# The Role of Diversity Training on Healthcare Professionals' Understanding of Diversity at UPMC Magee-Womens Hospital

by

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**The Role of Diversity Training on Healthcare Professionals' Understanding of Diversity at UPMC Magee-Womens Hospital**

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This qualitative inquiry was designed and conducted to evaluate the understanding and knowledge of diversity for ten healthcare professionals and leaders at University of Pittsburgh Medical Center (UPMC) Magee-Womens Hospital. This understanding was achieved by exploring how healthcare professionals conceptualize diversity, including race and gender differences, and about their participation in diversity trainings, resources, policies, and initiatives. Research has projected a demographic shift for minoritized individuals by 2050, including an increase in Women of Color. For healthcare professionals, the increase in the number of Women of Color as patients and the lack of a demographic shift of healthcare providers signal the importance of diversity training. It is becoming increasingly critical that healthcare professionals understand the health disparities and intersectionality of race and gender that Women of Color experience. The outcome of care is dependent on this level of understanding and, if not addressed, these biases can ultimately affect quality of care. The inquiry conceptualized diversity through Madeline Leininger's Cultural Care Diversity theory and Kimberlé Crenshaw's coined term of "intersectionality." This framework stressed the ethical responsibility healthcare professionals have to remain competent in understanding the multiple identities experienced by Women of Color and how this can impact their overall care. A description of the experiences of healthcare professionals provided insight and understanding on the need for a multi-dimensional approach to diversity training and resources at UPMC Magee-Womens Hospital. Data from the participants in

this inquiry was collected through face-to-face semi-structured interviews, resulting in four key findings. The data concluded how healthcare professionals conceptualize diversity, including how past experiences shape one's understanding of diversity. In addition, healthcare professionals were able to identify the race and gender disparities affecting the quality of care Women of Color receive, while also noting that no specific interventions are in place to address their specific needs. Lastly, healthcare professionals are charging Magee-Womens Hospital to hire diverse staff and mandating diversity training to allow for critical understanding of the disparities experienced by Women of Color. The inquiry concludes that healthcare professionals need effective, specific interventions and practices that mitigate disparities in healthcare, including an increase in the hiring of diverse staff, mandated in-person diversity training, specialized curriculum focused on critical social justice, and the reevaluation of UPMC's Center for Engagement and Inclusion diversity initiatives.

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# 1.0 Chapter 1

## 1.1 Introduction

As the United States undergoes healthcare reform, it is important to consider what "diverse healthcare" means in a country undergoing significant demographic change. By 2050, "it is estimated that 50% of the US population" will consist of minoritized individuals (United States Census Bureau, 2019). Of these changing demographics, Women of Color will make up approximately 53% of the population by 2050 (Taylor, Novoa, & Phadke, 2019). Several studies have made the assumption that the projected demographic shift for Women of Color will be reflected in the utilization of healthcare services (Manuel, 2018; Nair & Adetayo, 2019; Taylor et al., 2019). Hispanic women will lead this growth, increasing from 16.7% of the female population in 2015 to 25.7% in 2050 (Taylor et al., 2019). Asian women within the female population will similarly grow by 80%, from 5.3% in 2015 to 7.8% in 2050 (Taylor et al., 2019). The percentage of African American women will grow from 12.8% to 13.3% during the same time period (Taylor et al., 2019). White women, however, will drop from 61.8% of the female population in 2015 to 47% in 2050 (Taylor et al., 2019). With respect to gender, the Office of Disease Prevention and Health Promotion (2018) reports a higher rate of healthcare service utilization among women (90.3%) than men (84.7%). For example, women are 33% more likely to report medical symptoms to their primary care physician and utilize preventative services (Centers for Disease Control and Prevention, 2019; Manuel, 2018). However, Manuel (2018) indicates that despite greater healthcare service use among women, Women of Color continue to have an increased risk for unmet healthcare needs due to concerns for access and health perceptions.

Unfortunately, today's model of healthcare has been noted to have persistent racial and gender differences from the projected demographic shift (Nair & Adetayo, 2019). With the number of Women of Color on the rise, healthcare professionals will be tasked with caring for patients whose race and gender may differ from their own. Nair and Adetayo (2019) reviewed the scarcity of racial diversity among physicians and surgeons and their report indicates that as of 2017, 69.8% of physicians and surgeons are White males, making them the most common racial and gender group in this occupation (Nair & Adetayo, 2019). Representing 21.1% of physicians and surgeons, Asians are the second most common racial group (Nair & Adetayo, 2019). Overall, 88.9% of registered nurses are female, making them the most common gender in the nursing occupation (United States Census Bureau, 2019). In addition, 75.6% of registered nurses are White, making them the most common race in the occupation (United States Census Bureau, 2019). Representing 10.8% of registered nurses, Blacks are the second most common race in this occupation (United States Census Bureau, 2019). For behavioral health providers in 2015, Whites accounted for 83.6% of behavioral health providers (United States Census Bureau, 2019). Racial groups, including Asians (4.3%), Black/African Americans (5.3%), and Hispanics (5%), accounted for approximately 14.6% of behavioral health providers (United States Census Bureau, 2019). Lastly, the lack of diversity in healthcare leadership is quite large, with 98% of management in healthcare organizations being White men (Jackson & Garcia, 2014).

### 1.1.1 The Need for Diversity Training

For healthcare professionals, the increase in the number of Women of Color as patients and the lack of demographic shift of healthcare providers signal the importance of diversity training. Diversity training is designed to increase self-awareness, an understanding of various racial and

gender values, and a patient's beliefs in the healthcare profession where the patient-provider relationship is key to determining the quality of care (Dreachslin, Gilbert, & Malone, 2012). Interaction with a healthcare professional is such a personal relationship that it is vital for the professional to understand the racial and gender differences of the individuals with whom they are working (Dreachslin et al., 2012). Healthcare professionals who are mindful of this are in a better position to interact with their patients and provide competent care (Gibbs & Gallagher, 2017). Yet, studies have identified limited national efforts to incorporate diversity training in healthcare. In a national study of organizational efforts to reduce provider racial disparities, out of over 20 possible actions to increase cultural competence, 53% of organizations surveyed had 0 to 1 activity to reduce these disparities (Nair & Adetayo, 2019).

It is becoming increasingly critical that healthcare professionals gain a firm understanding of how and why race and gender influence the way patients experience illness, receive medical advice, and respond to treatment plans. The outcome of care is dependent on this level of understanding and if not addressed these biases can ultimately affect quality of care. Furthermore, the intersectionality of racism and sexism often results in Women of Color, particularly African-American, Latina, American Indian, and Asian and Pacific Islander women, consistently reporting the experience of bias and discrimination based on their race and gender in healthcare settings (Taylor, et al., 2019). This intermingled discrimination results in women, and especially Women of Color, feeling invisible or unheard when asking medical providers for help and expressing issues with pain or discomfort during and after receiving care (Taylor, et al., 2019).

In addition, the lack of understanding from healthcare professionals on race and gender disparities ultimately effects the quality of care Mothers of Color receive during preventative care and childbirth (Prather, Fuller, Jeffries, Marshall, Howell, Belvue-Umole, & King, 2018). The

Centers for Disease Control and Prevention has reported that African-American mothers die at a rate that is 3.3 times greater than Whites, and Native American or Alaskan Native women die at a rate 2.5 times greater than Whites (The Centers for Disease Control and Prevention, 2018). Research has shown that racial bias may cause doctors to spend less time with Black women, causing this population to receive less effective care (Prather et al., 2018). Prather et al. (2018) further claim that providers are more likely to underestimate the pain of their Black female patients, ignore their symptoms, or dismiss their complaints.

Incorporating diversity training into clinical education has the potential to improve the clinician's awareness and promote quality healthcare for Women of Color. Dreachslin et al. (2012) state that the goals of diversity training for healthcare professionals should be to increase the quality of care to various populations, build strong relationships and alliances with patients, and create a professional environment that effectively identifies and tackles the needs of diverse communities. Incorporating diversity training has the potential to impact patient care by building a level of trust and understanding between healthcare professionals and the patients they serve.

By having the appropriate skills and knowledge to encounter and interact with Women of Color, healthcare professionals will be better able to serve the nation's diverse population by having broadened perspectives of racial and gender similarities and differences. In many cases, healthcare professionals are only exposed to diversity principles as a component of their academic studies, but they are not taught how a lack of self-awareness when working with patients of various backgrounds can negate comprehensive medical care (Mercedes, Kamon, & Beatson, 2016). Hence, there is a need for increased diversity training for healthcare professionals, particularly those who care for the growing number of Women of Color.

### 1.1.2 Definition of Terms

For the purpose of this inquiry, the term *diversity* was conceptualized as the psychological, physical, social differences, and multiple dimensions that occur among any and all individuals; including but not limited to race, ethnicity, socioeconomic status, language, gender, gender expression, gender identity, and sexual orientation (Ahmed, 2007; Sensoy and DiAngelo, 2012). *Training* was conceptualized as a learned activity or educational opportunity that allows individuals to develop core competencies and undergo self-assessment, while increasing collaboration and interaction amongst each other (Polo, Cervai, & Kantola, 2018). In addition, the governmental records and data utilized in this inquiry classified *Women of Color* as African-American, Hispanic (hereafter Latina), Native American, Asian and Pacific Islander (Howell et al., 2019). Lastly, data reports employed in this inquiry classified *gender* as binary categories: female and male. Although this excludes "intersex persons and disguises the complexities of varied gendered identities," it enables the ability to capture how racial and gendered structures contribute to the observed disparities within healthcare (Howell et al., 2019, p. 7).

## 1.2 Problem of Practice

For the past four years, I have been employed at UPMC Magee-Womens Hospital in Pittsburgh, Pennsylvania, as a Licensed Clinical Social Worker. I bring special attention to the need for diversity training within healthcare organizations due to the lack of trainings and resources mandated for healthcare professionals at Magee-Womens Hospital, and the position I held as an African-American woman in a predominately White healthcare organization. As a

Woman of Color, it is important that I engage in and create opportunities to discuss what is and what is not happening in the space in which I am employed; therefore, I conducted this inquiry with concern and interest in understanding how healthcare providers in my place of practice understood diversity and/or accessing diversity training, particularly as they care for Women of Color at Magee-Womens Hospital. Fine (1994) suggests that researchers should "probe how we are in relation with the contexts we study and with our informants, understanding that we are all multiple in those relations" (p. 72). Healthcare settings need healthcare professionals who understand that the foundation of person-centered care is trust and respect for self-awareness, while also being aware of the need to broker this trust among Women of Color due to the historical context of gender and racial inequalities.

The largest industry in Pittsburgh is Healthcare and Social Assistance, with the University of Pittsburgh Medical Center (UPMC) being the largest non-governmental employer in Pennsylvania, with 40 affiliated hospitals and approximately 29,000 employees (UPMC, 2019). Within UPMC, approximately 60% of the managers are White females, with educational and clinical backgrounds in registered nursing (UPMC, 2019). In addition, more than 50% of the employed 4,900 physicians within the UPMC system are males (UPMC, 2019). Magee-Womens Hospital is a women's specialty care hospital that offers a wide range of services, including gynecologic and obstetric care, cardiology, geriatrics, urology, bone and joint care, bariatric surgery, and oncology care in Allegheny County. I was able to step away from my organization for a week of vacation and considered this time away as an opportunity to reflect on my organization's challenges with respect to race and gender. First, I took note of the disconnection between the demographics of the staff and patients, including the vast gender disparities. Nearly 70% of the physicians and healthcare professionals within this hospital setting are White males of middle to

upper class (Magee-Womens Hospital of UPMC, 2017). Conversely, approximately 93% of patients at Magee-Womens Hospital identify as female, while 7% identify as male. In 2015, 18.5% of patients identified as African-American, American Indian, Asian, Native Hawaiian, and Hispanic (Magee-Womens Hospital of UPMC, 2017). In the state of Pennsylvania, Allegheny County has the second highest percentage of African American residents (22%) compared to Philadelphia County (42%) (United States Census Bureau, 2019). In Pittsburgh, Women of Color, specifically Hispanic and Asian-American, will increase approximately 1% each year for the next five years (United States Census Bureau, 2019).

In addition to the disparity of race and gender of the employees at Magee-Womens Hospital, it is important to also note the differences in outcomes for Women of Color at Magee-Womens Hospital and within the Allegheny County region. Ley, Copeland, and Flint (2011) discuss how low-income Women of Color "continue to have enormously distinct rates of infant mortality and preterm births," (p.20) specifically stating that African-American women are twice as likely to have a preterm birth as White women. At the local level, "fetal deaths are 2 times more likely among Pittsburgh's Black women compared to White women" (Howell, Goodkind, Jacobs, Branson, & Miller, 2019, p. 17**)**. In addition, "Pittsburgh loses 5 of every 1,000 African-American women to cardiovascular disease" (Howell et al., 2019, p. 23). Magee-Womens Hospital reported several disparities among Women of Color related to the healthcare services that they provide. In the 2017 Community Health Needs Profile, it was stated that more Hispanic and African-American women (43%) reported not having a primary care provider compared to White, non-Hispanic women (12%) (Magee-Womens Hospital of UPMC, 2017).

Data further indicate that Women of Color and low-income residents within the Allegheny County area are not receiving "routine preventive care services, such as mammograms, colorectal

screening, and flu shots" (Magee-Womens Hospital of UPMC, 2017, p. 31). Although these disparities can be attributed to health-related social needs, such as the lack of access, Women of Color often will forego health services perceived as intimidating and/or culturally insensitive. Research shows that Women of Color, specifically African Americans, are often reluctant to use healthcare services due to skepticism about what might happen during the appointment (Scharff, Matthews, Jackson, Hoffsuemmer, Martin, & Edwards, 2010). Not only might this attribute to the low percentage of Patients of Color at Magee-Womens Hospital, but also stresses the need for diversity training that allows healthcare professionals to understand how these discrepancies in care can affect Women of Color. However, the first obstacle is understanding whether or not healthcare organizations and professionals have a shared goal and definition of diversity and the core components of diversity, such as gender and race differences, that impact the experiences of care for Women of Color (Ahmed, 2017).

In 2008, UPMC launched the Center for Engagement and Inclusion (CFEI) to address the need for culturally competent patient-provider relationships by providing health professionals with proper resources, policies, and initiatives. The Center's mission includes a "focus on making inclusion, dignity, respect, and cultural awareness core components of the employee, health plan member, patient, and community experience" (UPMC, 2018, p. 1). The CFEI resource center is for all UPMC employees, patients and their families, UPMC businesses and community organizations, and residents of the areas UPMC services. Although CFEI is available to the above-mentioned populations, this inquiry will focus only on diversity training in healthcare settings and those employed within the inquiry's hospital setting.

UPMC as an entity requires mandatory webinars and in-person clinical education lectures for all staff. CFEI has partnered with the UPMC's Education Department to administer diversity

training for healthcare professionals. UPMC's Education Department mandates all employees to complete the yearly education requirements or face disciplinary consequences and/or possible termination. The required hospital courses typically address updated clinical information for safe and ethical patient care. However, the annual training includes minimal instruction, specifically two 15- to 20-minute webinar-based training sessions on diversity and cultural competence. To date, the only diversity trainings that have been mandated are titled "Unconscious Bias for Health Professionals" and "Creating an Inclusive Workforce." The Unconscious Bias for Health Professionals web-based training provides a general overview of stereotypes that are automatic, unintentional, and able to influence behavior within the hospital setting. The Unconscious Bias training does not provide details regarding the common stereotypes specific to various populations. In addition, the Creating an Inclusive Workforce web-based training discusses the importance of exploring how each employee's role creates an inclusive workplace, with respect to talent, ability, diversity and cultural expertise. This training further discusses the act of practicing self-awareness, treating others fairly, and seeing value in different perspectives.

