Leadership and diversity: a call for new directions in reproductive health education and practice

1. Overview

The terms “diversity” and “cultural competence” are freely used by well-motivated health professionals to address real health care equity problems among various populations [1]. The primary areas of concern have involved race and gender differences. Significant differences in health education and patient care also exist between socioeconomic classes, geographic locations (i.e., rural vs. urban, north vs. south), disabled and abled communities, sexual orientations and age groups. Many pilot projects and studies in the developed world have been conducted over the past decade in an attempt to understand, address and rectify these differences. Although well-meaning, these endeavors alone are not sufficient to address the complex social issues that are part of true cultural competence and diversity awareness.

The bottom line is that health equity has been an issue for a very long time. And even without any additional input, the field of reproductive health will be significantly more diverse in 20 years through an organic process of assimilation, population growth, demographic change and accreditation mandates [2,3]. It is time for action, fresh thinking and a bold approach to address challenges posed by the naturally increasing diversity in our institutions and among our patients. As reproductive health researchers, educators and clinicians, our primary interest is to provide the best possible patient care. If we are to realize this goal, we must change the tenor and intensity of our efforts to adapt to cross-cultural care.

For the past decade, educators have asked, “How can we teach reproductive health professionals about diversity and make our institutions more diverse?” We should also ask, “How can we accelerate our response to a very real cultural evolution while building a high-functioning, respectful, and diverse profession?” In a 2000 study published in the Journal of Allied Health [4], researchers concluded, “Many of these efforts . . . are still too recent and limited to produce measurable results.” It appears that the answer, for now, is, “we don’t know.”

2. Adopting new assumptions to drive cultural change

We propose adding some new assumptions to our repertoire regarding cultural competence and diversity to better prepare reproductive health professionals for the certain changes we will experience in the next decade.

2.1. We must learn from a combination of the clinical and behavioral science literature

New, assertive approaches to customized, appropriate and high-quality patient care need to be implemented by a combination of evidence-based clinical and behavioral science. Our “outside of the box” thinking needs to be grounded in the social realities of the cultures that make up our world, while taking advantage of appropriate and affordable technologies to provide the best possible patient care.

2.2. Changes in our field’s cultural landscape are certain and will occur organically, with or without a better understanding of cultural diversity

An increasingly diverse patient and provider population is not only inevitable, it is already evolving. The result will be a richer and more vital society. We need to move quickly to take advantage of a rare opportunity to enrich the field of reproductive health as well.

2.3. The training and mentoring of our emerging leaders is a top priority

We propose building on current successes in raising awareness among the health care community about the need for cultural competence with an integrated approach to training emerging leaders in the field. Tying cultural competency education to assertive leadership training and mentoring programs can help prepare young leaders to continue — and enhance — the life’s work of more mature professionals.

2.4. Positive change requires fresh thinking and new directions

Learning about cross-cultural communication and recruiting for diversity are not enough to manage positive
change. We need to work closely with our colleagues and emerging leaders to identify bold new concepts to help accelerate change.

2.5. We must conduct ongoing discussions in a variety of venues to continuously adapt to cultural change

Reproductive health researchers, educators and clinicians benefit from ongoing discussion and debate about the science that motivates our work. It is essential to develop and manage platforms for continuous exchange about diversity, training and practice.

3. “Cultural competence” as a first step

The trend among many academic institutions for a decade or so has been to institute cultural competency and diversity awareness programs for their faculty, students and administration [1]. Rust et al. [5] define “cultural competence” for the medical profession to mean “a core set of skills that can be learned to respectfully and effectively communicate healthcare information with diverse patient populations.”

In spite of our efforts, the effectiveness of existing cultural competency training programs is debatable. A 2003 study summary [6] supports this point: “In general, students concluded that learning about social and cultural issues made little or no difference when they did their clinical rotations.” A 2005 study report [7] on resident preparedness to provide cross-cultural care concludes that “resident physicians’ self-reported preparedness to deliver cross-cultural care lags well behind preparedness in other clinical and technical areas.” Essentially, we need to open up what some call the “hidden curriculum” and find new ways to train health professionals about cultural competence and diversity [8].

