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Submitted to the Program of Organizational Dynamics, College of Liberal and Professional Studies in the School of Arts and Sciences in Partial Fulfillment of the Requirements for the Degree of Master of Science in Organizational Dynamics at the University of Pennsylvania
Advisor: Harvey Floyd, PhD

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Effective Engagement Of White Employees In Workplace Inclusion Strategies In Healthcare Organizations

Abstract

This capstone paper explores the subject of effective engagement of White employees in healthcare workforce inclusion strategies. While diversity, equity, and inclusion work in healthcare delivery organizations has become an increasingly high priority, leaders of this function must grapple with engagement of disparate audiences in order to achieve their goals. White employees wield outsized influence in creating a greater sense of inclusion in the workplace yet they are less likely to be engaged in diversity & inclusion work. The limited attention that this topic has received from academia was explored in three sections: (1) diversity approach, (2) Whiteness, which included work on privilege, 'fragility', and positive identity development, and (3) case studies. Qualitative interviews of 16 practitioners with diverse profiles produced findings regarding their overall approach, approaches to difference and commonality, and the effective engagement of White employees. Three participants voiced a concern about the framing of the research topic; their objections were valuable in highlighting the dialectical and strategic conflicts regarding a focus on racial identity. The participants largely agreed that the White encounter with workplace inclusion was exceptional, that psychological safety was paramount, and that development of positive work identities and relationships were key considerations. The participants' preferred strategic frames were mixed between healthcare quality, business, and social justice. The participants' leadership strategies to engage Whites were closely related to best practices for leading organizational culture change. After a synthesis of the extant literature and the interview findings, four critical insights were offered. The paper ends with a personal reflection.

Comments

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Advisor: Harvey Floyd, PhD

EFFECTIVE ENGAGEMENT OF WHITE EMPLOYEES IN WORKPLACE INCLUSION
STRATEGIES IN HEALTHCARE ORGANIZATIONS

by

Kenneth R. Rosso

Submitted to the Program of Organizational Dynamics,
College of Liberal and Professional Studies
in the School of Arts and Sciences
in Partial Fulfillment of the Requirements for the Degree of
Master of Science in Organizational Dynamics at the
University of Pennsylvania

Philadelphia, Pennsylvania

2019

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ABSTRACT

This capstone paper explores the subject of effective engagement of White employees in healthcare workforce inclusion strategies. While diversity, equity, and inclusion work in healthcare delivery organizations has become an increasingly high priority, leaders of this function must grapple with engagement of disparate audiences in order to achieve their goals. White employees wield outsized influence in creating a greater sense of inclusion in the workplace yet they are less likely to be engaged in diversity & inclusion work. The limited attention that this topic has received from academia was explored in three sections: (1) diversity approach, (2) Whiteness, which included work on privilege, ‘fragility’, and positive identity development, and (3) case studies. Qualitative interviews of 16 practitioners with diverse profiles produced findings regarding their overall approach, approaches to difference and commonality, and the effective engagement of White employees. Three participants voiced a concern about the framing of the research topic; their objections were valuable in highlighting the dialectical and strategic conflicts regarding a focus on racial identity. The participants largely agreed that the White encounter with workplace inclusion was exceptional, that psychological safety was paramount, and that development of positive work identities and relationships were key considerations. The participants’ preferred strategic frames were mixed between healthcare quality, business, and social justice. The participants’ leadership strategies to engage Whites were closely related to best practices for leading organizational culture change. After a synthesis of the extant literature and the interview findings, four critical insights were offered. The paper ends with a personal reflection.

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CHAPTER 1

INTRODUCTION

“Oh, I can't think about this now! I'll go crazy if I do! I'll think about it tomorrow.”

- Scarlett O'Hara, *Gone With the Wind*

This capstone paper addresses the subject of effective engagement of White employees in healthcare workforce inclusion strategies. But, I will not start the story in a hospital or doctor's office. It starts at my home in West Philadelphia this morning at 6:21 AM on a cloudy but bright Sunday morning.

I rolled out of the pile of crumpled sheets and glanced at my smart phone to find out the weather. Instead, I saw the news headline that yesterday, on April 27, 2019, a 19 year-old White nationalist walked into a synagogue near San Diego at the closing of the Passover holiday and opened fire, killing one and injuring three more worshippers. I am Jewish, White, and my mother was raised in San Diego. In the 5 seconds or so it took to see the glowing headline text, I was filled with sadness, bitterness, and fear. I felt no shock, anger, or urgency to act. Instead, I had the thoughts, “Here we go again,” and “Oh whatever, it's no use...” In an instant, I clicked off my phone, turned to check my wife was still sleeping, gathered my clothes, and walked down the hallway past the bedrooms of our two children and finally downstairs to knead and bake the bread dough I had started the night before.

In many ways, our country is a lot like me when it comes to facing White supremacy and racism. And just as Scarlett O'Hara felt she would “go crazy” if she faced a painful reality, Whites have done our best to avoid and forget how institutional racism *was* established and *is* maintained to this day. But the Presidential election in 2016, the new

media exposure of overuse of lethal force against African Americans by police, and the many instances of White supremacist violence have provided a teachable moment. Similarly, in the healthcare industry, the gross and persistent disparities along racial and class lines have pushed these issues to the fore. Healthcare leaders of diversity, equity, and inclusion now have national and institutional mandates to change the interpersonal and organizational dynamics that cause healthcare disparities.

But there is disagreement on how to change these dynamics. One critical area of disagreement is whether and how to address the issue of race, and those that are intersectional with race, in the healthcare workplace context. Since 85% of senior healthcare leaders identify as White and clinical professionals are also overrepresented by White individuals, this is a critical audience for engaging with the work of creating a more diverse and inclusive workforce. But there is significant evidence that Whites are prone to be disengaged in diversity work.

This situation sparks many interesting and thorny questions. Should we even address racial identity given that race is an emotional powder keg waiting to go off? Can we effectively create more inclusive working environments without directly referring to racism or the social construct of ‘Whiteness’? What are the best strategies and tactics for winning engagement of White healthcare leaders and workers for people of all racial identities? What are the interpersonal and organizational strategies that are most likely to result in including White employees in creating greater inclusion, for the benefit of all employees regardless of social identities? I will explore these issues through a review of literature, findings from 16 interviews, and interpretation of the findings using past research and theoretical constructs as guides. Ultimately, my hope is that the data and insights contained in these pages helps

healthcare industry leaders to create more diverse, more inclusive, and more equitable workplaces.

The remainder of this introduction contains seven sections. First, I provide an overall justification for the research project. After a note regarding my personal interest, I present a brief overview of the key literature that provided the background to the gathering of primary data. Next is a statement of my research question and overall goals of the research. I then reveal certain key assumptions and biases that impacted the project. The sixth section is methodology and the lastly, I outline the remainder of the capstone paper.

Justification

In 2017, the healthcare industry became the largest employer in the United States, with healthcare delivery being the largest subsector (Thompson 2018). At the same time our country is experiencing a renewed interest in facing and overcoming the impacts of racism and other systematic oppressions. These trends have provided leaders of diversity, equity, and inclusion in healthcare with a unique opportunity. With access to over 16 million employees, the diversity and inclusion arena in healthcare is the largest forum in the country for workers to grapple with the thorny issue of race and its intersections, including gender, socio-economic status, and age.

Healthcare policymakers, administrative heads, and clinical leaders no doubt realize the enormous import of this work and the urgency of this historic moment. The goals of creating a diverse, inclusive workforce and a more equitable, culturally competent healthcare system are now considered a major priority of healthcare delivery organizations (Agency for Healthcare Research and Quality [AHRQ], 2017; Dreachslin et al., 2017). The Affordable Care Act (ACA), passed in 2010 and implemented by 2014, created numerous regulations to

further the cause of diversity, equity, inclusion, and cultural competency. Hospital administrators, physician leaders, and staff charged with meeting this challenge are seeing slow progress in some measures and declines in others (Institute for Diversity in Health Management [IDHM], 2015; AHRQ, 2017; Diversity Best Practices, 2017). There is no readily available national data regarding inclusion, sometimes known as ‘diversity climate,’ save for data collected by individual healthcare institutions (Hofhuis et al., 2016; Aysola, 2018; Brimhall and Mor Barak, 2018).

On the diversity front, both the 2011 and 2015 data from the American Hospitals Association show that leaders identifying as White makeup 81% of front line managers, 85% of all C-Suite and board positions, and 91% of CEOs (IDHM, 2011, 2015). In contrast, in the patient population as a whole, non-Hispanic Whites comprise about 68% and in the US population, 61% identified as non-Hispanic White as of 2017 (IDHM, 2015; U.S. Census Bureau, 2018). This overrepresentation of Whites and White males in particular, persists despite, as the American College of Healthcare Executives (ACHE) notes, ‘two decades of success in attracting racially/ethnically diverse students to graduate studies in health administration’ (2015). Leaders now recognize that while front-end recruitment is a necessary precondition of more diverse representation, it is not sufficient. Rather, improving diversity also relies upon retaining and developing leaders from underrepresented groups through promotion of more inclusive work environments (Aysola et al., 2018). The limited studies of inclusion in the healthcare workplace are inconclusive (Diversity Best Practices, 2017).

Given the overrepresentation of White individuals in leadership and clinical professions, this is a critical audience for healthcare inclusion leaders. But Whites appear to

pose unique challenges to diversity work overall (McIntosh, 1988; Sue et al., 2010; DiAngelo, 2011) and there is evidence of Whites feeling excluded from inclusion efforts (Plaut, 2011; Shelton, 2013; Aysola et al., 2018). In a cross-industry study of 670 corporate leaders from 2012, 70% of White men and 60% of women and non-Whites were ‘not clear’ if diversity and inclusion work were intended for White men (Shelton 2013). In another study of healthcare leaders, 73% of white respondents believe opportunities for non-White leaders in healthcare have improved over the previous five years, while only 34% of minorities share that view (Witt/Keifer, 2015). This leads to the central research question of this capstone: how can healthcare diversity and inclusion leaders effectively engaging White employees in creating a more inclusive workplace?

Personal Interest

I chose this capstone topic for personal and political reasons. On a personal level, race and racism have had a big impact on my life and how I see the world. I am a White, Jewish man with ancestry in Eastern Europe, Italy, and Denmark. I spent my weekends at my father’s house in a mostly White suburb and my weekdays at my mother’s house in a West Philadelphia neighborhood that was majority African American and working class or poor. From ages eight to 12, my best friend was my Black neighbor Omar and my first cultural ‘home’ was Black and urban. My elementary schools were majority Black. As a result, I was aware of my Whiteness from early childhood. In my multicultural neighborhood, we talked and joked about identity all the time. I am sure that people today might be offended or confused by how freely we dealt with race. Looking back at that period, I was largely successful in bridging the divisions of race and class, and I benefited handsomely for it.

Then, Omar moved away, I changed schools, and teenage social identities became stronger. I was assaulted two times by African American teens in my neighborhood whom I did not know prior. After the worst assault, I struggled with intense fear and refused to leave the house except for school for several weeks. For the remainder of my high school years, I lacked a cultural home and struggled to connect with any one group of people.

Now, as an adult once again living and working in West Philadelphia, I have made the activist agenda of anti-racism central to my own healing work. In 2017, I joined a Parents Anti-Racism group in my neighborhood. In April 2018, I attended a White People Confronting Racism workshop with the activist organization Training for Change. I have worked on many issues of identity and oppression in my peer counseling network, Re-Evaluation Counseling. I have developed a few friendships and working relationships with People of Color. My life still feels segregated and I make plenty of mistakes that, I am certain, reproduce racism at the interpersonal and institutional levels. Part of me is still reaching for the Omar of my youth and all the people I have wanted to connect with more, but from whom I was separated by the circumstances of race, class, and other socialized divisions.

At the same time as my healing process has advanced, the national situation has also brought these issues to the fore. Despite societal progress, the election results of 2016, the exposure of extra-judicial killings of black people, and rising White supremacy were a personal wake-up call. These events demonstrated to me that a very large portion of White people in the United States lack the opportunities that I have had to work on their position relative to racism. Instead, it seemed many Whites saw racism as either nonexistent, not their fault, no concern to them, or even that racism was *done to them*. Others seemed to understand

their responsibility in racist systems, but chose to invest their time in ‘helping’ people of color. These responses got me interested in how I could help White people understand their self-interest in ending racism and build skills to support one another to do so.

I am also a coach, a consultant, and a student of Organizational Dynamics in the final semester of a six-year journey to a (second) Master’s degree. As a Dynamics student, I view the work of increasing diversity and inclusion as a culture change project. In such a project, leadership development, both at the senior level and throughout organizations, is critical to achieving success. On a personal level, I see diversity and inclusion work as a hopeful forum to increase White awareness and provide opportunities to overcome racial bias. Professionally, I was drawn to the industry focus of healthcare by my ongoing professional relationship with a leader of clinical care and quality in neuro-critical care at Children's Hospital of Philadelphia.

Lastly, as a citizen of the United States of America, my hope is that diversity and inclusion work can become more and more effective in creating opportunities for empathy, civility, and racial justice, and thereby help our country redefine its ‘dream’ in the era of a non-White majority.

Overview of Key Literature

There is a limited amount of academic literature directly addressing this study’s central question: How can leaders effectively engage White people in healthcare workplace inclusion? However, I found salient material in two closely related issues: one (1), diversity models and diversity approaches and how they impact Whites and non-Whites and two (2), White racial identity and how it interacts with inclusion strategies. I then explored two illustrative case studies in healthcare workplace inclusion. Lastly, I explored orienting

theories at the interpersonal level - psychological safety and positive identity development, and at the organizational level - organizational culture change.

From the work of Plaut (2011) and Apfelbaum (2016), I found support for the contention that White people's encounter with workforce -based inclusion efforts is exceptional. They also found that this encounter can be managed with adjustments in diversity approach, or the way in which diversity and inclusion are discussed. Successful approaches include using all-inclusive language explicitly calling out European ethnic identity and showing equal support for the value to the organization of differences and the value of treating workers with equality.

Scholars such as Helms (1995), McIntosh (1988) and Spanierman (2017) contend that, due to their insider position relative to the dominant culture, White people have unique challenges and opportunities vis-a-vis addressing racial inequality. The key takeaways for workplace inclusion leaders is that there is a developmental process for Whites to achieve higher levels of non-racist or ally-like behaviors. To reach these higher states, the experts in this area counsel that White people need challenge and support in both intra-group and inter-group interactions.

Holm's (2017) report on the Privilege and Responsibility Curricular Exercise (PRCE) at Henry Ford Health describes an interpersonal intervention that helped employees understand and interrupt the abuses of social privilege in the healthcare workplace. The PRCE provided a unique opportunity for Whites and non-Whites to work toward racial equity, but the resulting write-up was entirely qualitative and lacked empirical data. In contrast, Weech-Maldonado's (2018) study on the national diversity demonstration project was a rigorous two-year study of a comprehensive strategic intervention which tested both

interpersonal and organizational measures at two health systems. The intervention hospitals saw improvements versus the control hospitals in diversity leadership representation, human resource management, and diversity climate. The Weech-Maldonado result that was directly related to the current study showed that White non-racist attitudes worsened from pre- to post-intervention assessments.

Scholars such as Edmondson (2006) have shown that psychological safety at work enables learning and relationship-building. Since learning and relationships are central to promoting inclusivity, establishing psychological safety is key for inclusion leadership; this recommendation is particularly apt for engaging White employees. Dutton (2010), Ely and Roberts (2006) and colleagues have shown that the positive development of identity at work allows the development of positive relationships, both intra-group and inter-group, which are essential to withstand the rigors of inclusion work.

On the organizational level, Schein (2016) addresses culture change as a group learning activity that challenges underlying assumptions and triggers fears about survival and learning. Schein's most relevant recommendations for leading culture change are knowing the audience, providing a compelling vision, emphasize behavior change and not culture change, and connecting change-related beliefs, values, and behavior to stabilize newly formed cultures. Hiatt and Creasey (2012)'s change methodology draws upon longitudinal data regarding best practices in management of the 'people side of change'. These scholar-practitioners' work shows that executive sponsors are the most important role. Sponsor effectiveness depends on being active and visible throughout a change, building coalitions, and communicating directly to employees about the change. Regarding communications, Hiatt and Creasey warn leaders to attend closely to both the senders and receivers of

information – specifically, who they are and what they want to hear, based upon their self-interest. Receivers want to hear business-related information from senior-most leaders and they want to hear personal impact-related information from direct supervisors, ideally in a coaching conversation.

The literature summarized above has several gaps when considering the subject of effective engagement of White people in workforce inclusion in healthcare organizations. The work on diversity approach only considers how workforce inclusion is discussed, lacking emphasis on strategic frame (i.e. business case) or the content of actual interventions. The work on White racial identity development has not received a proper treatment from a healthcare organization perspective nor have the impacts of interventions designed with the ‘Whiteness’ lens been studied. Since healthcare organizations need to create more diverse and inclusive workplaces and White employees comprise the majority of influential roles, there is a need to explore the issues surrounding engagement of White employees in workplace inclusion. Lastly, my review of independent, non-peer reviewed research revealed that much of the work focused directly on the topic has been conducted outside the walls of academia.

Research Question and Goals

The main research question of this capstone paper is, “How can healthcare leaders effectively engage White employees in workplace inclusion strategies?” Answering this question led me on an intellectual journey through multiple academic disciplines, across 30 years of work in diversity and inclusion practice, and around adjacent subject areas. While it would have been impossible to report back from each waypoint on this journey, I distilled this immense body of learning into a few key topics. The key topics included diversity

approach (how diversity and inclusion work is discussed), Whiteness and non-racist White identity development, promising interpersonal and organizational strategies for engaging Whites, and workplace inclusion as a culture change project.

In answering the main question, my goal was to provide research-backed, timely, and actionable insights that would help practitioners effectively engage White leaders and employees in workplace inclusion. While I was specifically interested in those practitioners from large healthcare delivery organizations, I also hoped that the paper would appeal to other industries. Regardless of the usefulness of the findings, another goal was to spark a dialogue about whether, and how, leaders of diversity and inclusion work should address issues of racism and White supremacy. Lastly, my research was conducted with future investigators in mind; I hope this work sparks follow-on scholarship from across the many disciplines.

Assumptions and Biases

My research was written with numerous assumptions and biases. The assumptions were intentional in order to focus the scope and generate results that were timely and relevant to the audience. My biases were operating at an unconscious level. These assumptions and biases guided both the inclusion and the exclusion of certain data. Given the importance of approaching the research ethically, I will state these assumptions and biases to make my conceptual filter as transparent as possible:

- My social identities formed an inescapable filter of assumptions about myself, the research process, how the interviewees saw me, and innumerable other issues. For example, as a 42-year-old White man raised in a middle class household with prior training in sales, I reached out directly to esteemed healthcare leaders, sometimes

without a warm reference, and assumed I would get a positive response. I identify as an activist and I am surrounded by activists in a highly left-wing neighborhood community. Therefore, I assumed that the diversity and inclusion leaders with whom I spoke shared some of my basic social and political assumptions about the world. I sought to mitigate these biases by recruiting an advisor and reader with, what I guessed based on appearances and our personal interactions, were complementary social identities to my own.

- I am interested in the overall goal of ending racism and achieving greater racial justice in the United States. This speaks to my orientation towards the sometimes divergent goals of the workplace inclusion agenda: business performance, organizational effectiveness, and social justice. While I believe strongly in performance goals such as financial health and healthcare quality, thus my six-year pursuit in a degree in Organizational Dynamics, my anchoring goal is social change at the societal level. I believe that organizations fundamentally exist to serve the public interest of the societies in which they operate and, most importantly, to serve the interests of human beings as a whole. This bias caused me to create a goal of making the execution of this project itself, to a reasonable extent, an anti-racist endeavor. I mitigated this bias by fully exploring the opposing frame of reference - one that centers organizational interests - in the interpretation of the findings.
- Related to the bias described above, I assume that the reader has a basic understanding of two core, interrelated issues of my subject: institutional racism in the United States and health disparities. Therefore, in the text of the paper, I do not delve deeply into the unprecedented impact of White supremacy, nor do I explore the

particular populations, pathologies, or quality of care issues associated with the health disparity problem. I softened the impact of this assumption by providing the reader some limited background information on these topics. For further background on these issues, see the References.

