Advancing Diversity Through Inclusive Excellence in Nursing Education

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Nurse leaders call for a more diverse nursing workforce, but too few address the concept of inclusion as a recruitment and retention strategy or as part of improving the academic learning milieu. This article addresses organizational considerations of diversity and inclusion as part of the agenda established by the Association of American Colleges and Universities for inclusive excellence, building on the idea that academic environments only become excellent when an inclusive climate is reached. Six organizational strategies to inclusion are presented from the authors' experiences, some structural and others behavioral: admissions processes, invisibility, absence of community, promotion and tenure, exclusion, and tokenism. A call for structural and behavioral adaptions within nursing education to advance an inclusive excellence agenda is presented. (Index words: Diversity; Inclusion; Inclusive excellence; Nursing education; Academic culture; Organizational behavior) J Prof Nurs 31:89–94, 2015. © 2015 Elsevier Inc. All rights reserved.

DIVERSITY HAS GARNERED increasing attention in a society that is demographically pluralistic. In health care, both the Institute of Medicine (IOM), (2010) and The Sullivan Commission (2004) proclaim that health care providers should reflect diversity that mirrors those being served. The purpose of this article is to focus on nursing education and the professional formation of nursing students as diverse and inclusive providers of future care.

Many colleges and universities have focused on increasing the diversity of faculty, staff, and students. Diversity typically includes ethnicity, race, socioeconomic status, gender, sexual orientation, and other factors that each institution defines for its communities of interest (American Association of Colleges of Nursing [AACN], 2008; Marvasti & McKinney, 2011; Williams, Berger, & McLendon, 2005). Inclusion extends beyond the notion of diversity. Inclusion activities create organizational structures that advance communications, foster advanced decision making, and mitigate power differentiation between and among diverse individuals and groups. Inclusion results in enriched perspectives and creativity central to the purpose of becoming educated in a pluralistic academic culture.

To this end, the Association of American Colleges and Universities (AAC&U) has coined the term *inclusive excellence* (IE; Williams et al., 2005). Their work draws attention to the commingling of diversity with engaged ways of participating to achieve academic excellence and successful careers. Nursing educators can benefit from a focus on diversity, inclusion, and excellence in academic and clinical settings.

Historically, nursing in the past century has not been diverse; the world view in nursing has been narrower than might be desirable, with a latent expectation that nursing students adapt to Eurocentric norms (Hassouneh & Lutz, 2013). Today, through faculty, curricula, and co-curricular opportunities, higher education aims expand learners' world view by adding depth and breadth of knowledge, exposing learners to varying social constructs, and advancing students' ability to inquire and seek answers to questions in service of others (Morin, 2003).

The State of Nursing Demographics for Underrepresented Groups

To support the case for enhanced diversity in nursing education, an assessment of the demographics for underrepresented groups is in order. But demographics tied to the nursing workforce are inconsistent, with no existing

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national standardized definitions or data collection processes, creating variable and uneven study results. Data collected are often simplistic and not robust enough to establish a baseline for measuring diversity-oriented initiatives (i.e., race/ethnicity, gender, and age). The data that follow examine nursing diversity contrasted with other health care disciplines and the overall U.S. workforce.

The latest Health Resources and Services Administration (HRSA) report noted that the nursing workforce is still predominantly White—75% (United States Department of Health & Human Services [USDHHS], 2013). Only 5% of the nursing workforce is Hispanic/Latino, yet this ethnic group comprises 14% of the overall U.S. workforce. The proportion of men in nursing has increased from 7.6% in 2000 to 9.6% in 2011, per the American Community Survey (United States Census Bureau, 2013). Furthermore, and pulled from a variety of sources, the Bipartisan Policy Taskforce Executive Summary (Keckley, Coughlin, Gupta, Korenda, & Stanley, 2011) documents that a highly disparate gender distribution for registered nurses is 7% male to 93% female, compared with dentists with 22% female; pharmacists, 45% female; physicians, 30% female; and psychologists, 57% female. This illustrates the degree of gender imbalance in nursing in contrast to other health professions that have achieved gender recalibration.

