Don't all veins look alike? Comprehensively attending to diversity within the vascular surgical specialty

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Prior research has established diversity as a topic of empirical analysis in the vascular surgery literature. Building on the work of previously published articles on diversity in the *Journal of Vascular Surgery* and elsewhere, this article engages in a broad discussion of diversity in two interrelated arenas: educational/workplace diversity and culturally competent care. Interdisciplinary review of the literature indicates that diversity is often thought of as an end-state to be accomplished. A more fruitful way to encompass the changing aspects of diversity work is to think of diversity as a set of processes that can be adjusted based on a set of interrelated goals that matter differently to different groups. In considering diversity as a process, an approach to diversity emerges that considers both independent effects of gender and race/ethnicity as well as interactive effects between the two variables to address future trends in medical education. Such trends are diagnosed and multiple courses of intervention are offered as reasonable options for future efforts. A comprehensive definition of *diversity* will be established in order to encompass two different arenas in which diversity concerns arise: educational diversity and culturally competent patient care. Second, a discussion of the rationales for attention to diversity among vascular surgeons will provide different avenues into a conversation about diversity in the profession. In so doing, three successful efforts will be briefly discussed: the Ohio State University's MED-Path program, the Keck School of Medicine's chair-centered approach to diversity in residency training, and the American Association of Orthopedic Surgeons' (AAOS) approach to culturally competent care. (J Vasc Surg 2010;51:42S-46S.)

On the Fox television show "House," actor Hugh Laurie plays a politically-incorrect but presumably lovable curmudgeon whose challenge each week is to effectively diagnose and treat a patient-of-the-week with a set of seemingly random-occurrence symptoms that threatens their well-being. Despite his marginal social skills and penchant for making rude and inappropriate comments in the educational and patient-care contexts, House always manages to unnerve his residents, frustrate his colleagues, and of course, save the patient.

The premise of "House," a continuing series of vexing challenges featuring collections of symptoms that threaten to thwart accurate diagnosis, is a perfect metaphor for the challenges facing vascular surgery (VS) as a specialty in terms of provision of culturally competent patient care and its cognate educational/workplace diversity in the service of an equitable health care universe. Despite any professed US commitment to health care equity, there are a myriad of complex issues involved in establishing an equitable health system. The National Health Care Disparities Report indicates that equity is far from the current norm in the United States in terms of health care for certain populations—racial and ethnic minorities, low-income groups, and individuals with special health care needs. More specifically, poor, Asian, Native Hawaiian or Other Pacific Islander, American Indian, Alaska Native, and Hispanic individuals all reportedly received a poorer quality of health care than the comparison groups or had worse outcomes (www.ahrq.gov/qrdr08/datasources/index/html).

This article will proceed in three parts. First, a comprehensive definition of *diversity* will be established in order to encompass two overlapping arenas in which diversity concerns arise: educational diversity and culturally competent patient care. Second, a discussion of the symptoms facing VS as a specialty, and a diagnosis will be offered in each arena. In order to provide multiple avenues into the conversation, multiple courses of treatment for each diagnosis will be presented. In so doing, three successful efforts will be discussed in conjunction with the five strategies listed but not discussed in detail in recent issues of the *Journal of Vascular Surgery*.[1] We conclude with an appendix of recommended reading for further engagement with diversity issues and practices.

Defining diversity. Diversity, like apple pie and motherhood, is a long-celebrated hallmark of the United States of America. The *Oxford English Dictionary*, the dictionary of record for the English language, defines *diversity* as "being diverse; variety." *Webster's Encyclopedic Dictionary of the English Language* defines *diversity* as "the state of being diverse; difference, dissimilitude, unlikeness; multiplicity with difference; variety; distinctness or separateness of being." *Diversity* in these examples is a noun, an end to be sought.

Public opinion surveys reveal that most college-educated people tend to support the principle of diversity in

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schools, communities, workplaces, hospitals, courts, professional organizations, as well as more generally in US society.[2] Consistent with this common American opinion, *diversity* is often used to describe a desirable end to be achieved in an enlightened society. The *Oxford Encyclopedia of Social Work*, for example, focuses on cultural diversity, or multiculturalism, as a desirable descriptor of service provision to patients and clients.