- I have a bias for being direct and I assume others are being direct as well. This bias emerged in a coaching conversation with my advisor. My directness is partly a cultural artifact of growing up in a ‘low-context’ culture (Hall 1976) in which ‘what you see is what you get’. Also, as an activist, I enjoy the feeling of ‘speaking truth to power.’ As a former salesperson, my directness was a survival mechanism. I mitigated my directness bias in this research study by developing awareness through conversations with my advisor and other stakeholders. In addition, I asked my advisor, reader, and a third diversity and inclusion expert to review my interview questions before using them.
- I assume that, by combining the most important concepts from academic literature with lessons from the field, this will result in useful guidance for current practitioners in large, healthcare delivery organizations. This assumption reminds me of the famous caveat from the investment world: Past results does not dictate future performance. As an academic project, my paper will adhere to the scholarly orthodoxy of gathering data from past experience in order to form future solutions. The danger is that the newly-formed theories, largely rehashed from past experience, are ill-equipped or irrelevant to the inherently dynamic nature of reality. I mitigated the academic bias of my paper by grounding the research in primary data gathered from current-day practitioners. My interviewing methodology included a statement

- encouraging interviewees to act as ‘participant-partners’ rather than subjects, inviting them to stray from my agenda and generating more practical data. Lastly, to balance out the academic bias of the research, I included non-academic yet reputable sources in the Key Insights section.
- I had a bias for producing timely and relevant results to practitioners. This impacted the extent to which my research explored the history of diversity and inclusion practice. My sense was that the dynamism of the topic and the dynamism of the current historical moment deserved a treatment of the literature that shaded toward more recent work. With my advisor, I established a general preference for literature that was created in the last 20 years, while not excluding older work.

Methodology and Methods

My data collection strategy was designed to (1) gather relevant, valid, reliable primary data from practitioners of workplace inclusion in a resource-efficient manner, (2) build positive relationships that would become an ongoing resource for further research, and (3) generate self-reflective, experiential data regarding the relationship between the topic and my social identities. Based upon my goals for data collection, I chose the qualitative research methodology of semi-structured interviews.

From February 7 to April 8, 2019, I conducted 16 qualitative, semi-structured interviews of healthcare inclusion leaders and expert consultants. The interviews averaged 62 minutes in length, were recorded, and generated over 250 pages of transcript data. Of the 16 participants, 12 were leaders in eight healthcare delivery organizations in the United States. The remaining four participants were independent diversity & inclusion consultants or leaders of independent organizations with extensive experience working with healthcare

delivery organizations. The participants had to spend at least 30% of their time working on their responsibilities in promoting diversity and inclusion. I used a combination of purposive and convenience sampling techniques.

The most common position type (9 of 16) was a senior or mid-senior faculty member at a medical center with multiple appointments and varying responsibilities in promoting diversity and inclusion. I sought to compile a demographically diverse sample and therefore had to independently assess the racial and gender makeup of the participants prior to our interviews (See Table 1 below). These assessments were confirmed by 14 of the 16 interviewees during their interviews and no interviewees disconfirmed the independent assessment.

Table 1: Participant Race and Gender (Independent Assessment by Interviewer), ordered by participant count (#)

Race	Gender	#	Percentage
Black/African American	Women	5	31.3%
Black/African American	Men	4	25.0%
White	Women	3	18.8%
White	Men	2	12.5%
Latina	Women	1	6.3%
Latino	Men	1	6.3%
	Total	16	100.0%

In my outreach and in my interview introduction, I expressed my goal that the interviewees would be “participant-partners”: they would contribute to and benefit from the research (See Appendix A: Interview Agenda). I used the participant-partner concept in the interest of increasing equity and mutuality in the research relationship. I viewed the interview process as an organizational development intervention in which the thinking and behavior of workplace inclusion practitioners would be influenced by the process itself.

After the interviews were complete, I reviewed the recordings, transcriptions, and handwritten notes. Using this data, I listed the responses to each question, removing or altering all references to potentially identifying information. I analyzed the data as a whole to compile thematic categories. Consistent with a Grounded approach, during the data analysis stage, I did not attempt to fit the data into preconceived theoretical frameworks (Creswell and Poth, 2017). Then, I assessed the connections between the data, the extant literature, and organizing theories. After the analysis phase, I assigned pseudonyms to the participants.

A major limitation of the research methodology is that it did not include a formal empirical study. That is, I was not testing a specific hypothesis in regarding to the effective engagement of White people in workplace inclusion. I also did not compile a menu of strategies and interventions from the academic literature and then seek feedback on this agenda from the participants, nor did I gather quantitative data. However, one goal of this highly qualitative research is that it will form the foundation for a quantitative research in the future.

Language Usage

My use of language, particularly around social identities, was guided by prevailing norms of social science research and my involvement in various communities working toward racial equity. My word choices are guided by my intention to avoid reproducing legacies of discrimination or exclusion.

I used the following general guidelines from the writing center and diversity and inclusion offices of Hamilton College regarding the “Language of Difference”:

- Assume a wide audience
- Include a rationale for your choice (see specific rationales below)

- Use only the language that is necessary to the context - only mention difference when it is relevant
- Avoid terms that evaluate
- Use the appropriate degree of specificity; i.e. ‘Dominicans’ rather than ‘Hispanics.’
- Focus on people rather than on a method of categorization: ‘people with mental illness’ rather than ‘the mentally ill.’
- Avoid the term ‘minority’ if possible (Bowman et al, 2015)

Adhering to APA, 6th edition style guidance, I capitalized racial identities such as ‘Latino/a’, ‘Black’, and ‘White’, (2009, pp. 70–77).

I use the phrases ‘non-White’ and ‘People of Color’ interchangeably. Per the guideline above, I used these phrases when appropriate and, when called for, I used more specific words such as ‘Black’ when appropriate. Given that this research is focused on people with White racial identity or who enjoy White privilege, I chose ‘non-White’ to delineate those people that do not belong to this group. However, I was also aware of the danger that, to some readers, using the phrase ‘non-White’ centers Whiteness and devalues the diversity of the innumerable ethnic groups and nationalities whom do not experience White privilege. On the other hand, since my research dealt specifically with the set of advantages, mind frames, and behaviors in the workplace associated with White privilege in the US, I wanted to acknowledge the inherently political nature of this issue. Therefore, I use both non-White and People of Color.^{1 2}

¹ There is also a robust debate regarding the use of ‘People of Color’ (Glover, 2016)

² In the Re-Evaluation Counseling communities, a worldwide peer counseling organization of which I am a member, we use the phrase, ‘People of the Global Majority’ (Re-evaluation Counseling, 2016). People of the Global Majority is used to connote the reality that people of non-European ethnicities are the majority, by a wide margin, of the worldwide population. I have chosen not to use ‘People of the Global Majority’ because I believed it may have caused an unnecessary distraction to the reader.

I use the word ‘United States’ and not the word ‘American’. I do not use ‘American’ because this word, while used ubiquitously to refer to people who live in the United States of America, conflates the geographical designation of the Americas with a nationality designation of one country in that area (Kirk, 2013).

I use gender terminology (cisgender woman, cisgender man, transgender) and sex terminology (male, female) separately. However, when I reference literature that mixed gender and sex, sometimes my usage also became mixed.

I created pseudonyms for each of the 16 participants using gender-neutral names and used the pronoun ‘they’ in order to secure their anonymity.

Outline of Capstone Paper

The goal of this capstone paper is to advance knowledge and practice of the effective engagement of White people in workplace inclusion strategies in healthcare organizations. I pursue this goal by presenting the relevant knowledge on the issue, explaining my research methodology, presenting the findings, and offering an interpretation of these findings.

In chapter 2, I will present a review of academic literature in five sections. The first section presents the situation facing healthcare leaders who are charged with promoting an inclusive workplace strategy. Secondly, I will define several key terms that are connected to the research question, and in doing so provide general background to the current study. The third section presents key academic literature in two themes and two case studies. The fourth section presents helpful orienting theories for exploring this study’s focus area. The fifth and final section summarizes the chapter and identifies gaps in the literature.

Chapter 3 is an explanation of my research methodology. In this chapter, I will discuss the methodological approach of the study, the use of semi-structured interviews, sample selection, data analysis, and limitations of the methodology.

In chapter 4, I will present key findings from the primary research, which were gleaned from analyzing the data from 16 qualitative, semi-structured interviews of healthcare inclusion leaders and expert consultants. I present the critical data in the dominant themes that emerged from a close reading of each interview transcript, using extensive verbatim quotes from the participants.

Chapter 5 provides an interpretation of the findings from interviews with 16 healthcare leaders and consultants regarding the effective engagement of White people in workplace inclusion strategies. The first section of the chapter is interpretation of the findings as bounded by the concepts presented in Chapter 2, the Literature Review. These bounded interpretations include the sub-topics of response to the research, interpersonal strategies for White engagement, and organizational strategies for White engagement. The second section presents conclusions, which include a summary of interpretations, key insights for practitioners which includes non-academic sources of knowledge, and a personal reflection.

CHAPTER 2

LITERATURE REVIEW

Introduction

This review of academic literature will explicate relevant bodies of knowledge surrounding the primary research question: How can healthcare leaders effectively engage White employees in workplace inclusion strategies? The review has five sections. The first section presents the situation facing healthcare leaders who are charged with promoting an inclusive workplace strategy. Secondly, I define several key terms that are connected to the research question, and in doing so provide general background to the current study. The third section presents key academic literature in two themes and two case studies. The fourth section presents helpful orienting theories for exploring this study's focus area. The fifth and final section summarizes the chapter and identifies gaps in the literature.

Industry Context

The industry focus for this study includes urban healthcare systems in the United States, whether they are for-profit, nonprofit, academic, or nonacademic. All other sectors of the US healthcare system such as private practices, pharmaceuticals, and medical devices, are excluded from this scope. The terms, "healthcare system," "healthcare delivery networks," "medical centers," "hospitals," "hospital systems," "medical centers," and the like will be used interchangeably.

Along with rapid expansion, workforce shortages, and technology change, the creation of a more diverse and inclusive healthcare workforce and a more equitable system are major priorities of healthcare delivery organizations located in the United States of America (Dreachslin et al., 2017; Diversity Best Practices, 2017). The Affordable Care Act

(ACA), passed in 2010 and implemented by 2014, created numerous mandates, including increased diversity in the healthcare workforce, collection of diversity data, and investment in a culturally competent workforce (Diversity Best Practices, 2017). The ACA also created a National Prevention Strategy (NPS), which created a framework for alignment of healthcare quality and health equity.

The coming demographic shift in the United States from a White majority to a People of Color majority by 2045 is another source of pressure on healthcare providers to increase diversity and inclusion measures (Parker, 2019). Already, the cohort of young people born in 2007 or later are minority White (Frey, 2018). While the patient populations grows more diverse racially and ethnically, healthcare leadership diversity lags. Both the 2011 and 2015 reports from the American Hospitals Association show that leaders identifying as White make up 85% of all C-Suite and board positions and 91% of CEOs. In contrast, in the patient population as a whole, non-Hispanic Whites comprise about 68% and in the US population, 61% identified as non-Hispanic White as of 2017 (Institute for Diversity in Health Management [IDHM], 2017). Additionally, ‘controlling for education and years of experience, black men continued to earn median salaries that were 17 percent less than white men. Hispanic men earned 8 percent less and black women have moved from earning almost the same median salary as white women in 2007 to earning 13 percent less’ (ACHE, 2015).

While the data is clear that greater diversity and equity in the healthcare leadership is an area of need, perceptions of this need differ between Whites and non-Whites. According to an independent survey of healthcare leaders, 73% of White respondents believe opportunities for diverse leaders have improved over the previous five years while 34% of non-Whites agree (Witt/Keifer, 2015). Similarly, 67% of white respondents agree the

availability of leadership positions for People of Color in healthcare organizations has improved over the previous five years; only 30% percent of People of Color agree (Witt/Keifer, 2015). Not surprisingly, Weech-Maldonado (2018) reports that non-Hispanic White men have the highest 'job satisfaction' and perception of 'opportunity in the workplace' (p. 31).

Hospital administrators, physician leaders, and staff charged with meeting the regulatory mandate are seeing slow progress in some measures and declines in others (IDHM, 2017; AHRQ, 2017; Diversity Best Practices, 2017). There is no readily available national data regarding inclusion, sometimes known as 'diversity climate,' save for data collected by individual institutions (Hofhuis et al., 2016; Aysola, 2018; Brimhall and Mor Barak, 2018). Nevertheless, there is a growing chorus of support for rolling out comprehensive diversity and inclusion strategies in healthcare workforce. This policy statement of the American College of Healthcare Executives (ACHE) throws its support behind

'a commitment at all professional levels... within the organization through the awareness of diversity and inclusion issues, hiring practices that attract diverse staff, development and mentoring in educational programs and organizations, and organization-wide diversity and cultural competency training' (2015).

In this statement, the ACHE shows a growing recognition that a significant aspect of the diversity pipeline challenge lies in medical centers' ability to retain and develop leaders from underrepresented groups. For, the overrepresentation of Whites and White men in particular persists despite, as the ACHE notes in its 2015 policy statement, 'two decades of success in attracting racially/ethnically diverse students to graduate studies in health

administration'. Still, the number of People of Color medical student graduates is lagging. While comprising more than 30 percent of the U.S. population, Blacks and Latinos make up only 10.3 percent of medical school graduates (Charles, 2019). In order to retain and develop clinical and administrative leaders from these groups, the industry is now shifting attention and investment into creating more inclusive and empowering work environments in healthcare.

But Whites appear to pose unique challenges to diversity work overall (McIntosh, 1988; Sue et al., 2010; DiAngelo, 2011) and there is evidence of Whites feeling excluded from inclusion efforts (Plaut, 2011; Shelton, 2013; Aysola et al., 2018). In a cross-industry study of 670 corporate leaders from 2012, 70% of White men and 60% of women and non-Whites were 'not clear' if diversity and inclusion work were intended for White men (Shelton 2013). In another study of healthcare leaders, 73% of white respondents believed opportunities for non-White leaders in healthcare have improved over the previous five years, while only 34% of minorities shared that view (Witt/Keifer, 2015).

While no study has directly addressed the issue of engaging White employees in healthcare diversity and inclusion work, there have been studies that provide crucial insight and context for this topic. For example, beginning in 2009 and concluding in December 2013, Robert Weech-Maldonado of University of Alabama and Janice Dreachslin of Penn State led the National Center for Healthcare Leadership Diversity Demonstration project (Weech-Maldonado et al., 2018). In a similar time period, diversity leaders and consultants at Henry Ford Health System in Detroit rolled out their faculty and staff the Privilege and Responsibility Curricular Exercise [PRCE] (Holm et al., 2017). The Weech-Maldonado and

Holm studies are explored further in the Illustrative Case Studies subsection under Review of Extant Literature.

Definitions and Background

In US healthcare, the concept of inclusion is often linked together with the concepts of diversity, equity, health disparity, and cultural competence. However, these terms have different meanings in different contexts to different audiences. The use of language is critical in workplace inclusion practice because different social identity groups have different reactions to the same words (Stevens et al., 2008; Plaut et al., 2011). As a result, choosing the right communication strategy is a central challenge for practitioners. Therefore, defining the terms inclusion, diversity, equity, and cultural competence carries importance for both academic research and practical applications in the field. Exploration of these definitions also provides a general background to the current study, effective engagement of White people in workplace inclusion. My definitions rely heavily on the work of University of Southern California social scientist Michelle Mor Barak.

Inclusion

To Mor Barak, workplace **inclusion is the extent to which employees, regardless of social identity or group affiliation, feel they are a part of the organizational system, both in terms of formal processes like decision making and promotion and informal processes like ‘water cooler’ conversations** (2016). Therefore, this concept of inclusion encompasses both the organizational policies and procedures that dictate inclusivity, adherence to those formal rules, and self-reported perceptions of inclusion by employees.³

³ The interplay of formal and informal inclusion measures is important to consider. Some compliance-based strategies have been shown to have a negative impact on actual inclusion practices (Madera and Hebl 2013).

Another way to assess inclusion is to assess the absence of its opposite, exclusion. That is, to what extent does the combination of an organization's formal rules and informal interpersonal dynamics exclude people of various identities? Some researchers show that the fear of the pain of exclusion may be a fundamental driver toward seeking inclusion (Eisenberger et al., 2003). Further, the negative effects of interpersonal exclusion on job-related performance can be as significant as overt discriminatory practices (Thomas, 2008).

In contrast to defining inclusion in terms of its opposite, positive organizational scholars define inclusion as the presence of genuine positive relationships that bridge differences between individuals (Davidson and James, 2006). These high-quality relationships are central to building more inclusive culture because they allow workers to, as Stevens and Plaut put it, 'move beyond surface-level actions to actively incorporate diversity into their work lives' (2008, p.118). Genuine, positive relationships across difference provide the basis for an individual employee to feel that all their social identities are welcome, resulting in a lived sense of greater authenticity at work. These high quality relationships also encourage ongoing learning and resilience in the face of identity-based conflict (Stevens et al., 2008). By making workplace inclusion central to the project of overall employee growth and engagement, positive organizational scholars seek to elevate the work of inclusion as a mission-critical management practice.

Rather than pursuing a top-down approach to defining workplace inclusion, Jaya Aysola's (2018) research developed an operational definition of inclusion in the healthcare context using a grassroots approach by asking employees to define inclusion. Participants responded in narrative format to two questions: (1) Can you think about a time when "you/them feel included, valued, and welcome, OR excluded, devalued, and unwelcome as a

member of [this organization]” and (2) “Please comment on your perception of the general climate at the [organization] with regards to inclusion and respect” (Aysola et al., 2018). The researchers’ analysis of participant narratives resulted in a taxonomy of inclusion had the following themes:

- Presence of discrimination in both the interpersonal and institutional realms
- The silent witness
- The interplay between hierarchy, recognition, and civility
- The effectiveness of leadership and mentors
- Support for work-life balance
- Perceptions of exclusion by inclusion efforts

Therefore, for Aysola et al., an operational definition of inclusion in healthcare would consider both the absence of exclusionary policies and practices and the presence of inclusive ones. This duality highlights a central challenge of workplace inclusion - how can leaders implement a strategy that maximizes inclusion for some social identities without generating exclusion for others? Given the range of diversity in social identities, nationalities, and cultures, particularly in large healthcare delivery networks in the US, it is critical to understand the concept of diversity and how it relates to inclusion.

Diversity

Contemporary definitions of diversity attempt to reconcile the US-centric, narrow view with broader views that are more accepted by practitioners in global workplaces (Mor Barak, 2016, page 116-130). US-centric definitions have focused on promoting better representation of, and protecting the rights of, groups that have experienced systematic discrimination based upon race, gender, sexual orientation, and the like. This definition of

diversity is connected to compliance with national Equal Employment Opportunity laws, first instituted in the late 1960's, and the concept of affirmative action. As a result, this usage of diversity generally implies two separate groups of employees: those who have experienced nationally-recognized discrimination and those who have not (Mor Barak, 2016).

Practitioners who adhere to this concept of diversity may refer to some groups of employees as *diverse* (e.g. Female, Latinx, GLBTQ) and others who are not (e.g. White & Male). The unstated goal of these US-based diversity programs is to increase the representation and retention of employees that are *diverse*.

Meanwhile, global practitioners reject this US-based view as too narrow and contextual. Globalists posit diversity as the presence of employees with innumerable characteristics, both immediately observable and not (Mor Barak, 2016, page 126). This diversity allows for inclusion of features like ethnicity, nation of origin, religion, age, cultural background, rural/urban, and socio-economic background. Some scholars and practitioners have extended this diversity concept further to include *every employee* in the organization (Thomas, 1992). In recent years, this all-inclusive view of diversity expanded even further to include the diverse ways that employees' mental processes manifest at work. The diversity of thought concept has the advantage of speaking to the purported advantages for teams that harness more diverse perspectives (Reynolds and Lewis, 2017; Chamorro-Premuzic, 2017; Fernandez, 2007).

However the globalist, broadly-defined *diversity* is rejected by some compliance- and justice-oriented practitioners as an unacceptable dilution of the term (Mor Barak, 2016). They argue that the broad definition of diversity ignores historical and present-day oppression, which reinforces employer behavior that colludes with a discriminatory socio-

economic system. Mor Barak resolves this conflict between the justice-oriented diversity and the globalist diversity with a “both-and” definition:

Workforce diversity refers to the division of the workforce into distinction categories that:

- (a) Have a perceived commonality within a given cultural or national context, and that**
- (b) Impact potentially harmful or beneficial employment outcomes such as job opportunities, treatment in the workplace, and promotion prospects - irrespective of job-related skills and qualifications (2016, page 129)**

This definition of diversity both presents a broad scope and includes the concept of harmful outcomes. Mor Barak’s definition focuses attention on the *who* and the *why* of diversity: “Who is workplace diversity for?”, and “Why is diversity important?” These concerns are also central to an inter-group cultural diversity model as explicated by Robin Ely and Laura Morgan Roberts: “We define cultural diversity as differences among team members in race, ethnicity, gender, religion, nationality, or other dimensions of social identity that are marked by a history of intergroup prejudice, discrimination, or oppression” (2008, page 175). Ely and Roberts’ probing of the *who* and the *why* of diversity is critical to the project of promoting an inclusive healthcare workplace because they direct attention towards the various senders and receivers of communication and the impacts of the work.