Over one third of the U.S. population belongs to racial and ethnic minorities, yet minorities constitute only 16.8% of the nursing workforce (United States Census Bureau, 2011; USDHHS, 2010). These data reflect the magnitude of the issue and the challenge at hand for nursing education to advance a diversity agenda, not only for direct care positions but also for compounding the impact leading to diversity in leadership, faculty, research, and other visible professional positions where role models are needed. Furthermore, it is expected that by the year 2043, minorities will constitute over half of the U.S population (United States Census Bureau, 2012b). Currently, racial and ethnic minorities make up nearly half of the U.S. population younger than the age of five (United States Census Bureau, 2012a).

Status of Underrepresented Populations in the Nursing Education Pipeline

In contrast with workforce data, nursing education data document that effort toward recruitment of underrepresented populations has increased, yet many of these recruits disproportionately do not graduate (Gilchrist & Rector, 2007; Mulholland, Anionwu, Atkins, Tappern, & Franks, 2008; Pryjmachuk, Easton, & Littlewood, 2009). Underrepresented and diverse students outnumber diverse faculty who could serve as their role models. According to the AACN (2012), 26.8% of students in entry-level baccalaureate programs belonged to minority groups, of which 11.4% were men. They further report that 6.2% of full-time nurse faculty members are men, and 12.6% belong to minority groups—a marked imbalance.

Some faculty members have been implicated as gatekeepers to the nursing profession who limit entry of underrepresented populations into nursing (Davis &

Bartfay, 2001; Hassouneh, 2008). By virtue of their role in student admissions, faculty members have been implicated in stereotyping and discrimination, although many times this occurs without conscious intent (Bell-Scriber, 2008; MacWilliams, Schmidt, & Bleich, 2013). Nurse educators who have been socialized to Eurocentric values may hold a world view that is more exclusive than inclusive. Switching to a faculty example of gatekeeping, Hassouneh and Lutz (2013) noted patterns of control and exclusion of minority nursing faculty in rank and tenure decisions. "Academe is a model based on commonalities – not a community built around the concepts of diversity" (Medina & Luna, 2000, p.48–49). The injustices experienced by historically underrepresented populations (i.e., African American, Hispanic/Latino American, Native America and "others") in the academy mirror a social system where the White majority holds the power and the minority is marginalized.

Strategies to Advance IE in Nursing Education

An inclusive culture is one that (a) fosters and values diversity; (b) builds communication, decision making, and reward and recognition mechanisms that elevate diversity through respectful engagement; and (c) creates intentional feedback loops, both internal and external, that advance awareness of diversity and inclusion blind spots, with action to support improvements. As used here, a diverse culture differs from an inclusive culture. A diverse culture is open to creeds, cultures, ethnicities, gender, and other human qualities. We define that an inclusive culture is one that brings diverse perspectives into decision-making structures at all levels, allows for and celebrates differences as enriching, and reduces and/or eliminates barriers to full engagement of all. Even if diversity in academe is sparse, the culture can be inclusive for those who represent diverse qualities and traits; the opposite is also true, whereas a diverse culture may not be inclusive.

Together, a diverse and inclusive organization eradicates individual and organizational practices that perpetrate attitudinal or repressive structural barriers, in lieu of practices that honor, celebrate, and reward differences within the culture. An inclusive culture is an outcome to achieve but only through appreciating differences. A group may be diverse but not inclusive, if diverse members are viewed with a perspective of unequal power, limited engagement, or silenced voice.

Nursing education practices can accelerate an inclusive culture through six strategies that the authors identify as foundation for further enhancement and outcomes measurement. These strategies have been identified from the literature, lived experience, and observations of academic practices. Further, ideas specified in the work of the IOM's Future of Nursing (2010) report and Benner, Sutphen, Leonard, and Day's (2010) work on radical transformation give us grounding in these strategic areas of focus. Six strategies will next be presented: improve admissions processes, reduce the

invisibility of underrepresented cohorts, create communities of support, ensure that promotion and/or tenure structures are balanced, eliminate exclusion, and stand against tokenism.