However, Americans differ greatly about how to "achieve" the desirable goal of diversity, a phenomenon known as the *principle-policy-paradox*.[3] One practical approach to diversity is embodied in the following definition: "The concept of diversity encompasses acceptance and respect. It means understanding that each individual is unique and recognizing individual human differences that can focus on the dimensions of race, ethnicity, gender, sexual orientation, socioeconomic status, age, physical abilities, religious beliefs, political beliefs, or other factors. Diversity can be viewed as the exploration of these human differences in a safe, positive, and nurturing environment. It is assumed that humans seek to understand each other and move beyond simple tolerance to the goal of embracing and celebrating the rich dimensions of diversity contained within each individual and within the collective of humans in society" (http://gladstone.uoregon.edu/~asuomca/diversityinit/definition.html).

Another approach to diversity is to ignore or behave as if one is "blind" to diverse backgrounds of patients, residents, and colleagues, based on the premise that "much has been made of the fact that race is not a sensible biological concept and ethnicity is even more confusing."[4] Many Americans, including many medical professionals, conclude from this premise that identities like race, gender, and class should not matter. We might expect that when a vascular surgeon opens up a patient, all veins—at least in terms of race, gender, or class—should, in fact, look alike. Extending the logic to broader practices can then produce the following results: "The basic emphasis in recent decades has been on policies that simply ignore divisions of race, ethnicity, class, and immigrant status and assume that the problem is nothing that relates to those facts but one of laxity in the institutions serving certain groups of people or the lack of appropriate market incentives, which are assumed to have provided for the mobility and incorporation of previous groups into the mainstream."

Resolving a debate over policies and practices to achieve the goal of diversity is far beyond the scope of this brief article and indeed beyond any one medical professional or scholar's reach. However, if we shift our thinking away from diversity as a permanent end-state at which the United States will arrive toward conceptualizing diversity as a process, we can move beyond political stalemate to targeted, time-bound, professionally-relevant approaches to diversity that can achieve the goal. While this view of diversity is not yet widely held, it is a notion worth considering.

Diversity as a process is viewed as organic, dynamic, and changeable, and perhaps most importantly, pegged to relevant situational contexts. Because human beings are organic and continue to change with age/maturity, physiology, and life experiences, it stands to reason that the diversity in which they are involved is not predictable but is interrelated with the other individuals in the group, class, or work setting, to name just a few contexts. In this perspective, even the definition of *diversity* itself is organic and depends on whom or what is defining the term.

Health care professionals' conceptualization of diversity. Varying public health institutions continue to define *diversity* as a noun and, more importantly, conceptualize diversity to involve two distinct types: race/ethnicity and gender (http://www.4woman.gov/OWH/multidisciplinary/reports/GenderBasedMedicine/question6.cfm). Following the practice of the Accreditation Council of Graduate Medical Education (ACGME), Kane et al[1] defined *diversity* as a noun with two mutually exclusive dimensions: race/ethnicity and gender. We noted the pitfalls of defining *diversity* as a noun in the previous section, but in this section, we want to focus on the implications of conceptualizing diversity in a two-dimensional, mutually exclusive manner. In the following paragraphs, we illustrate how conceptualizing categories as completely distinct risks misdiagnosis of the problem and ultimately threatens any proposed prescription.

Between 1999 and 2005, VS has more than held its own on the numbers of female trainees entering the profession, relative to Interventional Cardiology (IC), Interventional Radiology (IR), and Orthopedic Surgery (OS). One could reasonably conclude from this isolated statement that perhaps VS can stand pat in its attempt to achieve gender diversity. In a separate section of the article, the authors show that there remains work to be done on racial/ethnic diversity in the profession. What we cannot tell from the data is how many of these women are also members of under-represented racial or ethnic groups.

Why do we need to know about both autonomous (between groups) and interactional (within group) effects among this kind of data? Past college graduation rates, which create the pool of eligible medical school applicants indicate a far smaller gender gap in college graduation among white women and men (+12.8%) than for African American women and men (+31.7) (http://nces.ed.gov/pubsearch/pubsinfo.asp?pubid=2005168. Taking demographic trends such as these into effect, the independent effect of gender overall (8% more women than men in the medical applicant pool by 2020) is dwarfed by the projections that women will account for over 60% of medical school applicants among Latinos and almost 70% of African American medical school applicants.[5]

Without looking at the intersections of race/ethnicity and gender, a policy prescription to "increase the proportion of minorities in the pool of qualified individuals in vascular training programs" has less than a 50% chance of success from the outset because more than 50% of the minority medical school applicant population, women of color, may need additional attention to gender issues not addressed by standing pat on current gender-based efforts. In this sense, VS should build its efforts in a way that