Health Disparity and Health Equity

A lack of diversity in healthcare leadership and health professions is considered a significant factor in ongoing health disparities in the US (Marrast et al., 2014). Carter-Pokras and Baquet (2002) define health disparity as ‘a chain of events signified by a difference in:

(1) environment, (2) access to, utilization of, and quality of care, (3) health status, or (4) a particular health outcome that deserves scrutiny' (p. 427). This definition refers to the systemic, holistic nature of the health disparity issue. The CDC, tracking the consensus among public health practitioners, goes beyond Carter-Pokras and Baquet's *disparity* by introducing the concept of fairness: health disparities are inequalities that represent "unfair health differences closely linked with social, economic or environmental disadvantages that adversely affect groups of people" (Centers for Disease Control, 2013). The AHRQ identifies the following groups as "priority populations" for health equity research, policy, support, and funding: women, children, the elderly, ethnic minorities, racial minorities, special needs population, urban or rural population as well as the lesbian, gay, bisexual and transgender (LGBT) population (2019).

Promotion of health equity is presented as the antidote to health disparity. Braveman and Gruskin (2003) offer a succinct definition: "equity in health is the absence of systematic disparities in health (or in the major social determinants of health) between groups with different levels of underlying social advantage/disadvantage—that is, wealth, power, or prestige" (p. 254). For healthcare delivery organizations, the inclusion of systematic, societal disadvantage in the health equity concept justifies the expansion of their mission from the patient level to the broader social, economic, and political determinants of health in the US.

Cultural Competence

The National Quality Forum, the leading independent organization promoting health quality and equity, defines **cultural competence as the health care systems' ability to ensure that "diverse patient populations receive high-quality care that is safe, patient**

and family centered, evidence based, and equitable” (National Quality Forum, 2009).⁴

Healthcare organizations are investing in cultural competence at many levels:

- diversifying their leadership and provider populations,
- educating providers and staff on salient cultural features of their patient populations,
- mainstreaming diversity content in medical education,
- increasing their service level for non-English speakers,
- training regarding societal privilege,
- unconscious bias training,
- engaging with community-based organizations and many other initiatives (Weech-Maldonado et al., 2018; Holm et al., 2017; Dreachslin et al., 2012; Aysola et al., 2018).

Therefore, cultural competence is an integrative concept for the healthcare system that seeks to incorporate the goals of diversity, inclusion, and health equity. However, within the context of the healthcare workplace, cultural competence is just one factor, albeit a critical one, in creating an inclusive healthcare workplace (Person et al., 2015).

White people

The persistent, severe health disparities between Whites and non-Whites in the US healthcare system highlight the importance of leaders gaining a full understanding of the White racial identifier and Whiteness as a social construct. Despite the social power of Whiteness in present day US society, there is no biological basis supporting Whiteness and other racial categories (Cavalli-Sforza et al., 1996; Cooper et al., 2003). More specifically, there are no genetic differences between human beings beyond the superficial differences

⁴ It is unclear how the NQF defines “diverse populations” in its definition of cultural competence. Per the discussion of diversity above, the term “diverse people” connotes that some people are diverse (e.g. underrepresented minorities, historically disadvantaged groups) and some people are not (e.g. overrepresented and historically advantaged groups).

that arose from environmental adaptation, such as skin color.⁵ In fact, geneticists have found greater variability within “racial groups” than across them (Gannon and LiveScience, 2016).

Whiteness is a social construct that was created by Europeans, at the latest, in the early 17th century within the context of their military and economic domination of non-European people in Africa, Asia, and the Americas (Painter, 2011; Lipsitz, 2018).⁶ The concepts of Whiteness, White supremacy, race, and the racial inferiority of non-Whites developed to explain the systems of domination designed to extract value from land, labor and other resources from non-Whites (Lipsitz, 2018; Coates, 2015; Hall 1995). The colonizing societies created Whiteness and ascribed to it a certain set of phenotype-based (particularly skin color), ethnic, religious, and other characteristics to the colonized people in order to explain, communicate, and reinforce economic, political, and social domination.

By the time of the first US census in 1790, the Census Bureau had three racial designations: (1) Free White males, free White females (2) All other free persons, and (3) Slaves (Pew Research Center, 2015). It is interesting to note that, in the first census, White was the only race named.⁷ Thirty years later the word ‘colored’ appeared in the 1820 census and then, in the 1850 census, ‘Black’ and ‘Mulatto’. In 1960, all racial designation became self-reported, whereas in the past, the census taker would assign race. In 2000, US census subjects were allowed to designate two or more races. In 2010, Hispanic was separated from

⁵ Despite the extensive evidence debunking a biological basis for racial designations, the scientific argument for racism persists. See the New York Times article from January 5, 2019, ‘White Supremacy, Genetics, and Dr. James Watson’ (Charlton and Harmon, 2019).

⁶ According to (Simon, 2017), the written origins of the phrase ‘White people’ can be traced to October 29, 1613, when the English playwright Thomas Middleton’s *The Triumphs of Truth* was first performed. The African king character (likely played by an Englishman) looked out upon the English audience and declared: “I see amazement set upon the faces/Of these White people, wond’rings and strange gazes.”

⁷ ‘Slaves’ included the relatively small numbers of non-African slaves present in the country at the time (Pew Research Center, 2015).

Race as a category, allowing for dual designation of Hispanic and White or Hispanic and non-White. In the 220 years from 1790 up until 2010, all census forms have placed White at the top of the list (Pew Research Center, 2015).

According to US Census estimates for 2017, approximately 76.6% of the US population identified as “White only” or “White and Hispanic”, while 61% identified as White only (U.S. Census Bureau 2018). In large, US healthcare delivery networks, White people make up the vast majority of senior leadership positions (IDHM, 2017). The most recent data from the American Hospitals Association shows that Whites make up 85% of all C-Suite and board positions and 91% of CEOs. First- and mid-level managers are 81% White on average. In the healthcare workforce as a whole, depending on geography, White people make up between 65% and 90% of doctors, nurses, and technical professions (Valentine et al., 2016; IDHM, 2017). Meanwhile, patient populations better reflect the diversity of the US population as a whole, with non-Hispanic Whites making up about 68%. Therefore, Whites are disproportionately represented in positions of power and influence in the present-day US healthcare system.

Engagement

This study uses a general conception of engagement and not the human resources concept of employee engagement. Merriam Webster’s definition of the verb, *to engage* is apt: to offer something as backing to a cause or aim (2019). Using this definition, engagement in workplace inclusion would be: the extent to which employees offer their backing to the workplace inclusion effort. Because workplace inclusion strategies can comprise a variety of goals, strategies, and tactics, engagement translates to a variety of behaviors. These behaviors could include listening, learning, attending a webinar, voicing a

question or concern, joining a committee, paying for food and beverage at an event, creating a new position, or incorporating a recommended action into their work practices.

Review of Extant Literature

There is a limited amount of academic literature directly addressing this study's central question: How can leaders effectively engage White people in healthcare workplace inclusion? However, scholars have explored two related issues: one (1), diversity models/diversity approaches and how they impact Whites and People of Color and two (2), White racial identity and how it interacts with inclusion strategies. In this literature review, I explore each of these topics in turn and review two case studies of action-research in healthcare diversity and inclusion - one intervention at the interpersonal level and one at the organizational level.

Diversity Models and Diversity Approaches

Victoria C. Plaut led or co-authored numerous studies on White perceptions of workplace diversity & inclusion during the 2000s, published a meta-report in 2011, and has participated in prior and subsequent scholarship, such as Stevens et al. (2008, 2009), Morrison et al. (2010, 2011), and Downey et al. (2015). Plaut's (2011) report provided a detailed view of five studies that explored White reactions to two dominant diversity models, 'colorblindness' and multiculturalism, and their perception of inclusion in diversity strategies. These varying approaches echo Mor Barak's description of the contrasting definitions of diversity itself described above: the narrower, power-informed, social justice *diversity* and a more globalist and organizational *diversity*. Plaut's findings showed that

- White's perceptions of diversity models are different than those of non-Whites,
- Whites' perception of diversity can be managed with adjustments in messaging, and

- Active management of language that is inclusive of White group-level identities is desirable for diversity efforts and the organization as a whole (2011, page 349).

In Study 1, Plaut et al administered a custom-designed implicit association test (IAT) to 39 multiracial undergraduate students designed to test their association between typical multicultural or colorblind messages and inclusion versus exclusion. The results showed “Whites showed a significant bias for pairing a traditional conception of multiculturalism with exclusion (and colorblindness with inclusion). For minorities, there was no significant difference” (2011, page 341)⁸.

In Study 2, the researchers used the previous results to test the impact of a new ‘all-inclusive multiculturalism,’ (AIM) which explicitly includes European Americans in the multicultural project, on 35 White undergraduate students (Plaut, 2011, p. 342; Stevens et al., 2008). The control subjects who were primed with the legacy concept of multiculturalism were significantly quicker to associate multiculturalism with exclusion compared to the subjects who were primed with multiculturalism language that included European Americans. Thus, “Study 2 provides insight into how a subtle change in the framing of multiculturalism can make a significant difference” (p. 343).

Plaut’s Study 3 revisited Study 1’s associations with traditional multiculturalism (lacking explicit inclusion of Whites) and colorblindness. This time, 53 multiracial undergraduates responded to different diversity messages by pressing the key for “Me” or “Not Me”. In addition, participants were asked to what extent they agreed with diversity messages regarding the University community. The results supported the hypothesis that White associated either diversity message with “Me” less than people of color, especially

⁸ The researchers controlled for social desirability using Crowne and Marlowe’s abbreviated 8-item scale.

with the multicultural messaging (Plaut, 2011, p. 344)⁹. And, most significantly for establishing the link between endorsing diversity strategies, the more participants associated “Me” with multiculturalism, the stronger they endorsed diversity concepts in higher education (p. 345).

Plaut et al’s Study 4 extended the University-based studies to a large healthcare organization context and focused the analysis on White men and men of color. As before, group status predicted diversity endorsement and feeling included in organizational diversity. However, even when controlling for group status, “perceptions of inclusion was still a significant predictor of diversity endorsement” (p. 346). Therefore, Study 4 supported the contention that the observed difference in diversity endorsement between Whites and non-Whites can be explained in part by different perceptions of inclusion in diversity strategies. Lastly, Study 5 sampled White male business school students’ ratings of organizational attractiveness (stated desire to work there) given either colorblind or multiculturalist messages together with the individuals’ *need to belong* (NTB) rating.¹⁰ The results showed that White men with higher NTB preferred organizations that expressed colorblind attitudes toward diversity (p. 348). This lends support to the overall notion that White’s lower support for diversity strategies is due in part to perceptions of being included in those strategies.¹¹

⁹ The proportion of White participants associating multiculturalism with “Me” was 0.46 vs. people of color at 0.84 (p. 343)

¹⁰ An example of a need to belong statement was, “It bothers me a great deal when I am not included in other people’s plans” (Plaut, 2011, page 347).

¹¹ Independent, non-academic research has corroborated White’s perception of exclusion from diversity and inclusion efforts. In the White Men’s Leading Through Diversity & Inclusion Study, a cross-industry study of 670 corporate leaders from 2012, 70% of White men and 60% of women and non-Whites were ‘not clear’ if diversity and inclusion work were intended for White men (Shelton, 2013). In another study of healthcare leaders, 73% of white respondents believe opportunities for non-White leaders in healthcare have improved over the previous five years, while only 34% of minorities share that view (Witt/Keifer, 2015).

Taken together, Plaut's work represents foundational scholarship in the study of the inclusiveness of diversity messaging and its impact on people with White racial identity. Each study demonstrated support for hypotheses using rigorous social science procedures and quantitative data analysis. However, there are several factors that may weaken the generalizability of the results. Regarding the overall methodology, using the IAT method has been criticized for lack of test retest reliability (Rae and Olson, 2018; Erwin, 2007). That is, the speed with which participants associate concepts seems to change significantly from one test to the next.

On a study-by-study basis, there are weaknesses to Plaut's work. Study 1 showed that Whites were faster at pairing traditional multicultural words with exclusion than inclusion. But this result does not exclude the fact that White participants paired multiculturalism with *both* inclusion and exclusion, no matter how fast their implicit associations. The same can be said for people of color in the study - they also associated multiculturalism with both inclusion and exclusion. In addition, while it is a helpful finding that Whites had significantly higher implicit preference for color blindness, this says nothing about connections between those individuals' implicit bias and 'evaluative biases', otherwise known as prejudicial beliefs (Greenwald et al., 2002; Amodio and Devine, 2006).¹² Finally, pertaining to Plaut's finding on White diversity endorsement, it is important to note that stated endorsement of workplace inclusion strategies is but one measure of engagement and is not a predictor of

¹² As Amodio and Devine demonstrate in a series of behavioral studies, 'implicit stereotyping processes are predictive of instrumental forms of race-biased behavior, whereas implicit evaluative processes are predictive of consummatory forms of race-biased behavior' (2006, p. 659). The researchers argue this difference is seen because implicit bias is associated with emotional centers of the brain whereas evaluative bias is associated with cognition.

behavior. Similarly, increased awareness of bias does not necessarily impact changing prejudicial behavior (Devine et al. 2012).

A logical enhancement of Plaut's work is to connect attitudes toward diversity approaches and the impact on behavior for Whites and non-Whites. The work of Evan P. Apfelbaum does just this in a series of experiments wherein participants are given challenging tasks after exposure to differing diversity approaches. In addition to linking diversity approach to behavior, Apfelbaum's work explores whether 'social groups' numerical representation in an organization, in absolute terms as compared with the majority group (typically, White men), is one critical factor that influences whether a diversity approach that highlights differences is helpful or harmful' (Apfelbaum et al., 2016, p. 547). The researcher's five studies support the overall idea that diversity approaches must be tailored to fit each organization's unique situation regarding its relative numerical representation of various non-dominant groups.

Like Plaut, Apfelbaum focuses on how diversity & inclusion work is presented and messaged. While Plaut used the models colorblindness, multiculturalism, and all-inclusive multiculturalism, Apfelbaum focuses on diversity approach, which is 'how diversity and social group differences are discussed' (2016, p. 547). A critical insight is that diversity approaches 'provide a blueprint for intergroup processes and relations at work' (p. 547). The scholars theorize that diversity approach has a significant impact on non-dominant groups due in part to their 'representation-based concerns', or how strongly individuals feel they are representative of their group and therefore will be evaluated based upon this membership (p. 548). Apfelbaum hypothesizes that representation-based concerns, while seeded in society-level experiences, are stimulated in the workplace by numerical inferiority. Representation-

based concerns are a critical factor in feelings of marginalization and general disengagement for non-dominant groups. His studies establish differences in representation-based concerns and expected numerical inferiority, and evaluate the impact of two diversity approaches, ‘value in equality’ and ‘value in difference’, on the ‘performance and persistence’ of Black women and men and White women in carrying out work-like tasks (p. 548). Here are Apfelbaum’s definitions of the two approaches:

- ‘A value in equality approach affirms that group membership will not be an obstacle to career opportunities and advancement, and that all employees are judged equally and fairly based on their skills, qualifications, and effort’ (p. 548)
- ‘A value in difference approach advocates for the importance of creating a workplace environment that appreciates (and is inclusive of) social group differences’ (p. 548).

Apfelbaum et al.’s five studies found support for their hypotheses. Study 1 showed that, when imagining employment at ‘Redstone’ - a fictional professional services firm - Black women and men possessed greater representation-based concerns than Whites (p. 549). All participants predicted that Black men and women were the smaller minority than White women. In Study 2, White women performed better and more persistently on the tasks after reviewing a value in difference approach to diversity, whereas Black women and men performed marginally better given the value in equality approach (2016, p. 551). In Study 3, after reducing the positivity of Redstone’s diversity statement and increasing emphasis on ‘race’ and ‘gender’, Black women and men still showed the greatest concerns about representation. More significantly for the current study, Apfelbaum found that “for White participants, the value in difference approach led to better performance and greater persistence than the value in equality approach” whereas Blacks performed better with the

value in equality approach (p. 553). Studies 4 and 5 further supported the hypothesis that numerical representation influenced which diversity approach would help performance of nondominant groups the most¹³.

Apfelbaum's work illustrates the difficult balancing act for designers of workplace inclusion strategies. Since Whites (and White men in particular) tend to be the dominant group in many work settings, their representation concerns are low and therefore the value in difference approach is preferred. The opposite is usually true for Blacks, whose representation concerns are higher and therefore prefer the value in equality approach. This insight about minority representation is critical not only for tailoring today's diversity approaches in White man-dominated workplaces, but also has implications for workplaces wherein previously marginalized groups become the majority.

Apfelbaum work implies that a 'both-and' diversity approach may be preferred for engaging both dominant and non-dominant groups. In addition, this work also lends credence to theory that merely increasing the representation of groups is insufficient to achieve sustainable gains for non-dominant groups (2016, p. 562). Rather, based upon this research, interventions that both increase representation and create an inclusive culture that alleviates the representation-based concerns (or 'stereotype threat level') of non-dominant groups is preferred. Lastly, Apfelbaum's work supports the scholarly argument for heightened concern for heterogeneity and asymmetry of stigmatized groups' needs in facing workplace

¹³ Study 4 introduced this statement to test the hypothesis that perceived representation mediates which approach will help performance: "You are among [5%/40%] of employees at Redstone who are [racial minorities/women]" (Apfelbaum 2016, p. 555). When presented with the 5% condition, all groups showed better performance on the tasks with the value in equality approach; when presented with the 40% condition, they performed better with the value in difference approach (2016, p. 556). Finally, in Study 5, Apfelbaum's team analyzed public diversity statements and attrition rates of women and racial minorities versus dominant their respective groups at 151 law firms in 2011. They observed that "when firms' emphasis on the value in difference approach was high, there were lower rates of attrition of women, whereas when firms' emphasis on the value in equality approach was high, there were lower rates of attrition of racial minorities" (p. 556).

challenges (Ely et al., 2012). One limitation of the work is the fictional workplace context - an elite professional services organization - differs significantly from large hospital systems, which is the focus of the current study. This factor reduces the applicability of Apfelbaum's findings.

White Racial Identity: Privilege, Fragility, Positive Identity Development, and Allyship

Plaut and Apfelbaum's work is illustrative of an organizational management perspective on the asymmetrical needs and dialectical concerns of Whites and non-Whites involved in workplace inclusion strategies. In their focus on the condition of White racial identity in the workplace, management scholars show influences from a separate stream of social science called Whiteness studies. Whiteness scholars are largely trained in education and adult learning, sociology, or psychology. Eschewing a power-neutral, primarily interpersonal view of racism, 'Whiteness scholars define racism as encompassing economic, political, social, and cultural structures, actions, and beliefs that systematize and perpetuate an unequal distribution of privileges, resources and power between White people and people of color' (DiAngelo, 2011, p. 56). Whiteness theorists such as Helms (1990, 1995), Frankenberg (1993), and Dyer (1997) showed how Whiteness is not just a racial identity or designation, but rather is a social process, a location of race privilege, and a set of cultural practices.

White privilege has become a shorthand for White people's preferred status in US legal, political, economic and social systems at the expense of non-Whites (McIntosh, 1988; DiAngelo, 2011; Lipsitz, 2018). White privilege 'lives' in laws, policies, and social practices, and it is enacted as patterns of thought and action, both for Whites and non-Whites. One of the most essential parts of White privilege and Whiteness is that they remained unexamined,

both by White people and people of color (McIntosh, 1988; Helms, 1990; Painter, 2011; Bazelon, 2018).¹⁴

Robin DiAngelo's work in the 2000's built on this conception and explicated how Whiteness plays out in the realm of workplace diversity and inclusion efforts. DiAngelo's 2011 article *White Fragility* (and 2018 book of the same name), sums up her findings regarding White people's hair trigger when exposed to racial stress, which results in 'a range of defensive moves': outward display of emotions such as anger, fear, and guilt, and behaviors such as argumentation, silence, and leaving the stress-inducing situation' (p. 57).

White 'fragility', or lack of 'racial stamina', develops from early childhood as a result of

- segregation (locational, representational, and informational),
- being centered in society as objective, normal, individual, and universal
- entitlement to racial comfort
- racial arrogance (strong positive image of Whiteness vs. others)
- racial belonging (internalized through US mainstream cultural representation)
- psychic freedom from the social burden of race, and
- general, 'constant' messages of White supremacy (pps. 58-63).