The employees at Magee-Womens Hospital have access to UPMC's CFEI resources and trainings that provide education on diversity initiatives related to various patient populations. Unfortunately, with only two mandated diversity trainings, healthcare professionals are given little education and resources on how to care for Women of Color. This minimal instruction on diversity has likely impacted how healthcare professionals are approaching patient care, as they are providing care without understanding who the patients are and where they come from (Gibbs & Gallagher, 2017). In addition, the understanding and goals of diversity training have not been adequately articulated. It is imperative that health professionals receive adequate education to effectively

provide health services that consider the social identities, cultures, gender, and backgrounds of all patients.

## 1.3 Overview of Inquiry

The purpose of the inquiry was to investigate the understanding and knowledge of diversity for healthcare professionals and leaders at Magee-Womens Hospital. This understanding was determined by asking employees about their knowledge of diversity, including race and gender differences, and about their participation in diversity trainings, resources, policies, and initiatives. The inquiry assessed both diversity and the impact it has on patients based on race and gender due to the need for healthcare professionals to understand the intersectionality of multiple identities that Women of Color experience, and the impact it has on their overall care. The aim of the inquiry was to bring awareness to the need for a multi-dimensional approach to diversity training at UPMC Magee-Womens Hospital.

To delve deeper into the problem area, the following inquiry questions were developed to allow for a better understanding of how healthcare professionals at Magee-Womens Hospital of UPMC understand diversity.

1. How do healthcare professionals at Magee-Womens Hospital understand diversity?
2. In what ways do they understand race and gender diversity, specifically?

Guided by these questions, the inquiry fostered a better understanding of what healthcare professionals and leaders at Magee-Womens Hospital of UPMC believe could potentially aid in increasing understanding of diversity within healthcare settings. There are also potentially various ways an understanding of diversity can impact the day-to-day clinic duties for healthcare

professionals at Magee-Womens Hospital of UPMC. This inquiry shed light on aspects of healthcare professionals' clinical behaviors that have changed as a result of engaging with previous trainings or discussions around diversity, and in what ways an understanding of diversity has affected the way healthcare professionals interact with Women of Color.

There are perspectives and viewpoints on diversity that could be influenced by engaging or completing a training, including the health inequities across various populations, gender, race, and socioeconomic status. It would be best to understand the aspect and/or perspective that was drawn from participating in a training, understanding a policy, or even reading available resources and how these either increased or decreased their own awareness when working with individuals with various social identities. It was hoped that participating in a training or utilizing a CFEI resource would have caused staff to reflect on previous patient interactions and how those should or could have been changed with the knowledge acquired as a result of completing that training. The inquiry was conducted using one-on-one interviews. In Fall 2019, 10 healthcare professionals and/or leaders were invited to participate in one-on-one interviews to discuss their understanding and perspectives of diversity, including knowledge of gender and racial differences among the patient population at Magee-Womens Hospital.

## 1.4 Setting of Inquiry

Magee-Womens Hospital of UPMC is a nonprofit, 383-bed acute care specialty women's hospital located in Allegheny County, Pennsylvania (Magee-Womens Hospital of UPMC, 2017). This specialty women's hospital provides a wide range of healthcare services to the Greater Pittsburgh area, with service to patients of various social, economic, racial, and cultural

backgrounds. UPMC Magee-Womens Hospital has expanded its clinical care to men, as well as a full-service Emergency Department and services including imaging, oncology, cardiology, orthopedic surgery, lupus care, gastro-enterology, colorectal surgery, pulmonology, urology, and behavioral healthcare. In addition to being one of the nation's top 10 hospitals specializing in women and the leading hospital in Pittsburgh for gynecological care, at the end of fiscal year 2015, Magee-Womens Hospital of UPMC provided services to approximately 22,000 patients (Magee-Womens Hospital of UPMC, 2017). Furthermore, Magee-Womens Hospital of UPMC is a teaching hospital, with residency and fellowship programs in family practice, internal medicine, and many specialty areas. The hospital's reach extends across western Pennsylvania through relationships with UPMC's network of hospitals, as well as with a wide range of local UPMC healthcare providers, clinics, and community outreach organizations (Magee-Womens Hospital of UPMC, 2017).

## 1.5 Significance of the Inquiry

This inquiry has significance for several stakeholders, including UPMC-Magee administrators, patients, and department managers who are part of the decision-making process at this place of practice. Although the CFEI creates and develops goals for diversity training for the UPMC hospital systems, all UPMC-Magee administrators decide whether the developed training is relevant to their department and take the responsibility of disseminating all resources to employees and staff. The department managers are responsible for verifying that such material correlates with the roles and responsibilities of clinic staff, as well as giving staff appropriate time to complete trainings and utilize appropriate resources. In addition, the Allegheny County

Department of Health, Allegheny County Department of Human Services, and the Pennsylvania State Department of Health also could benefit from this inquiry, as each of these agencies have a legal mandate to provide support to vulnerable populations. The study can offer these agencies a framework to use in implementing appropriate services and resources to Women of Color in healthcare settings and to the staff as well.

The perspectives gleaned from healthcare professionals allow stakeholders to look closely at the current education and accessible resources being offered to clinic staff and ways to improve practices to better serve Women of Color. Increased diversity understanding can not only increase the quality of patient care but can also increase innovation. Healthcare professionals can provide better patient care if they understand and represent the diversity within their patient population. Weech-Maldonado et al. (2012) state that "to serve our patients, we have to respect them…to respect them, we have to know them" (p.52). Understanding differences in languages, beliefs about medicine, death, and afterlife, can also help healthcare professionals relate to their patients and prepare themselves for those difficult conversations. In addition, the inquiry can not only benefit patient care, but the culture of a workforce as well. Workforce cultures that are inclusive and value diversity enhance productivity and innovation by having a variety of viewpoints and expertise on the subject (Weech-Maldonado et al., 2012).

## 1.6 Delimitations of the Inquiry

The inquiry has a few delimitations. The first delimitation is that this inquiry did not assess participants' understanding of the variety of the forms of diversity that are present within the patient population at Magee-Womens Hospital, with the focus being on race and gender only. The

second delimitation is that UPMC encompasses various hospitals that represent several patient populations within the Western Pennsylvania region. The results of this inquiry did not represent the entire UPMC system, but a subset of this population at Magee-Womens Hospital. While this is a delimitation, it is pertinent to the demographics of this region. To narrow the scope of this inquiry, one main concept was examined, which is diversity, specifically employees' understanding of how important race and gender are to healthcare delivery and utilization. This inquiry did not explore other aspects of diversity such as unconscious bias of employees, self-awareness of employees, understanding of diversity as a result of UPMC trainings, or assessment of current diversity policies within UPMC's healthcare system. Moreover, this inquiry did not make direct correlations between any training and people's actions following the training. The researcher investigated through face-to-face interviews how participants are making sense of and understanding diversity at one time point. The researcher did not assess any behavioral changes through observation that may have resulted from participation in a training or use of a diversity resource. As mentioned in the final chapter, further work could use additional methods to capture a behavior and clinical changes of healthcare professionals during their daily clinical duties.

## 1.7 Conclusion

Respect is at the heart of applying diversity, and patients who feel their healthcare providers respect their beliefs, customs, values, and traditions are more likely to communicate with them freely and, in turn, lead to a reduction in healthcare disparities and improve patient outcomes (Gibbs & Gallagher, 2017). Much progress is to be made in ensuring that all patients, specifically Women of Color, are treated with equal respect and dignity. Poor communication between

healthcare professionals and Women of Color can lead to greater health disparities and lower levels of satisfaction with healthcare.

A lack of diversity in healthcare settings and within its leadership is among the leading barriers contributing to racial and ethnic disparities of care. In addition, a lack of diversity awareness among those who work with Women of Color can negate them from receiving comprehensive medical care. Efforts to improve diversity training among healthcare professionals and organizations would contribute to improving the quality of healthcare for all consumers. Healthcare professionals at Magee-Womens Hospital are given little education on how to care for patients of various social characteristics. The inquiry explored how the healthcare professionals at Magee-Womens Hospital understand diversity and how it influences their daily work.

# 2.0 Chapter 2

## 2.1 Review of Literature

This literature review conceptualizes diversity through Madeleine Leininger's (1985) Cultural Care Diversity theory, Intersectionality, and three themes. Leininger's Cultural Care Diversity theory provides further definition of diversity and supports the importance of understanding the whole patient, including race and gender. Kimberlé Crenshaw (1991) coined the theory of "Intersectionality" to address and discuss the marginalization of Women of Color. Regarding racial and gender inequalities, Intersectionality can be interpreted as the relation between the two, or how race and gender may influence one another. This is to say that discrimination experienced because of gender can also be directly related, encouraged, and shaped by an individual's race (Carbado, Crenshaw, Mays, & Tomlinson, 2013). Furthermore, Crenshaw et al. (2019) suggest that although women do share common experiences, the experiences for Women of Color are often not taken seriously by their White counterparts, causing concerns to be excluded, dismissed, and often ignored (p. 178). With the use of Leininger's Cultural Care Diversity theory and Intersectionality, one can recognize and understand the racial and gender disparities among Women of Color and how they impact their overall care.

The first theme of the literature review is focused on how healthcare professionals have been instructed to recognize diversity and build cultural competence, as well as the outcomes from implemented interventions. A second theme focuses on the purpose, content, and methods used for teaching and incorporating diversity training into healthcare settings (Castillo, Brossart, Reyes, Conoley, & Phoummarath, 2007; Walton, 2011). Lastly, it is important to examine the structural

foundations that influence practices in healthcare settings; therefore, this review includes a look at how healthcare organizations develop policies and practices that meet the demand of a more diverse patient population by providing culturally competent care (Grant, Parry, & Guerin, 2013). The purpose of the literature review was to understand diversity, as it relates to increased understanding among healthcare professionals in healthcare settings, with respect to race and gender. In addition, the literature review investigated how an increased understanding of diversity stems from training and leadership within healthcare organizations.

To further explore the topic of diversity in healthcare, it is important to define several terms relevant to this inquiry, including *cultural competence*, *cultural awareness*, *values*, and *beliefs*, which are terms often explored in the literature. For the purpose of this inquiry, *cultural awareness* is defined as the "recognition that there are various distinctions of one's own and other's culture," and *cultural competence* is "the ability of individuals to use education, experience, experiential and interpersonal skills to increase their understanding and appreciation of cultural differences and similarities within, among, and between groups" (Govere & Govere, 2016, p. 403). Lastly, *beliefs* are defined as the "principles that people generally hold to be true, usually without concrete proof or evidence," while *values* are "ideas that people hold to be important and can govern the way they behave, communicate, and interact with others" (Govere & Govere, 2016, p. 403).

## 2.2 Conceptualizing Diversity

For the purpose of understanding differences, all members of an organization should take the necessary time to learn and know more about different ideas, views, values, and worldviews of those around them (Yang & Konrad, 2011). Healthcare providers must respond to changing

patient demographics in order to provide competent care. Leininger's Cultural Care Diversity theory identifies the need for the provision of culturally competent care. This theory is predicated on the premise that culturally competent care is essential for the promotion of health and wellbeing of cultures (Leininger & McFarland, 2006). Early in her career as a nurse, Leininger recognized the importance of the concept of caring in nursing. During the 1950s, Leininger identified a lack of cultural and care knowledge as the missing link to nursing's understanding of the many variations required in patient care to support compliance, healing, and wellness (Leininger, 2002).

Leininger & McFarland (2002) state that sociocultural factors within an historical context and environmental context can influence patient beliefs, values, practices, and their healthcare decisions. A meaningful and satisfactory fit of culture care beliefs, values, and practice between healthcare providers and care recipients may be needed to preserve, maintain, or change care practices for the benefit and satisfaction of clients (Leininger & McFarland, 2006). Leininger's theory provides a general set of assumptions stating that culturally competent care does the following:

1. Consciously addresses the fact that culture affects the provider–patient relationship;
2. Includes compassion and clarity, by asking each client what his/her cultural practices and preferences are;
3. Incorporates the client's personal, social, environmental, and cultural needs/beliefs into the plan of care wherever possible; and
4. Respects and appreciates cultural diversity, and strives to increase knowledge and sensitivity associated with healthcare concerns. (Leininger, 2002, p. 97)

The purpose of Leininger's theory on Cultural Care Diversity is to "discover, document, know, and explain the interdependence of care and culture phenomena with differences and

similarities between and among cultures" (Leininger, 2002, p. 25). While care, caring, and culture represent central concepts of the theory, Leininger (2006) found that the perspective that one has on one's environment, worldview, and professional role can profoundly be influenced by one's understanding of cultural differences.

When healthcare professionals are respectful and understanding of racial and gender differences and the inherent needs that these differences bring to their patient populations, then a healthy, therapeutic relationship can be established. The intersection of race and gender adds to the complex experience of Women of Color in healthcare settings. "Intersectionality" refers to the intermingled identities and domains that may contribute to the experiences of oppression within discriminatory health environments and systems (Crenshaw, 1989). It is important to not solely focus on different identity domains, but the experience involved when multiple identities merge in different contexts. This experience may impact the way Women of Color vocalize, express, and experience healthcare needs. Multiple layers of oppression can reinforce each other; therefore, applying an Intersectional approach to diversity training can allow healthcare professionals to "understand the qualitatively different experience" Women of Color have compared to White women (Bagshaw, 2019, p. 26). This inquiry argues that Intersectionality can complement the way in which Women of Color view themselves within a healthcare system, ultimately resulting in the necessity for healthcare providers to have a more thorough understanding of their patients' health needs. Although I do not use this theoretical framework to guide this inquiry, I have provided an overview to further stress the importance of providing diversity training to healthcare professionals.

## 2.3 Diversity Training for Healthcare Professionals

While diversity in patient populations has steadily increased, the skills needed to provide culturally competent care for patients is evolving (Young & Guo, 2016). The diverse characteristics of patients strongly influence their understanding of healthcare, access to healthcare facilities, and utilization of healthcare services. Several scholars and policymakers recommend incorporating diversity training into healthcare settings on the premise that an inclusive and culturally sensitive healthcare system will reduce racial and ethnic health disparities (Grant et al., 2013; Khanna, Cheyney, & Engle 2009). As an outcome of ongoing research and policy discussions, an increasing number of healthcare settings and medical schools are integrating diversity training into their existing training programs or curriculum (Khanna et al., 2009). Although there is no one-size-fits-all approach to understanding patient diversity, themes within the scope of diversity training relate to self-assessment, learning, and acceptance of cultural similarities and differences have been suggested by many experts in the healthcare field (Beard, 2016; Young & Guo, 2016).

Each healthcare professional has a perspective that is uniquely personal. The next several sections are focused on diversity training among nurses, physicians, medical students, and mental health professionals (including psychologists, psychiatrists, and social workers). These professions were chosen for further exploration due to their consistent patient contact and relevance to the multidisciplinary team approach at UPMC Magee-Womens Hospital. The mentioned professions bring a different approach and level of expertise to the overall patient experience. For the purpose of diversity training, the next sections will highlight how diversity training is viewed according to each separate profession.

### 2.3.1 Diversity Training in Nursing

In a study conducted by Debiasi and Sellck (2017), the authors concluded that nurses meet with patients more consistently than any other healthcare professional within a hospital system, suggesting the importance of diversity training for these practitioners. Debiasi and Sellck (2017) argue that diversity training in the field of nursing is essential because it "provides the opportunity to administer quality care to patients, which bridges the divide between the culture of medicine and the beliefs that make up a patient's value system" (p. 40). These authors used a mixed-methods design, including a pre-training self-report and client assessment to determine baseline understanding, a diversity training, and a post-training client survey and nurse assessment, to determine if diversity training improved nurses' ability to provide culturally competent care (Debiasi & Sellck, 2017). Out of the 21 questions asked during the pre-training assessment, 20 questions had increased scores post-training, suggesting that they had a better understanding of what it means to be culturally competent during daily clinical practice.