Strategy One: Improve Admissions Processes

Hassouneh and Lutz (2013) note that admission processes are rooted in dominant academic paradigms, resulting in restrictive admission decisions. Most of the admission processes select students based exclusively on grade point averages and standardized tests, which have advantaged White mainstream students; other measures might have revealed equal to or better than qualifiers for underrepresented persons to enter the discipline. If face-to-face interviews are conducted, another avenue for bias is introduced. Organizational scientists have now tested the human attributes associated with high-performing nurses, and tools exist to measure essential characteristics needed in the practice setting. These include nonbiased attributes such as resourcefulness, resilience, relationship capacity for service to others, ambiguity tolerance, exactness, values, patient centricity, command, work intensity, positivity, and achievement orientation (Talent Plus, Inc., 2010). Science-driven quality selection processes can be enhanced through faster selection and increased efficiency, ability to handle a high volume of applicants, rapid feedback to admission decision makers, real-time data analytics, and impartial candidate selection. Although we offer no specific suggestions for admissions based on diversity criteria, especially when the applicant pool is large and spaces are limited, we do believe that there are specific strategies that can be used to partner with other schools to create a cohort model for accepting students from richly diverse programs. An articulation agreement, coupled with scholarship opportunities, and early advising with an associate degree nursing program can create a rapid influx of diverse students into a baccalaureate program.

Strategy Two: Reduce the Invisibility of Underrepresented Cohorts

Invisibility deals with the latent belief or blind bias that diverse or underrepresented individuals have no place in decision-making forums, as leaders, or as representatives merely because they never have been present in those forums. For instance, a male or a Native American female may be excluded from someone engaging them as a nurse because being male or Native has not been tied to the dominant view that only White females are nurses. Therefore, these nondominant individuals are invisible or not considered plausible as competent nurse providers. For persons not stigmatized by being different, the issue itself is invisible. An inclusive environment bolsters the likelihood of retention and support of underrepresented groups by thoughtfully assessing who may be invisible, using definitions noted earlier, and normalizing their existence.

The intentional engagement and involvement of students and faculty in a variety of committees and task forces can inform curriculum, the selection of faculty and

students, and other organizational practices. Intentionally selecting clinical practice sites where diverse populations reside, creating cases for simulation where cultural–ethnic practices are explored, generating public images of diverse students and faculty as leaders (vs. tokens), and storytelling designed to create inclusive visibility are interventions of merit. These actions may enable faculty to address barriers to learning and respond to the needs of culturally diverse students in an inclusive manner. Nursing schools are in a position to audit their clinical sites and complete a content analysis of simulation and simulation debriefings to measure intentional exposure to diverse populations of patients. Similarly, they can review committee structures from a diversity perspective and debrief at the end of committee meetings to ensure that inclusive participation was achieved.

Nurse educators should provide for their students an environment that promotes a culture of inclusion rather than exclusion. Involving diverse students in the classroom and clinical setting honors each and all student's background and culture. Note that historically marginalized students have had expectations to adapt and assimilate into the dominate culture since colonial times (Freire, 1970). With this sensitivity, nurse educators can uniquely empower voices of underrepresented students and use them as teaching assets. Student-centered learning requires a shift in power from the teacher to reciprocal accountability between teachers and learners. The student voice becomes as important as the teacher's in student-centered learning and changes the student's now-visible relationships with others (Young & Paterson, 2007). It is a prerequisite for patient- and family-centered care, teamwork, and clinical competence.

Strategy Three: Create Communities of Support

There are many field-based comments from students and faculty as to what it means to be "different" from White female nurses. Several nursing organizations address diversity to create community, such as the National Black Nurses Association (2014), the American Assembly for Men in Nursing (2011), the National Association of Hispanic Nurses (2014), Sigma Theta Tau (Wilson, Sanner, & McAllister, 2003) and others, yet the stretch of these coalitions does not extend to everyday academic settings or to daily work life. Student services professionals and faculty can strategically think beyond the walls of the school in order to connect diverse students with a community of support if this is not possible within the academic setting. Diverse students may be found in academic settings beyond the school, faith communities, social groups, and other disciplines. This effort to commingle and support diverse students can vitalize underrepresented students, may uncover community-based relationships useful to the school or the curriculum in other ways, and form partnerships that might advise nursing programs on diversity and inclusion. Ultimately, there is a need for mentorship—both for diverse faculty and for students. Further, opportunities for integration, where inclusion and voice are given priority must also unfold, such as in interprofessional discussion groups, or in celebrations that reflect heritage (i.e., Black History Month),