DiAngelo notes that, rather than directly address racism and White privilege, educational efforts tend to 'reproduce the comfortable illusion that race and its problems are what "they" have, not us [White people] through coded language' (p. 55). She goes on to point out that when trainers allow White privilege to '[remain] unnamed and explicitly denied' in diversity education, this reinforces the very dynamics that create the need for such training (p. 64). However, when faced with reality of racial discrimination or White

¹⁴ The events surrounding the 2016 election cycle have pushed the issue of Whiteness into the public domain, which both created opportunities for learning and exacerbated tensions (Bazelon, 2018; Ross et al., 2018).

supremacy, this will often ‘trigger patterns of confusion, defensiveness, and righteous indignation’ (p. 64)¹⁵ Meanwhile, well-meaning Whites who position themselves as tolerant liberals employ tactics such as self-defense, which conflates the mere statement of racist reality with an ad hominem attack, or victimization, which equates their emotional discomfort with the truly deadly impacts of racism on people of color (pps. 64-65). Both reactions allow the individual to avoid responsibility for engaging in behaviors that will alter White racial privilege. Ultimately, DiAngelo’s prescription for ‘White fragility’ is for Whites to build up their racial tolerance by building ‘the stamina to sustain conscious and explicit engagement with race’ (p. 66). In this way, Whites can participate in an anti-racist agenda, the goal of which ‘is to generate the development of perspectives and skills that enable all people, regardless of racial location, to be active initiators of change (p. 66). However, DiAngelo joins fellow anti-racist theorists (Helms, 1990; Hooks, 1995; Derman-Sparks and Phillips, 1997) and activists in asserting, ‘White racism is ultimately a White problem and the burden for interrupting it belongs to White people’ (p. 66).

DiAngelo’s assertion that White people have a primary responsibility for addressing racism and improving racial equity stands in stark contrast to many current approaches to workplace diversity and inclusion. This contrast represents the ongoing ‘discursive’ conflict between the goals of ‘social justice,’ which include ending race-based oppression writ large, and goals of organizational performance (Mease, 2016). These divergent goals impact the scholarship and practice of workplace inclusion. While social justice-oriented practitioners of workplace inclusion may insist upon directly addressing Whiteness in order to reduce its pervasive, if unintentional, cultural impact, leaders and managers assiduously avoid using

¹⁵ See also Kidder et al. 2004 and Sue et al. 2010 for examples of White reactions to racial subject matter.

words and concepts that link White employees to the ongoing causes of racial inequity (Mease, 2016). Therefore, diversity leaders can be informed by the social justice lens but, bound by the business imperatives and normative standards of workplace conduct, may be unable to use direct language to help Whites ‘build up racial tolerance’. This paradox represents a major practical limitation of DiAngelo’s work for practitioners of workplace inclusion. Another weakness of this article is that, while it draws on empirical studies, DiAngelo does not offer an agenda for empirical research going forward.

Whiteness scholars developed another critical idea for exploring the effective engagement of White people in workplace inclusion: the development of positive, non-racist, White racial identity. The Helms White Identity Model (1990, 1995) shows how a ‘healthy White identity’ transcends individual, institutional, and cultural racism by two processes: ‘abandonment of racism and the development of a non-racist White identity’ (Helms, 1990, p. 49). These two major phases are further broken down into the six (6) stages shown in Tables 2 and 3 below. Helms used this developmental model to create the White Racial Identity Attitude Scale (WRIAS) to measure the degree to which a White person has incorporated a non-racist perspective on their identity. The WRIAS scale was used by Robert Weech-Maldonado in the National Center for Healthcare Leadership Diversity Demonstration project, which is presented later in chapter 2.

Table 2: Abandoning Racism Phase, Helms' (1990) White Racial Identity Development

Model using 'People of Color (POC)' in place of 'Black'¹⁶

Phase	Stage	Description of cognition, emotion, behavior
Abandoning Racism	Contact	<ul style="list-style-type: none"> -Initial encounters Whiteness, People of Color-ness -Unaware, or superficially aware of being White -‘benefits from...racism without necessarily being aware that he or she is doing so’ (p. 55) -Typical statement: ‘I don’t notice race’ (p. 57) -Expected positive self-esteem due to lack of dissonance
	Disintegration	<ul style="list-style-type: none"> -Growing awareness of racism, White privilege and ‘moral dilemmas’ of being White’ causes cognitive and emotional dissonance (p. 58) -Examples of dissonant concepts: being moral yet treating POC as such results in exclusion by Whites, believing in freedom versus reality of racial inequality; belief in individual merit versus ‘treating [POC] as a group with regard to individual merit’ (p. 58) -In order to avoid dissonance, Whites may retreat to denial by ‘selectively attend[ing] to only information that gives him or her greater confidence...’ (p. 59) -‘To the extent that cross-racial interaction is unavoidable, the White person will attempt to develop new beliefs’ (pps. 59 -60)
	Reintegration	<ul style="list-style-type: none"> -Conscious acknowledgement of White identity and, ‘in the absence of contradictory experiences,’ accepts belief in White racial superiority because ‘he or she has earned such privileges and preferences’ (p. 60) -Guilt & anxiety turn into fear and anger, although mostly ‘lie just beneath the surface’ waiting to be triggered (P. 60) -Behavior can be passive or active; most express passively, unless personal or societal conditions spark re-stimulation -Passive = avoid physically or mentally; Active = treating POC with inferiority, shaming, physical harm

¹⁶ See Language Notes in chapter 3, Methodology for a brief justification for usage of People of Color.

Table 3: Defining Non-racist White Identity Phase, Helms' (1990) White Racial Identity Development Model using 'People of Color' (POC) in place of 'Black'

Phase	Stage	Description of cognition, emotion, behavior
Defining Non-racist White Identity	Pseudo-independent	<ul style="list-style-type: none"> -Actively question the proposition that POC are inferior -Begin to acknowledge responsibility for 'wittingly and unwittingly' perpetuating racism (p.61) -Pseudo-independent is primarily intellectualizing phase where Whites 'submerge tumultuous feelings' (p.61) -Despite abandoning belief in supremacy, behavior will still behave in ways that 'unwittingly' perpetuate racism (p.61) -Behavior of seeking interaction with POC, but with a 'helping' mode seeking assimilation from POC (p.62) -Expressing disdain for racism while devoting attention to helping POC without facing other Whites
	Immersion	<ul style="list-style-type: none"> -Searching for redefinition: "Who am I racially?" and "Who do I want to be?" (p.62) -Seeks role models of Whites who fought racism -Changing POC is no longer the focus, but starts to consider how to confront White behaviors -Possibility for healing from old emotional wounds -Once these old feelings are expressed, White person may feel 'euphoria,' which supports 'newly developing identity' and taking action on racism -Can see Whiteness as something other than oppressor
	Autonomy	<ul style="list-style-type: none"> -Seeking to fully internalize non-racist White identity -No longer feels the needs to 'oppress or idealize' POC because race is no longer a threat or sanctuary (p.66) -Actively seeks to learn from other cultural groups -Learning about intersection with sexism, other -isms -Still there will be instances of behavior that reinforce institutional and personal racism, but will be aware -Conscious use of privilege and willingness to take action

Helms and her colleagues' work on positive identity development laid the groundwork for the concept of White allyship. Tatum (2003)'s straightforward definition of the White ally is 'a White person who understands that it is possible to use one's privilege to create more equitable systems; that there are White people throughout history who have done exactly

that; and that one can align oneself with that history' (p. 37). In 2017, the contemporary Whiteness scholars Lisa B. Spanierman and Lisa Smith built considerably on the ally concept. Spanierman and Smith's eight-article study explores numerous dimensions of White allyship (*The Counseling Psychologist*: Volume 45 Issue 5, July 2017). Spanierman's 'aspirational' definition of White allyship as

- demonstrating nuanced understanding of institutional racism and White privilege;
- enacting a continual process of self-reflection about their own racism and positionality;
- expressing a sense of responsibility and commitment to using their racial privilege in ways that promote equity;
- engaging in actions to disrupt racism and the status quo on micro and macro levels;
- participates in coalition building and work in solidarity with people of color; and in the process,
- encountering resistance from other White individuals (p. 608-609).

Despite the usefulness of White allyship, Spanierman and Smith, echoing founding scholar of multiculturalist psychology Derald Wing Sue and others, add the caveat that 'regardless of their commitment and dedication to racial justice, White individuals likely cannot completely purge the impact of racist socialization' (2017, p. 609). Moreover, the creation of a White ally identity has created numerous pitfalls connected to 'the paternalistic meme of White individuals as saviors of people of color' (p.609). Spanierman and Smith go on to enumerate these pitfalls and offer context and a path forward for avoiding them. The scholars' and their colleagues' narrow focus White allyship is both the strength and weakness of the work. The strength is that the issue is fully explored within the context of counseling psychology. The weakness is the lack of relevance of this highly refined, idealized view of

allyship to practitioners of workplace inclusion in healthcare. I surmise that, due to their professional training, counseling psychologists display greater levels of social awareness and greater levels of self-reflection from the typical hospital workplace.

Even so, White allyship offers individuals with White privilege a positive identity and set of behaviors with which to address racial inequity. Moreover, the concept of allyship in general enables workplace inclusion leaders to put forth a positive vision for engaging dominant or non-marginalized groups in creating an inclusive culture.

Illustrative Healthcare Workplace Interventions

While empirical studies of workforce inclusion strategies in healthcare are scant, there are two that have relevant findings for the current study of effective engagement of White people in workplace inclusion. The articles by Robert Weech-Maldonado and Amanda Holm describe two studies that illustrate two interventions, one at the organizational change level and one at the interpersonal level, that provide a helpful context for the issue of engaging White employees in healthcare inclusion work.

From the article, “Recognizing Privilege and Bias: An Interactive Exercise to Expand Health Care Providers’ Personal Awareness” (Holm, Rowe Gorosh, Brady, & White-Perkins, 2017), we learn about the Privilege and Responsibility Curricular Exercise (PRCE), an educational intervention designed by the Institute on Multicultural Health at Henry Ford, a the largest hospital system in Detroit, to build awareness of, and skills to address, racial bias and its intersections. The PRCE was one part of a series of Continuing Medical Education trainings between 2009 and 2012 focused on building healthcare workers’ awareness of race privilege and other privileges, the impacts of those privileges, building ‘cultural humility’, and how to use one’s privilege to help reduce health care inequities (Holm et al., 2017). The

trainings were designed to ‘[prepare] participants to serve as “ambassadors” of health care equity and advocates of culture change in various business units and locations’ (p.360).

The Holm study is solution-oriented research describing one intervention to interrupt and transform the abuses of White privilege in a workplace setting. Holm and company describe an intentional exercise in beginning the employee journey toward using their privileges to creating a more equitable healthcare delivery system. The PRCE was modeled on the work on White privilege of McIntosh (1988).¹⁷ Workshop facilitators used McIntosh’s privilege ‘knapsack’ concept: a physical pouch into which participants place pennies that largely race-based privileges. In the PRCE, the designers expanded McIntosh’s list to 22 statements, which included intersectional issues such as gender, ethnicity, class (‘SES’: socio-economic status) language, and housing status (p. 322). See Table 4 below for a partial list of the PRCE’s privilege statements. Participants visited small displays placed around the room with the privilege statements, placing a penny from that station into their bag. At the end, the participants tallied their pennies and then were led through a series of large group and break-out sessions that asked people to notice who had less or more pennies and to have a dialogue about the meaning of the exercise (p. 361).

Table 4: A selection of statements from Henry Ford Health System’s Privilege and Responsibility Curricular Exercise with possible related social categories

Statement	Possible related social categories
If I should need to move, I can be pretty sure of renting or purchasing a home in an area in which I can afford and in which I	Race, ethnicity, religion, SES, sexual orientation

¹⁷ McIntosh’s model has undergone significant critique and development. See J. Lensmire, Timothy & K. McManimon, Shannon & Dockter Tierney, Jessica & E. Lee-Nichols, Mary & Casey, Zachary & Lensmire, Audrey & M. Davis, Bryan. (2013).

would want to live.	
If I ask to talk to the person in charge, I will be facing a person similar to me.	Race, ethnicity, gender, sexual orientation
If I walk into an emergency room I can expect to be treated with dignity and respect.	Race, ethnicity, physical/mental ability, SES, sexual orientation, body type
I can be sure that if I need legal or medical help, my race will not work against me.	Race
I can go home from most meetings feeling somewhat engaged, rather than isolated, out-of-place, or unheard.	Age, race, ethnicity, gender, language

Holm's study is also helpful in that it identifies, in an anecdotal way, White participants' reactions to the process of group exploration of societal privilege. The scholars cited numerous examples of 'White fragility' at work. For instance, as the researchers state, 'Some participants from historically dominant groups, when sharing that they could not claim a statement, felt the fact that they could not claim a privilege disproved the importance of social identities (p. 362).' For example, when considering the experience of passing through airport security checkpoints as an indicator of privilege, some White participants expressed their anxiety that they would be singled out for a more thorough search. Consistent with a common feature of White group-level attitudes, these individuals then took this as evidence that societal bias was fairly ubiquitous, irrespective of race privilege. On the emotional side, Holm comments, 'those [participants] with the most privileges expressed a mixture of appreciation and of embarrassment and guilt', which the scholars interpreted as 'precursors to both cultural humility and a fresh motivation to promote system changes' (p. 362). This result demonstrates both the positive impacts of examining social privilege and a common feature of 'White fragility'.

The primary weakness in the researchers' results were purely qualitative and did not empirically analyze the outcomes of the PRCE. The reason provided for this was that 'the exercise was embedded within a broader campaign to change HFHS's organizational culture around healthcare disparities, making it difficult to isolate its effects' (p. 363). It is clear that follow-up research should include a more rigorous and quantitative assessment of pre- and post-intervention attitudes.

While Henry Ford's PRCE demonstrated several important concepts surrounding engaging White people in workplace inclusion at the interpersonal level, Robert Weech-Maldonado and Janice Dreachslin's work on the national center for healthcare leadership diversity demonstration (NCHLDD) project illustrates critical concepts on an organizational level. The NCHLDD employed a pre-post control group design with two hospital systems on the East Coast to assess the impact of a 'systematic, multifaceted, and organizational level cultural competency initiative' on diversity, inclusion, and cultural competency metrics (p. 32). The overall findings were that 'overall performance improvement was greater in each of the two intervention hospitals than in the control hospital within the same health care system' (p. 30). These improvements were seen in diversity leadership, strategic human resource management, and diversity climate. Also, Blacks at the intervention hospitals showed improved 'individual level competencies for diversity attitudes and implicit bias' (p. 30). However, Whites experienced the opposite effect - 'deterioration,' or worsening, of their non-racist identities from the pre- to post-intervention (p. 39).

Weech-Maldonado and Dreachslin begin their study noting the numerous health disparity and leadership diversity metrics had either remained stable or worsened from 2011 to the 2014 reports on quality from the AHRQ. These disparities were found between the

health outcomes, care delivered, and job satisfaction between Whites and underrepresented minority and marginalized groups (Weech-Maldonado, 2018, p. 31). Regarding White job satisfaction, the researchers point out, ‘non-Hispanic White men [expressed] the most job satisfaction with equity and opportunity in the workplace’ (p. 31).

Their ‘systematic diversity intervention’ was anchored in two levels of data: the organizational level and the individual level (See Figure 1 below). The organizational-level assessment was on ‘diversity leadership,’ ‘strategic human resource management,’ and ‘patient cultural competency’ and the individual-level assessment was on ‘diversity attitudes,’ ‘implicit bias,’ and ‘racial /ethnic identity status. The organizational outcome measures were ‘workforce diversity’ and ‘diversity climate’ (p. 32-33). Relevant to the current study, to measure racial identity status, the researchers used Helms’ (1990, 1995) Black and White Racial Identity Attitude Scales (BRIAS and WRIAS).

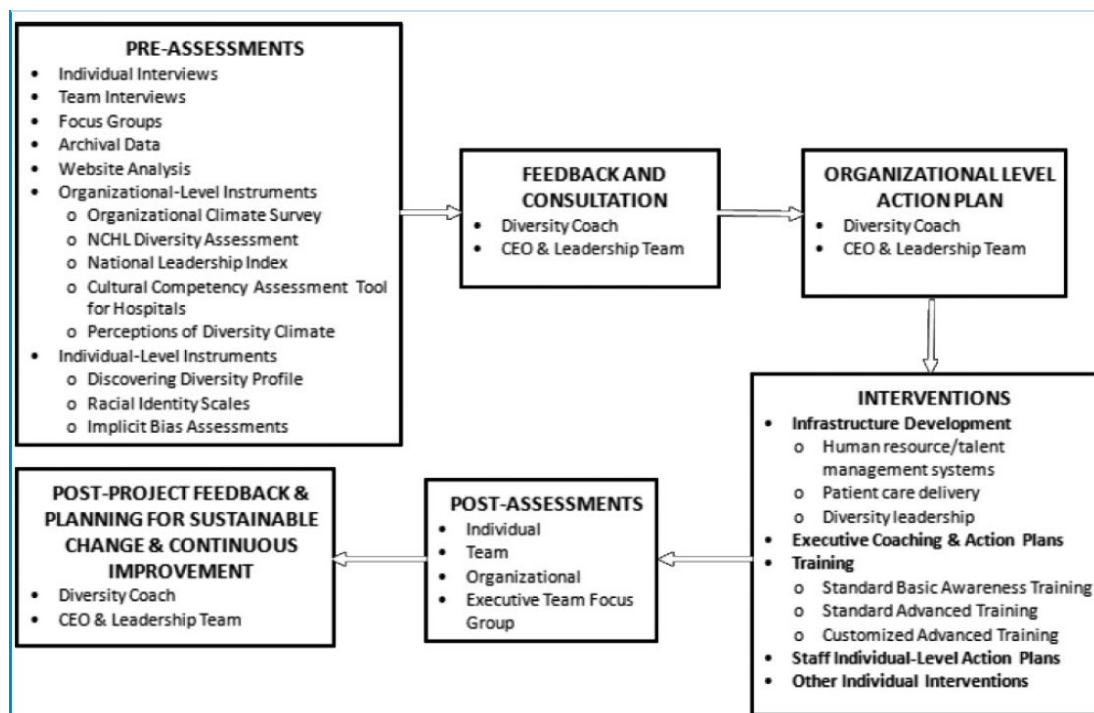
Figure 1: Conceptual framework of the NCHLDD (Weech-Maldonado, 2018, p.32)



The NCHLDD performed an extensive array of interventions at the two experimental hospitals and, within the self-same two healthcare networks, performed no interventions at

control hospitals. The diversity and inclusion interventions were comprehensive both vertically and horizontally in the experimental hospitals (see Figure 2 below).

Figure 2: NCHLDD project intervention flow diagram (Weech-Maldonado, 2018, p. 33)



There were numerous findings from Weech-Maldonado that are relevant to the current topic. The overall finding that, ‘performance [in diversity and inclusion measures] was greater in... the intervention hospitals’ lends support to strategic interventions that directly targets both the organizational level and the interpersonal levels (p. 30). There were significant outcomes in terms of representational diversity and scores for ‘organizational inclusion’ and ‘organizational fairness’ (p. 39).

However, the finding that is most relevant to the current study was on the individual attitude measures. While Blacks’ scores ‘improved,’ Whites experienced ‘deterioration’ of their non-racist identities on the Helms WRIAS from the pre- to post-intervention (p. 39). This means that the impact on Whites’ reactions to the project’s menu of training, coaching,

and support was to retrench into more racist states of White identity. Additionally, there was an telling result regarding employee turnover that affected the sample:

Anecdotal evidence from leadership team post-intervention group interviews and observations by the diversity coach... indicates that some of the turnover was due to the project itself, which resulted in some departures by individuals who were not supportive of the enhanced focus on diversity as well as the addition of new staff who joined the hospital because of the diversity focus (p. 39).

While the researchers do not report on what the racial identity of the leaders whom departed nor those who joined. However, it is indicative of sometimes conflicting goals of increasing representational diversity through some combination of new hires and replacing those that left, and fostering more inclusion with the individuals already in place.

Orienting Theories

Psychological safety

Inclusion work in healthcare organizations involves asking employees to learn new concepts, build new relationships, adopt new behaviors, and adhere to new policies (Dreachslin et al., 2017). Learning and growth at work are predicated on the existence of employee's psychological safety (Edmondson, 2002, 2019; Dollard and Bakker, 2010; Nembhard and Edmondson, 2006). Workers feel psychologically safe when they perceive a high degrees of security in employment status and trust in their work relationships. When psychological safety is high, workers can develop trusting relationships, learn new skills, and help organizations grow and innovate (Edmondson, 2002; Hackman and Lorsch, 1987). On the flip side, when fear and mistrust are dominant, employees exhibit disengagement,

stagnation, resistance to change, and other behaviors intended to shield individuals from further insecurity, both real and emotional (Ross et al., 2018; Dollard and Bakker, 2010).