Furthermore, the literature suggests that nurse educators play a central role in a nursing student's academic progression and professional position within a hospital setting (Beard, 2016). Nurse educators must understand how patients' diverse backgrounds can influence their assumptions regarding healthcare decisions and appropriate ways to increase this awareness among nursing students and nurse professionals, which necessitates a greater knowledge of teaching practices that promote equity (McElroy, Smith-Miller, Madigan, & Li, 2016). In addition, if the delivery of the best possible care for all patients is the goal, nurses must have expertise and skill in the delivery of culturally appropriate and culturally competent nursing care. All nurses must take an active role in obtaining a knowledge base upon which to develop cultural competency. The ability to deliver nursing care that will allow effective interactions and the development of

appropriate responses to persons from diverse cultures, races, and ethnic backgrounds is critical for nurses in the 21st century (Marion et al., 2016). Literature further suggests the need for diversity training in both nursing education programs and healthcare settings (McElroy et al., 2016).

### 2.3.2 Diversity Training for Physicians and Medical Students

Horwitz, Sonilal, and Horwitz (2011) conducted a systematic review of the impact of diversity training on quality care provided by physicians and medical students. The authors examined the ways issues of diversity can be adequately addressed in healthcare settings, with an emphasis on advocating that physicians adopt a proactive leadership style to manage problems related to misunderstandings and assumptions about diverse patient populations (Horwitz et al., 2011). In order for leadership training among physicians to be fully effective, diversity training should be integrated across the entire organization. Furthermore, the research suggests that a culturally sensitive lens allows a physician to frame the patient's medical problem in a way that makes more sense for the patient (Horwitz et al., 2011).

Carpenter et al. (2015) argued that a diversity lecture for medical students or physicians should improve doctor-patient communication. The authors conducted a randomized study of 180 first-year medical students who took an online Web-based curriculum or traditional lecture-based cultural competency training, with use of a pre- and post-test survey to measure knowledge levels (Carpenter et al., 2015). Although there were no reported significant differences between the methods of Web-based or traditional lecture training, results were associated with equally high positive attitudes and diversity understanding among first-year medical students post-training. The authors covered seven main areas during the training, including health disparities, incidence and

prevalence, stereotyping, exploring culture, perception of health and illness, communication and language, and gender issues (Carpenter et al., 2015). The results indicated that knowledge scores improved by 84.4%. The authors proposed that if any method of diversity training does make a difference among medical students, training should be undertaken throughout a physician's career (Carpenter et al., 2015). Appreciation of cultural diversity should also increase patients' adherence to treatment regimens and improve outcomes, including patient satisfaction (Carpenter et al., 2015).

### 2.3.3 Diversity Training for Mental Healthcare Professionals

Until recently, diversity training has not been formally considered for psychiatrists or other mental healthcare professionals (Stanhope et al., 2005). There has been a tendency to assume that diversity, especially diversity related to ethnicity, inherently leads patients to have different beliefs about mental health and that this should be the focus of exploration (Stanhope et al., 2005). Stanhope et al. (2005) chose to evaluate cultural competence, based on the evaluation of statewide diversity trainings for behavioral health professionals. They concluded that not only is there a need for diversity training among behavioral health professionals, but also the need for a specialized curriculum that best prepares these individuals to handle a multitude of patient social issues. Psychiatry, psychology, and even social work departments have a history of concern with cultural differences in access and use of mental health services and treatment outcomes. These professionals often view the experience and expression of mental illness as fundamentally different across diverse racial and ethnic groups and argue these differences must be considered to provide effective and equitable treatment for all (Stanhope et al., 2005). While there is widespread agreement that diversity training must be integrated into every aspect of service delivery within

the behavioral health system, there is still much to learn about how to train and educate all behavioral health professionals. This review of literature across various departments of healthcare professionals has shown that when all levels of employees are given the tools, training, and understanding of diverse populations, changes in patient satisfaction and outcomes are the result (Stanhope et al., 2005).

## 2.4 Incorporating Diversity Training into Healthcare Settings

Diversity training can be a way to promote the practice of self-reflection in hopes that this training will help healthcare professionals dig deeper into the value of diverse perspectives and experiences while understanding the differences between themselves and others. Although the objective of self-reflection may be important when incorporating diversity training into healthcare settings, research also suggests that other elements, including the methods of diversity training in which a diversity lecture occurs, may be essential to transform thinking or remove bias and stereotyping from those working with diverse populations (Mercedes, Kamon, & Beatson, 2016). In an effective diversity training, seeking awareness, proper knowledge, understanding, and attendance are the objectives that will enable healthcare professionals to understand and accept the dynamics of differences between people in order to collaborate with the patient and family to deliver care that is respectful of the patient (Delgado, Frguson, Gannor, Gillett, Engstrom, & Ness, 2013).

### 2.4.1 Purpose of Diversity Training

Diversity training to create behavioral change can be divided further into awareness and skills training. The expectation is that once healthcare professionals are aware of their biases through proper dissemination of knowledge, they can replace those biases with effective behavior. Kalinoski, Steele-Johnson, Peyton, Leas, Steinke, and Bowling (2013) conducted a review of diversity training research and provided a useful definition within two broad categories: training designed to disseminate information and training designed to create behavioral change. The authors stated that the purpose of diversity training within healthcare settings is to distribute information that informs healthcare professionals of a diversity strategy and expectations, to result in cognitive-based change (Kalinoski et al., 2013). Kalinoski et al. (2013) found that diversity training related to skills training was most effective in making clinic practice changes among healthcare professionals and their relationships with patients of various populations.

### 2.4.2 Objectives of Diversity Training

Walton (2011) focused on the development of a diversity training that allowed individuals "to be open-minded, focusing on building trust and seeking to understand the individual beliefs of patients" (p. 26). Walton (2011) found a statistically significant difference in the pre- and post-test study measuring cultural awareness, suggesting that participants can learn cultural awareness from diverse populations and can apply culturally aware interventions following an education session based on clinical research. Most medical students participating in the Walton (2011) study reported a willingness and desire to establish a therapeutic relationship with individuals who were different from them and reported they would approach patients with an open mind. Moreover, the following

themes were identified as important to developing a healthy relationship with a patient: approaching the patient with an open mind; developing trust; assessing beliefs, culture, and knowledge; educating and re-educating with patient and family; providing reassurance to the patients regarding their treatment plan; and creating a sacred space (Walton, 2011). These findings suggest that healthcare professionals can learn from an educational research presentation, gain cultural awareness, and individualize care to a specific patient.

A systemic review of diversity educational interventions in healthcare settings demonstrated that such trainings could not only improve healthcare professionals' knowledge, but they can also improve their attitudes and skills (Mercedes et al., 2016). Mercedes et al. (2016) further stated that such trainings can often neglect to incorporate material on the causes and nature of health disparities (Mercedes et al., 2016). If diversity trainings are going to be effective at assisting in the elimination of health disparities, they need to incorporate material designed to increase a healthcare professional's understanding of these causes. Mercedes et al., (2016) expanded upon previous models of diversity training by incorporating the historical context of racism and its impact on health disparities as core training components. Further, the need for researchers to add to the growing literature on the overall effectiveness of diversity training was stressed.

### 2.4.3 Methods of Diversity Training

Although literature promotes the overall importance of competent care, a recurrent method of delivering diversity training is the use of a one-hour diversity class. Diversity trainings have the potential to provide healthcare professionals with crucial skills related to cultural awareness, communication, teamwork, and problem-solving as they work with individuals of differing

backgrounds (Delgado et al., 2013). These skills are essential to quality patient interactions among increasingly diverse patient populations (Delgado et al., 2013).

Delgado et al., (2013) conducted a descriptive study to determine the effectiveness of an in-person course on diversity issues for nurses within a hospital setting. During the diversity course, “participants explored their cultural heritage, issues related to health disparities, and implications for healthcare providers” (Delgado et al., 2013, p. 206). The study included the use of pre- and post-surveys at 3- and 6-month post training to assess the impact of the training on the participants’ cultural competence. Baseline data revealed that the nurses were aware of the differences in various populations, but participation in the one-hour training showed a significant increase in awareness (Delgado et al., 2013). The authors claimed that awareness is "not the same as competence but should be present before competence can be obtained" (p, 209). Furthermore, they state that the class also may have also increased participant awareness to personal biases or identified the limited knowledge one has about various cultures (Delgado et al., 2013). These results suggest that diversity training should be included in biannual clinical update activities. This will assure that as patient demographics change, clinical care remains competent and respectful.

## 2.5 Implementing Diversity Training into Healthcare Settings

When incorporating diversity training into healthcare settings, it should include translating individual commitment to organizational commitment (Curtis, Dreachslin, & Sinioris, 2007). Research suggests that reviewing the development and overall structure of healthcare organizations should be sought to identify how diversity training or related cultural competency assessments are represented and expressed in creating change (Grant et al., 2013, p. 252).

Organizational policies have been enacted to not only define goals and strategies, but to promote, protect, and maintain the health of various populations (Grant et al., 2013). Healthcare organizations must develop policies and practices that meet the demands of a more diverse patient population by ultimately providing culturally competent care.

Although stakeholders responsible for diversity training in most organizational settings agree that behavioral change is key, awareness building and associated attitude change remain the focus of most implemented diversity trainings (Curtis et al., 2007). Consequently, researchers recommend a systems approach to diversity training, where training is a key component to healthcare organizations' strategic goals for improved quality of care. Curstin et al., (2007) concluded that a systems approach requires the following steps: “determine diversity and cultural competence goals in the context of strategy, measure current performance against needs, design training to address the gap, implement the training, assess training effectiveness, and strive for continuous improvement” (p. 257). It is with hope that measuring positive changes that signify return on investment can be used to convince stakeholders of the value of incorporating diversity training into their healthcare systems, especially since patient demographics are everchanging.

Weech-Maldonado, Elliott, Pradhan, Schiller, Hall, and Hays (2012) found a positive relationship in hospital cultural competency at the organizational level. This was assessed as adherence to the Department of Health and Human Services Office of Minority Health’s cultural standards and patient experiences with care in California hospitals. This study contributed to the literature by using a pre– and post-intervention assessment, titled the *Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS),* to explore the impact of a structural, mandated cultural competency policy on performance measures at the organizational and individual levels among two health systems (Weech-Maldonado et al., 2012). The results showed

that hospitals with a greater cultural competency policy have better assessment scores for doctor communication, hospital rating, and hospital recommendation. Furthermore, HCAHPS scores for diverse patient populations were higher at hospitals with greater cultural competency on other dimensions, including nurse communication, staff responsiveness, quiet room, and pain control (Weech-Maldonado et al., 2012). These findings indicate that greater hospital cultural competency as a result of diversity training may improve overall patient experiences but can particularly benefit interactions with patients of different backgrounds among the nursing or hospital staff. Such effort may not only serve longstanding goals of reducing disparities within patient experience but may also contribute to general improvement in the quality of service delivery.

### 2.5.1 Barriers to Implementing Diversity Training into Healthcare Settings

Celik, Abma, Widdershoven, van Wijment, and Klinge (2008) conducted a qualitative study that explored the existing problems to the implementation of a diversity training policy in a healthcare setting. Interviews were performed with several stakeholders on the following topics: sex, culture, age, disability, and socioeconomic status. Subthemes included policy level guidelines, recruitment, educational and financial policy, and the patient care process. The results indicated that several barriers were in the way of mandating policy regarding diversity training in healthcare settings. The barriers could be divided into three main categories, including lacking awareness and knowledge of diversity, poor information and communication, and organizational constraints. The authors further stated that this lack of awareness stems from healthcare professionals having a neutral approach and believing that “every patient is similar and should be treated alike with respect to warmth” (Celik et al., 2008, p. 67) Therefore, the inability to understand the importance of diversity training can become an impediment when trying to mandate or implement such

training for healthcare professionals. Lastly, the conditions regarding time constraints for health professionals while they are on duty limits their ability to be mindful of diversity factors that are important to patient care. This unfortunately limits their ability to participate in diversity training and their awareness of diversity considerations when working with patients.

The mentioned barriers and opportunities can be considered when developing mandated, educational diversity programs, which can then be used for training professionals in healthcare practice. The current perception of care practices may heavily hinge on what professionals have learned and how they were generally professionalized. Accumulating and distributing knowledge are essential in healthcare and can be achieved by developing open dialogue within organizational networks, similar to UPMC's CFEI. Such networks could allow healthcare professionals to learn from one another and discuss best practices on how to teach this information to their staff. Educational programs, such as diversity training, and organizational networks can be appropriate tools to take patients' needs and preferences into account to improve their quality of care (Celik et al., 2008).

## 2.6 Conclusion

Leininger's Cultural Care Diversity theory stresses the notion that patient care is predicated on the understanding of beliefs, practices, and the values of patients. A lack of this understanding on the part of healthcare professionals can ultimately lead to greater health disparities and lower levels of patient satisfaction within healthcare. For Women of Color, healthcare professionals must become educated regarding the impact of racial and gender disparities and how the intersection of these two characteristics influences the lived experiences for Women of Color within healthcare

settings. Intersectionality means that a person's various identities determine their lived experience due to societal structural factors and power dynamics, including treatment in healthcare settings. Leininger's Cultural Care Diversity theory and the perspective of Intersectionality will guide the importance of understanding diversity and the experiences of Women of Color in healthcare settings, while also understanding the tenants of Intersectionality and how it impacts care received for Women of Color.

To enhance providers' understanding of diversity, training programs should focus on professionals in the context of their particular healthcare setting. This supports the need to intensively educate and train professionals on how to handle care from a diversity perspective in their particular context. The importance for all healthcare professionals, including nurses, physicians and medical students, and mental health professionals, to be given tools, training, and understanding of diverse populations is imperative to improving patient and employee experiences. In order to adequately address diversity, proper tools, such as educational lectures, are needed to promote self-assessment, learning, and acceptance of cultural competence and differences among various patient populations. In addition, a diversity educational lecture can help to stimulate a "sense of urgency" and overcome the lack of awareness and knowledge of diversity.

The literature seemed also to focus on effective practice and policy in healthcare settings for all healthcare professionals. Apart from training programs, accumulation and dissemination of knowledge seem to be essential in healthcare. This could be achieved by promoting knowledge-building networks, spaces, and organizational systems to address gaps in knowledge. In these networks, professionals can learn with and from each other in terms of how to consider diversity and how to apply existing best practices. Educational programs and knowledge networks can be

appropriate tools to help practitioners take patients' needs and preferences into account in order to improve the quality of care among diverse patient populations.

# 3.0 Chapter 3

## 3.1 Methodology

This inquiry examined how the healthcare professionals at Magee-Womens Hospital understand diversity. In addition, the inquiry assessed specifically healthcare professionals' understanding of diversity, including racial and gender differences, and how it relates to the patient population at Magee-Womens Hospital. The inquiry was guided by the following questions: How do healthcare professionals at Magee-Womens Hospital understand diversity; and in what ways do they understand race and gender diversity, specifically?