In 2002, the Institute of Medicine (IOM) issued a lengthy report on racial and ethnic disparities in health care [9]. Although well researched and developed by a renowned panel of experts, the question of provider bias outside of race and gender was given little attention. “Many other strategies must be undertaken . . . to eliminate racial and ethnic disparities in healthcare,” begins one general recommendation in a related IOM brief [10]. Our challenge is to identify novel approaches that can help rectify diversity problems.

4. Recommendations for action

4.1. Accelerate the organic process of change

In today’s information-technology-rich society, there are many ways to learn from each other about how to initiate faster change. Some potentially useful ways to accelerate our response to the changing cultural landscape is to develop online provider communities for debate and discussion, conduct regular meetings on the topic and sponsor ongoing brainstorming sessions. Positive experiences with diversity create more fertile ground for potentially faster change. In a 2001 article on diversity in medical school [11], the authors attributed increased value for diversity education with cross-cultural experiences: “The more diverse the class, the more comfortable the students were with diversity and the more they valued its contribution to their medical education.”

5. Train and mentor our emerging leaders

Our best and brightest are already identifying themselves through their volunteerism and published research. Younger leaders often have fresh assumptions about health care delivery and diversity, and are more likely to develop creative solutions and coping mechanisms in the absence of best practices for cross-cultural care [12,13].

If we are to accelerate the organic process of change that is necessary to meet the goal of better patient care, health professions students, residents and young practitioners need to be identified, carefully mentored, thoroughly trained and intensely rewarded. We need to invest in our young leaders to ensure that what is done by the current generation continues and thrives in the future. We should integrate cross-cultural training with practice tips and management tools for bottom-line success, media training and ongoing platforms for discussion and brainstorming about pressing issues of concern.

5.1. Conduct key research to better identify health professionals’ knowledge, attitudes and perceptions about diversity

In their 2003 report, “Unequal treatment” [10], the National Academy of Sciences identified a number of areas of research that could help fill gaps in our understanding about ethnic diversity. Their recommendations include better understanding clinical decision making and the roles of stereotyping, uncertainty and bias; understanding patient-level influences on care; and understanding the influence of health care systems and settings on care for minority patients. Future research needs to take all areas of diversity into account while utilizing novel approaches to cross-cultural training and education.

5.2. Enhance and expand health professional education on personal and group biases

Racial and gender biases remain key issues among health care providers and their patients. For example, in a 2002 study of medical students at the University of Chicago [14], only minority students showed increased cultural sensitivity after diversity training; some students even showed minor decreases. Another study reported in 2005 [15] found that “engendering genuine self-reflection can substantively improve the delivery of health care to the nation’s diverse population.”

Health professions students, educators and providers in the field can benefit from continuing education on the
characteristics and effects of biases on decision making and clinical care.

6. Summary

The answer to providing the best possible patient care to a diverse patient population is grounded in understanding, adaptation and creativity. We need to understand and apply the principles of diversity and cultural competence — including our own cultural biases — while creatively adapting to the reality of a changing professional environment. This should continue to be our top priority.

The next step in accepting the “normality” of diversity is to tear down the physical and social barriers that separate racial groups and to become more accepting of those who are of a different religious affiliation or sexual orientation. It is only then, when we come to the table with an unbiased eye, that we can finally embrace the beauty of our differences. The benefits of a well-acculturated profession and higher quality care for all of our patients are worth the investment.

Michael A. Thomas, MD
Division of Reproductive Endocrinology and Infertility
University of Cincinnati Medical Center
Cincinnati, OH 45267, USA

Wayne C. Shields
Association of Reproductive Health Professionals
Washington, DC 20037, USA

References