As described above, when White people are asked to consider the topics of diversity, inclusion, race and associated issues, particularly on the interpersonal level, they are particularly prone to exhibit behavior that signals a loss of psychological safety (Sue et al., 2010; DiAngelo, 2011). These “defensive moves” include disbelief, distancing, anger, and avoidance (Kidder et al., 2004). Some White people may fear that working on diversity and inclusion issues poses a threat to their job status due to perceived or real efforts to increase the representation of non-Whites (Shteynberg et al., 2011). Another threat to White’s psychological safety is the fear of their behavior being labeled “racist” and therefore subject to ridicule, exclusion, and loss of status (Sue et al., 2010). The racist/not racist binary reflects White people’s perception that improving racial equity is a ‘zero-sum game’: non-White people’s gains are White people’s losses (Norton and Sommers, 2011). The consequences for Whites in loss of psychological safety underlines the primary importance of diversity leaders creating an atmosphere of security in workplace inclusion strategies, messaging, and interventions.

Positive Identity and Relationship Development

A major assumption of workplace inclusion strategies is that a culture of inclusion enables positive identity development at work (Stevens et al., 2008; Groggins and Ryan, 2013). Positive organizational scholars show that all workers try to self-construct identities at work that express positive attributes such as goodness and worthiness (Dutton et al., 2010; Wrzesniewski and Dutton, 2001). In turn, positive identities help employees develop the social resources, or positive relationships, needed to secure other resources such as task-level

help, time, money, and political capital (Dutton and Ragins, 2017; Dutton et al., 2010). In addition, these positive relationships increase worker resilience in the face of stressful conditions (Carmeli et al., 2009). While positive relationships have numerous dimensions, leading positive organizational scholar Jane Dutton offers the following general definition: ‘a positive work relationship [is a] reoccurring connection between two people that takes place within the context of work and careers and is experienced as mutually beneficial, where beneficial is defined broadly to include any kind of positive state, process, or outcome in the relationship’ (2017, p. 9).

Positive identity and relationships at work are critical concepts for workplace inclusion theorists and practitioners (Davidson, M. N., & James, E. J. 2006; Ely and Roberts, 2008; Creary 2019). Because ‘stereotypes and power imbalances between groups at the societal level pose threats to people’s identity’, ‘members [should] submit to outward-focused goals – for example, the goal of advancing broad social ideals, furthering an organization’s mission, or enhancing the quality of their relationships’ (Ely and Roberts 2008, page 176). Ely and Roberts (2008) show how the positive relationship view takes into account three factors that the ‘difference’ approach does not: simultaneity, intra-group relations, and diversity as an asset (pps.176 - 179). As a precursor to the more recent concept of intersectionality, ‘simultaneity refers to the fact that people hold multiple identities, some culturally marginalized...and some privileged (e.g., men, Whites, heterosexuals), and that the meaning and impact of each depends in part on the others’ (p.177). A study of intra-group relations, including in more privileged identity groups, shows that ‘sameness is more than just the absence of difference; it has its own dynamics that influence how diversity plays out’ (p.178). Lastly, echoing the

appreciative inquiry approach (Cooperrider and Whitney, 2005; Bushe, 2012), the positive relationships approach incorporates the many assets of diversity in work groups. These assets, in particular group learning, are enabled by ‘culturally diverse teams whose members anchor on outward focused goals’ (193). More diverse teams create a fertile ground for building more positive relationships. In this way, diverse, inclusive teams create what Dutton calls the ‘social resources’ needed to fulfill both organizational goals and positive identity development goals.

Organizational Culture Change

In this study, the operational definition of workplace inclusion is ‘the extent to which employees, regardless of social identity or group affiliation, feel they are a part of the organizational system, both in terms of formal processes like decision making and promotion and informal processes like ‘water cooler’ conversations’. This definition shows how inclusion is organization-wide and it deals with issues of both a technical and cultural nature. Therefore, promoting healthcare workforce inclusion can be viewed as an organizational change project featuring the issue of culture. I use two sources of knowledge to explicate inclusion strategies as organizational culture change: Edgar Schein, preeminent organizational psychologist, and Jeff Hiatt and Tim Creasey, leaders at ProSCI, an independent science-driven organization dedicated to research and training in the practice of change management.

Edgar Schein’s (2010, 2016) work on organizational culture and culture change shows that, far beyond the visible signs, these processes reflect “shared learning of the group as it solves problems of external adaptation and internal integration; which has worked well enough to be considered valid and, therefore, to be taught to new members as the correct”

way of being in relation to those problems (2016, p. 6). This body of shared learning can be perceived through visible, feelable signs, what Schein (2016) calls ‘artifacts’, such as office layout, manners of speech, emotional expression, embedded skills, shared meanings (p.17). Culture is also communicated through espoused beliefs and values, which can be found in official communications, and ideologies and rationalizations which may not be explicitly stated (p.18). At the deepest level, the level hidden from most of the employees, are the basic underlying assumptions. Organizational culture is inherently differentiated between overlapping subcultures, diffuse across groups, and dynamic over time, but has ‘some stability’ (p.10). Therefore, culture change, planned or unplanned, involves changes to artifacts, espoused beliefs, and underlying assumptions of individuals working within one or many groups within an organization.

To Schein, planned management of culture change moves through three stages: one, creating motivation and readiness, two, learning new concepts, new meanings, and new standards of judgement, and three, internalizing new concepts, meanings, and standards (p. 323). Change begins with ‘disconfirmation’ of existing structures of belief about how the organization can sufficiently meet its goals. Schein cites a relevant example of disconfirmation from healthcare: “there are many change programs that require doctors to give up some of the autonomy that they have always assumed was intrinsic to their role, or to learn new behavior patterns vis-a-vis patients, nurses, or technicians” (2016, p.326). Disconfirmation challenges the basic assumptions of the culture and individuals experience fear regarding survival and anxiety about needing to learn new ways of being. It is worth enumerating Schein’s specific categories of fears based upon learning anxiety since they

speak directly to the project of promoting diversity and inclusion in the workplace (See Table 5 below).

Table 5: Schein's (2016) list of learning fears based sparked by organizational change

Fear	Description
Fear of loss of power or position	New learning may mean loss of status or power
Fear of temporary incompetence	Giving up old ways of doing things means giving up expertise; we know we will have to do things that we have not mastered yet
Fear of punishment for incompetence	If learning period results in mistakes or too long a duration, we fear productivity may be harmed, resulting in reprisal by management
Fear of loss of personal identity	If new learning requires us to take on a new way of being, we may not want be 'that kind of person'
Fear of loss of group membership	If new learning challenges shared assumptions of their group culture, changing those assumptions also may result in, or appear to result in, separation from the group

These fears trigger resistance in various forms, including denial, scapegoating, dodging, and bargaining (p. 327). Leaders' natural inclination may be to attempt overcoming learning anxiety by increasing the threat of survival if learning does not take place, but this may 'increase defensiveness,' 'overall tension,' and more 'unpredictable and undesirable resistance' (p.327). Instead, Schein counsels change leaders, in his Stage 1 of change leadership, to create psychological safety in order to shepherd employees through the process. Schein's eight strategies for creating safety are:

- Provide a compelling positive vision

- Provide formal training
- Involve the learner
- Train relevant ‘family’ groups and teams
- Provide resources
- Provide positive role models
- Provide support groups
- Remove barriers and build new supporting systems and structures (p. 328-330)

Schein’s Stage 2, ‘the actual change and learning process’ is comprised of two methods of learning in the workplace: one, imitation and identification learning and two, scanning and trial-and-error learning. The imitation and identification learning requires that the change leaders model the type of learning that they wish to see and train other leaders to do the same. The primary leadership implication of scanning and trial-and-error learning is to create both ad hoc and formal opportunities for workers to be self-directed in finding solutions to problems of culture change. In fact, the overall principle for Stage 2 is ‘the change leader must be clear about the ultimate goals, ... but that does not necessarily imply that everyone will reach that goal in the same way’ (p.332).

However workers learn the new skills and shared assumptions indicative of culture change, Schein has further recommendations for maximizing the chances that changes will be adopted and stick, including

- Connect beliefs, values, and behavior. ‘Behavior change leads to culture change only if the new behavior is perceived to make things better and therefore becomes internalized and stable’ (p. 333)

- Change leaders should emphasize behavior change but remember that culture change is only happening when existing employees ultimately move through “cognitive redefinition” of core assumptions (p. 333)
- Remember learning can be new concepts or just new meaning for old concepts
- Develop new standards of evaluation and controls
- Define change goals concretely, not as a culture change (p. 338)

Beyond this menu of recommendations, Schein’s work has strong implications for workplace inclusion leaders in healthcare seeking to effectively engage White employees. One implication is that the culture of inclusion can be seen as shared learning of new basic assumptions. This gives the change leader a manageable practice area (learning) in which to focus her efforts. The other implication is that, in order to successfully engage White employees and all stakeholders, effective change leaders must actively manage psychological safety.

Jeffrey Hiatt and Tim Creasey are the CEO and Chief DEvelopment Officer of ProSCI, an independent, science-driven organization dedicated to the practice of change management based in Colorado, USA.¹⁸ Hiatt and Creasey’s 2012 book *Change Management: The People Side of Change* lays out a comprehensive change management agenda for at both the individual and organizational levels (Hiatt and Creasey, 2012). The authors cite ProSCI’s longitudinal research of senior leaders, project managers, and change managers at over 1,000 organizations around the world, which results in the bi-annual Best Practices in Change Management report (Creasey and Hiatt 2019). In the 2018 Best

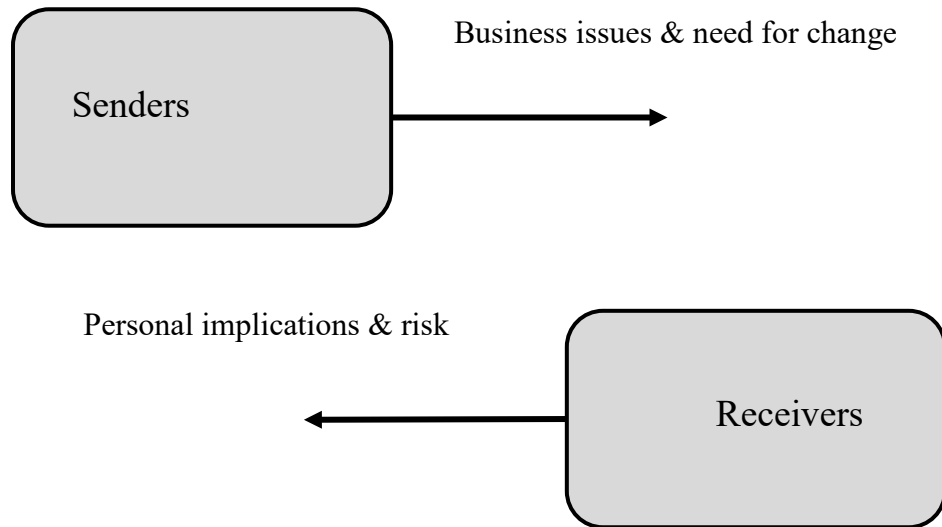
¹⁸ Disclosure: In 2015, I was certified as a ProSCI Change Management Practitioner.

Practices, 24% of the responding organizations in the study were healthcare delivery organizations (p. 27).

A core tenet of Hiatt and Creasey's (2012) work is that all 'organizational outcomes are the collective result of individual change' (p. 4) The individual change model is known as the acronym ADKAR, which stands for awareness, desire, knowledge, ability, and reinforcement (p. 46). To Hiatt and Creasey, change leaders must attend to each of these factors in order to help individuals successfully move through significant changes in a workplace setting. To facilitate individual changes that meet organizational outcomes, the ProSCI change management model sets the stage, prepares each player, and provides the framework of a script for carrying out the change drama. The organizational concepts from Hiatt and Creasey that are most relevant to the current study are *senders and receivers* and *authority for change*.

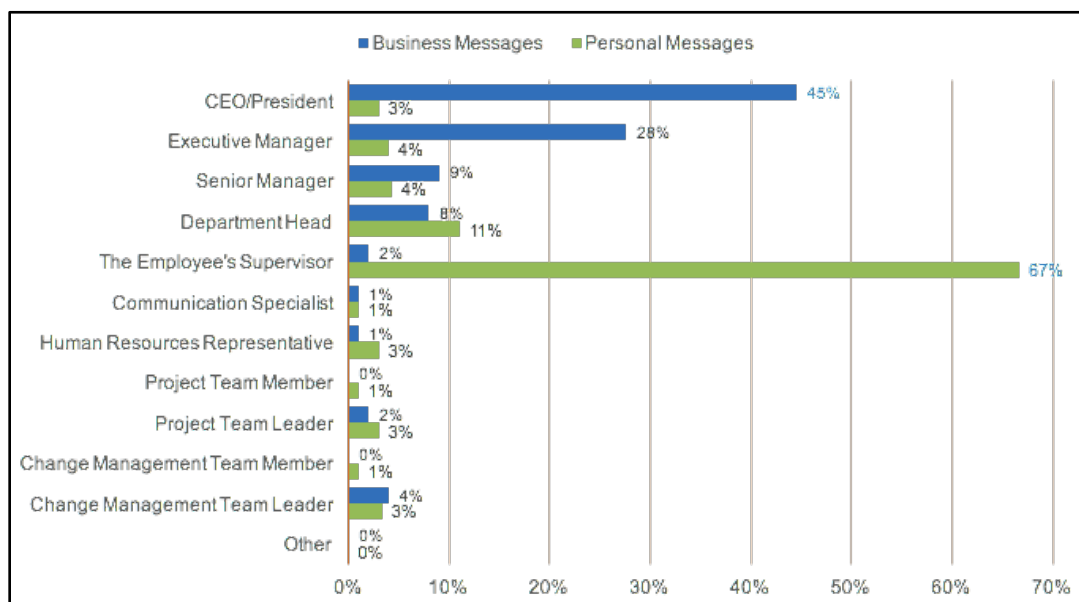
Senders and receivers recognizes the fact that in every organizational change, there are senders who provide information and receivers who are given information (p. 16). Of the many implications of this simple concept is that senders' communications are seen a certain way based on who they are, where they sit in the organization, and how they are likely to be impacted by the change. Similarly, the change-related information has a particular impact on receivers of information based on who they are, where they sit in the organization, and how likely they are to be personally impacted. While senders, largely senior and middle management, may be communicating about the things they are most concerned with, this may or may not be what receivers are concerned with. Thus, senders and receivers are often not in dialogue with one another, particularly at the early stages of a change (see Figure 3).

Figure 3: Disconnect between senders and receivers of information about organizational change (Creasey and Hiatt, 2012)



Senders may spend 95% of their communications on business-level impacts and 5% on the impact to individual constituencies. Conversely, receivers may spend 95% of their time thinking about what the implications and risk are to them and 5% of their mindshare is dedicated to business-level impacts. The ‘consequence is that much of the key business information communicated by the supervisor to the employee’ in early conversations is not heard (Hiatt and Creasey, 2012, p. 17). Instead, receivers may be thinking about ‘whether or not they trust the sender,’ ‘their current job performance,’ ‘their past experiences with change,’ or ‘what they have heard from their friends or colleagues’ (p. 17). Based upon the ProSCI longitudinal studies, receivers prefer two primary senders and particular messages (See Figure 4).

Figure 4: Preferred senders of change-related information according to receivers



“Practical tips for making change stick.” A presentation by Michelle Bundy, ARMA Nova at Freddie Mac, February 21, 2018. Tysons Corner, Virginia; ProSCI Best Practices in Change Management, 2016 edition

One preferred sender is the immediate supervisor, from whom they want to hear information about personal impact, group impact, and day-to-day job impact. The other preferred sender is the business leader, from whom receivers want to hear the business reasons for changing, the alignment with vision and strategy, and what the risks are for not changing.

There are numerous implications of ProSCI’s *senders and receivers* concept for workplace inclusion leaders looking to effectively engage White employees. The most relevant implications areas are for the communications plan and the coaching plan. For communications planning, senior leaders and change managers should consider each specific audience, including those with a White racial identity, carefully. Early communications must be clear, repeated numerous times, and the preferred types of messages should come from preferred senders. Senior leaders communicate about the business and strategy and

immediate supervisors communicate about personal-level impacts, otherwise known as What's In It For Me? [WIIFM] (p.67-69). For many employees, even senior managers themselves, fully understanding the WIIFM is possible only with an individual coaching conversation rather than group communication. To the extent that White employees may have different WIIFMs, questions, and concerns in relation to diversity and inclusion strategies, coaching would be a critical activity for managing resistance and building grassroots change leadership (Hiatt and Creasey, 2012, p. 69; Creasey and Hiatt 2019).

Another key concept relevant from Hiatt and Creasey that is relevant to the current topic is *authority for change*. The last six ProSCI longitudinal studies (2018, 2016, 2014, 2012, 2010, 2008) have found that the existence of a highly engaged executive sponsors is the number one predictor of successful organizational changes (Creasey and Hiatt, 2019). In 2016, 72% of the surveyed projects that successfully met their targets had executive sponsors that were 'extremely effective' whereas only 29% had 'very ineffective sponsors' (Creasey and Hiatt, 2017, p. 7). According to this research, the three primary roles of the executive sponsor of change are:

- Actively and visibly participate in the change process
- Build coalitions of sponsorship to rally support and mitigate resistance to the change
- Communicate directly with employees about the change and why it is needed (Hiatt and Creasey, 2012, p. 23)

If these three pieces are in place, the change efforts has the resources it needs, broad-based support, and employees understand the change and where to go for concerns and questions. However, 'many projects struggle because they lack sponsorship,' and it may be because executive sponsors

- Sign the check and ‘disappear’
- Abdicate their role to a middle manager or consultant
- Lack the power themselves to authorize and lead
- Are distrusted by employees because of past change efforts or other factors (Hiatt and Creasey, 2012, p. 24)

The primary implication of Hiatt and Creasey’s executive sponsorship insights for workplace inclusion leaders is that they should train their executive sponsors to be active and visible, build coalitions, and communicate directly. This training should be codified in a sponsorship plan, start at the beginning of the change process, and continue throughout the change. When combined with Schein’s work on leading culture change, these recommendations form a holistic agenda for helping inclusion strategies reach their goals.

Summary and Gaps in Literature

This chapter dealt provided a review of extant literature regarding the topic of effective engagement of White people in healthcare workplace inclusion strategies. This review had four major goals: (1) to provide context through a description of the current situation and definitions of key terms, (2) explore the extant literature, including two illustrative case studies, (3) present orienting theories, and (4) summarize the review and identify gaps in the literature.

Due to persistent and gross health disparities and a push for greater healthcare quality, the issue of promoting greater diversity, inclusion, and equity in the US healthcare system is a high priority for sector leaders. An overrepresentation of White individuals in leadership positions has remained fairly stable over the last 20 years despite some success in increasing the representational diversity of the ‘top of the funnel’ for leadership positions. This has led

to an increased focus on increasing retention and advancement through a more inclusive workplace environment. Since at least 85% of senior leaders in C-suite are White, this indicates a focus on successful engagement of Whites in workplace inclusion strategies is promising.

In order to establish a common understanding of relevant topics and provide background to the current study, I defined seven abstract concepts: inclusion, diversity, health disparity and health equity, cultural competence, engage, and White people. I relied heavily on Mor Barak (2013) to define inclusion as ‘the extent to which employees, regardless of social identity or group affiliation, feel they are a part of the organizational system, both in terms of formal processes like decision making and promotion and informal processes like “water cooler” conversations’.

Despite the relatively scant scholarly attention that this particular topic has received, there were several key learnings that emerged from the review of literature. From the work of Plaut (2011) and Apfelbaum (2016), we found support for the contention that, due to their overall social position of numerical dominance and power, White people’s encounter with workforce -based inclusion efforts is exceptional. They also found that this encounter but can be managed with adjustments in diversity approach, or the way in which diversity and inclusion are discussed. Active management of diversity approach for Whites can result in beneficial work-related outcomes. The recommended diversity approach implied by the research is ‘all-inclusive,’ does not use language exclusionary to European Americans, and stresses the organization’s belief in both the value of employee differences and in the value in equality between employees. Lastly, this body of research calls for approaches to be tailored based upon the particular situation with regards to representational diversity.

The literature on White racial identity also pertains directly to this topic. Scholars such as McIntosh (1988), DiAngelo (2011), Helms (1995), and Spanierman (2017) show that, due to their unique position relative to institutional racism, White people have unique challenges and opportunities vis-a-vis addressing racial inequality. The challenges include unconscious rehearsal of social privilege and greater sensitivity to race-related dialogue. On the positive side, Whites have the potential to make an outsized impact on racism due to their proximity to power. The key takeaways for workplace inclusion leaders is that there is a developmental process for Whites to achieve higher levels of non-racist or ally-like behaviors. The experts in this area counsel that White people need challenge and support in both intra-group and inter-group interactions. In addition, leaders should have the expectation that there will be cognitive, emotional, and interpersonal challenges along the way.