## 3.2 Inquiry Setting

Magee-Womens Hospital is one of 40 UPMC licensed hospitals and 16 total hospitals in Allegheny County. Magee-Womens Hospital is the primary source of specialty care for women in Allegheny County as well as the surrounding counties (Magee-Womens Hospital, 2017). In the 2016 Community Assessment Report, it was noted that this hospital served approximately 22,000 patients in that year (Magee-Womens Hospital, 2017), with approximately 93% of patients identifying as female, while 7% identified as male. In 2015, 37.7% of patients identified as African-American, American Indian, Asian, and Hispanic (Magee-Womens Hospital, 2017). In addition, Magee-Womens Hospital is primarily known for their services with gynecology and obstetrics. Nearly 10,000 babies were born at Magee in 2017, accounting for 45% of all births in

Allegheny County (Magee-Womens Hospital, 2017). The Neonatal Intensive Care Unit (NICU), the largest in Pennsylvania and one of the largest in the country, treats more than 1,500 seriously or critically ill babies each year (Magee-Womens Hospital, 2017).

Approximately 2,300 healthcare professionals are employed at Magee-Womens Hospital, with most being White males across various medical disciplines, including but not limited to, physicians, physician assistants, medical residents and fellows, nurses, nurse practitioners, medical assistants, patient care technicians, behavioral health staff, administrators, department leaders, and office staff (Magee-Womens Hospital, 2017). According to the *U.S. News & World Report*, approximately 58% of the physicians at Magee-Womens Hospital identify as male, while 41% identify as female (*U.S. News & World Report*, 2019). Of these physicians, less than 30% identify as racial minorities, such as African-American, Native American, Asian-American, and Hispanic, with approximately 70% identifying as White (*U.S. News & World Report*, 2019). I chose to conduct the inquiry within this setting due to administrative support and the relationship I have with the healthcare professionals of this hospital. Cohen, Manion, and Morrison (2018) state that accurate data in qualitative research can be obtained if the interviewer establishes rapport and relationships with the participants.

### 3.2.1 Department Units at Magee-Womens Hospital

This inquiry focused on the employees within all departments at Magee-Womens Hospital. The 24 departments available to women at Magee-Womens Hospital are divided into two categories: Obstetrics & Gynecology and Specialty Services for Women. The Obstetrics & Gynecology departments include the Center for Diabetes and Pregnancy, the Center for Medical Genetics and Genomics, the Dan Berger Cord Blood Program, the Fetal Diagnosis and Treatment

Centers, Gynecology, High-Risk Pregnancy, Labor and Delivery, the Lactation Center, Midwives at Magee, the Neonatal Intensive Care Unit, Perinatal/Neonatal Substance Abuse Unit, Postpartum Care, Pregnancy Loss, and the Womancare Birth Center. Regarding the Specialty Services for Women, the departments include Behavioral Health, Center for Bladder and Pelvic Health, Center for Fertility and Reproductive Endocrinology, Center for Women with Disabilities, Fibroid Treatment Center, Breast Imaging, Women's Midlife Health Center, and the Women's Cancer Center.

The Department Units at Magee-Womens Hospital are dedicated to providing comprehensive care, with a traditional focus on gynecologic and obstetric services. Currently, healthcare professionals within all of these departments have access to the UPMC CFEI resources via an online portal and the webinar-based trainings on Unconscious Bias and Creating an Inclusive Workforce. The online resources include UPMC CFEI's Culture Vision initiative. This initiative provides reading materials that enable employees to deliver treatment and services that promote UPMC's value of dignity and respect for all (UPMC, 2018). These tools and resources respond to the health, beliefs, and practices, and the cultural and linguistic needs of diverse patients, employees, and health plan members in the communities the hospital intends to serve. This initiative was created to ensure the hospital's ability to provide healthcare for all communities, including people of color (UPMC, 2018). Through an online portal, employees can review documents and brochures that detail health needs of the mentioned patient populations and how to better understand their health through the lens of cultural competence.

In addition, the webinar-based trainings on Unconscious Bias and Creating an Inclusive Workforce are included in the clinical educational mandates given each Fall. The duration of the Unconscious Bias training is approximately 20 minutes, while the Creating an Inclusive Workforce

training is approximately 15 minutes. Both web-based trainings utilize patient scenarios and vignettes to display and recognize how unconscious biases and/or inclusive workspaces can impact interactions with other co-workers, patients and their families, and customers. At the end of both the Unconscious Bias and Creating an Inclusive Workforce webinar-based trainings, employees are given a 10-question quiz to test definitions, such as diversity, cultural competence, and appropriate responses to implicit bias during the clinic day. The purpose of these courses is to help learners become self-aware of unconscious bias and how to manage these biases to create a more inclusive work environment. The CFEI has developed learning forums that examine the impact of unconscious biases within the workplace as it pertains to decision-making and best patient care practices (UPMC, 2018).

### 3.3 Paradigm Approach

For this inquiry, I selected a constructivist approach towards data collection and analysis. The assumptions guiding the constructivist paradigm are that knowledge is socially constructed by people active in the research process, and that researchers should attempt to understand the complex world of lived experiences from the point of view of those who live it (Jones, Torres, & Arminio, 2014). The constructivist paradigm describes how individuals come to an understanding of their experiences and beliefs about the world and emphasizes that research cannot be independent of them (Jones, et al., 2014; Mogashoa, 2014).

The constructivist paradigm poses questions and problems, while allowing participants to find their own understanding and perspectives (Lindgren, 2009). Constructivism involves essential aspects such as culture, language, an individual's interests and needs, personal experience, and

their interpretation of reality (Mogashoa, 2014). The constructivist paradigm allows for participants to formulate their own inquiries and allows for a multitude of interpretations, and expressions, while encouraging the use of collaborative efforts with respect to the offerings of diversity training. Furthermore, the perspectives and insights gained from interacting with diversity training and resources should reflect transparency and respect towards a participant's understanding and values. To remain consistent with the constructivist paradigm, it was important that I remained objective in my viewpoints and did not allow personal values and understanding to inhibit the analysis of the data collected.

### 3.4 Researcher's Reflexivity

At the time of the inquiry, I held the role as the Lead Supervisor for the outpatient oncology social workers in the Women's Cancer Program. The department team consisted of four social workers and an intern responsible for alleviating any barriers to care that impeded oncology patients from receiving adequate cancer treatment. Barriers can include transportation, financial resources, insurance concerns, and additional support that can assist patients going through the cancer journey. One of the aspects of the position that I most enjoyed was being a patient's advocate to help cancer patients make informed health decisions. However, this sole duty allowed me to see firsthand how healthcare professionals interact with Women of Color. Patients within the Women's Cancer Program truly valued the relationship they have with healthcare professionals and often continue care at this facility if their desire to communicate with a provider is met. In addition, the understanding healthcare providers have about their own identity, race, etc. and how it may impact their patient's experience can foster better communication with that particular

patient. “The way health-care providers perceive themselves as competent providers is often reflected in the way they communicate with patients” (Gibbs & Gallagher, 2017, p. 3). I often supported patients during their consult visits and chemotherapy treatments and have seen a multitude of patients from various cultural backgrounds treated differently due to their background characteristics. For example, patients who have minimal education, language barriers, minimal family support, and a lack of financial resources are often treated differently from those who do not have these attributes.

I identify as a Black, heterosexual, educated woman in a predominately White hospital setting. Although diversity is defined as more than race, it’s important for me to understand that I am a Black woman focused on research, driven to identify and advocate for a population that I identify with, Women of Color. Ahmed (2017) states that “if your arrival is a sign of diversity, then your arrival can be incorporated as good practice” (p. 153). The author further suggests that People of Color provide organizations with tools and ways of turning action points into outcomes (Ahmed, 2017). It was crucial that I avoided biases within my inquiry, but equally important to understand the perspective and experience I brought as a minoritized individual to this healthcare organization.

In addition, I needed to be mindful of my professional relationship with each individual within the sample of the proposed inquiry. Jones et al., (2014) state that “the relationship between the researcher and participants is one of the hallmarks of qualitative inquiry” (p. 120). I, therefore, wanted to ensure that I have a relatively close working relationship with each of the participants prior to beginning the inquiry, and one that could be built upon throughout the course of their participation in the inquiry. Such a connection is not only important to the type of inquiry in which I’ve chosen to engage, but also to the overall functionality and rapport of the team and its efforts.

Due to the understanding and perspectives of diversity being shared for this inquiry project, it was important for me to be cognizant of this professional relationship and create a safe space for employees to be open in sharing their perceptions towards this research.

### 3.4.1 Inquiry Approach

I selected a qualitative approach by using one-on-one semi-structured interviews. Trussell, Paterson, Hebblethwaite, Xing, and Evans (2017) state that "qualitative research expands disciplinary boundaries that exist between fields of social inquiry and, consequently, the underpinnings of the very creation of knowledge" (p. 2). Therefore, it is critical in qualitative research for researchers to recognize human interaction and holistically understand how these interactions may affect their own values and understandings from their worldview. Taylor and Bogdan (1998) state that qualitative methodology produces a person's own written or spoken works and observable behaviors. The purpose of this qualitative inquiry was to document the descriptive experiences of healthcare professionals as they perceive diversity at Magee-Womens Hospital. Moreover, the principal function of qualitative research is to address those individual opinions, attitudes, beliefs, reflections or experience of things that cannot be measured in the statistical sense but offer value in the identification, knowledge and understanding of the experience (Creswell, 2003; Tashakkori & Teddlie, 2003). In other words, the focus is on understanding an experience or an event (Caelli, Ray, & Mill, 2003). A significant amount of research has been conducted using this approach and has addressed how diversity shapes healthcare professionals' understanding and experiences while working with Women of Color. Assuming that the discussions from the interview protocol (Appendix E) allowed for considerable

assessment of understanding diversity, such an approach allowed for effective ways to further implement diversity training and offerings to healthcare professionals within the UPMC system.

#### 3.4.1.1 Sample

In qualitative research, it is more likely that the sample size will be small, often due to constraints of cost, "including time, money, stress, administrative support, and resources" (Cohen, Manion, & Morrison, 2018, p. 204). The inquiry was completed during clinic days, between patient hours of 8 a.m. and 5 p.m. Time was, therefore, a constraint because participants were required to take time out of their day to participate in a one-on-one, face-to-face interviews. In considering this constraint, I interviewed a minimum of 10 healthcare professionals using purposive sampling. Purposive sampling is when the researcher selects a sample based on their own knowledge about the study and population (Cohen, et al., 2018). The sample was comprised of healthcare professionals to include nurses, physicians, and mental health providers from various departments at Magee-Womens Hospital. Participants were invited utilizing the confidential, UPMC email server. An initial email announcement (Appendix A) was generated from my own University of Pittsburgh account to 60 employees of Magee-Womens Hospital to briefly outline the proposed inquiry and objectives to encourage those invited to participate in the one-on-one interviews. Later, a second email (Appendix B) was sent privately to participants who responded and agreed to participate in the inquiry. This second email offered detailed information pertaining to the interview protocol, location of the interview, contact information, and a Doodle link to schedule the semi-structured interview. Participants were purposefully selected and invited based on the selection criteria, including those who were healthcare professionals, employees, and/or leaders of Magee-Womens Hospital and in some capacity had direct contact with caring for Women of Color.

For the qualitative interviews, all participants completed a demographic survey (Appendix C). The total of ten (N=10) staff members from Magee-Womens Hospital who were interviewed included two fellows, two physicians/surgeons, three social workers, two administrators, and one nurse practitioner (See Table 1). The number of years participants held their current positions varied between 1 to 20 years, with an average of approximately 4.8 years. Among this group, the number of years worked specifically at Magee-Womens Hospital varied from 1 to 20 years, with an average reported years worked at Magee-Womens Hospital approximately 5.5 years. All participants were female. Nine spoke English as their dominant language, and one spoke English and Tagalog. Of the participants, four were White, while five were African-American and one was Asian-American. In terms of their education level, four of the participants held a Master's degree in Social Work (MSW), while four reported having a Doctor of Medicine (MD) degree; one reported having a Master's degree in Nursing (MSN); and one reported having a Doctorate (PhD) in Nursing (Table 1*)*. The participants' names have been changed to maintain anonymity.

**Table 1: Characteristics of Inquiry Sample**

| | Gender | Race/Ethnicity | Degree Type | Current Position |
|---|---|---|---|---|
| Ashley | Female | African-American | MD | Fellow |
| Carrie | Female | White | MSN | Administrator |
| Darlene | Female | Asian-American | MD | Physician |
| Julia | Female | African-American | MSW | Social Worker |
| Cheryl | Female | African-American | MD | Physician |
| Alisha | Female | African-American | MD | Fellow |
| Kennedy | Female | White | MSW | Administrator |
| Kelly | Female | African-American | MSW | Social Worker |
| Stephanie | Female | White | PhD | Nurse Practitioner |
| Margie | Female | White | MSW | Social Worker |

## 3.5 Participant Role Responsibilities

Overlap is present in the job responsibilities associated with job titles. The responsibility of the nurse practitioner at Magee-Womens Hospital allows for work in direct contact with patients for assessment, ordering, and interpreting diagnostic results, disease diagnosis, and formulation of treatment plans, while also assisting in other research and clinical projects. The two participants classified as physicians/surgeons include an assistant professor of surgery and a neonatology physician. The assistant professor of surgery holds the responsibility of managing the clinical care of patients affected by breast cancer and surgical problems of the breast, while also managing personnel with respect to running the flow of the department. The neonatology physician's role entails taking care of premature infants, while also interacting with mothers prenatally through

prenatal counseling, as well as attending the delivery, stabilizing the infant, and then taking care of the infant after delivery. Social workers can be classified as patient navigators/oncology social workers and medical social workers due to the overlap of responsibilities. The patient navigators/oncology social workers uphold the responsibility of assisting patients who have a diagnosis of cancer, mostly for breast or gynecological cancers. The patient navigators/oncology social workers also assist patients with removing barriers to care, including resources, emotional support, transportation needs, help with insurance, and support groups, etc. The medical social worker works primarily with pregnant women, but also guides obstetric and gynecological patients who need assistance while in clinic, ranging from crisis intervention and completing full assessments to assisting with resources or intervention strategies that can be useful before and after pregnancy. The neonatology medicine fellows described their role as working between two hospitals, including Magee-Womens Hospital and Children's Hospital. They are responsible for providing and/or learning about the care of newborns while working alongside the nurses, physicians, and nurse practitioners. Administrators include The Director of Operations and the Manager of Social Work. The Director of Operations continues to have clinical responsibility for the clinical staff but also the operational side of decision making for, budgets, projects, and administrative duties throughout the department. Lastly, the Manager of Social Work manages and oversees the day-to-day duties of the inpatient and outpatient social work staff. The Social Work Manager is also responsible for seeing patients clinically when social work staff are not available.

## 3.6 Data Sources

The primary source of data was a set of one-on-one semi-structured interviews with healthcare professionals at Magee-Womens Hospital. Semi-structured interviews are formal engagements where the interviewer develops and uses an interview guide, questions, and topics to be covered during the conversation (Cohen & Crabtree, 2006). Although in these instances the interviewer uses a guide, the interviewer can stray from that guide to gather additional information when appropriate. Semi-structured qualitative interviews for individuals can allow the researcher to gather data on the more intangible aspects of an organization's culture, for example, one's values, assumptions, and beliefs (Cohen, Manion, & Morrison, 2018). Essentially, interviews can do what surveys cannot, which is to "explore issues in-depth, to see how and why people frame their ideas in the ways that they do, and why they make connections between ideas, values, events, opinions, behaviors, etc." (Cohen, et al., 2018, p. 506). The interviews took place at the hospital setting, in a private office that was located by each participant. All interviews lasted from 45 to 60 minutes. The interviewer allowed the participant to talk and respond freely while maintaining the parameters of each question. All participants were engaged during the interview and allowed the researcher to ask clarifying questions and to explore with the participants their own understandings of their experience. For the semi-structured interviews, the topics and questions were given, and the questions were open-ended. In addition, the wording and sequence of each question was tailored to each individual interviewee and the responses given, with appropriate prompts and probes (Cohen et al., 2018).