giving all the opportunity to enjoy and appreciate differences. Metrics to determine the impact of inclusion are a challenge but possible. A review of external speakers brought in for scholarly presentations, intentional programs and social functions within the academic life, and educational programs and seminars that foster awareness and solutions to structures that limit inclusion can be documented, the narrative representing degrees of effort and progress.

The challenge of finding mentors who represent diverse backgrounds is real for nursing programs, and not every person is a qualified mentor even if they represent that trait and human quality. Simple solutions, such as using technology to create virtual mentorships, or identifying individuals from other disciplines or industries who can help a mentee navigate structural barriers, or individuals who show a special sensitivity to the diverse candidate and are willing to walk the journey in a supportive manner can suffice until there are more broad-based mentors in nursing education.

Strategy Four: Ensure Promotion and/or Tenure Structures are Balanced

We do not intend to debate the merit of tenure in higher education, but it must be looked at from a power structure perspective in terms of diversity and inclusion. The majority of nurse faculty who control promotion and tenure decisions in nursing, which equate to controlling higher level roles and responsibilities, are White women trained in a particular tradition. Many promotion and tenure structures fail to accommodate various forms of scholarship first noted by Boyer (1990) and Glassick, Huber, and Maeroff (1997), which may deter faculty with substantive talents, skills, and abilities dominant in individuals from diverse cultural and ethnic backgrounds, from achieving parity in an academic setting. Scholarship that is generated from field-based work should be considered as valid if it is evidence based and disseminated. Using Boyer's model, some schools have accepted work that has led to inventions, patents, and computer algorithms—very different from a traditional research manuscript.

Faculty governance structures yield another form of opportunity for inclusion—or exclusion—from decision-making and authority-yielding opportunities, noting who is qualified by rank to serve on committees. Minority faculty members are at a disadvantage in these systems, in particular, minority faculty from historically marginalized groups (i.e., African American, Hispanic/Latino American, Native American, etc.; Hassouneh, 2008). Tenure criteria with related metrics that acknowledge multiple forms of scholarship should be considered and articulated to enhance the usefulness of the tenure process and create equitable opportunities for all faculty; further, diversity-sensitive mentors with a goal of like-kind mentors over time are additional strategies for ensuring balanced opportunities. Although it may be difficult for some seasoned and tenured faculty to examine these practices, it is not impossible to examine and challenge the rites and rituals of committee appointments, exposure to leadership opportunities, and mentoring to improve balance in representation and preparation for success in gaining tenure.

Strategy Five: Eliminate Exclusion

Exclusion varies from invisibility in that it reflects intentionality often for the benefit of the oppressor. Rankism, racist, and sexist behavior are exclusionary in nature (Fuller, 2004). It becomes the responsibility of administrators to provide protective mechanisms for those individuals who whistle blow; zero tolerance policies and a code of conduct are needed and must be persistently enforced. Perhaps, the most difficult to measure exclusionary behaviors are best identified by objective outsiders who have sufficient prolonged engagement to offer recommendations and work with oppressors. If academic leaders have a blind spot to being a part of the problem, methods to achieve awareness, such as the use of 360 degree feedback mechanisms or employee/faculty engagement surveys can enlighten the issue. Further, the use of culture surveys developed by human resource professionals is needed in the academic environment to expose issues but to also measure success.

Strategy Six: Stand Against Tokenism

Tokenism exists in nursing when, because of a desire to have a diverse person serve as a figurehead in a public role and activity, and the person does so with sparse support from the individuals he or she represents. Generally, tokenism makes all parties feel good at the onset, with the diverse individual later feeling betrayed or subjected to isolation over time as the minority goes it alone. Strategies for avoiding tokenism include the thorough preparation of underrepresented individuals for situation-specific assignments, discussing the norms for decision making and politicking in groups, pointing out how authority and power are differentiated, and practicing giving voice—rehearsing—for influencing others with a different view or perspective. Again, this strategy is difficult to measure from an improvement perspective, but it is not difficult to debrief individuals who have been assigned to roles or have opportunities to represent faculty, staff, or students and learn from their encounters. Simple questions, "Did you feel that you had the support of your peers while taking on this assignment?" or "Did you enter this assignment in a manner that you were set up for success?" can reveal support versus tokenism. Mechanisms for discussing these issues are already in academic cultures, but there must be space made on the agenda for the discussion.

