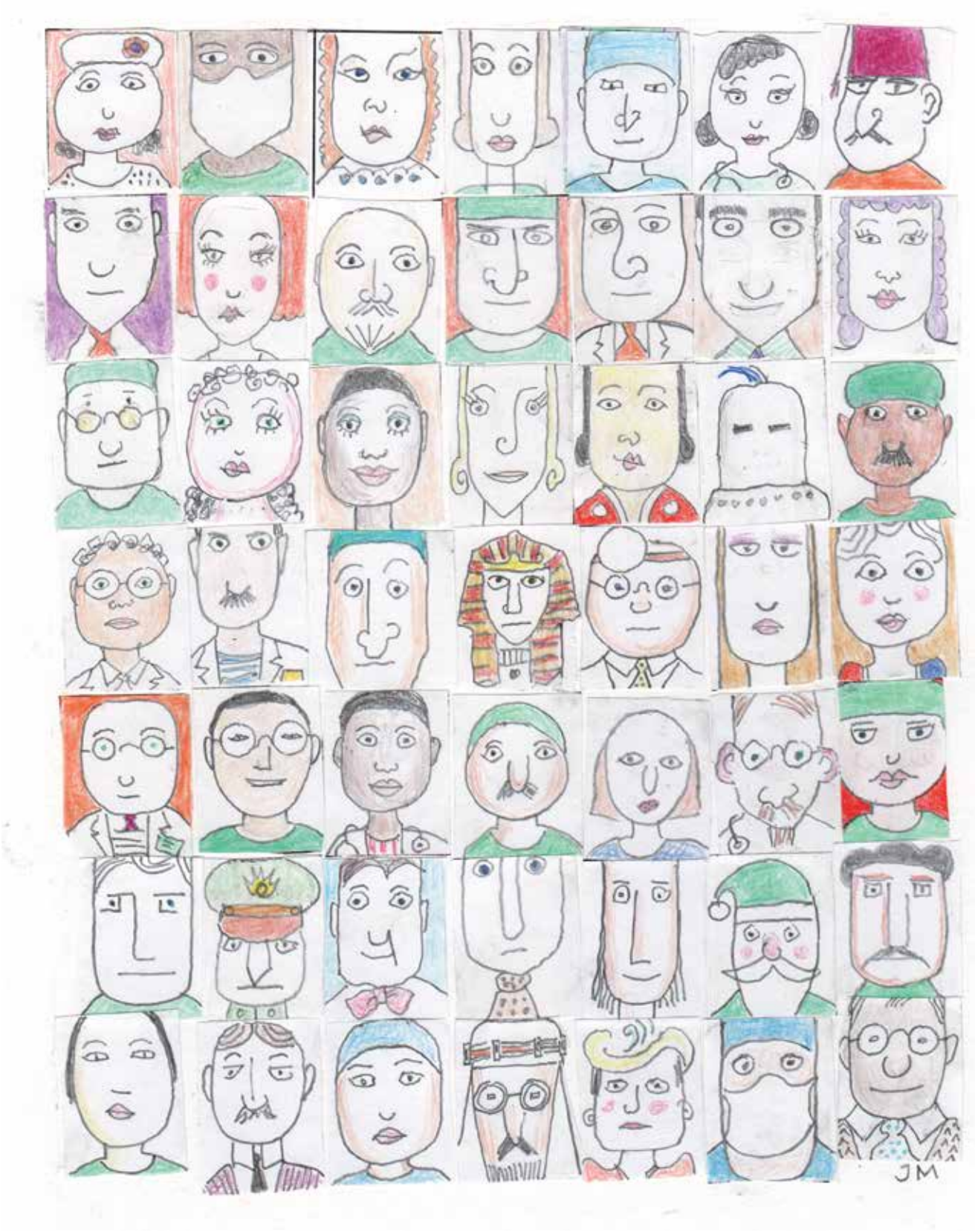

Illustration by Jim M'Guinness

Inclusion as a core competence of professionalism in the twenty-first century

Eve J. Higginbotham, SM, MD

The author (ΑΩΑ, Morehouse School of Medicine, 2008, Faculty) is the inaugural Vice Dean of Inclusion and Diversity at the Perelman School of Medicine of the University of Pennsylvania and a member of the Alpha Omega Alpha Board of Directors.