The focus of the primary data source was on the understanding of diversity. The interview protocol (Appendix E) was crafted based on assessing gender and race differences. It was with hope that the structured interviews would gain insight and reflection on participants' understanding

of diversity as it relates to race and gender differences, and participation and understanding of diversity training. Prior to conducting the interview, a written consent (Appendix C) was used requesting consent to proceed with the interview questions. In addition, demographic variables of the participants were obtained through a demographic survey that was distributed individually with the second email (Appendix B). During the interviews, participants were given descriptions of the purpose and nature of the inquiry. In addition, to ensure that all responses remained anonymous and confidential, participants were assigned a pseudonym used to identify their responses during the data analysis process. Participants were asked about subjects within different categories, including questions pertaining to their workplace, available diversity resources and offerings, accessibility, perceptions of diversity based on participation in trainings, and recommendations to consider for future interventions. The semi-structured interviews also assessed the participants' opinions on diversity as it relates to caring for Women of Color. Participants received a $25 Amazon thank-you gift card for completing the interview.

### 3.6.1 Data Analysis

Cohen et al. (2018) recommend that qualitative researchers utilize inductive content analysis. A researcher who uses inductive analysis "reads, re-reads, reflects on, infers from and interprets the raw data/transcripts" (Cohen et al., 2018, p. 645). From this analysis, interpretations of the data can then be developed and placed into categories, which can comprehensively explain a phenomenon.

In order to analyze the data qualitatively, I first transcribed all interviews. The interviews were recorded on an Apple iPhone utilizing the Voice Memo software and uploaded to a MacBook Air iCloud Drive. From the transcribed interview sets, I then performed an inductive content

analysis by documenting, highlighting, and making notation of all interesting quotes from each interview. Thorough content analysis can involve coding, categorizing, comparing, and concluding. *Coding* can be defined as the "translation of question responses and respondent information to specific categories for the purpose of the analysis" (Cohen et al., 2018, p. 525). Based on the qualitative data received from interviews, common themes related to specific behaviors and examples were coded and assembled into detailed tables. I manually created code categories to reflect the subjects from the interview protocol (Appendix E), including definitions of diversity, racial diversity, and gender diversity, available diversity resources and offerings, accessibility, perceptions of diversity based on participation in trainings, recommendations to consider for future interventions, and their opinions on diversity as it relates to caring for Women of Color. Each developed code category was then designated its own document, and relevant quotes were copied into each category from the transcribed interviews. From the code categories, themes were then created based on the frequency of quotes in each category. Conclusions were then created from the text.

## 3.7 Limitations

The first limitation of this inquiry is regarding the representation and demographics of the interviewees. Ten participants were interviewed to assess perceptions of diversity and its influence on caring for Women of Color, which did not represent all healthcare professionals of the Magee-Womens Hospital. In addition, this inquiry did not proportionally represent an array of ethnic groups, such as Pacific Islander, Hispanic, and Native-American descent. As illustrated in the descriptive data, participants of this inquiry were African-American/Black, White/Caucasian, or

Asian-American. One of the disadvantages to having low representation from all ethnic groups is the understanding and interpretation of examples provided for Women of Color. A number of instances arose during the interviews when the researcher reminded participants that references to Women of Color were meant to encompass all People of Color, not just African Americans. In addition, all participants identified as female. Although the employees of Magee-Womens Hospital are primarily male, there was no interest expressed during the recruitment process from male employees to participate in the inquiry. Four (4) males were identified and recruited during the recruitment process, but only one (1) male responded at that time. The interview with this male was scheduled, then cancelled due to a personal conflict of the potential interviewee. The interviewer was asked by the interviewee to reschedule and attempted to do so, but no response was given from the recruited male.

The research inquiry was also limited in that the sample size was small. The intent of the inquiry was to identify an equal number of healthcare professionals, from clinical positions and departments within Magee-Womens Hospital. Midway through the interviews, it was observed that a number of overlapping responses had been given by the interviewees. Replicating this research inquiry on a larger scale and within a longer timeframe might provide yet another future research opportunity.

Subsequently, all semi-structured interviews were audio-recorded instead of video-recorded due to a lack in resources. Cohen et al., (2018) states that “non-verbal communication can give important information in addition to the verbal communication” (p. 523). At the time of transcription, the researcher only had access to the verbal communication, which may omit important data categories and information.

Lastly, bias may have been introduced in this inquiry because of the selection of participants with whom the researcher had an existing relationship before conducting the inquiry. Hamersley (2013) discusses objectivity and the potential for observer bias in qualitative research. The author further claims that if the interviewer also serves as a colleague, the interpretation of the results can result in subliminal bias (Hamersley, 2013). Since I was an employee at Magee-Womens Hospital, it was likely that the participants and I had increased rapport, which could have resulted in bias as an interviewer and interviewee. Indirectly, my presence as the interviewer could have influenced response and behavior during the semi-structured interviews. To avoid bias, I addressed these limitations by establishing trustworthiness. Bryman (2012) discusses the aspect of confirmability, which ensures that findings are a result of the inquiry, not the biases of the researcher. In addition, confirmability recognizes that complete objectivity is not possible in social research, but that researchers need to demonstrate that they act in good faith, without being influenced by their personal values and relationships (Bryman, 2012). The researcher made a conscious effort to mitigate selection bias by extending invitations to participate in this inquiry regardless of what the researcher thought potential participants' perspective on the subject matter of this inquiry might be. There is a possibility that some of the participants who were interviewed and the researcher might share similar or the same perspectives on the focus of this inquiry. In some cases, this might be a result of having worked alongside some of these participants on workplace diversity issues, such as inclusion and cultural issues. Bias also may have been introduced if there were instances in which a participant chose to provide a socially acceptable answer to an interview question as opposed to answering the question based on how they truly felt about the particular topic.

## 3.8 Conclusion

The inquiry examined data derived from interviews with healthcare professionals and leaders at Magee-Womens Hospital to assess their understanding of diversity as it relates to race and gender differences, while also examining the influence that this understanding has on their caring for Women of Color. A semi-structured interview protocol assessed diversity understanding through a set of questions on various subjects pertaining to participants' understanding of diversity and its impact on their behavior during their clinic day duties. In addition, the semi-structured interviews were conducted to focus on the present status of diversity, understanding of trainings offered within the organization, and insights gained on racial and gender disparities that impact the patient population at Magee-Womens Hospital.

# 4.0 Chapter 4

## 4.1 Findings

This qualitative inquiry was undertaken to explore how a sample of healthcare professionals at Magee-Womens Hospital understand diversity, and specifically, in what ways they understand race and gender diversity. In this chapter, a description of the themes that emerged, based on the inquiry questions, are presented. The analysis of the data produced results that describe participants' understanding of diversity, including race and gender differences in caring for Women of Color. While there are clear variations in the interviewees' experiences, there are also many similarities. In reflecting on these four themes, including definition of diversity, identifying differences for Women of Color, minimal interventions in place to address disparities, and the need for organizational commitment to hire a diverse workforce and mandate diversity training, several conclusions can be drawn that will advance practice in healthcare focused on diversity, specifically race and gender differences when caring for Women of Color.

## 4.2 Defining Diversity

Diversity can be seen in each of us and all of us, individually and collectively (Quinn, Gwede, & Meade, 2018). Diversity is what makes us both different and similar. In other words, diversity can be what we see and what we cannot see in one another. All ten participants described diversity in their own terms and gave a basic understanding as to what diversity, gender diversity,

and racial diversity represented to them. Combined, participants defined diversity as inclusion, integration, and encompassing of all races, cultures, ethnicities, socioeconomic backgrounds, genders, gender identification, sexual identification, religion, morals, and values. While all of the healthcare professionals interviewed spoke of diversity, some in more detail than others, it was clear that the meaning of the word is often conceptualized broadly, encompassing several different terms and notions. Julia was able to speak on how her definition of diversity is all-encompassing of various groups, stating,

> When I think of diversity, diversity is age, gender, gender identification, race, culture, ethnicity – you know it could even be the diversity in the way that the people present themselves. Diversity in my opinion is all-encompassing of all those different things, including sexual identification.

Although nine participants described diversity as inclusive or all-encompassing, Alisha described diversity as pertaining to race only. She stated that "the word *diversity* is always used with the word *race*" in the context of trying to expand diversity in a community or program. Subsequently, Kelly, Darlene, and Kennedy included other considerations of diversity to include lifestyle, characteristics, perspectives, family composition, etc. The interview discussion around diversity represents the participants' descriptions of diversity as they experience it through their professional context. This discussion caused healthcare professionals to become more aware or to try to understand differences as it relates to various groups.

While participants were able to define *diversity*, most did not have varying definitions of racial or gender diversity. Kennedy spoke to how she would not give racial or gender diversity any different definition from diversity but stated that "race and gender both have a variety of subsystems" that make it diverse. Eight participants responded with definitions of *racial diversity*

by separating people by race, including Latinx, Hispanic, European, African-American, Native-American, Asian, and non-American. For example, this definition provided by Kelly stated,

> *Racial diversity,* I would say, is separating people from being of Latinx or Hispanic descent; then you have European, African-American, Native-American, Asian, and not even American at the end of that.

In addition, there was some discussion about diversity in relation to gender and gender identification. Four out of the ten participants included gender and gender identification when identifying their definition of diversity. Julia defined *gender diversity* as being "fluid or nonbinary," while Cheryl stated, "I think there is an element of intersectionality that happens between race and gender that is not captured in that just catch-all term of diversity, so I do think that requires some nuance." The intersectionality or interconnected nature of social categorizations, such as race and gender, is a major concept to this theme as it describes the way Women of Color encounter the world. Pertinent to this inquiry, the lived experiences of discrimination for Women of Color is greater than the sum of racism and sexism. Cheryl further noted that it is "important to acknowledge the power and role of race and gender together," and the implications it has on the differences in care for Women of Color.

Participants also talked about how they have come to understand or define *diversity*. Nine participants discussed their upbringing, including geographic location, learned values, college experience, media, literature and education that have shaped their definitions of *diversity*. Margie spoke of how her upbringing and lived experiences with segregation and being active in the Civil Rights Movement have been influential to the courses that she decided to take during her graduate program. Julia, Alisha, Cheryl, and Carrie also discussed growing up as a minority in predominately White areas and how this impacted their perspective of the world around them.

Nonetheless, participants' upbringing served as a major influencer of their perspective throughout the interviews and impacted their responses to other questions, such as their ability to call attention to disparities for Women of Color. Stephanie discussed how her learned values, including family values, have shaped her definition of diversity, while four participants discussed how media have influenced or harmed their view of diversity as related to certain populations, specifically African Americans. Darlene and Ashley discussed how the literature they have read, or the education and training they have received have shaped definitions of diversity, including the differences in the geographic locations of their training compared to the demographics seen at Magee-Womens Hospital. Lastly, Cheryl was able to reference how her upbringing shaped her definition of diversity, specifically regarding racial diversity:

> I would say I went to private school growing up until seventh grade, so I was one of three Black kids in the school. I think I very much am aware of being a minority in certain spaces. So, I think that's why when I think of diversity and inclusion, particularly I kind of gravitate towards racial diversity.

Participants of this inquiry demonstrated basic understanding of diversity, racial diversity, and gender diversity, including definitions that addressed differences in race, culture, language, gender, experiences, morals, values, etc. As demonstrated by this theme, diversity can cut across several different dimensions and perspectives, and it is important to recognize that upbringing and other lived experiences can shape the way one defines *diversity*. Everything we think, say, and do can ultimately guide our behaviors during day-to-day interactions. How healthcare professionals understand and process diversity is important to identifying the disparities in care affecting Women of Color. Ahmed (2017) states that "the absence of an agreed-on meaning for diversity can mean that it can be defined in quite different ways (p.79)." Therefore, the collective understanding of

diversity is the foundation to facilitate collaboration, support, and change within healthcare settings (Yang & Konrad, 2011).

### 4.3 Identifying the Disparities in Healthcare for Women of Color

Since being employed at Magee-Womens Hospital, five healthcare professionals have noted an increased awareness of the disparities for Women of Color by participating in research and assessing daily responsibilities in clinical practice. Research and assessment of clinical practice can impact and make a profound contribution to the care received by patients. Margie and Stephanie recognized that their findings in research and clinical practice are relevant to the lived experiences and care Women of Color are receiving. Margie spoke of how the empirical research she participated in clearly showed the differences, such as "African-American patients getting shorter, less intensive treatment than White patients." Stephanie was able to expound upon these differences by describing the experience of a Black woman receiving shorter chemotherapy treatment from a physician who had difficulty understanding patient preferences and symptoms. Stephanie explained that,

> Each patient usually gets 12 rounds of Taxol chemotherapy. This young, Black woman was having a terrible time with it. I saw her first and she was just crying, like tears coming down her face the whole time I saw her. She was miserable and really wouldn't state why she was sad. So, I said to my doctor, "Hey, could you stop in and do a little pep talk, you know, she said she was really sad"? So, he goes in and says, "You're on number 10?" Then proceeds with, "Are you miserable?" She just went… "Yeah." He goes, "Let's call it and stop the chemotherapy."

Margie and Stephanie both discussed how these experiences for Women of Color are often the result of minimal rapport built between patients and providers. Stephanie states, “I think it has to do with this racial divide of how we speak and understand each other,” while Margie declares that “Without trust what we do is not very meaningful.”

As Women of Color, Kelly and Cheryl alluded to how experiencing microaggressions from other healthcare providers has impacted the medical decisions that are made for Women of Color. *Microaggressions* can be defined as intentional or unintentional “verbal, behavioral, or environmental indignities that communicate negative racial insults towards people of color” (Lerner & Fulambarker, 2018, p. 43). These participants stated that hearing these remarks confirms the fears they have about working in an environment that is not understanding or inclusive to the experiences minoritized populations experience in predominately White settings, while also feeling the need to advocate on behalf of Women of Color due to their experiences being ignored. Cheryl stated,

> Oftentimes when you see how those little comments or microaggressions that happen are representative of healthcare providers, with added overall attitudes about a specific race, and how those microaggressions and attitudes affect the medical decisions that they make, it's very disappointing. And I think a lot of times if things were to get brought up, they're not really acknowledged. I think there's a big misconception here that we don't have a problem and I know working in the NICU specifically, it's very apparent there's a problem.

This perspective demonstrates how ignoring or undermining the needs and disparities of Women of Color is only causing further harm and neglect towards this population, while also stressing how imperative it is for healthcare professionals to be aware of these differences and practice inclusivity in communicating with their patients and colleagues.

All ten participants were able to provide multiple examples of how they have seen Women of Color receive different treatment than White patients at Magee-Womens Hospital. Healthcare professionals of this inquiry identified that there are noticeable differences in care for Women of Color based on race and gender compared to White patients, including differences with approach to care, access to care, language barriers, and preconceived notions. An observation identified by the researcher during the interviews were the examples provided on behalf of Women of Color when describing disparities. A number of instances arose during the interviews when participants provided examples that only represented African-American women, when the questions requested race and gender differences for Women of Color. I made several attempts throughout the interviews to remind participants that references to Women of Color were meant to encompass all People of Color, not just African Americans. However, during the interviews the researcher observed that several participants showed most comfort in providing examples of race and gender differences that impacted African-American women at Magee-Womens Hospital. This represents the participants' descriptions of understanding and acceptance of racial differences within the inquiry's hospital setting. Differences in understanding also can include a discussion of side effects and symptoms, concerns for pain, or even the interpretation a patient has of their diagnosis. Ashley stated,

> I've seen firsthand and I'm like, this really doesn't make any sense. For example, when a Black mom comes in and she has signs and symptoms that are classic for preterm labor, but then she gets sent home. And then within 24 hours, she's back and she's in labor and delivers the baby prematurely when there are interventions that could have been made to change the course of that outcome. Seeing that happen for someone who's a Woman of

> Color versus knowing that if she had been Caucasian or, you know, that would have ended up differently.