I present two case studies to illustrate an interpersonal-level and organizational-level intervention to promote healthcare workplace interventions, including engagement of White employees. Holm's (2017) report on the Privilege and Responsibility Curricular Exercise at Henry Ford Health describes a workshop that helps employees understand and interrupt the abuses of social privilege in the healthcare workplace. While the PRCE provided a unique opportunity for Whites and non-Whites to work toward racial equity, the resulting write-up was entirely qualitative and lacked empirical data. In contrast, Weech-Maldonado's (2018) study on the national diversity demonstration project was a highly rigorous, two-year study on a comprehensive strategic intervention testing both interpersonal and organizational interventions at two health systems. The intervention hospitals saw improvements versus the control in diversity leadership representation, human resource management, and diversity climate. However, the finding most relevant to the current topic was that the measures of

White non-racist attitudes deteriorated. All findings are somewhat called into question because there were very few employees who were sampled before and after the intervention and the senior leadership team experienced attrition, due in part to the project itself.

I describe three major orienting theories for making meaning of the topic at two levels, the interpersonal and the organizational. On the interpersonal level, I examine psychological safety, and positive identity and relationship development. Scholars such as Edmondson (1999, 2006) have shown that psychological safety at work enables learning and relationship-building. As developing a more inclusive workplace is fundamentally about learning, it is essential that workplace inclusion leaders foster a sense of security. This can be particularly true for White individuals because they are prone to insecurity when exposed to issues surrounding diversity and inclusion. Dutton (2010, 2017), Ely and Roberts (2006) and colleagues have shown that the positive development of identity at work (i.e. worthiness, goodness) allows the development of positive relationships (i.e. mutually beneficial), which are essential to withstand the rigors of inclusion work.

I explore the organizational theory of culture change through the eyes of Schein (2010) and Hiatt and Creasey (2012). Schein explains how culture is shared learning from solving problems that operates at visible levels such as language and invisible levels such as shared underlying assumptions. As workplace inclusion leaders know well, culture change is a group learning activity that challenges underlying assumptions and triggers fears about survival and learning. Numerous of Schein's recommendations for leading culture change are apt for inclusion leaders seeking to effectively engage employees with White racial identity. These recommendations include knowing the audience, providing a compelling vision,

emphasizing behavior change and not culture change, and connecting beliefs, values, and behavior.

Many of Schein's recommendations are echoed by Hiatt and Creasey (2012) and the ProSCI, an independent change management research organization. Relying on ProSCI data from longitudinal studies over a 20 year span, Hiatt and Creasey show how leading the 'people side of change' leads to successful organizational changes. Their work has implications for communications, coaching, and executive sponsorship of workplace inclusion efforts. In official and unofficial communications, inclusion leaders should attend closely to both the senders and receivers of information - who they are and what they want to hear based upon their self-interest. Receivers, including White employees involved in a change, want to hear business-related information from senior-most leaders and personal impact-related information from direct supervisors, ideally in a coaching conversation. Based on convincing data from the field of change management, Hiatt and Creasey argue that executive sponsors are the most important role in leading the people side of change. However, in order to be effective, executive sponsors need to be active and visible throughout a change, build coalitions, and communicate directly to employees about the change.

The extant literature summarized above has several gaps when considering the subject of effective engagement of White people in workforce inclusion in healthcare organizations. The work on diversity approach only considers the impact on White employees from how workforce inclusion is discussed. Further research should focus on strategic frame (i.e. business case) and on the actual interventions. The work on White racial identity development has not received a proper treatment from a healthcare organization

perspective nor have the impacts of interventions designed with the ‘Whiteness’ lens been studied. Given the healthcare industry’s professed need to improve workplace inclusion and the persistent lack of racial diversity in healthcare leadership, there have been little academic study of the interpersonal and organizational issues surrounding engagement of Whites in promoting a more inclusive workplace.¹⁹

¹⁹ For non-academic studies of engagement of White people in workforce inclusion, see Shelton (2013), Diversity Best Practices (2013), Witt/Keifer (2015), and White Men as Full Diversity Partners (2018).

CHAPTER 3

METHODOLOGY

This study was designed to explore the effective engagement of White people in healthcare workplace inclusion strategies. In this chapter, I discuss the methodological approach of the study, the use of semi-structured interviews, sample selection, data analysis, and limitations of the methodology.

Data Collection

My data collection strategy was designed to (1) gather relevant, valid, reliable primary data from practitioners of workplace inclusion in a resource-efficient manner, (2) build positive relationships that would become an ongoing resource for further research and implementation of inclusion strategies, and (3) generate self-reflective, experiential data regarding the relationship between the topic and my social identities.

Qualitative Methodology

Based upon my goals for data collection, I chose the qualitative research methodology of semi-structured interviews. Workplace inclusion, diversity, and allied topics are socially constructed, symbolic, and imbued with multiple meanings (Mease, 2016). Qualitative research is a good match with the topic because its goal is ‘to describe, decode, translate or otherwise come to terms with the meaning, not the frequency, of certain more or less naturally occurring phenomena in the social world’ (Van Maanen, 1979, p. 520). Further, ‘the focus in many qualitative studies typically is on the unfolding of process rather than the structure’ (Hari Das 1983, page 301). The process of creating meaning in workplace inclusion research is mediated by the dynamic interplay between social identities, power, and privilege of the researchers and the subjects (Mease, 2016; Sue et al., 2010). Qualitative

research therefore stands a better chance of capturing the ‘serendipitous’ (Hari Das 1983, page 301) nature of inclusion research. Further, meta-analysis of the interplay between the researcher’s social positionality and that of the subjects yields unique, actionable insights on the topic at hand (McIntosh, 1988; Helms, 1993; DiAngelo, 2011; Lensmire et al., 2013).

Semi-structured Interviews

Per the goals listed above, I chose qualitative interviews of leaders and consultants in healthcare workplace inclusion in order to generate relevant, observable data on the topic, build relationships for future research, and create opportunities for recording self-reflected, experiential meta-data. I chose semi-structured interviews to create reasonable boundaries around the data while allowing participants to use their own words to describe their work. Semi-structured interviews acknowledge that the same words will have different meanings for different study participants (Louise BARRIBALL and WHILE, 1994). Semi-structured interviewing also adheres to the Grounded Theory, which directs the researcher to allow participants to define which data is relevant to the topic at hand (Creswell and Poth, 2017). My semi-structured interviewing method also reflected a Grounded approach in that I allowed my ever-evolving thinking on the topic, my relationship to the subjects, and the purpose of the study to impact the process of interviewing. For example, if a participant expressed a strong preference for using particular words in reference to diversity and inclusion topics, I would adopt these words for use in subsequent questions. While the words occasionally changed, my questions had specific outcomes that I believed would be essential to inform my thinking about how practitioners see effective engagement of White people in healthcare workplace inclusion (See Table 6 below).

Table 6: Prepared statements and questions and desired outcomes of semi-structured interviews

Prepared Statements and Questions	Desired Outcomes
<p>Statement: Thank you very much for agreeing to be a participant-partner of this research project regarding the effective engagement of White people in workplace inclusion strategies in healthcare delivery organizations. My use of the phrase “participant-partner” communicates my hope that you will get to contribute to and benefit from the research process.</p> <p>Our one-hour qualitative interview session is being recorded and transcribed to aid data collection and analysis. I will also be taking handwritten notes. The data is confidential and your identity will remain anonymous throughout the research process.</p> <p>There will be three main parts to the interview - one, getting to know you and your overall approach to promoting an inclusive workplace, two, hearing your thoughts about, and experiences with, engaging White people with this work, and three, a discussion about how you see this work evolving.</p>	<ul style="list-style-type: none"> ● Build rapport ● Frame topic ● Prime participant’s thinking about the topic ● Build trust
<p>Question: Do you have any questions before we begin?</p>	<ul style="list-style-type: none"> ● To help the participant voice questions about the research or inform me of logistical issues ● To help the participant focus on the topic at hand
<p>Question: What does your typical work day look like?</p> <p>What are your formal and informal responsibilities for promoting workplace inclusion? About how long have you held this position/appointment?</p>	<ul style="list-style-type: none"> ● Build rapport ● Understand the participant’s role - in name and in practice - in promoting inclusion ● Understand the participants relative power and influence
<p>Question: What got you into the work of diversity, equity and inclusion?</p>	<ul style="list-style-type: none"> ● Build rapport ● Prime participant in thinking about

<p>What do you enjoy about this work? What about the work has been challenging? Could you tell me about a past experience that has been influential for you?</p>	<p>how their personal story influences their work</p> <ul style="list-style-type: none"> ● Begin explanation of the strategies and tactics
<p>Question: How would you describe your overall approach to promoting an inclusive healthcare workplace? (Prompt examples: unconscious bias or cultural competence) Can you describe a recent example of this approach? Would say your work focuses mostly on structural aspects of inclusion or interpersonal aspect? What are you most proud of in terms of your work in this area?</p>	<ul style="list-style-type: none"> ● Develop understanding of participants thinking, language, strategies, and tactics around inclusion ● Elicit narrative with specific examples
<p>Statement: Next, I will ask you about the social identities that you think are relevant to your work in this area. As you may know, social identities can be more visible like gender and race, or less visible such as place of origin or class background. For example, the identities that I believe impact my research and how others view it include: White, male, cis-gender, Jewish, raised middle class, and activist.</p>	<ul style="list-style-type: none"> ● Prime participant and ‘soften’ the impact of a possibly sensitive question about identity ● Build trust by making visible my awareness of how social identities influence the study ● Model how I would like the participant to answer
<p>Question: Which social identities do you feel most influence your work, and how others perceive your work, in promoting an inclusive workplace?</p>	<ul style="list-style-type: none"> ● Understand how the participant views the interplay of identity and workplace inclusion strategy ● Gauge the participant’s level of awareness around identity
<p>Question: How would you describe your approach in helping employees with various identities to think about their commonalities and what makes them different? Can you think of an example?</p>	<ul style="list-style-type: none"> ● Understand the participant's strategy for discussing difference ● Assess how much important the participant places on differences and commonalities
<p>Question: When you think about effectively engaging White people in healthcare workplace inclusion strategies, what are some thoughts you have?</p>	<ul style="list-style-type: none"> ● Understand what associations the participant has around the primary research question ● Understand the participant’s strategies and tactics around engaging Whites in inclusion

<p>What behaviors would indicate to you that the White employees in your organization are fully engaged in helping create an inclusive workplace?</p> <p>Can you think of any particular moments that stand out, either positively or negatively?</p> <p>Can you think of any examples, either in your organization or another, when you felt that a White person was being effective in helping create an inclusive workplace?</p>	<ul style="list-style-type: none"> ● Illicit specific examples and rich narratives regarding White engagement in inclusion
<p>Based upon your experience and expertise, how might you recommend a new healthcare leader go about creating an inclusion strategy that fully engages White people?</p>	<ul style="list-style-type: none"> ● Understand the participant's strategies and tactics around engaging Whites in inclusion ● Prime the participant's thinking to illicit data that is future-looking
<p>How do you see the work of creating an inclusive healthcare workplace developing over the next 5-10 years?</p> <p>How would you like the work to evolve?</p>	<ul style="list-style-type: none"> ● Understand the participant's vision for the future ● Understand how the participant sees their work making that vision a reality
<p>What recommendations or resources might you have for me as I move forward in my research?</p> <p>Do you have colleagues at other healthcare systems that you feel I should interview as a part of this study?</p> <p>Are there any reports, websites, or other data you think I should see?</p>	<ul style="list-style-type: none"> ● To recruit the participant as a collaborator in the research process ● To gain warm introductions to more participants ● To gain further reference materials

I prepared primary questions (bolded in Table 6) that I believed were mostly likely to fulfill the intended outcome. If the primary questions did not fulfill the intended outcome, or were not appropriate or useful, I prepared secondary questions in order to reach the desired outcomes. I avoided strict time limits and goal-directed questioning because, as Corbin and Morse note, 'interactive interviews are shared experiences in which researchers and interviewees come together to create a context of conversational intimacy' (2003, page 338). This intimacy results in participants providing narrative-driven data which creates novel

insights into their thinking around the topic (Ramos, 1989). If the participant fulfilled an intended outcome of a question with a previous answer, I would skip this question. If the participant gave me an answer to a question that I did not ask, I did not stop, correct, reframe, or redirect the participant's answer. Depending on the pace and length of the participant's answers, I skipped questions in order to reach subsequent questions that I perceived to be more important to reaching the intended outcomes.

The 16 interviews of healthcare inclusion elites were conducted over the virtual meeting application Zoom and lasted for 60 minutes. Each interview's audio file was recorded. There were six videos recorded. If the interviewee logged on to the virtual meeting space using only audio and not video, I did not ask them to use the video portion. The reason for this decision was two-fold. One reason was efficiency in that having the participant attempt to log on to the video portion may have resulted in technical challenges, which in turn may have taken away significant time from the interview session. The other reason that I did not ask all the participants to log on to the video feed is to reduce the chances of the participant experiencing the emotional agitation that is sometimes caused by technological challenges and the resulting problem-solving. Knowing that the interviewer-interviewee relationship was in its early, formative stages, I did not want to unnecessarily create agitation. As Corbin notes, creating an atmosphere of comfort and intimacy, rather than control, is critical in qualitative interviews because a home-like atmosphere is more likely to induce responses that capture the holistic nature of an issue (Corbin et al., 2008; Corbin and Morse, 2003).

Sample

In pursuit of primary data regarding the effective engagement of White people in healthcare workplace, I used a combination of purposive and convenience sampling techniques to recruit 16 elite practitioners of healthcare workplace inclusion in major medical centers. The purposive technique was used my selectivity in gaining referrals to either organizational leaders in major medical centers or expert consultants to this group. The organizational leaders had to have at least 30% of their time dedicated to workplace inclusion. The consultants were required to have significant experience serving the healthcare industry. In my email and telephone outreach, I specified these criteria. If I was unsure about the target's eligibility, I would set up an introductory phone call. I also set up introductory phone calls for participants with whom I had no prior contact or introduction.

I also used a convenience sampling technique in that, starting with my prior client in the healthcare space, I gained warm introductions to contacts in my client's network and I set up interviews as soon as the person was identified. I did not recruit a representative sample in terms of type of organization (e.g. for-profit/nonprofit), geography (rural/urban) or relationship to academia (university based/community based). However, my sample's demographic diversity was generally representative of healthcare inclusion leaders (see Table 7 below).

I also applied a convenience sampling technique in the speed with which I identified, connected with, and interviewed the sample, which occurred over a period of two months in early 2019. The primary driver for this condensed time frame was to generate data and results that were as recent as possible to the publication date. Considering that timeliness is critical in fast-moving and socially constructed topics such as diversity & inclusion, condensing the

time frame allowed me to generate more relevant results for practitioners. Thus, timeliness was critical to pursuit of my goal of relevancy.

In my outreach and in my interview introduction, I expressed my goal that the interviewees would be “participant-partners”: they would contribute to and benefit from the research. Equity in the research relationship was top of mind because the inherent power imbalance between researchers and subjects is a critical concern of qualitative research, particularly in healthcare (Råheim et al., 2016; Hewitt, 2007). I developed the participant-partner concept in the interest in increasing equity and mutuality in the research relationship. In addition, I viewed the interview process as an organizational development intervention in that the thinking and behavior of workplace inclusion practitioners would be influenced by the process itself. Such collaborative, generative interventions reflect the influence of appreciative inquiry (Cooperrider and Whitney, 2005) and collaborative inquiry (Kasl and Yorks, 2002). Additionally, my recruitment of participant-partners acknowledged the prominent role of social interaction in making new meanings around socially-constructed topics. As Wasserman explains, “The communication perspective on social construction theory contends that meaning is continuously emerging in the turns and processes of social interactions and speech acts of persons in conversations” (2018, page 249).

The participant-partners consisted of 12 organizational leaders in healthcare inclusion and four (4) expert consultants. I recruited the majority of the interviewees from inside healthcare organizations to ground the data in an industry-native frame of reference. I included consultants with expertise in inclusion in order to provide a novel, outsider perspective and to leverage the consultants’ knowledge across clients and industries. The 12 organizational leaders were comprised of seven (7) medical leaders and five (5) staff. The

medical leaders were clinicians, academics, and teachers in major medical centers that held multiple appointments but who had dedicated at least 30% of their time to workplace inclusion. Five (5) of the six medical leaders had a primary appointment at their medical school, and were therefore primarily responsible for promoting inclusion at the school level rather than system-wide. The staff participants were leaders on the administrative side of healthcare whose primary responsibility was promoting an inclusion agenda in the organization as a whole. There were eight (8) sampled healthcare organizations: four (4) academic medical centers, two (2) nonprofit managed care organizations, one (1) pediatric hospital, and one (1) regional community health network. All of the sampled organizations were non-profit organizations.

I recruited a diverse sample of participant-partners in terms of their visible social identities, particularly their race and gender (See Table 7 below). These identities were an independent assessment made by myself. I am a White man and I based my assessments upon contemporary socially constructed views of race and gender, using the prospective interviewees' photographs and names. Of 15 total interviewees, there were four (4) Black women, four (4) Black men, three (3) White women, two (2) White men, one (1) Latina woman, and one (1) Latino men. In terms of racial identity, there were eight (8) Black participants, five (5) White participants, and two (2) Latino/Latina participants²⁰. This sample is 67% people of color versus 71% of diversity & inclusion leaders in healthcare were people of color in 2015 survey data from the AHA (IDHM, 2017). 53% of the participants were women.

²⁰ Neither the Latina or Latino participants also self-identified as White.

Table 7: Independent, external assessment of participant race and gender identity

Race	Gender	Count
Black	Women	4
Black	Men	4
White	Women	3
White	Men	2
Latina	Women	1
Latino	Men	1
	Total	15

During the interview phase, the participant-partners named other, non-visible identities, either in response to the explicit question about identity, or in their answers to other questions²¹. These identities included biracial, GLBTQ²², American, first generation immigrant, Jewish, ancestor of holocaust survivors, large, and elder.

Data Analysis

After the interviews were complete, I reviewed the recordings, transcriptions, and handwritten notes. Using this data, I listed the responses to each question, removing or altering all references to potentially identifying information. I analyzed the data as a whole to compile thematic categories. Consistent with a Grounded approach (Creswell and Poth, 2017), during the data analysis stage, I did not attempt to fit the data into preconceived theoretical frameworks (see Chapter 4: Findings. Finally, I assessed the connections between

²¹ Some interviewees did not describe their racial identities. Some interviewees did not reveal further identities beyond their race and gender.

²² Gay, Lesbian, Bi-Sexual, Transgender, or Queer/Questioning

the data, the extant literature, and organizing theories (see chapter 5: Interpretation of Findings).

Limitations

My research methodology was limited in several ways. First, the entirely qualitative nature of the semi-structured interviews lacked a quantitative assessment of the interviewee's perspectives. Therefore I was unable to test particular hypotheses about effective engagement of White employees in workplace inclusion. In addition, since my interviews intentionally lacked a strict adherence to the agenda, not all of my original questions were answered and I received answers to questions that I did not ask. I also did not use a data-driven process to test assumptions about what the most helpful interview questions might be prior to beginning the interviews. Instead, I created the questions and the preparatory statement using the concepts I had encountered during the literature review period and the feedback I received from my advisor and a third party expert.

My sampling technique was another area of limitation. Given my bias for producing timely data and results, my entire research period was 6 months long. This condensed time frame limited my choices in sampling. I settled on a combination of purposive and convenience sampling techniques, which limited my ability to recruit a sample that reflected an 'ideal' distribution of attributes. My sample's distribution of gender identity and of White and People of Color identities generally reflected that of healthcare leaders of diversity and inclusion. However, there were other attributes that were not distributed representatively, such as title, institution type, and geography.

Language Usage

My use of language, particularly around social identities, was guided by prevailing norms of social science research and my involvement in various communities working toward the human liberation. My use of language may not satisfy or comfort all readers. My hope is that I invite the reader into a dialogue.

I used the following general guidelines from the writing center and diversity and inclusion offices of Hamilton College regarding the “Language of Difference”:

- Assume a wide audience
- Include a rationale for your choice (see specific rationales below)
- Use only the language that is necessary to the context - only mention difference when it is relevant
- Avoid terms that evaluate
- Use the appropriate degree of specificity; i.e. ‘Dominicans’ rather than ‘Hispanics.’
- Focus on people rather than on a method of categorization: ‘people with mental illness’ rather than ‘the mentally ill.’
- Avoid the term ‘minority’ if possible (Bowman et al, 2015)

Adhering to APA, 6th edition style guidance, I capitalized racial identities such as ‘Latino/a’, ‘Black’, and ‘White’, (2009, pp. 70–77).