On July 6, 2005, the United Kingdom figuratively held its breath as it waited to hear whether London had won the bid for the 2012 Olympics. The country had lost three times before, and it was universally expected that its traditional rival France would be the victor. Crowds had already assembled at the Champs-Élysées in Paris, awaiting the announcement from distant Singapore. But the citizens of the world, in disbelief, instead heard celebratory voices from the streets of London. Not only had London edged out its traditional rival, but it had also squarely placed an innovative concept at the core of its bid: diversity and inclusion. The bid's tag line, "Everyone's London 2012," and the inclusion of thirty East End young people in the country's delegation to Singapore, strategically positioned London ahead of the traditional, homogenous delegation from France.

Tragically, the next day the focus on inclusion and diversity was in jeopardy, when an explosion on the London transportation system fatally wounded fifty-two people. The very initiative that had gven London its competitive edge demonstrated its flip side within twenty-four hours.[1]

The United Kingdom's London Olympics staff and volunteers created the most inclusive Olympic event in history. Their goal of positioning inclusion and diversity central to the games at a time when competing priorities were making it difficult to accomplish was viewed at times as unreachable. In his book, *The Inclusion Imperative: How Real Inclusion Creates Better Business and Builds Better Societies*,[1] Stephen Frost, the designated lead for inclusion and diversity efforts at the 2012 Olympics, details how this was accomplished. Further, he provides a solid rationale for why these concepts should be at the core of every organization. The 2012 Olympics inspired a new generation of Olympic enthusiasts, while at the same time reducing legal risks associated with the games and contributing to a more cost-effective delivery of services. The value proposition for this model created benefits for the entire Olympics organization and community. These goals correspond to the interests of health care, given the complexities of the industry and the increasingly diverse communities that as providers we aim to serve.

In his recent editorial in *The Pharos*, Dr. Steve Wartman[2] enumerates the significant trends affecting academic health centers that are creating a transformative tsunami of uncertainty and extraordinary changes in the health care landscape. This new era of leadership must embrace inclusion as a core competence in its effort to deliver high quality patient care, to remain competitive in research, and to optimize the education of the next generation of health care professionals.

Tomorrow's demographics and today's disparities

Significant changes in the demographics of the United States will continue to drive the transformation of medicine. By 2060, it is predicted that Hispanics and African Americans will make up forty-five percent of the population. Much of this change is driven by an increase in the number of immigrants to the United States, as many as 40 million since 1965, with more than fifty percent from Latin America.[3] Not only will diversity increase, but the population will rise by as many as 100 million by 2050. Moreover, the proportion of those over the age

of sixty-five will increase from our current thirteen percent to twenty percent by mid century.[4] Thus, the communities in which our current graduates will be ultimately serving as physicians will be markedly different from those of the early twenty-first century.

This year marks the thirtieth anniversary of the Margaret Heckler Report on Black and Minority Health, which documented disparities in health among minority populations in the United States.[5] Despite the prominence of this report and its highlighting of the national economic impact of health disparities, significant progress is still lacking. It has been estimated that the cost of health inequalities to the U.S. economy between 2003 and 2006 was 1.24 trillion dollars; had health equity among African Americans, Hispanics, and Asians been achieved during the same period, 229.4 billion dollars would have been saved.[6]

Diversity and inclusion

While there has been focus on diversity—the differences among people in a group or community—for decades, there has not been as much attention paid to inclusion, which is the process of respectfully engaging all members of a community, organization, or nation. In *The Inclusion Imperative*, Frost notes three levels of diversity awareness:

- Diversity 1.0, programs that increase awareness about diversity.
- Diversity 2.0, efforts to highlight the benefits of diversity.
- Inclusion 3.0, when diversity is fully embedded in the organization's fabric.

Diversity 1.0 and 2.0 are usually top-down approaches, but Inclusion 3.0 capitalizes on empowered individuals and is a bottom-up engagement with leadership support. In this phase of diversity/inclusion, more complex problems can be solved, employees are more productive, and the organization may as a result witness a more positive bottom line. Inclusive leadership fosters the ideals of authenticity, transparency, and respect. Rather than framing efforts to diversify as a zero-sum game in which one group loses based on the gains of another, the enterprise itself grows by "enlarging the pie."[1]

How does inclusion relate to the house of medicine?