Examples such as this further suggest that Women of Color face diagnostic delays and under-treatment when presenting concerns to their providers. Ashley concluded by stating, “This type of dismissive behavior could mean life or death for some patients.”

Kelly, Kennedy, and Julia identified examples of differences with respect to the type of insurance Women of Color obtain and the type of support that they receive with accompaniment to appointments. Participants were able to connect this to access in care for Women of Color and preconceived notions that clinic staff may have. Margie states, “Preconceived notions is probably the biggest one that affects their level of care.” The belief that Black mothers are negligent if they are not present in the NICU consistently, or that Black patients do not have the necessary supports throughout diagnosis and treatment are a few examples mentioned by participants. Alisha stated,

> Often times when I'm called to deal with a situation, or even just in passing, it's always this mother's being difficult, and 90% of the time it’s an African-American woman. And their definition of *difficult* is usually “when a patient is just questioning their care because they feel healthcare doesn't have their best interests at heart, or just asking more questions.” And then when I walk in, it's not even that. The patient is typically very pleasant. When a patient is labeled difficult, I feel like it's impacting their healthcare. Typically mothers labeled as difficult have been avoided, or when they press on, you know, needing assistance, they're delayed in getting their assistance, or they're being sent home because they refused an exam, but they're still cramping, so they can still be in preterm labor. They are just always kind of written off, and then that's where things get disregarded.

Lastly, four participants were able to identify how language barriers can impact the care received by Women of Color, including a lack of understanding from providers and an absence of clinic documents available to patients who do not speak or understand English. Kelly further suggested that language barriers can allow care to "fall through the cracks."

> For me, my biggest things are patients who are coming from other countries or cultures. So, for instance, a patient came from Jamaica. I saw some people not understand that culture or care to, and let things fall through the cracks. And so that affected how the patient received treatment in a timely manner. It'd be nice to see every woman from every ethnicity be able to say, I came here, I feel good, I feel included, and I feel like I'm being provided the best care, while not experiencing microaggressions that unfortunately Women of Color have experienced and do experience.

Participants recognized that Women of Color consistently suffer from the negative effects of microaggressions and poor understanding of patient preferences by healthcare professionals. In addition, participants demonstrated that research and their clinical experiences have not only shown disparities in treatment planning for Women of Color, but the need for healthcare professionals to build proper rapport with their patients for better clinical understanding. Lack of trust and preconceived notions only lead to dismissed symptoms and delay in care, ultimately resulting in increased medical complications for Women of Color (Committee on Healthcare for Undeserved Women, 2018). In addition, participants have declared that the inability to provide adequate treatment and resources for patients of various cultures has allowed care to be overlooked and minimized, which could be mitigated if medical providers would begin to simply listen to the medical concerns voiced by Women of Color.

### 4.4 Minimal Interventions to Reduce Disparities

Participants of this inquiry had difficulty identifying specific programs that are in place to address the needs and disparities mentioned for Women of Color at Magee-Womens Hospital. No participants were able to identify any interventions in place to address or reduce the disparities experienced by Women of Color. Healthcare organizations need to be responsive to the needs for Women of Color. A diverse hospital system should acknowledge that employees and patients originate from various backgrounds. A hospital system also should practice diversity in the programs and resources made available to various patient populations (Weech-Maldonado et al., 2012). Although participants were not able to identify specific race or gender affiliated interventions, participants were able to identify programs within the hospital that aid patients, including the social work program, a weekly department meeting, and a breastfeeding support group. Carrie, Ashley, Kelly, and Kennedy were able to speak about the social work program that is available throughout the hospital to assist with alleviating barriers for all individuals in need. Ashley stated,

> I mean, I know that in the NICU, and I'm sure in the Labor and Delivery units, there are social workers. I know that those people are knowledgeable about, you know, if people need access to different things to assist their overall access to healthcare. I know about that, but that's not necessarily above and beyond and it's not population specific.

Participants noted that social workers have been engaged in the needs of various populations by providing patients with resources and education about their medical treatment plans. In addition, Kelly addressed her role as a social worker to not only advocate on behalf of patients, but to also educate hospital staff to ensure that they are sensitive to the health disparities impacting Women of Color. However, relying on a specific group of healthcare professionals, like social workers, to

address the disparities experienced by Women of Color only ignores the harsh realities of hospital systems not adequately providing supports.

Stephanie spoke about a weekly meeting among clinic staff that takes place for metastatic breast cancer patients to address their overall needs throughout care. This meeting is not limited to Women of Color, but is an opportunity for nurses, social workers, and nurse practitioners to brainstorm together on patient needs. In addition, Alisha was able to identify a support group available at Magee-Womens Hospital for Women of Color to increase breastfeeding. Alisha said,

> Nothing comes to mind, unfortunately, that I know of to have significant effects on increasing their care for the better. However, to increase breastfeeding in African-American women, they have started a support group, which is different. I mean that's a start.

In order to resolve these disparities, it is important for organizations to clarify their commitment to providing competent care. This can be achieved by creating a supportive foundation of resources and programs that not only address needs but establish rapport with healthcare professionals. Ashley and Cheryl further expressed that Magee-Womens Hospital is not trying to address the needs of Women of Color. The experiences of Women of Color are vastly different than White women, including the social implications that impact the medical aspects of care. Stephanie indicated that not enough attention is being given to this matter, describing it in this way,

> Some people will be more sympathetic and recognize. Others are sort of judging. I don't see anything specifically directed towards Women of Color. You know, nothing that says let’s try to do something more proactive to make people feel more included.

However, participants did not elaborate on the programs or resources they feel would make the most impact in addressing the needs for Women of Color at Magee-Womens Hospital. In sum, further examinations between the relationship of implemented resources and their impact on the disparities Women of Color face need to be researched. It is critical that parity of access to appropriate interventions be achieved for Women of Color who have a long-standing history of healthcare inequities, including a lack of access to quality medical care.

### 4.5 Organization Commitment

While policies and procedures that support diverse practices are vital to meeting the needs for Women of Color, these methods cannot be the only interventions in place to address disparities in care. Healthcare professionals of this inquiry are calling for healthcare settings to hire diverse staff to build rapport with Women of Color, while also mandating diversity training for increased understanding of race and gender differences. Organizations should not only make certain that staff and employees practice sensitivity towards the needs of Women of Color, but organizations should also hire a diverse workforce (Anderson, Scrimshaw, Fullilove, Fielding, & Normand, 2003) and a culture of sensitivity will not occur unless leaders hire employees who are from diverse backgrounds (Anderson et al., 2003).

The inability to establish rapport can indicate a lack of trust building and openness between providers and patients (Walton, 2011). Some signs of a provider's inability to establish rapport may include, but is not limited to, a lack of communication and respect for a patient's experience and their inability to see the patient's needs that are communicated to providers (Walton, 2011). In this area, five of the participants who were interviewed spoke mostly about their perception of

patient-provider relationships and how they have recognized that there is a lack of trust between the two. Darlene and Margie further spoke of how an increase in this relationship can positively contribute to increased participation of Women of Color in healthcare. This commitment begins at the top levels of administration with consistent demonstration of its importance, which could then result in their hiring more diverse staff to represent the diversity that exists within Magee-Womens Hospital's patient population. Darlene stated,

> I think some of the biggest aspects that I feel would also increase participation of Women of Color in healthcare in general is helping ensure that they come to a healthcare system where it is apparent that the workforce is also extremely diverse. And I think that if you just think about even Women of Color, seeking medical care, if they are given a choice to see somebody who appeared to be more like them, versus somebody who was not like them, they may think that compliance and ability to come to appointments is also affected by that.

Statements such as this may suggest that patients would feel reassured that their concerns matter if those concerns are received by and they are cared for by an individual who looked like them. Margie echoed this statement by signifying that,

> I always feel, particularly with African-American patients, that the patient will do best with an African-American social worker because I think the trust issue is a lot stronger, and without trust what we do here is not very meaningful.

UPMC's Center for Engagement and Inclusion is a hospital initiative that carries out the mission of providing employees with necessary tools that they need to develop self-awareness about values and personal beliefs. This initiative aims to offer employees the opportunity to experience a full, vibrant cultural understanding of various types of people. However, participants

displayed difficulty in recognizing if they found the Center valuable in addressing race and gender differences. Participants were asked two questions regarding diversity training: 1) What diversity training or resources have they participated in at Magee-Womens Hospital, and 2) Are they familiar with UPMC's Center for Engagement & Inclusion. Of the ten participants, five responded that they have completed a diversity training since working at Magee-Womens Hospital. The completed diversity trainings were either a webinar diversity training from a UPMC leadership conference or a mandated in-person session in response to discriminatory behavior experienced by an employee. The other five participants indicated that they have not participated in a diversity training since being employed at Magee-Womens Hospital.

For those who completed the webinar, respondents indicated that they did not remember any key information that they learned. These findings suggest that webinar-based trainings are ineffective in allowing participants to leave with increased knowledge of the facilitated subject matter. However, participants who completed an in-person session stated that it allowed for open dialogue of biases, and a temporary change in behavior was noticed by department members who completed the in-person session. This perspective challenges the purpose and objective of diversity training, which is to ultimately create sustained behavioral change (Kalinoski et al., 2013). Regarding UPMC's Center for Engagement and Inclusion, seven participants indicated that they were familiar with the Center, while three indicated that they were not. Of the seven, two participants indicated that they had not utilized any training or resources through the Center, while Kennedy and Carrie stated that they had participated in a session for UPMC leaders. Stephanie indicated successfully downloading materials from the Center's website, while Margie and Kelly indicated that their attempt to utilize the Center was not useful in assisting with their patients' needs. Margie states:

> My attempts in the past to use them have shown it to be a Center that exists on paper. And when I have sought out actual concrete things to make my work better with patients of other racial backgrounds, the results have not been forthcoming. It exists on paper to probably meet certain regulatory, licensing requirements.

Participants of this inquiry have discussed the benefits of hiring a diverse staff, including the results of rapport building that can occur between patients and providers. However, in addition to hiring diverse staff, healthcare organizations must implement appropriate policies and procedures that support the disparities experienced by Women of Color (Anderson et al., 2003). UPMC's Center for Engagement and Inclusion carries out the mission of ensuring that all employees have the appropriate resources to understand patient differences, but an increased understanding from participating in such interventions seems to be lacking among the participants. This not only challenges the goals and objectives of diversity training, but diversity initiatives implemented in major health systems, such as UPMC. Organizations provide a frame in which "things happen, or don't happen" (Ahmed, 2017, p. 50). In other words, healthcare organizations must reevaluate and explore if what their mission states is actually occurring and being implemented by their employees.

## 4.6 Conclusion

This chapter concludes the analysis of the participants' responses to the inquiry questions, "How do healthcare professionals at Magee-Womens Hospital understand diversity and in what ways do they understand race and gender diversity, specifically"? The data provided represented common and distinctive experiences of diversity at Magee-Womens Hospital. The themes

identified are those resulting from experiences of the healthcare professionals interviewed, including the definition of *diversity*, identifying differences for Women of Color, minimal interventions in place to address disparities, and the need for organizational commitment to hire a diverse workforce and mandate diversity training.

In addition, I observed that participants were more inclined to give examples relating to African-American women, although the definition of Women of Color is all-encompassing of various races and ethnicities. Only female participants were successfully recruited, which ultimately led to a limitation presented in this inquiry. In the next chapter, I will provide conclusions and recommendations in order to provide a comprehensive review of the inquiry.

# 5.0 Chapter 5

## 5.1 Discussion of Findings

In this chapter, I briefly expound upon the inquiry focus and purpose. I then provide a discussion of the results and the themes that emerged from the analysis. Lastly, I conclude with a summary of recommendations for practice, as well as research. The statistics are clear; the United States is undeniably becoming increasingly diverse with a populace from distinct racial backgrounds. The United States Census Bureau indicates that racially minoritized populations are increasing at a much faster pace than the White population, predicting that Women of Color, specifically, will make up approximately 50% of the population by 2050 (Taylor, Novoa, & Phadke, 2019; United States Census Bureau, 2019). The same is true for Women of Color in Pittsburgh, Pennsylvania. “The U.S. Census American Fact Finder” estimates that Women of Color in Pittsburgh, specifically Hispanic and Asian-American, will increase approximately 1% each year for the next 5 years (United States Census Bureau, 2019). With the number of Women of Color on the rise, healthcare professionals will be tasked with caring for patients whose race and gender may differ from their own. However, diversity in healthcare’s patient and professional population continues to be limited, even with the projected demographic shift. When an inflexible, White healthcare system is tasked with caring for a racially diverse group of patients, the quality of care can suffer.

The purpose of the inquiry was to evaluate the understanding and knowledge of diversity for healthcare professionals and leaders at Magee-Womens Hospital. This understanding was determined by asking employees about their knowledge of diversity, including race and gender

differences, and about their participation in diversity trainings, resources, policies, and initiatives. The findings shed light on healthcare professionals' perceptions of race and gender and what is understood from participating in UPMC's Center for Engagement and Inclusion diversity trainings. Magee-Womens Hospital was chosen as the inquiry setting due to it's being the primary source of specialty care for women in Allegheny County in Pennsylvania as well as surrounding counties (Magee-Womens Hospital, 2017). The primary inquiry questions were: (1) How do healthcare professionals at Magee-Womens Hospital understand diversity? and (2) In what ways do they understand race and gender diversity, specifically? The inquiry's focus was on healthcare professionals who are employees and/or leaders of Magee-Womens Hospital, and in some capacity have direct contact with caring for Women of Color.

## 5.2 Summary of Key Findings

The themes identified through this inquiry included the following: (1) participants' conceptualization of diversity; (2) participants' identification of disparities for Women of Color; (3) minimal interventions in place to address disparities; and (4) the need for organizational commitment to hire a diverse workforce and mandate diversity training. The data suggested that past experiences do shape one's understanding of diversity, including racial and gender identity, and that some healthcare professionals are aware of the race and gender differences affecting Women of Color simply from interactions that they have with them in day-to-day clinical practice. Along with past experiences, two healthcare professionals who identify as Women of Color also spoke of their understanding of disparities through their own experience of microaggressions and how these experiences create a sense of urgency to advocate on behalf of their patients of color.

Although the healthcare professionals interviewed shared similar experiences and perspectives, there was a lack of consistency in participants' responses on whether or not participating in diversity training aided in their understanding of diversity, race, and gender disparities for Women of Color.

Participants also identified that specific, mandated diversity training needs to be implemented for all employees but did not clarify the duration of training that they think would work best at Magee-Womens Hospital. Participants also suggested that the hiring of diverse staff to increase rapport building between patients and providers was essential in promoting a culture of acceptance. Overall, the desire to accept, understand, and respect patients from diverse backgrounds was evident among the healthcare professionals interviewed, but a lack of knowledge on how to best understand and practice respect of differences for Women of Color was demonstrated from participants. Here, I offer three key points for consideration that have been gleaned from this inquiry.

