Editorial

Through Diversity, Dignity; Through Belonging, Justice

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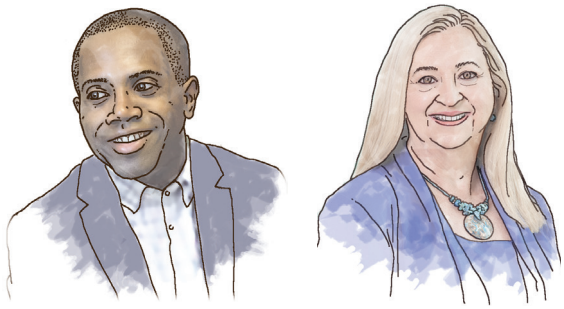

We read with keen interest the US Supreme Court's decision on the cases of *Students for Fair Admissions Inc (SFFA) v President and Fellows of Harvard College* and *SFFA v University of North Carolina et al*.[1] The court's 6-3 ruling effectively signaled the end of race-conscious affirmative action policies at universities across the United States. As educators and leaders within academic and health care institutions, we are struck by 3 salient themes that we think might be relevant to improving diversity, equity, and inclusion in our education and clinical care systems. First, we are reminded of the crucial role of group decision-making for transforming systems. Second, we emphasize the importance of forging a sense of belonging within teams and communities, empowering individuals from diverse backgrounds to contribute their unique perspectives. Third, the decision serves to remind us that bending the arc of the moral universe toward justice requires our collective imagination, our prophetic action, and sometimes our dissent.

Through reading the Supreme Court decision, we are reminded that both Harvard College and the University of North Carolina devoted most of their histories to sustaining admission systems that intentionally excluded women, Blacks, and other minoritized people. For example, Harvard College, founded in 1636, did not admit its first Black student until 1865. Meanwhile, the University of North Carolina at Chapel Hill, founded in 1789, did not admit its first Black student until approximately 1951, and this occurred solely due to a court order. We are reminded of how much of a change it was for these 2 institutions to have a group of people working together as part of their admissions committee to recruit a diverse class; their holistic review focused on assessing applicants across a broad range of subjective categories including academic performance, extracurricular activities, athletic excellence, and many more.

In health care systems, multidisciplinary teams make subjective clinical decisions with potential for life and death consequences for patients. These situations can range from bioethics committees addressing ethical dilemmas in health care settings, to multidisciplinary tumor boards navigating complex cancer treatment choices, to liver transplant teams making decisions about transplant eligibility, to multidisciplinary groups allocating treatments for patients with advanced heart failure. In contemporary health

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care, many of these group decisions are filled with conflicts, uncertainty, and ambiguity; and these decisions are occurring amidst a backdrop of heightened skepticism and mistrust for science across many segments of our population, particularly in our Black, Hispanic, and rural communities.[2,3] Moreover, our patients and families are coming to us from an aging population that is more racially, ethnically, and socioeconomically diverse, despite being simultaneously more socially and politically fragmented. And yet, significant underrepresentation of specific racial/ethnic and socioeconomic groups persists in the medical, nursing, and other health care professions.[4,5]

Ample research suggests that diversity can be associated with improved creativity and innovation in team science.[6,7] Diverse clinical teams have been associated with increased trust and improved communication among certain minoritized communities, and diverse clinical and research teams may be more capable of addressing health disparities and exploring social determinants of health.[8,9] For us to care for our increasingly pluralistic and fragmented communities effectively and ethically, we need to ensure that our pipeline of future clinicians, administrators, researchers, and leaders looks more like the communities we serve. If the legacy of this Supreme Court ruling is that our training institutions can no longer use race as a criterion in the admissions process, then our learning institutions must find innovative strategies to ensure that that they can sustain a diverse learning environment. Otherwise, we wonder how long these training institutions will be allowed to hide behind an anachronistic "best and the brightest" discourse on merit that feigns blindness to how this very discourse *necessarily* disadvantages the underrepresented and minoritized applicants.[10,11]

Beyond diversity, effective group decision-making in health care benefits from structured approaches to improve inclusion and belonging among all members of the team. For us to be able to reap the benefits of diversity, health care organizations must be intentional in creating networks, norms, and a level of trust that facilitate coordination, cooperation, and consensus. Networks include those deep connections that individuals can forge among people from similar backgrounds or characteristics; networks also include those connections that individuals develop across diverse groups, providing them access to new information, opportunities, and perspectives.[12] Structured approaches to improving team communication and collaboration create norms for how to do things in groups.[13,14] All members of the team, particularly members of historically marginalized communities, benefit from a high level of psychological safety that allows them to disclose, discuss, and learn from the process and outcome failures that might otherwise potentially go unreported.

Effective group decision-making in health care benefits from evidence-based strategies to reduce both explicit and implicit bias. Groupthink, a phenomenon in which a highly cohesive group might come to a premature consensus without critically evaluating alternative viewpoints or considering potential consequences is one example of a potential systematic bias that can impact subjective group decision-making at all levels of health organizations, from frontline clinical teams to senior managers and leaders.[15] On the other end of the spectrum, polythink involves a group decision-making dynamic whereby different members in a decision-making unit espouse their different opinions, resulting in increased intragroup conflict, a disjointed decision-making process, and potential for decision paralysis as each group member pushes for their preferred action.[16] Certain reflective behaviors have been studied as potential strategies to help improve knowledge sharing and decision-making and minimize bias in professional group settings. For example, de Groot et al[17,18] described several reflective group communication behaviors that have been associated with interprofessional learning, collaboration, and decreased bias and disparities in health care settings: (1) embracing different opinions that differ from the dominant view, (2) sharing opinions openly, (3) discussing research and other aspects of knowing and how it might be relevant to a particular decision, (4) being open about mistakes and taking responsibility for errors, (5) asking for and giving

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feedback, and (6) experimentation or actively envisioning alternatives.[17-19]

What will this Supreme Court ruling mean for our ability to address health disparities and promote equitable access to health care across our health care system? If we are to eradicate health inequities, our learning institutions must remain committed to diversity. If we value justice, our learning institutions must also be willing to prepare our learners to effectively participate in group decision-making processes. An educational culture that elevates consensus building as a moral activity of the highest order is one that values dignity and belonging, one that values humility, one that values the ability to see the humanity in people different from us, one that values different forms and sources of knowledge, one that insists that its members see the inequities in our systems and work together to eliminate them. It will not be enough for these institutions to speak in tongues about diversity, equity, and inclusion when their prophetic actions come from an understanding of merit that precludes the very diversity, equity, and inclusion to which they purport to aspire. As diversity in our world expands, so too must our commitment to dignity, belonging, and justice.

The statements and opinions contained in this editorial are solely those of the coeditors in chief.

FINANCIAL DISCLOSURES
None reported.

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