In his preface to AΩA's 2015 monograph, *Medical Professionalism: Best Practices*, Dr. Richard Byyny noted the intentions of the founders of AΩA in 1902, specifically the stated mission of the society: "The mission of AΩA is to encourage high ideals of thought and action in schools of medicine and to promote that which is the highest in professional practice."[7] What better way to achieve the highest standards in professional practice than by including the perspectives of all who are able to contribute to the needs of society? Such a course is a natural extension of those principles, particularly given the complexity of addressing health disparities and the dimensions of human suffering that go far beyond the capacity of any one group of individuals to address. Weaving inclusive leadership into the core mission of modern health care organizations is an imperative that cannot be ignored.

Inclusive leadership in patient care

Today's focus on value-based purchasing of health care and the shift towards accountability for the health of populations are compelling arguments for considering the centrality of inclusion. Given the ebb and flow of global immigration and the persistent disparities in health care, leadership must remain mindful of the important intersection of culture and health. A true patient-centered approach to care must incorporate engagement of the patient. Barondess notes engagement as one of the seven components of a patient-centered approach to care, the others being competence, reliability, dignity, agency, a dual focus on illness and disease, and concern for quality.[8] Moreover, in addition to establishing trusting patient-physician relationships, physicians in this era of team-based care need to learn how to effectively work with teams of health care professionals whose members approach patient care from different perspectives.[2] Of overarching importance, recognizing that one's own unconscious bias may interfere with effective, high quality care[9] is an important step in enhancing a physician's quality of engagement with her patients.

Inclusive leadership in research

As Wartman[2] noted, the lone investigator is no longer the dominant way research is conducted in academic medical centers, having been replaced by inter- and transdisciplinary teams to move the research agenda forward. An MIT monograph, *The Third Revolution: The Convergence of the Life Sciences, Physical Sciences, and Engineering*, highlights the benefits of merging scientific talent in the fields of molecular and cellular biology with that in genomics, engineering, and the physical sciences. As one example, interdisciplinary collaboration after the emergence of X-ray imaging in 1895 led to the advanced imaging methods that exist today. The pace of innovation can be hastened by overtly reducing barriers to effective teamwork across disciplines.[10]

However, one of the barriers to progress in this new era of intensified collaboration is the lack of diversity that exists within the biomedical scientific workforce. Inequities in NIH funding patterns have been well documented.[11] In their thoughtful commentary in 2011, the leadership of the National Institutes of Health highlights its interest in deepening NIH's efforts to increase diversity among researchers in the United States. The authors note "residual cultural biases . . . have disproportionate adverse consequences on minority subgroups of our scientific community."[12]

Inclusive leadership in interprofessional education

There is no need to reiterate the rationale for interprofessional education. The business case for interprofessional

training has been noted by others.[13] At the core of delivering an effective educational and training experience is instilling in future health care professionals the benefits of working with other professionals, the value that other professionals bring to the delivery of care, and the importance of respecting the unique contributions of distinct practice experiences.

How does one become a more inclusive leader?

Physicians need to consider inclusive leadership skills as core to medical professionalism in the twenty-first century. Morrow[14] highlights three ways that we exhibit our leadership, emphasizing the importance of self-awareness, engaging effectively with others, and cultivating a culture in which everyone feels respected and connected. Recognition of our own biases and understanding how these innate preferences may influence our interactions and decisions moves us from a state of unconscious incompetence, or being "color blind," to conscious competence, a first critical step.[15] The next step is to consciously recognize and avoid that unconscious bias in dealing with others, resisting the snap judgment that is often based on that bias. When interacting with patients, for example, it is important to ensure that all patients are informed of the full slate of potential interventions based on evidence-based practice guidelines, instead of making assumptions based on preconceived ideas about what a given patient may (we think) prefer as an intervention. Even leading a meeting can be an opportunity to be inclusive by making sure that everyone has an opportunity to participate in the discussion and that no one dominates the process. Finally, as leaders, ensuring that the culture supports inclusive practices is important. Flexible hours and support for faculty or medical staff engaged in significant caregiving responsibilities are examples of policies that support the efforts of a segment of the professional staff, respecting the special circumstances they face. Engaging large segments of the organization in a whole-scale strategic planning process is another example of fostering inclusion.[16]

By fully embracing the importance of inclusive leadership, we can better leverage the full breadth of talent in our organizations. Such inclusivity will help us to deliver culturally appropriate patient care, to fully engage all members of the health care team, and to be more innovative in our research endeavors. As noted by Stephen Frost, "Diversity is a reality, inclusion is a choice."[1]

Choosing inclusion is the mark of leadership, deeply imbedded in the core values of professionalism.