### 5.2.1 Key Finding #1: The Need for More Complex Understanding of Diversity

The healthcare professionals in this inquiry came from diverse backgrounds and cultures, but collectively had the same *basic* understanding of diversity, racial diversity, and gender diversity. Their conceptualization of diversity included statements on inclusion, integration, and encompassing of all races, cultures, ethnicities, socioeconomic backgrounds, genders, gender identification, sexual identification, religion, morals, and values. However, without understanding that diversity includes relation to human rights, social welfare, and distributive justice, this conceptualization is inadequate (Sensoy & DiAngelo, 2012). Sensoy and DiAngelo (2012) explain that there are two different ways to conceptualize diversity, which include considering diversity

from a critical social justice lens and a lens of individualism. Considering diversity from a critical social justice lens can be defined as thinking with "complexity," or "below the surface to explore its multiple dimensions and nuances" (Sensoy & DiAngelo, 2012, p. 1). When individuals understand diversity from a critical social justice lens, they are able to understand the various social groups and areas of social injustice that need to be considered when speaking about diversity. In other words, a critical social justice lens is not blind to the segregation that exists across social groups. The healthcare professionals of this inquiry portray a lens of individualism, in that they understand diversity in terms of individuality, or uniqueness to one's social identity. Although appreciation of differences is important, understanding diversity through a critical lens allows for oppressions experienced and verbalized by minoritized groups, such as Women of Color, to be accepted and heard.

In addition, the vast majority of healthcare professionals interviewed developed their understanding of diversity, racial diversity, and gender diversity from upbringing, including learned family values or media influence. Socialization, or the act of learning from one's upbringing, can shape the way in which we view the world, both personally and professionally (Quinn et al., 2018). Similar to the foundation of a house, people's roots and past experiences can serve as the foundation on which their life is built. Consistent with these findings, Leininger and McFarland (2006) state that the historical and environmental context in which people live can influence not only beliefs and values, but practices and healthcare decisions for patients. Therefore, it is most important that healthcare professionals at Magee-Womens Hospital understand the influence their learned values and experiences can have on their behavior towards their patients. This can include being aware of learned stereotypes that may impact diagnoses and care for Women of Color.

### 5.2.2 Key Finding #2: Disparities in Healthcare Are Prevalent for Women of Color

All of the healthcare professionals interviewed spoke of the race and gender differences affecting Women of Color receiving care at Magee-Womens Hospital. Differences mentioned included preconceived notions about health literacy, differences in prescribed treatment plans, access to care, and language barriers. While most of the examples provided in the inquiry were significant to the differences in care experienced by African-American women, the consensus was that Women of Color at Magee-Womens Hospital do not receive the same medical treatment as their White counterparts. The healthcare professionals of this inquiry were knowledgeable about disparities affecting Women of Color through reading literature and noting the experiences they see during their clinic day. The importance of identifying health disparities is consistent with one of the major tenets in Leininger's Cultural Competence Diversity theory, in an effort to stress the value of how recognizing differences can increase rapport within the provider-patient relationship (Leininger, 2002).

However, healthcare professionals who were interviewed were not in disbelief that disparities exist for Women of Color at Magee-Womens Hospital, but they were shocked that the disparities had been overlooked and not discussed by their colleagues and the leadership within this hospital's setting. Healthcare professionals of color in this inquiry spoke specifically of the microaggressions and preconceived notions towards Women of Color and how these perspectives affect the medical decisions made on their behalf. It could be inferred that these healthcare professionals are not surprised by what their patients are experiencing due to their own experiences of indirect discrimination. Magee-Womens Hospital cannot ignore that the mistreatment in medical care for Women of Color, specifically African-American women, is predicated on the historical complexities and stereotypes of race. Therefore, interventions to alleviate disparities at

Magee-Womens Hospital should critically focus on justice and the basic human rights that minoritized groups, such as Women of Color, are often not given.

Furthermore, the healthcare professionals of this inquiry were concerned that the disparities mentioned have been consistently kept quiet within the hospital, with no interventions in place to address them. At the conclusion of the inquiry's interviews, some participants mentioned that this was their first time engaging in dialogue regarding their interpretation and understanding of disparities impacting Women of Color at Magee-Womens Hospital. Although pleased with the inquiry's focus, these participants expressed disappointment in the lack of conversation around diversity within their departments. In addition, healthcare professionals of this inquiry were unable to identify any interventions that assisted with alleviating the disparities experienced by Women of Color. Participants of this inquiry were unable to pinpoint the programs or resources they feel would make the most impact in addressing the needs for Women of Color at Magee-Womens Hospital. The inability to identify proper interventions could be a result of their basic understanding of diversity and lack of knowledge on best practices when caring for Women of Color. Smedley, Stith, and Nelson (2003) suggest that failing to understand the deeply rooted causes of disparities for minoritized populations, such as Women of Color, will only further ignore their needs for appropriate interventions. This inquiry's setting cannot solely rely on its employees to solve the mistreatment experienced by Women of Color. Management at Magee-Womens Hospital, under the leadership of UPMC, must show their priorities by implementing effective strategies that support their patients' experiences and the inequalities that are impacting their care. To begin to eliminate disparities several steps need to be taken, including listening to patients' needs; improving access to care by providing resources specific to those needs; and providing

specific diversity education and training to staff to address the marginalization experienced by Women of Color as a result of their race and gender.

### 5.2.3 Key Finding #3: Current Diversity Training Is Insufficient

Diversity policies and initiatives tend to start from the leadership of the organization. When organizations implement and carry out diversity initiatives, all employees can benefit from the broadened perspectives (Curtis, Dreachslin, & Sinioris, 2007). The healthcare professionals interviewed agreed that diversity training should be mandatory to achieving a critical understanding of race and gender differences within the staff of Magee-Womens Hospital. However, the healthcare professionals of this inquiry that participated in diversity training stated that the current webinar method was insufficient for increasing their knowledge. They stated that a 15- to 20-minute webinar was not conducive to their learning, nor did the content in the webinar appear challenging to the disparities experienced by Women of Color. The participants suggested that organizations such as UPMC have to take an active interest and show commitment to improving the diversity training offered to staff and ensure that it provides specific education pertinent to caring for Women of Color. Curstin et al., (2007); Celik et al., (2008); and Grant et al., (2013) found that organizations who committed and implemented diversity training for all staff saw a transformation of staff thinking about and a decrease in their stereotyping of diverse populations with whom they work. Stanhope et al., (2005) concluded that there is a need for specialized curriculum in diversity training that best prepares specific departments to handle a multitude of patient social issues. Although the content within diversity training is important, research also suggests that elements of training, including the duration and methods in which a

diversity lecture occurs, are essential in order for individuals to leave with increased knowledge (Mercedes, Kamon, & Beatson, 2016).

## 5.3 Recommendations for Practice

Although this inquiry illuminates the understandings of diversity by the healthcare professionals who were interviewed, there are three implications for practice that leadership of Magee-Womens Hospital should consider to improve practice efforts. The recommendations discussed address a need to increase hiring of diverse staff, to integrate content focused on critical social justice into diversity training, and to reevaluate the initiatives under UPMC's Center for Engagement and Inclusion.

### 5.3.1 Hire Diverse Staff

The lack of diversity in healthcare is one of the most critical challenges facing healthcare systems today (Taylor, et al., 2019). With the projected growth of minoritized populations by 2050, UPMC needs to be prepared to meet the needs of and respond to an increasingly diverse patient population across all of their hospital systems. Understanding how to serve patients of different backgrounds is vital to providing alternative resources and interventions that will address the disparities expressed by various populations. Many healthcare professionals in this inquiry confirmed the need for a more diverse staff. Chapman, Kaatz & Carnes (2013) state that hiring additional providers of color in healthcare can reduce the impact of health disparities because these providers are noted to exhibit significantly less racial bias and preconceived notions. This

implication could have the potential to decrease the discrimination experienced by Women of Color at Magee-Womens Hospital; allow for different perspectives from employees; and contribute positively to minority retention and relationships for both patients and employees. Various participants in this inquiry spoke about the negative outcomes that occur when a relationship is not built between the provider and patient, including preconceived notions and differences in recommended care. This researcher who identifies as a Woman of Color, agrees with the importance of positive relationships between patients and providers, in addition to having a provider who is sensitive to and genuinely caring about my health concerns. Harris-Perry (2011) also implicitly supports this experience when she outlines the ways in which African-American women are "misrecognized," or made invisible, due to the misunderstanding of their concerns being viewed as problematic. This researcher hopes that Magee-Womens Hospital will use the findings of this inquiry to better understand the contributions that diverse staff can make. Although diversity in numbers may not solely contribute to mitigating all disparities for Women of Color, it can certainly be the first step in displaying organizational commitment to accepting differences across various racial and gender groups. Magee-Womens Hospital can attract diverse staff by first examining current data and understanding where their organization stands in relation to the medical industry overall (Smedley, Stith & Nelson, 2003). This can include their understanding of university enrollments and graduation rates to see if their representation is in line with the future generation of healthcare professionals. From this understanding, the leaders at Magee-Womens Hospital should cultivate relationships with universities and communities that represent their desired demographic. For example, the Hospital can build a network with local African-American health-related organizations to ensure that information is readily available to applicants. However, it is most important that UPMC not only promotes diversity and inclusion, but clearly reflects this

in the literature and website of the organization (Smedley, Stith & Nelson, 2003). When applicants of color research the organization, it should clearly depict acceptance of various genders and races via the organization's public relations methods.

### 5.3.2 Implement Specialized Training Curriculum

Several studies suggested that a one-size-fits-all approach should not be taken when developing content for diversity training, but rather recommended specialized curriculum for healthcare departments (Stanhope et al.; 2005, Young & Guo, 2016; Beard, 2016; Horwitz et al., 2011). Healthcare professionals of this inquiry agreed and stated that not only should all employees be required to complete mandated diversity training, but training should be developed to meet the needs of each hospital department. For example, training content should include case examples that are specific to a department's role and function and exemplify how Women of Color may experience mistreatment when interacting with that department. To assist in the elimination of health disparities for Women of Color, management at Magee-Womens Hospital needs to incorporate material designed to increase a healthcare professional's understanding of the historical context of racism and its impact on health disparities for this population. These healthcare professionals need to understand social justice and systems of oppression, including understanding that disparities are created due to historical structural injustice and unequal social power. Training sessions should highlight the complexities around race and gender, including microaggressions, social oppression, and inequality that many Women of Color face when interacting with predominately White healthcare professionals. This researcher recommends that diversity training not simply focus on inclusion and bias but delve deeper into the underlying issues that cause disparities to exist. In order for healthcare professionals to address systems of oppressions, they

must first understand the root causes of that oppression (Peterson, 2019). This includes challenging racial socialization and allowing healthcare professionals to understand their own racial identity; explore their own internalized racism; reeducate themselves about race and how racism works; and reframe old racial stereotypes and beliefs that have resulted in negative patterns of thinking, feelings, and behaviors (Singh, 2019). In addition, this training should be given from a critical social justice lens and include content on Intersectionality. The concept of Intersectionality is crucial for creating a space centered on social justice principles (Lerner & Fulambarker, 2018). Crenshaw (1991) coined the term *Intersectionality* to note that the experience of being both a Woman of Color and a woman is more than the emergence of two social identities. Bringing Intersectionality into the training's curriculum can allow healthcare professionals to understand more clearly the complexities within social groups and how their own perceptions of race and gender are influenced by their own personal upbringing. This then may allow them to better understand how the intersections of race and gender have impacted the overall experiences of care for Women of Color.

Lastly, diversity training at Magee-Womens Hospital should be specific, mandatory, on-going, necessary for promotion, and clearly defined as an expectation of every employee. As demonstrated in this inquiry, it is clearly not enough to require short, webinar-based trainings. Instead of having employees complete a webinar-based diversity training once per year, employees should be mandated to attend an hourly session, at the time of biannual clinical updates, with evaluation to follow from leadership. Delgado et al., (2013) support this recommendation of an hourly training session and conclude that diversity training included at the time of clinical update activities will ensure that as patient demographics change, clinical education also remains competent. After completing the training, employees at Magee-Womens Hospital should be

encouraged to participate in a support group or be assigned a mentor with whom they can meet and share their experiences for further teaching and development strategies. Celik et al., (2008) state that these support groups or organizational networks would allow for continued connection, engagement, and open dialogue among staff. Authorities also suggested that the purpose and objective of the implemented diversity training be reevaluated. If pre- and post-test assessments reveal that the diversity training is not producing intended results and understanding, then UPMC's Center for Engagement and Inclusion should reevaluate the delivery of the training.

### 5.3.3 Reevaluate UPMC's Center for Engagement and Inclusion

In tangent with reevaluating the goals and objectives of diversity training, this inquiry produced an implication for practice around organizational diversity initiatives. Within this inquiry, healthcare professionals and authors Gibbs and Gallagher (2017) agree that healthcare organizations who understand their own culture are in a better position to interact with their patients and provide culturally acceptable care. However, a major issue they find with incorporating diversity work into an institution is this idea of a "tick box" approach. Ahmed (2012) describes this approach as "showing that an institution is following procedures, when they are really not behind them." To make a commitment to diversity work, UPMC's Center for Engagement and Inclusion (CFEI) must expand their offerings and increase funding for additional employee resources that promote a deeper understanding of diversity. This will further demonstrate that UPMC is pledging to the act of doing something, rather than simply stating that a diversity initiative is in place. Several healthcare professionals who participated in this inquiry were unaware that UPMC's CFEI even existed, which demonstrates that this initiative is "non-performative." *Non-performative* is a concept that describes "the reiterative and citational practice

by which discourse does not produce what it claims" (Ahmed, 2012, p. 117). The researcher hopes that this implication for practice charges UPMC's Center for Engagement and Inclusion to review their diversity initiatives and ensure that they are producing what they claim. A widely known and practiced diversity initiative can make a huge difference at Magee-Womens Hospital, and having the right one in place is conducive to the growth and development of this hospital. This diversity initiative can not only strengthen employee engagement at all UPMC hospitals but enhance their awareness and appreciation for the differences in others.

## 5.4 Demonstration of Scholarly Practice

Presently, the UPMC Center for Engagement and Inclusion does not provide baseline data of healthcare professional's knowledge of diversity at Magee-Womens Hospital, nor how it impacts their practice when working with minoritized populations, specifically Women of Color. This inquiry provides baseline data on how a subset of healthcare professionals at UPMC Magee Womens hospital are understanding diversity, specifically race and gender. As a Demonstration of Excellence for Completion of the Educational Doctorate degree, I will provide the Center for Engagement and Inclusion with a report of the inquiry findings, including analysis from participant interviews. The report provides a clear explanation of how understanding diversity may influence the care provided for Women of Color at Magee-Womens Hospital. Along with the report, a professional presentation will be conducted for the leadership team at Magee-Womens Hospital. The results from this inquiry not only provide the hospital themes and salience of those themes from the inquiry's sample, but also provide implications for the need to collect systemic baseline data across the population of healthcare professionals; data about health outcomes; and data about

patient perspectives of their interaction at this hospital. The researcher hopes that these results will then be used to create specialized curriculum for all departments within Magee-Womens Hospital, while also allowing for deeper discussions among staff and patients.

## 5.5 Implications for Research

The findings of this inquiry lead to recommendations for future research, including those for healthcare professionals and their organizations. Regarding the methodology, limiting the inquiry to Magee-Womens Hospital limited the perspectives of diversity and the understandings gained on the differences in care for Women of Color within UPMC. A broader geographic sample may have led to greater details of diversity within the sample. Although not purposeful, all participants of this inquiry identified as female. Future research should aim to select a more diverse sample to include various genders, which may lead to increased perspectives and understandings. Allmark (2004) supports this recommendation by stating that in qualitative research, representation of the sample matters to avoid underrepresentation of minoritized groups.