I use the phrases ‘non-White’ and ‘People of Color’ interchangeably. Per the guideline above, I used these phrases when appropriate and, when called for, I used more specific words such as ‘Black’ when appropriate. Given that this research is focused on people with White racial identity or who enjoy White privilege, I chose ‘non-White’ to delineate those people that do not belong to this group. However, I was also aware of the

danger that, to some readers, using the phrase ‘non-White’ centers Whiteness and devalues the diversity of the innumerable ethnic groups and nationalities whom do not experience White privilege. On the other hand, since my research dealt specifically with the set of advantages, mind frames, and behaviors in the workplace associated with White privilege in the US, I wanted to avoid obscure the inherently political nature of this issue. Therefore, I occasionally selected the phrase People of Color in order to frame this orientation to Whiteness in the positive. There is a robust debate regarding the use of ‘People of Color’ (Glover, 2016).²³

I use the word ‘United States’ and not the word ‘American’. I do not use ‘American’ because this word, while used ubiquitously to refer to people who live in the United States of America, conflates the geographical designation of the Americas with a nationality designation of one country in that area (Kirk, 2013).

I use gender terminology (cisgender woman, cisgender man, transgender) and sex terminology (male, female) separately. However, when I reference literature that mixed gender and sex, sometimes my usage also became mixed.

I created pseudonyms for each of the 16 participants using gender-neutral names and used the pronoun ‘they’ in order to secure their anonymity (see Table 8).

²³In the Re-Evaluation Counseling communities, a worldwide peer counseling organization of which I am a member, we use the phrase, ‘People of the Global Majority’ (Re-evaluation Counseling, 2016). People of the Global Majority is used to connote the reality that people of non-European ethnicities are the majority, by a wide margin, of the worldwide population. I have chosen not to use ‘People of the Global Majority’ because I believed it may have caused an unnecessary distraction to the reader.

Table 8: Pseudonyms for participants

Deandre	Lane
Dionne	Lonnie
Emery	Marques
Finley	Oakley
Francis	Quinn
Harper	Robin
Jamie	Sydney
Jo	Zari

CHAPTER 4

KEY INTERVIEW FINDINGS

“Healthcare systems have been working on this issue for the last 40 years [and] have made very little progress. I always ask why? And lots of times, it's because the mindset of the leaders is not aligned with the tactics that they're trying to implement...” - Emery, participant

“Call him Voldemort, Harry. Always use the proper name. Fear of the name increases fear of the thing itself.” - Albus Dumbledore, Harry Potter and the Goblet of Fire

Introduction

This study explores the topic of effective engagement of White people in workplace inclusion strategies in healthcare delivery organizations. In chapter 4, I will present key findings from the primary research, which were gleaned from analyzing the data from 16 qualitative, semi-structured interviews of healthcare inclusion leaders and expert consultants. I present the critical data in the dominant themes that emerged from a close reading of each interview transcript. I use direct quotes from the interviews, anonymized to ensure the confidentiality of the participants. After the analysis was complete, I created pseudonyms for each participant.

Of the 16 participants, 12 were leaders in eight healthcare delivery organizations in the United States. The remaining three were independent diversity & inclusion consultants or leaders of independent organizations with extensive experience working with healthcare delivery organizations. Table 9 below presents relevant characteristics of the workplaces and positions of participants. It is important to note that the majority of the organizations were academic medical centers within a larger health network, but that other organizations were represented. The most common position type (9 of 16) was a senior or mid-senior faculty

member at a medical center with multiple appointments and varying responsibilities in promoting diversity and inclusion.

Table 9: Participant organization type, position type, and primary responsibility in diversity and inclusion work

Organization Types	#	Position Types and Levels	#	Primary Diversity & Inclusion Responsibility	#
Academic medical center	4	Senior healthcare leader (Faculty)	5	Enterprise DI Strategy & Leadership	5
Nonprofit managed care	2	Mid-senior healthcare leader (Faculty)	4	Advisor or Consultant to Enterprise DI Leader	5
Consultancy	2	Mid-senior healthcare leader (Staff)	3	Faculty Diversity Recruitment & Retention	3
Pediatric	1	Senior consultant	3	Medical Education and Programming	2
Community health	1	Senior organizational leader	1	Research & Assessment	1
Independent organization	3				
Totals	13		16		16

There was also significant demographic diversity in the sample. Table 10 below shows the gender and race distribution of my sample, which I assessed independently by using publicly available profiles with photographs on the internet. My independent assessment was based upon my interpretation, as a White, cisgender man, of prevailing cultural norms regarding the visible signs of gender and race designation. This independent assessment of race and gender was confirmed by self-designation for 14 of the 16 participants in their responses to the interview question regarding social identities. Of the

remaining two participants, one designated their gender, which confirmed my independent assessment, but did not mention a racial identity. The other participant did not self-assess their race or gender because I did not ask them this question. Neither of these two participants *disconfirmed* the independent assessment.

Based upon my independent assessment, the demographic distribution of racial identity of the sample was comparable with that of Diversity and Inclusion leaders in hospitals nationwide (IDHM, 2017). As of 2015, the AHA found that 77% of D&I leaders identified as ‘minorities’ whereas I identified 69% of my sample as either Black/African American or Latina/o. It is important to note that the AHA designation of minority did not specify whether their definition of ‘minority’ included or excluded a designation of ‘underrepresented’.

Table 10: Participant race and gender (independent assessment by interviewer), ordered by participant count (#)

Race	Gender	#	Percentage
Black/African American	Women	5	31.3%
Black/African American	Men	4	25.0%
White	Women	3	18.8%
White	Men	2	12.5%
Latina	Women	1	6.3%
Latino	Men	1	6.3%
	Total	16	100.0%

The interviews were conducted over an internet-based meeting platform and lasted from 45 - 110 minutes, with a mean of 62 minutes. Prior to the interviews, I notified the participants that the interview would be recorded and I notified them again immediately prior to the interview in a preparatory statement (See Appendix A). Some of the interviewees

were recorded in video and audio and some in audio only. I took handwritten notes and the interviews produced 286 pages of transcript data. I combined these various data sources and organized the results into thematic categories. I then reflected on the process of interviewing in order to produce self-reflective data.

Findings Grouped by Theme

Below I describe the interview data in four broad thematic categories: personal identities and stories, approaches to difference and commonality, general inclusion approaches, and effective engagement of White people in workplace inclusion strategies. Under each theme, I list the relevant questions and describe the responses using sub-themes, tables, and direct quotations. Because the interviews were semi-structured, I allowed the participants to co-determine the pacing of the interview. Therefore, not all questions were asked to all participants. I also received many answers to questions I had not asked. Under some thematic categories, I discuss and present the numerical count of ‘mentions,’ or relevant statements, by participants that correspond to those themes. Readers should be aware that I coded these statements independently and did not rely upon computer-aided coding of the transcript data or recordings. Therefore, these numerical counts should be considered approximate representations of actual response data. I replaced the participants’ names with gender-neutral pseudonyms and use gender-neutral pronouns (e.g. they, their) to refer to the participants.

Personal Identities and Stories

Relevant questions:

- *What got you into the work of diversity, equity and inclusion?*
- *Could you tell me about a past experience that has been influential for you?*

- *Which social identities do you feel most influence your work, and how others perceive your work, in promoting an inclusive workplace?*

In research on fostering diversity and inclusion, numerous scholars have described the importance practitioners (and researchers) knowing and naming their relevant social identities (Helms, 1993; Sue et al., 2010; Rast et al., 2018). These personal attributes create a lens through which the leader approaches their work. This is particularly important when the work itself deals directly with issues of difference, workplace equity, and other touchstones of the diversity domain. Since the current study deals with White racial identity, it was critical to understand the participants' relevant social identities, both racial identity and those that intersect with race.

The participants self-designated 58 social identities that they felt either influenced their own approach to workplace inclusion or influenced how others' viewed them. In Table 11 below, I list the identities along with the number of mentions. The most mentioned themes were race, national ancestry, gender, sexuality, class upbringing, and occupational. Some participants only included more visible identities such as gender, ethnicity, and race, whereas some participants listed many of their less visible identities as well.

One of the most important findings from the social identity question was the large number of identities that were only mentioned by one (1) participant: 45 identities, or nearly 78% were mentioned only once. This finding speaks to the diffuse, multitudinous nature of social identity. Another interesting finding deals with the difference between my independent assessment of participant's race using publicly-available profiles and their self- assessment of which identities were most influential in their work. While all six (6) of the White participants cited their Whiteness as influential, only five (5) of the eight (8) African

American participants to whom I posed the question about identities mentioned their Black identity²⁴. The Latina/o participants did not use the words “Latina” or “Latino”, but instead mentioned their parents’ Latin American country of origin.²⁵²⁶

²⁴ Two of the African American participants did not specify their racial identity in response to my question. For the other participant that did not specify their identity, I had not asked them the question about identities.

²⁵ See Language Notes in chapter 1 for an explanation of the use of gender-neutral pronouns.

²⁶ I did not provide a citation for this statement in order to protect the identity of the participants.

Table 11: Self-designated social identities that participants believed influenced their work or how others perceive their work, sorted by number (#) of mentions

Social Identities	#	Social Identities	#	Social Identities	#
White	6	Elder or "Old"	1	Raised in city	1
Woman	6	Bisexual	1	California raised	1
Black or African American	5	"In another era, probably bisexual"	1	Raised by single parent	1
Heterosexual or Straight	4	Cognitively Different	1	Safety net hospital	1
Man	3	ADHD	1	Cardiologist	1
Cisgender	3	Geek	1	Academic	1
Child of immigrants	3	"American" nationality	1	Woman in male-dominated workplace	1
First gen. college	3	Immigrant	1	Worked in toxic workplace	1
Caribbean	2	English language speaker	1	Young Dean	1
Parent	2	Jewish	1	Multi-disciplinary training	1
Raised in lower SES home	2	Seventh Day Adventist	1	Lawyer by training	1
Activist	2	Agnostic or Atheist	1	Diversity Expert	1
Physician	2	Descendent of slaves	1	Mentor	1
Multi-generational Black	1	Child of Holocaust survivors	1	Low SES grad student	1
Biracial	1	Child of Black activists	1	Educated	1
Honduran-American	1	Child of labor activists	1	High income and wealth	1
Parent of child on spectrum	1	Child bully	1	Well-travelled	1
Parent of child was bullied	1	Child of physicians	1	Safe home neighborhood	1
Grandparent of biracial children	1	Raised in all-White town	1		
Youthful appearance	1	Raised in black and brown neighborhood	1		

These social identities connected to the life stories of the participants. Finley's comments are a good example of numerous participants' regarding formative childhood experience: "...growing up in the city of [redacted], [I] was aware of some of the stark differences in the neighborhoods and also in people's level of quality of life and wellness. At a very young age, I was curious as to why are there such drastic differences" (personal communication, March 22, 2019). Similarly, Deandre recalls their experience in high school sports: "One very tangible example and thing I always remember is we had a dirt track at my high school, and I ran track and played football. We would go to other schools, 90%, 95% of which had all weather tracks. That being a very tangible sort of and visual example of asking yourself, why is this?" (personal communication, February 25). In addition to noticing disparities, Robin describes early experiences of activism: "[my work promoting diversity and inclusion started with] the work that I had done in social justice my whole life from the time I was a teenager, starting with doing civil rights work, then anti-war work then work with the farm workers union" (personal communication, February 11, 2019). Other participants cited later experiences in their professional lives as influential in their journey to workplace inclusion leader. I found Dionne's story particularly relevant to the topic of the current research:

...my main professional field...is tobacco use prevention and treatment...And tobacco, from being so embedded in US history...and the fact that slavery being used to grow tobacco as America's great cash crop for so long, on through to the targeted advertising that has really [creates] a vector for the tobacco epidemic [in] populations that are already marginalized (personal communication, March 1, 2019).

As this quote demonstrates, the participant's stories demonstrate the powerful connections, at the individual and collective levels, between personal experience, social disparity, and economic reality. These connections can also be seen in the intersectional nature of the participants' social identities.

Overall Approaches to Workplace Inclusion

Relevant Questions:

- *How would you describe your overall approach to promoting an inclusive healthcare workplace?*

The participants addressed this open-ended question about their overall approach in two general ways: interpersonal descriptions of inclusion and organizational inclusion strategies. Participants discussed three (3) interpersonal themes and 14 organizational themes regarding their approach to inclusion. Table 12 below lists all the interpersonal themes and the nine most mentioned organizational themes. Under this and subsequent thematic sections, I discuss and present the numerical count of 'mentions,' or relevant statements, by participants that correspond to those themes. Readers should be aware that I coded these statements independently and did not rely upon computer-aided coding of the transcript data. Therefore, these numerical counts should be considered approximate representations.

Table 12: General approaches to workplace inclusion: interpersonal descriptions and organizational strategies, ordered by count (#)

Interpersonal Inclusion Descriptions	#
Authentic Felt experience	6
Interpersonal Relationships, Empathy	6
Belonging	2
Organizational Inclusion Strategies (top 9 themes)	#
Training	8
Holistic, Aligned Strategy and Tactics	6
Using Science, Research, Assessment	6
Inclusive Culture/Climate	5
Diversity recruitment & retention	5
Education, professional	4
Education, general employee	3
Goals & Targets	3
Business and Performance Case as primary driver	3

On the interpersonal level, six of the 16 participants mentioned the importance of inclusion as a felt experience and that it revolved around interpersonal relations. Sydney's response is an apt summary of this theme: "Yes, so for me, [inclusion] is a feeling. It's creating an organizational culture where people feel valued, where people feel respected, and respect is kind of a subjective thing" (personal communication, February 7, 2019). For

Francis, inclusive leadership starts with self: "...I would love to take people through truly what I call inner work. And so inner work is who am I? How do I see myself through my identity lens?" (personal communication, February 25, 2019). Emery went further in stressing the importance of healthcare leaders taking on internal development in order to effectively promote inclusion:

Healthcare systems have been working on this issue for the last 40 years, have made very little progress. I always ask why? And lots of times, it's because the mindset of the leaders is not aligned with the tactics that they're trying to implement and they don't know it, whether it's unconscious bias, whether it's a lack of competency. Our work is largely at the personal level, at the leadership behavior level. For me, it's the foundation piece that has to be addressed (personal communication, February 12, 2019).

Four participants used metaphors for describing inclusion and associated concepts, including Robin, who stated, "Dr. [name redacted] has said for years that diversity is being invited to the dance and inclusion is actually being allowed to dance. I like to say that belonging is when you get to actually choose some of the music." Robin was joined by two others in connecting empathy with inclusion. Empathy, as a key mode of interrelating, was a critical concept in connecting professional training of clinicians with healthcare inclusion. Two quotations demonstrate this point: "Relationships to self, to patients, to peers, and to the wider society. We say that the physician is tasked with managing, negotiating, mediating those four critical relationships" (Lane, personal communication, February 20, 2019); "[I published an article on] inclusion as a core competence to professionalism. I've

spoken about professionalism and wellness and inclusion being in overlapping spaces” (Zari, personal communication, February 13, 2019).

While the responses regarding interpersonal issues, most of the participant responses to my question about inclusion approach dealt with organizational strategies and tactical interventions. The training theme was the most commonly cited (7 mentions), closely followed by the importance of a holistic, embedded, aligned inclusion strategy (6 mentions) and using science, research, and assessment in the work (6 mentions). Participants mentioned two general types of training: leadership training and general training around inclusion and associated issues. For example: “[we] provide training for ‘leading for the future’ or ‘leadership 2020’, which at its core is unconscious bias training” (Jo, personal communication, April 8, 2019); “The penny exercise in particular is pretty galvanizing” (Dionne); “We mandate diversity and cultural adaptability training for all employees. That includes CEO on down (Deandre).”

On the strategic level, participants discussed “goals that are enterprise wide”, “taking a holistic approach”, and ensuring that “our priorities are aligned with the plan of this school and the university” (Sydney; Robin; Quinn, personal communication, April 8, 2019). The concept of embedding inclusion strategy is connected to the concept of inclusion as a cultural project. Robin underlines the necessity of looking beyond the diversity numbers: “...are we really willing to look at diversifying the very nature of the culture to make it more, to have it take more advantage of everything that different people have to offer?” Lonnie echoed this sentiment in saying, “the goal we hope to achieve is a culture change. Culture change

that respects more inclusivity” (personal communication, March 4, 2019). Jo commented that the leaders they work with are aware and accepting of the need for greater inclusiveness, but “the question is, ‘How do I shift my culture?’”. Emery sums this up with a metaphor: “I also equate ‘D & I’ [with] safety, [as in] manufacturing...D & I is the same thing. It's a permanent mindset that overlays everything else within an organizational system”.

While arguing that inclusivity transcends numerical data, participants cited using objective assessment based on “sound scientific and social theory” (Lonnie) as a cornerstone of developing embedded inclusion strategies. The most commonly cited assessments were “diversity engagement survey”, “climate assessment”, and various measures to determine the recruitment and retention of underrepresented groups (Oakley, personal communication, March 25, 2019; Jo). Several participants also related the use of objective assessment to their overall strategy of setting goals and targets. For example, Deandre described goals for leader recruitment, diversity climate, and “purchasing ... from a diverse supplier standpoint.” Lonnie’s goal was clearly stated as “increase by 50% the [medical school] faculty representation [of underrepresented racial and ethnic groups] over three to five years”.

In fact, at least five (5) of the participants reported that they were held directly accountable, at least in part, for increasing the percentages of women and underrepresented racial and ethnic groups at their institution (Zari, Jamie, Lonnie, Oakley, Quinn). Therefore, at a practical and operational level, these and other participants reported that the work of creating an inclusive workplace is inseparable from the work of increasing representational diversity.

Seven participants mentioned professional training and general employee education programs as key organizational strategies. Harper's two major undergraduate nursing courses dealing in health equity and quality were designed to "[challenge students] to understand that the patients that they take care of come with a set of experiences that are important." Lane also discussed holistic diversity and inclusion curriculum for medical students focusing "on diversity in its broadest sense, but making sure that we keep in mind the historical notions, around diversity, particularly racial and ethnic minorities that are underrepresented in medicine." For hospital-wide employee education, Sydney's activities were emblematic of many participants' work in this area: their primary duty was to "develop the... diversity education plan and put in place diversity education modules, train the trainer programs, cultural awareness events and heritage month celebrations".

In response to the overall approach question, Participants 11 and 14 stressed the importance of nesting workplace inclusion within the overall strategies of, respectively, business and organizational performance. After describing the major demographic shift in the US away from a White majority, Lonnie pointed out, "So if we are in fact to have a strategy that is economically viable going forward and if business enterprises, particularly in healthcare, are going to be a true growing concern, they necessarily have to accommodate a very new clientele, a very new customer." In terms of how the business of healthcare should serve the increasingly diverse "customer" or patient cohort, both Lonnie, Marques, and Oakley mentioned the phrase, "organizational excellence." Oakley's comments along these lines are an apt summation of this approach:

we recently adopted the approach of inclusive excellence, the idea that every individual's background and unique abilities and talents and various identities really does contribute to making the workplace a better place and looking from the institutional lens to be able to leverage those unique qualities that individuals bring in order to maximize the ability to create those outputs that are mission driven for us.

Approach to Identity, Difference and Commonality

- *How would you describe your approach in helping employees with various identities to think about their commonalities and what makes them different?*

Following up on the question regarding their personal identities, I asked the participants to discuss their approach, given the variety of identities at play, to working with employees on differences and commonalities. The responses were highly varied across topics and overlapping. Below I present them in four major themes: highlight and managing difference and intersectionality, highlight common experience including bias, highlight organizational and professional goals, manage complexity and intersectionality, and downplay differences (See Table 13).

Table 13: Approaches to identity, difference, and commonality, top four themes by count (#)

Approach	#
Highlight and managing difference and intersectionality	12
Highlight common experience including bias	6
Highlight organizational and professional goals	4
Downplay differences, including race	3

Twelve participant's responses were descriptions of how their organization highlights and helps employees manage difference and intersectional identities. In their regular diversity and inclusion training, Sydney's organization uses an exercise with "an identity wheel that talks about primary characteristics, secondary characteristics, and organizational characteristics... So you're bringing into any interaction, primary, secondary, organizational, institutional, societal identity structures... [the issue of] identity... as an intersectionality, plays into our monthly programs." Similarly, Finley uses "some group exercises that we do if we, for example, in some of CNEs or the training where we have people step into a circle as we call off different identities... We may say African-American, we may say single parent, we may say raised in a middle-class family, or LGBTQ ally. It also really highlights the intersectionality of our identities." Rather than have employees designate their own identities in a group, Deandre plays a guessing game wherein he asks the crowd to guess, "where do you think I grew up, where I live now. Am I married? Do I have kids? What's my racial and ethnic background?" People have a lot of fun with this, myself included. Then, they break up into pairs and play with each other.' Dionne's program uses 'the penny exercise', a workshop based upon Peggy McIntosh's work which seeks to educate the attendees on privilege. This requires participants to locate stations around the room that correspond to privilege statements that describe their life, such as "I can be reasonably sure that the police are there to protect me and people like me." Each station has pennies that participants place in a small sack. At the end, participants could their pennies and stand up when the number range that corresponds to their number is called. Rather than running workshops with

broad appeal, Emery reported focusing on training leaders to manage four “paradoxes” that vex (largely White men) leaders in the US: sameness and difference, individual and collective, claiming group membership without losing individuality, and challenge and support.