References

1. Frost S. The Inclusion Imperative: How Real Inclusion Creates Better Business and Builds Better Societies. London: Kogan Page; 2014.

2. Wartman S. The academic health center in a disrupted world. The Pharos 2015 Spring; 78: 2–9.

3. Restuccia D. A study on the changing racial makeup of "the next America." Huffington Post 2014 Apr 13. http://www.huffingtonpost.com/2014/04/13/changing-racial-makeup-_n_5142462.html.

4. Kotkin J. The changing demographics of America. Smithsonian Mag 2010 Aug. http://www.smithsonianmag.com/40th-anniversary/the-changing-demographics-of-america-538284/?no-ist.

5. Heckler M. U.S. Department of Health and Human Services Task Force on Black and Minority Health. Report of the Secretary's Task Force on Black and Minority Health. Washington (DC): U.S. Department of Health and Human Services; 1985–1986. http://collections.nlm.nih.gov/catalog/nlm:nlmuid-8602912-mvset.

6. LaViest T, Gaskin DJ, Richard P. The Economic Burden of Health Inequalities in the United States. Washington (DC): Joint Center for Political and Economic Studies; 2009. https://www.ndhealth.gov/heo/publications/The%20Economic%20Burden%20of%20Health%20Inequalities%20in%20the%20United%20States.pdf.

7. Byyny RL, Papadakis M, Paauw D. Medical Professionalism: Best Practices. Menlo Park (CA): Alpha Omega Alpha Honor Medical Society; 2005.

8. Barondess J. Medicine and professionalism. Arch Intern Med 2003; 163 (2): 145–49.

9. Schulman KA, Berlin JA, Harless W, et al. The effect of race and sex on physicians' recommendations for cardiac catheterization. N Engl J Med 1999; 340 (8): 618–26.

10. Sharp P, Cooney C, Kastner M, et al. The Third Revolution: The Convergence of the Life Sciences, Physical Sciences, and Engineering. Washington (DC): Massachusetts Institute of Technology; 2011. http://dc.mit.edu/sites/dc.mit.edu/files/MIT%20White%20Paper%20on%20Convergence.pdf.

11. Ginther DK, Schaffer WT, Schnell J, et al. Race, ethnicity, and NIH research awards. Science 2011; 333 (6045): 1015–19.

12. Tabak LA, Collins FS. Weaving a richer tapestry in biomedical science. Science 2011; 333 (6045): 940–41.

13. Knettel A. Making the Business Case for Interprofessional Education and Training. Washington (DC): Association of Academic Health Centers; 2011. http://www.aahcdc.org/Resources/ReportsAndPublications/IssueBriefs/View/tabid/79/ArticleId/99/Making-the-Business-Case-for-Interprofessional-Education-and-Training.aspx.

14. Morrow C. Moving the dial: Measuring inclusive leadership. Profiles Diversity J 2014 Apr 1. http://www.diversityjournal.com/13313-moving-dial-measuring- inclusive-leadership/.

15. Holder G. Hidden Bias: How Unconscious Attitudes on Diversity Undermine Organizations and What to Do About It. Providence (RI): GH Consulting; 2008. http://www.ghc-solutions.com/research_hidden-bias.html.

16. Higginbotham EJ, Church K. Strategic planning as a tool for achieving alignment in academic health centers. Trans Am Clin Climatol Assoc 2012; 123: 292–303.

The author's address is:

Perelman School of Medicine
Office of Inclusion & Diversity
3400 Civic Center Boulevard
Building 421 South Pavilion, 6th Floor
Philadelphia, Pennsylvania 19104-5162
E-mail: ehig@upenn.edu.