IE—A Summary of the Opportunity

IE is becoming a universal framework for transactional change that addresses all levels in higher education institutions and requires the intentional integration of diversity and inclusion into day-to-day operations. This is important because everyone in higher education institutions, from top-down to bottom-up, is held accountable for the academic culture, and educational thought leaders

tout inclusion and diversity as critical to meet the needs of a pluralistic society. IE has been adapted by universities across the country with the dual focus of building greater structural diversity while improving the organizational culture. To understand IE, we must view diversity and quality as inseparable. The IE framework features first-generation organizational, departmental, and academic quality metrics to create measurable change with ongoing monitoring and cyclical follow-up but needs refinement. The IE metrics in use provide a feedback loop for change and improvement in higher education and will eventually lead to second generation comparative benchmarks and model processes and practices (Williams et al., 2005).

The AAC&U engaged in the IE process with three targeted goals: to integrate diversity with quality efforts, to situate this work at the core of institutional functioning, and to realize the educational benefits available to students and to the institution when this integration is achieved and sustained over time. They define IE broadly so that institutions and, we contend, nursing programs can achieve four elements:

1. A focus on student intellectual and social development.
2. A purposeful development and utilization of organizational resources to enhance student learning.
3. Attention to cultural differences learners bring to the educational experience and that enhance the enterprise.
4. A welcoming community that engages all of its diversity in the service of student and organizational learning (Williams et al., 2005).

To Williams et al.'s work, we add a fifth element: attention to increasing faculty diversity. A diverse faculty offers multiple perspectives on ways to approach patients and families, multiple ways of problem-solving that is patient centric, and space for each student to express their strengths as individuals rather than as conformists. External nursing groups that represent diversity, such as the Association of Black Nurses or the American Assembly for Men in Nursing, are links to recruitment and retention strategies.

The work of the AAC&U (Williams et al., 2005) advances the culture of nursing education in a reformed health system. Specifically, we believe that intentional efforts aimed at IE could positively influence the nursing workforce shortage, promote visibility of the profession to broader segments of society, improve the quality of decision making in and relevance of nursing education that bridges to practice, and promote holism in the next generation of nurses. IE provides a level-playing field for diverse students, yet still ensure the quality of the graduate nurse entering the workforce.

The recruitment of underrepresented populations into the nursing profession offers at least a partial solution to predicted nursing shortages, shortages that Auerbach, Buerhaus, and Staiger (2011) state are because of an aging population, primary care physician shortages, and increased demand for registered nurses under the Affordable Care Act. Buerhaus, Auerbach, and Staiger (2009) suggested recruitment of men and Hispanics into the profession as a strategy to avoid this deficit. Citing similar concerns about demand, Juraschek, Zhang, Ranganathan, and Lin (2012) estimated 918,000 unfilled nursing jobs by the year 2030.

There is a perilous consequence if nursing fails to expand its utility to meet the public's needs. Pragmatically, as the discipline competes with expanded opportunities for women, the Eurocentric model of promoting the profession could become a perfect storm leading to inadequate workforce supply, beyond the reasons that it is socially just to have a diverse workforce to align with the populations served by nursing. Social Justice dictates that "One cannot expect positive results from an educational…program which fails to respect the particular view of the world held by the people. Such a program constitutes cultural invasion, good intentions notwithstanding" (Freire, 1970, p. 84). So, in addition to the inherent values tied to enhanced learning and educational outcomes, a stronger sense of self and place for faculty and students, and a culture that frames problems through a broader set of lenses to unleash creativity and innovation, the pragmatic reality is that nursing must adapt to supplying health care to those we have a social contract to serve.

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