This qualitative inquiry, including the semi-structured interviews, allowed the researcher to gather information pertaining to the focus of this inquiry. However, the researcher was unable to determine if all participants felt comfortable speaking fully about their experiences. Although one-on-one interviews allow for honest expression focused on the inquiry, including an anonymous pre- or post-survey may have allowed for other generalizations to be discovered by the participants. For example, a survey could have addressed how healthcare professionals perceive the nature of the working relationships between patients; specific actions from the healthcare organization that have hindered or helped the care for Women of Color; and more

exploration of the nature of Magee-Women Hospital's culture and its impact on Women of Color receiving care. The survey also could have provided opportunity for healthcare professionals to address issues that they may have felt were politically inappropriate to speak about with the researcher. These findings could broaden the discussion and shed light on issues that healthcare professionals feel are often ignored.

Keeping this in mind, future research should explore the complexities healthcare professionals of color face during day-to-day duties, such as the mentioned experience of microaggressions, and how this impacts healthcare decisions made on behalf of patients. When qualitative research welcomes feedback from all relevant individuals, it allows them to participate in decisions that affect their everyday lives (Lyons, Bike, Ojeda, Johnson, Rosales, & Flores, 2013). Participants also stated that due to the mistreatment they witness and experience, they feel a need to ensure that Women of Color are being properly advocated for. Future research should assess these perspectives and if this alters the emotional or mental well-being of healthcare professionals and their capacity to provide care.

In addition, future research should include the perspectives of minoritized patients to clearly depict their experiences with health disparities and how they perceive their relationships with healthcare professionals. Lyons et al., (2013) further state that when the research is harmonious with the community, it places the community's needs above everything else. This understanding would allow healthcare professionals to be much better equipped to understand and serve various populations effectively, while giving organizations the information needed to implement resources that are most appropriate for diversity training curriculum.

A considerable amount of literature addresses the issues of diversity in the workplace and the methods of diversity training that can benefit healthcare organizations wanting to increase

understanding of differences. However, a dearth of research focuses on the methods of diversity training that increase understanding of the disparities experienced by Women of Color. Diversity training research should focus on social justice and equity to include more critical thinking and attention to the complexities Women of Color experience. Leininger's Cultural Care Diversity theory aims to expand awareness by "discovering, documenting, knowing, then explaining" the connectedness between differences in culture and care (Leininger, 2002, p. 25). By focusing research on Women of Color, a researcher is able to expand the data available for this underrepresented population and provide healthcare organizations, such as Magee-Womens Hospital, with the understanding needed to best serve them. This inquiry's setting is the only specialty women's hospital in the state of Pennsylvania. It is imperative that this setting has access to data that support the needs of Women of Color. In addition, research on whether diversity training is associated with patient outcomes should be explored, as well as the observation of behavioral and organizational change after diversity training is completed. Future research needs to consider long-term effects of diversity training on mitigating disparities for Women of Color and the interventions that address their needs when they are receiving care.

## 5.6 Conclusion

This chapter concluded the qualitative inquiry of the role diversity training has on the understanding of diversity for healthcare professionals, including how they understand race and gender diversity when caring for Women of Color. The purpose of this inquiry was to evaluate the understanding and knowledge of diversity for healthcare professionals and leaders at Magee-Womens Hospital through semi-structured interviews. All healthcare professionals spoke of their

experiences as they relate to their day-to-day clinical duties at Magee-Womens Hospital while caring for Women of Color. From the transcribed interviews and data analysis, four themes emerged: definition of diversity, identifying differences for Women of Color, minimal interventions in place to address disparities, and need for organization commitment to hire a diverse workforce and mandate diversity training. The data revealed several implications for practice and recommendations for further research that can expand awareness for healthcare settings. While this inquiry confirms the continued need for diversity training, it adds a new depth and dimension towards the need to address disparities experienced by Women of Color receiving care within UPMC. The researcher hopes that this work will be one of many future studies to shed light on how healthcare settings and professionals can better serve diverse patient populations.

## Appendix A: Email Invitation to Participate

Dear Invitee,

My name is Brittany Moore. I am a doctoral student in the School of Education at the University of Pittsburgh. I am kindly requesting your participation in a doctoral research inquiry that I am conducting titled: **The Role of Diversity Training on Healthcare Professionals' Understanding of Diversity at UPMC Magee-Womens Hospital**. The intention of this inquiry is to examine and assess within Magee-Womens Hospital the understanding of diversity, as it relates to race and gender differences, and the care for Women of Color at Magee-Womens Hospital. Criteria to participate in the inquiry is as follows: you have a role as a healthcare professional, are an employee, and/or leader of Magee-Womens Hospital and in some capacity have direct contact with caring for Women of Color.

The inquiry will involve semi-structured interviews with healthcare professionals at Magee-Womens Hospital. The interviews will be conducted in a private area, with a duration of approximately 45-60 minutes per interview. The goals of the structured interviews are to gain insight and reflection on employees' understanding of diversity training, specifically race and gender differences. Participation is completely voluntary, and you may withdraw from the inquiry at any time. The inquiry is completely anonymous; therefore, it does not require you to provide your name, but will require you to give demographic information. If you would like to participate in the inquiry, please reply directly to bjm138@pitt.edu stating your interest.

Participants will receive a $25 Amazon thank-you gift card for completing the interview. Your participation in the research will be of great importance in bridging connections between best healthcare practices and key outcomes for personnel and patients of diverse backgrounds.

Thank you for your time and participation!

Brittany Moore, LCSW, OSW-C
Doctoral Student, The University of Pittsburgh

## Appendix B: 2nd Email to Volunteered Participants

Dear Participant,

Thank you for your willingness to participate in the interview! Prior to the interview, you will be asked to sign a consent form. Please note that your participation is voluntary. You do not have to answer any questions you do not want to answer. If at any time you do not want to continue with the interview, you may decline. Your time and involvement are profoundly appreciated.

The entire interview will take approximately 45-60 minutes. As previously mentioned, participants will receive a $25 Amazon thank-you gift card **for completing the interview**.

If you wish to continue with participation, please complete the attached demographic survey and return prior to our scheduled interview. Using the doodle poll, please select a date that works best for you: <doodle poll link>

Disclaimer:
This inquiry is being conducted in part to fulfill requirements for my Doctor of Education degree in the Social Comparative and Policy Analysis Program at the University of Pittsburgh.

The inquiry has been approved by the Institutional Review Board of the University of Pittsburgh. The chairperson of this dissertation is Dr. Gina A. Garcia. She can be reached at ggarcia@pitt.edu for further questions or concerns about the inquiry.

Sincerely,

Brittany Moore, LCSW, OSW-C
Doctoral Student, The University of Pittsburgh

## Appendix C: Informed Consent

**INQUIRY TITLE:** The Role of Diversity Training on Healthcare Professionals' Understanding of Diversity at UPMC Magee-Womens Hospital.

**PRINCIPAL INVESTIGATOR**:
Brittany Moore, LCSW, OSW-C
bjm138@pitt.edu
(412) 641-4469

You may contact the study investigator if you have any questions about the study, concerns or complaints. Contact Principal Investigator, Brittany Moore at (412) 641-4469.

**INTRODUCTION**
Thank you for your willingness to participate in the inquiry titled, The Role of Diversity Training on Healthcare Professionals' Understanding of Diversity at UPMC Magee-Womens Hospital. The intention of inquiry is to examine and assess healthcare professionals' understanding of diversity.

The inquiry will involve semi-structured interviews with healthcare professionals at Magee-Womens Hospital. The interviews will be conducted in a private area, with a duration of approximately 60 minutes per interview. The goals of the structured interviews are to gain insight and reflection on employees' understanding of diversity, race, and gender differences, and its impact for Women of Color at Magee-Womens Hospital.

**STUDY RISKS**
Please note that your participation is voluntary. You do not have to answer any questions you do not want to answer. If at any time you do not want to continue with the interview, you may decline. Your time and involvement are profoundly appreciated.

**STUDY BENEFITS**
Participants will receive a $25 Amazon thank-you gift card for completing the interview. Your participation in the research will be of great importance to assist in bridging connections between best healthcare practices and key outcomes for personnel and patients of diverse backgrounds.

**CONFIDENTIALITY**
To maintain the essence of your words for the inquiry, the interview will be audio-recorded, and I will be taking notes. This is done for data analysis only. Using the audio recording, I will transcribe the data and keep all information confidential in a password-protected computer. All individual identification will be removed from the hard copy of the transcript. Participant identity and confidentiality will be concealed using coding procedures. For legal purposes, after completion of the inquiry all data will be disposed of and deleted.

Excerpts from the interview may be included in the final dissertation report. However, under no circumstances will your name or identifying characteristics appear in these writings. If, at a subsequent date, biographical data were relevant to a publication, a separate release form would be sent to you.

**WITHDRAWAL FROM STUDY PARTICIPATION**

You can, at any time withdraw from this research study; you can also withdraw your authorization for us to use your identifiable information for the purposes described above. This means that you will also be withdrawn from further participation in this research study. Any identifiable research information obtained as part of this study prior to the date that you withdrew your consent will continue to be used and disclosed by the investigators for the purposes described above. To formally withdraw from this research study, you should provide a written and dated notice of this decision to the principal investigator of this research study at the address listed on the first page of this form. Your decision to withdraw your consent for participation in this research study will have no effect on your current or future medical care at a UPMC hospital or affiliated healthcare provider or your current or future relationship with a healthcare insurance provider.

**PAYMENTS**

All participants will be distributed a $25 Amazon gift card in-person immediately after the interview is complete.

**CONSENT TO PARTICIPATE**

The above information has been explained to me and all of my current questions have been answered. I understand that I am encouraged to ask questions, voice concerns or complaints about any aspect of this research study during this study, and that such future questions, concerns or complaints will be answered by a qualified individual or by the investigators listed on the first page of this consent document at the telephone numbers given. I understand that I may always request that my questions, concerns or complaints be addressed by a listed investigator. I understand that I may contact the Human Subjects Protection Advocate of the IRB Office, University of Pittsburgh (1-866-212-2668) to discuss problems, concerns, and questions; obtain information; offer input; or discuss situations that occurred during my participation. By signing this form, I agree to participate in this research study. A copy of this consent form will be given to me.

_____ _____

Participant's Signature Date

**INVESTIGATOR CERTIFICATION**

I certify that I have explained the nature and purpose of this research study to the above-named individual(s), and I have discussed the potential benefits and possible risks of study participation. Any questions the individual(s) has about this study have been answered, and we will always be available to address future questions, concerns or complaints as they arise. I further certify that no research component of this protocol was begun until after this consent form was signed.

| | |
|---|---|
| _____ | _____ |
| Printed Name of Person Obtaining Consent | Role in Research Study |
| _____ | _____ |
| Signature of Person Obtaining Consent | Date |

## Appendix D: Demographic Survey

**Inquiry on Diversity Training in Healthcare Settings: Participant Information**

Thank you for agreeing to participate in this inquiry. All responses will be kept confidential and your identity will remain private. Your responses to these questions are optional but will be helpful for reporting findings.

1. E-mail address:_____
2. What is your sex or gender identity? _____
3. How do you identify racially/ethnically? _____
4. Birthplace: ☐ U.S. ☐ Outside of U.S.
5. Language(s) spoken: _____
6. What is the highest level of formal education that you have obtained?
    a. Degree type (BS, BSN, MSW, MSN, MD, PHD, etc.) _____
    b. Year completed: _____
7. Current position:
   _____
8. How long have you worked in your position? _____
9. How long have you worked at Magee-Womens Hospital? _____
10. To add to the validity of the inquiry, would you be willing to review preliminary results from this inquiry? ☐ Yes ☐ No

## Appendix E: Interview Protocol

**Introduction** "Hello and thank you for agreeing to be interviewed."

Thanks are extended to you for participating in the University of Pittsburgh's research on diversity practices in healthcare. My name is Brittany Moore. For this 60-minute interview, your participation is voluntary. You can stop the interview at any time or skip any questions.

This list of questions will serve as a guide for the interview process. As each individual being interviewed has a unique perspective of the experiences regarding their understanding of diversity and the influence it has on the care for Women of Color, follow-up questions may be necessary to gather a more thorough depiction of the experience. However, these questions will ensure that the same basic information is gathered from all individual participants. This list will ensure the interaction is focused and on target with the purpose of the inquiry.

### Preparation for the Interviews

The following questions and responses will be audio-recorded. May I have your permission to audio record and begin this interview?

- Do you have any questions regarding the Informed Consent Form?
- Precautions will be taken to protect the identity and privacy of all participants. Information within the dissertation will refer to all participants using an ID#. All stored data will have this number on it and not your real name. I will not associate the information you provide with your name in reports, but it may be possible for someone to think they can identify you. Do you have any questions regarding the confidentiality of information?
- For the purpose of the transcript, please state your current position.
- Please describe your background, providing information about your education and experience that helped prepare for your current role.

**Please remember that this is for transcript purpose only.**

### Interview Questions

### Icebreaker Questions

1. Tell me about yourself; what is your current position at UPMC and what does your position entail?
2. On a daily basis, how would you describe the demographics of the patients you see, for example, race, gender, income, etc.?

**Let's talk about your understanding of diversity.**

1. What does *diversity* mean to you?
2. How do you define *racial diversity*?
3. How do you define *gender diversity*?
    a. Can you describe a prior life experience that has shaped your definitions of *racial* and *gender diversity*?
4. How do your definitions of *diversity* apply to the current work that you do?
    a. How does your definition of *diversity* impact your day-to-day duties?
5. How did you come to your understanding of diversity?
    a. Specifically, how did you come to learn about racial and gender differences? (Prompt: reading, media, colleagues, conference, etc.)

**Let's talk more about your understanding of diversity and its impact on care for patients.**

1. Since working at Magee-Womens Hospital, how has your perspective of racial and gender differences changed as a healthcare professional?
2. The literature demonstrates that gender and racial differences are apparent for Women of Color in healthcare. Give an example of a racial and/or gender disparity that you see impacting Women of Color receiving care at Magee-Womens Hospital.
3. Give an example of how Women of Color are receiving adequate care at Magee-Womens Hospital.
4. In what ways do you think race and gender differences affect the care that Women of Color receive at Magee-Womens Hospital?

**Let's talk about diversity training.**

1. Describe any diversity training or resources you have participated in at Magee-Womens Hospital. What did you learn?
2. Are you familiar with UPMC's Center for Engagement and Inclusion? If so, have you utilized any trainings or resources through the Center?

## Appendix F: Organization Letter of Support

UPMC LIFE CHANGING MEDICINE

Magee-Womens Hospital
of UPMC
Administration

300 Halket Street
Pittsburgh, PA 15213

Dear Dr. Garcia & Brittany,

I am writing to let you know that I approve your current study at UPMC Magee-Womens Hospital to interview 10 healthcare professionals on their understanding of diversity. I understand that the data from the conducted interviews will be used by Brittany Moore, an EdD Candidate in the Social and Comparative Policy Analysis EdD program of the University of Pittsburgh's School of Education, as part of her dissertation research supervised by Dr. Gina Ann Garcia.

As I understand the methodology, Brittany will interview 10 healthcare professionals within the various departments at UPMC Magee-Womens Hospital. The interviews will be conducted in a private area, with a duration of approximately 45-60 minutes per interview. I further understand that interviewed participants will be asked about subjects within different categories, including understanding and perceptions of diversity in healthcare settings and understanding of racial and gender diversity. The structured interviews will also assess information as to the participant's definitions of diversity, specifically racial and gender diversity as it relates to Women of Color.

In addition, I understand that the data from the interviews will be de-identified, all responses will remain confidential, and audio recordings from the interview will only be used at Brittany's discretion for data transcription. Only members of the research team will have access to the study data. Upon completion of the interview, participants will receive a $25 Amazon gift card, provided they offer the required contact and identification information. Any such information provided for the purpose of receiving the compensation will also be kept confidential.

Sincerely,

Maribeth McLaughlin, MPM, BSN
VP of Operations, UPMC Magee-Womens Hospital
VP Women's Health Services, UPMC

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