

The Case for Diversity and Inclusive Learning

A Diverse Nursing Workforce Contributes to Health Equity

- Health inequities persist in underserved communities where access to care is limited and where social determinants impact health outcomes. These areas tend to be poorer and more diverse than communities that are well-served [1].
- Minority providers currently care for the bulk of minority patients in the United States and play a larger role than non-minority providers in treating patients in poor health [2-5]. Language and cultural barriers limit providers' ability to serve the needs of minority patients in ways that are linguistically and culturally relevant [6].
- Nursing students should possess the background, qualities and skills to provide culturally-effective care and meet the needs of a rapidly diversifying patient population. These skills cannot be detected from grades and test scores alone.

An Inclusive Learning Environment Benefits All Students

- Educating students in environments that value diversity and inclusion produces graduates better prepared to practice in underserved communities and whose understanding of the cultural needs of patients improves patient satisfaction and trust [7]. This is beneficial for *all* students – not just those who are underrepresented.
- While diversity is an important first step in enhancing the educational environment [8], it should not be viewed as the end goal – but rather an important means toward achieving key educational and workforce goals as defined by the school in its mission [9-14].
- When framed in the context of holistic review, diversity is student-specific and multidimensional. Diversity does not exclusively refer to race, ethnicity and gender. Rather, diversity encompasses multiple dimensions. Examples include socioeconomic status, life experiences, sexual orientation, languages spoken, and personal characteristics among others.

Diversity is Essential for Excellence

- Diversity is an essential tool for achieving a school's mission and core educational goals. When well-conceived and intentionally fostered, diversity can act as a catalyst for institutional excellence with the end goals of student success, quality patient care, and improved community health.

Endnotes

- 1 Smedley, B. D., Stith, A. Y., & Nelson, A. R. (2003). *Unequal treatment: Confronting racial and ethnic disparities in health care*. Washington, DC: Institute of Medicine, Committee on Understanding and Eliminating Racial and Ethnic Disparities in Health Care. <http://www.iom.edu/Reports/2002/Unequal-Treatment-Confronting-Racial-and-Ethnic-Disparities-in-Health-Care.aspx>
- 2 Edwards, J. C., Maldonado, F. G., & Engelgau, G. R. (2000). Beyond Affirmative Action. *Academic Medicine*, 75(8), 806-815. doi:10.1097/00001888-200008000-00011.
- 3 Terrell, C., & Beaudreau, J. (2003). 3000 by 2000 and beyond: Next steps for promoting diversity in the health professions. *Journal of Dental Education*, 67(9), 1048-1052.
- 4 Komaromy, M., Grumbach, K., Drake, M., Vranizan, K., Lurie, N., Keane, D., & Bindman, A. B. (1996). The Role of Black and Hispanic Physicians in Providing Health Care for Underserved Populations. *New England Journal of Medicine N Engl J Med*, 334(20), 1305-1310. doi:10.1056/nejm199605163342006
- 5 Marrast, L. M., Zallman, L., Woolhandler, S., Bor, D. H., & McCormick, D. (2014). Minority Physicians' Role in the Care of Underserved Patients. *JAMA Internal Medicine JAMA Intern Med*, 174(2), 289. doi:10.1001/jamainternmed.2013.12756
- 6 Manetta, A., Boker, J., Rea, J., Stephens, F., & Koehring, N. (2007). A Study of the Physician Workforce Supply for the Latino Population in California. *Academic Medicine*, 82(2), 127-132. doi:10.1097/acm.0b013e31802d8798
- 7 Saha, S. (2008). Student Body Racial and Ethnic Composition and Diversity-Related Outcomes in US Medical Schools. *Jama*, 300(10), 1135. doi:10.1001/jama.300.10.1135
- 8 Milem, J. F., O'Brien, C. L., and Bryan, W. P. (2013). The matriculated student: Assessing the impact of holistic review. In *Roadmap to excellence: Key concepts for evaluating the impact of medical school holistic admissions* (pp. 19-29). Washington, DC: Association of American Medical Colleges.
- 9 Addams, A. N., Bletzinger, R. B., Sondheimer, H. M., White, S. E., & Johnson, L. M. (2010). *Roadmap to diversity: Integrating holistic review practices into medical school admission processes*. Washington, DC: Association of American Medical Colleges.
- 10 Coleman, A. L., Palmer, S. R., & Winnick, S. Y. (2008). *Roadmap to diversity: Key legal and educational policy foundations for medical schools*. Washington, DC: Association of American Medical Colleges. <https://www.mededportal.org/icollaborative/resource/659>
- 11 Milem, J. F. (2003). The educational benefits of diversity: Evidence from multiple sectors. In M. Chang, D. Witt, J. Jones, & K. Hakuta (Eds.), *Compelling interest: Examining the evidence on racial dynamics in higher education* (pp. 126-169). Stanford, CA: Stanford University Press.
- 12 Gurin, P., Dey, E., Hurtado, S., & Gurin, G. (2002). Diversity and Higher Education: Theory and Impact on Educational Outcomes. *Harvard Educational Review*, 72(3), 330-367. doi:10.17763/haer.72.3.01151786u134n051
- 13 Milem, J. F., Chang, M. J., & Antonio, A. L. (2005). *Making diversity work on campus: A research-based perspective*. Washington, DC: Association of American Colleges and Universities.
- 14 Milem, J. F., Dey, E. L., & White, C. B. (2004). Diversity considerations in health professions education. In Institute of Medicine (Ed.), *In the nation's compelling interest: Ensuring diversity in the health care workforce* (pp. 345-90). Washington, DC: The National Academies Press.