Six participants chose to accentuate their employees’ commonalities in the realm of workplace inclusion, including their shared experience of having biases and a common organizational mission. Robin describes their organization’s evolution of focus from difference to commonality:

if I'm sitting here and leading a session and I emphasize to people that I'm telling White people, "You'll never understand what it is to be black." And I'm talking to a man and saying, "You'll never understand what it is to be a woman", we always thought that that kind of would wake people up to see that they had to learn it. But now we can actually watch the way the brain was responding and what we would see is that the empathy centers of the brain would diminish when we would do this and their defensive posture would come up. So when you say to somebody, "You'll never understand what it is to be such and such", rather than wanting to understand more, they actually get more protective and defensive. And that was really at the core of beginning to change some of our strategies. And so what we began to see was that if instead of doing that, we would say, "Well, I've got bias about this issue. You may have bias about another issue, but we've all got bias."

Similarly, Marques reported going away from having people call out their identities “because I think in the context of most trainings, people don't really know

each other, and they may not [want to reveal sensitive information about themselves].” Instead, Marques’ workshops have attendees take an IAT [Implicit Association Test], reflect on it, and then go through another bias association exercise as a group. This helps employees understand that “bias is ubiquitous” and to help “people talk about race.” This common ground theme is echoed by Zari and Lonnie, but with a focus on organizational goals. As Zari responded, “I think just having a discussion about what is the common purpose of the group or the organization [is a good start]. And then building from that common purpose the rationale for bringing together diverse perspectives to enhance the purpose or to drive the purpose.” To participants, the commonality that speaks to the most immediate concerns of employees is around their professional development. Quinn communicates this through the lens of self-actualization: “I approach things as everyone in our environment, wants to feel valued, wants to feel that they’re able to contribute, wants to feel that their potential can be recognized... And that’s both from the custodian and the security guard to the scientist in the lab.” Likewise, Lane, as a curricular leader in a medical school, stresses the student’s common ground as doctors-in-training working to build their humility and core relationships, which help them understand the relevant social, cultural, and power structures to doctoring.

In addition to their advocacy for establishing common ground in the organizational goals, Lonnie advocated against a focus on focusing on different identities because this would “[allow] each group to formulate its own lens through which it sees diversity and inclusion... if you allow a cultural separation, there’s only so much progress that can be made.” Lonnie went on to state, “the whole point of the

existence of diversity and inclusion initiatives is to mute, M-U-T-E, the significance of the self-assignment of race or ethnicity.” Robin and Harper also discuss downplaying the significance of race due to the sensitivity it invokes, but they do not claim that this strategy is a core tenet of workplace inclusion.

Effective Engagement of White People in Workplace Inclusion Strategies

- *Do you have any questions before we begin?*
- *When you think about effectively engaging White people in healthcare workplace inclusion strategies, what are some thoughts you have?*
- *What behaviors would indicate to you that the White employees in your organization are fully engaged in helping create an inclusive workplace?*
- *Based upon your experience and expertise, how might you recommend a new healthcare leader go about creating an inclusion strategy that fully engages White people?*

In the responses to these four questions, the participants revealed their viewpoint on the central topic of the research - effective engagement of White people in workplace inclusion strategies. I divided this section into three themes: (1) support for, objection to, or no reaction to the research topic, (2) interpersonal issues of supporting White engagement, and (3) organizational strategies to support White engagement.

Support, objection/concern, or neutral reactions to the research topic.

In their responses to the first question following my reading of the preparatory statement and continuing throughout the interview, participants voiced support, objection or concern, or voiced neither support nor objection/concern to my framing

of the research topic. Table 14 below shows the distribution of these reactions. There are several important caveats related to these findings. First, voicing support or concern does not preclude the existence of either sentiment being experienced by the participants. A participant voicing support or concern does not imply that the participant experienced 100% support for or concern with the topic. Similarly, if the participant did not voice support or concern, this does imply that they experienced either sentiment. Last, that a participant objected to an aspect of the research topic does not imply an objection to the entire project. Indeed, for a senior leader or consultant to agree to a one hour interview is reasonable evidence of overall support for the endeavor.

Table 14: Participant reactions to the research topic

Reaction	#
Did not voice support or objection/concern	9
Support	4
Objection/Concern	3

Nine participants did not voice support or object/concern with the framing of the research topic. Four participants mentioned support for the research topic, effective engagement of White people in workplace inclusion. The supportive statements included, “you're on the right track to get us some good stuff” (Oakley), “...don't hesitate to send me a note...I've enjoyed the conversation a lot” (Robin), and “your work is very exciting and will be a great addition to these efforts” (Finley).

There were three participants that voiced a concern or objection. All three expressed their concerns or objections at the beginning, following the reading of my

preparatory statement (see Appendix A). I consider them critically important data points. Therefore, I have provided extended quotations of each concern or objection.

First, Zari:

Yeah, I have a little bit of a concern about the title. So I'm not comfortable with that. So I don't know if there's an alternative working title, but every time you reference it, it's a little bit uncomfortable...Well, I think that certainly these days we think more about ancestry as opposed to White and Black. So ancestry would be I think a better term because certainly, there's only one human race.... Yeah, European ancestry would be a better term at least in my view.

Zari expressed a concern with the title of the research including the 'White' racial designation. Their preference would have been to use "European" ancestry-based designation.

Lonnie did not voice a concern regarding use of racial language, although they did criticize the preparatory statement as "inflammatory". This criticism came packaged with a recommendation from Lonnie regarding my research methodology:

Was there any attempt to kind of have balance between major academic centers, moderate academic centers, community not-for-profit centers, traditionally minority centers? What was that thought process? [I answer this question] So I only bring that up because I think it helps establish some context. As one might imagine, a topic that begins with almost an inflammatory entree is going to generate a set of responses that will depend upon the day-to-day activities in a given center.

At this stage, I was curious to hear more about Lonnie's reason for choosing the word, "inflammatory", but I prioritized moving forward with the interview. However,

Lonnie's response to my second question, *How would you describe your formal and informal responsibilities in [diversity and inclusion] work*, brought us back to his initial reaction to my research topic:

Lonnie: Yeah. So I'm happy to answer that. But I think it would not be fair if we don't address the construct that you've outlined with the sentence that you brought forward.

Ken: Sure.

Lonnie: The fact that we're having a discussion that uniquely focuses on effective engagement of White people in workplace inclusion strategies is in and of itself a pause moment because the whole point of the existence of diversity and inclusion initiatives is to mute, M-U-T-E, the significance of the self-assignment of race or ethnicity of either of the groups that might be involved in a particular workplace environment. As long as we continue to articulate race as a descriptor of those that are participating in improvement and quite frankly those that are targeted, we continue to end up with somewhat polarizing views, and we perpetuate these differences that are stratified by race and ethnicity rather than ameliorate and amalgamate the population. So we have a better sense of who's under, at least in our sense, healthcare, who's under our care.

Lonnie: To be very explicit, I don't think it's wise to think about an effective engagement strategy for White persons and an effective engagement strategy for Hispanic persons and an effective engagement strategy for persons of African descent because that necessarily means that you are allowing each group to formulate its own lens through which it sees diversity and inclusion. One of the strategies that leads to a

successful diversity and inclusion space is a strategy that's built around cultural competence. But if you allow a cultural separation, there's only so much progress that can be made.

Lonnie: I think the key consideration for any dialogue you have with anyone who is a participant partner must necessarily be what is the greater good in having these efforts, that is what appeals to everyone. No one is going to lose their identity being engaged in diversity and inclusion, but everyone will seek what constitutes real value.

Lonnie's statements continued as he explicated his view on the correct framing of workplace inclusion - the 'business case' given the country's demographic shift toward a more racially and ethnically diverse, non-White (my wording) majority. This exchange generated many important self-reflective insights concerning the strategic and interpersonal dynamics surrounding my salient identities as a researcher, particularly race, those of the participants, and the weighty choices confronting leaders of healthcare workplace inclusion in terms of strategy and strategic messaging (See Personal Reflections in chapter 5). For the purposes of this section, the primary finding with Lonnie's reaction to my research topic is that they objected to my implication, by choosing this topic and interviewing practitioners on it, that focusing on White engagement in workplace inclusion was an important concern. Lonnie argued that, at some level, that a focus in *any* particular group, people with White racial identity or privilege included, was at best, an unwelcome distraction from a more efficient and effective strategy. Lonnie confirmed my interpretation of his reaction to my research topic in a follow up following email later the same day:

Ken,

Thank you for the inclusion.

One more thought- it is important for me to make certain that the emphasis on (White) race is muted. In nearly every public discourse, once race enters the discussion, all progress stops and acrimony begins. It is indeed a four letter word and is both halting and counterproductive. Given the contemporary associations with “White” race, that concept becomes especially halting.

The notion of developing an “inclusion” strategy for any given race or ethnicity is by definition contrary to the premise of inclusion. That is especially the case for “White” leaders/employees. A goal of our work is to reduce the impact of stereotypes; focusing on the needs of White leaders/employees only endorses the already extant stereotypes.

I am of the mindset that change as drive by a social justice imperative and now an emerging business objective is sufficient. Given the rapidly changing demographics in this country, those who wish to engage will be on the forefront of change and will serve as change (maybe even “choice”) architects. With sufficient “diversity of thought” created by persons that are representative of all stakeholders, including White professionals and patients, we will evolve a very different workspace and a very different, more equitable, approach to health and healthcare.

Best wishes with your work

[Lonnie] (March 4, 2019)

The follow up email confirmed that, in contrast to Zari’s concern regarding use of the word, “White”, Lonnie’s objection was more fundamental. Additionally, his objection compelled him to step outside the normal bounds of research subject to explicitly direct me

toward, what he believed strongly, was a more useful frame for my research. This behavior also follows my intention in the preparatory statement that interviewees, as ‘participant-partners’ would ‘get to contribute to and benefit from the research process’ (see Appendix A).

Quinn had a similar critique to the research topic, although their comments were more circumspect than those of Lonnie, made later in the interview, and in response to a direct question about effective engagement of White people:

So, I looked at your question, and I actually [inaudible - perhaps “felt”] [somewhat] difficult, that's not the correct word. Difficult thing to answer, because I don't think it's what is it White people do versus Asian people do or black people do. And what people do and I think that one of the difficulties, we can have some time when we try to lump everybody into a bucket. So, me, when you describe yourself in your identity, it's not a White identity that everybody shares, it's your unique identity, set of identities. And so I think one of the issues for me is not to think of it is for me, as I don't really think of this is how do I engage White employees in the work of our organization? I think of it as how do I engage the employees of students, the members of our organization in the work of our organization, understanding that each one comes with this very differently? Each one has different perspective, each one has their own set of biases, their own set of issues that come together. And stress that more than White people do this, or Asian people do that. I just think it's a healthier approach.

Like Lonnie, Quinn communicated that focusing on engaging any one racial identity is not on their agenda of workplace inclusion, at least explicitly.

Interpersonal issues in effective engagement.

The participants described many salient issues regarding interpersonal aspects of effective engaging White people in workplace inclusion. I drew out four relevant themes regarding this topic: exceptionality of engaging White racial identity or racial identity in general, particular challenges associated with engaging White people, positive identity development in general and White ally identity development specifically, and psychological safety (See Table __). Due to the participants' wide ranging comments on this issue, the data for number of mentions contains overlap. For example, the mentions for the general issue of exceptionality has overlap with several others listed in Table 15.

Table 15: Participant mentions (#) of interpersonal themes in effective engagement of White people in workplace inclusion

Interpersonal issue	#
Exceptionality of engaging people with White identity	9
Challenges or lack of challenge of White engagement	9
Psychological Safety: Build trust and avoid blame, shame, guilt	7
Positive Identity, Relationship, & White Ally Development	7

Exceptionality of engaging people with White identity.

Nine participants mentioned the issue of whether employees with White racial identity were apt to need different treatment than other groups in the development of strategies to engage employees in workplace inclusion. Emery describes how many senior leadership groups, mostly White, “don't know that they're a group and don't know that they set the organizational norms and rules. It's...not the majority group necessarily, but it's

whatever the dominant group is that establishes the cultural norms in a system”. Likewise, Deandre stresses the outsized opportunity in engaging White leadership:

...the first thought that comes to mind is that there is a lot of power and opportunity that folks with that [White] identity hold, whether they know it or not. I think if there are opportunities to really harness that in a way that help individuals that are more marginalized in lots of different ways, to really be champions and allies, it has the potential to really impact organizations like this one in terms of their culture, and then in their provision of service to others.

Similarly, Jo’s response to the question about effective engagement of White people dealt with the strategic nature of White positionalality: “Well, for the most part, multiculturals are different from the White power structure, that's where the difference lies”. In contrast, Quinn gave voice to the view White racial identity is not exceptional: “...I don't think it's what is it White people do versus Asian people do or black people do. [It's] what people do”. Lonnie goes further to state that White racial identity or racial identity in general, should not be accentuated: “We can spend our time trying to re-engineer labels and to revisit how we are self-described, or we can recognize that we have a history that is very diverse, and we come from heterogeneous experiences”.

Particular challenges involved in engaging White people in workplace inclusion.

Nine participants mentioned particular challenges involved in engaging White people in workplace inclusion. Six participants mentioned the challenge of White people feeling excluded from inclusion work or were not participating in as great numbers as hoped (Sydney, Robin, Emery, Zari, Harper, Oakley). As a result, as Oakley commented, “In my experience doing this work we often will I think have a similar thing that I've heard over in

my career is we end up singing to the choir meaning that we have these topics and usually the folks who are in the room are non-dominant group members.” Robin provided one explanation for the lack of White participation: “...so much of the diversity conversation for so many years was aimed at White people...And even in our language, I mean how many times have you heard somebody describe employees of color as diverse employees?I mean diverse employees is everybody.” Emery posits the lower participation in part to a struggle for Whites, and men in particular, to connect diversity and inclusion priorities with their “vested self-interest.” Oakley voiced their interest in addressing the issues of microaggression and fragility, but did not provide details.

Emery discussed at length the challenges inherent in commonly held White views on similarity and difference:

“In the US in particular, there's a tendency at a cultural level, particularly for Whites to focus on sameness at the expense of difference...I was with a [White leader] Saturday night. [He said] ‘I don't see skin color. I treat everybody the same.’ I said, ‘What you don't see as a White person is that you're telling that person as long as you fit in my world - you act White, think White, talk White, basically, be White - we're good.’ From an individualistic standpoint, lots of times for Whites, when they hear their colleagues of color talk about some of the struggles that they face because of simply the complexion of their skin...They hear it as a personal attack when it's not meant as a personal attack. It becomes personal, particularly when the White person continues to sort of protest and take it very personally...There's a tendency lots of times for Whites to not challenge and support other Whites. They're waiting for the

person on the team when something goes down a little bit iffy. They're looking for that one black person to say, "Was that offensive to you?"

Finley describes the challenge of White employees in workshops admitting their societal advantages relative to non-Whites: "I think it's the [idea of] unearned advantage that kind of is difficult for [White employees]. They often will go back to pointing out that, 'Well my ancestors came over ... [emigrated] from Europe with two dollars in their pocket and they worked hard and accomplished a lot'. Finley goes on to reflect on what she perceived as over-sensitivity on behalf of the White workshop attendees: "I remember when we're doing these talks and sometimes the organizer of the talks would come up to me and say, 'We're so glad you're here, but we just want you to kind of be a little gentle because we don't want to make people feel too guilty'.

The issues of sensitivity to issues of race, power, and privilege also connected, in the responses of participants, to the impact of contemporary social and political events on interpersonal issues of workplace inclusion. Participant responses regarding the societal and social context for their work ranged from the euphemistic ("the current climate" or "current political situation") to the more direct ("after the election, people were a bit freaked out") to the polemical ("the racist-in-chief... has encouraged racist and xenophobic hate [speech]") (Marques). Most participants discussed the negative consequences of the societal context. After the presidential election of 2016, Deandre's health system ran special educational sessions for groups that were concerned about being targeted, included "LGBT people wondering, 'is my same sex marriage going to be upheld?'" and hospital staff wondering if undocumented patients would need extra support. In 2016 and 2017, Lane reported

that his medical students had a “big” negative reaction (“they killed me in reviews”) to his usage of a real-life example of an unconscious patient in the ER who, as his doctors discovered after opening his shirt, had a large “racist tattoo” across his chest. Lane used this as an opportunity for students to explore their reactions, both cognitive and emotional, to the patient, and to question their own snap judgements about patient choices. While intended to be an exercise in empathy, checking bias, and humility, Lane decided to remove it from the curriculum because the content became such a distraction. Despite these negative experiences, some interviewees saw “a silver lining” to the current societal climate around race (Finley). Two participants felt that the increased exposure of racist incidents and policies resulted in more conversations about race (Finley and Marques). Emery felt that the country “retrenching on race” provided extra motivation to do the work of creating more diverse, inclusive workplaces as it served as an “anecdote” of sorts to the societal situation.

In contrast to those participants that reported significant challenges, Lonnie pointed to evidence at their institution that White involvement in workplace inclusion issues was not posing a challenge:

I am happy to tell you that the majority of persons who attend those events, those programs, are not minorities, but they are non-minorities or White individuals, persons of European descent...That critical mass of people doing the [health equity] work is way over represented by persons of European descent or White physicians, White practitioners, White investigators.

Because Lonnie saw strong participation from people with White racial identity, this bolstered his view that focusing on White engagement represented a well-intentioned, but

perhaps ill-advised “social re-engineering” project. Rather, they argued that workplace inclusion leaders were better advised to focus on the higher, common organizational goal of “economic security”. For, “once we begin to talk about the fact that patients we will be serving, communities we will be serving, will be very different demographically, that changes the whole [economic] model and causes many more people to be engaged, willfully, reluctantly, doesn't matter. That's the new business model going forward, everyone has to be involved” (Lonnie).

Psychological safety: build trust and avoid blame, shame, guilt

Seven participants described the importance of creating psychological safety for White people in workplace inclusion work. This safe space is created by facilitating dialogue “truly without blame, shame or guilt” and communicating that “isn't about White people are the enemy or if you're White, you're racist” (Francis, Sydney). Finley echoes, “The other thing that we really try to emphasize is that we need to have safe spaces to talk about race. Part of that has to be people have to be able to be vulnerable and say things out loud that are uncomfortable, and we have to show respect towards each other”. In order to reduce the sense of individual blame, Dionne points to the importance of “taking the individual burden off of people, to illustrate, we're in this societal milieu, where we've all been programmed with these implicit rules. And what we want to do is make those rules explicit.”

Positive development of identity, relationship, and ally behavior.

Seven participants discussed themes of positive identity development, positive relationship development, and helping White employees to be effective allies of the workplace inclusion agenda. To Zari, diversity and inclusion leadership must help people be authentic by “starting the conversation where people are in their appreciation and

understanding” because “people need a bridge”. Beyond awareness, Emery stresses that inclusive leadership development for Whites is also about a “set of competencies about how leaders lead across that continuum. That's where we work. What's the behavior and mindset that leaders need to have in order to lead effectively?” To Lane, positive relationships form a critical foundation for inclusion. This is accomplished by “facilitating the student's involvement in community health and community engagement...It allows us to support students coming together. We're bringing our talents we're bringing our passion to do something that's beyond ourselves... at the same time, it speaks to communities of color in terms of the services they're providing” (Lane). Quinn sums up a value proposition for building relationships across difference in pursuit of inclusion:

if you want to start a program, you want to start an effort, you want to reach out, to want to create a change. And there are some people who are extremely resistant to change most people are, and then there are individuals who say, ‘I don't get it, it's a change. I'm not necessarily comfortable with it. Let's talk about what it might be’. . . . And so by joining forces and coming together, you're helping what I'm thinking about what I'm trying to move forward, move forward. But by virtue of our working together and working with others, we may end up in a slightly different place, but I think it will be a better place.

Numerous participants discussed the importance of helping White people and others with social privilege to become effective allies or champions, to move from awareness to acting in active support of inclusion. To several participants, the foundational behaviors that indicated a White employee was engaged were “curiosity,” “willingness to engage in conversations,” “body language,” “listening,” and “being willing to understand the life

experience of” non-Whites (Lane; Finley; Zari; Dionne; Robin) . Sydney stressed the importance of champions starting with changing their thinking to “eliminate colorblindness as the default” view of race and ethnicity. Marques provides their rationale for developing allies: “most of the work that I do is around allies because just the way we're not going to solve gender equity if only women are working on it, we're not going to solve racial and ethnic group equity and inclusivity if we view it as a problem for underrepresented racial and ethnic group people.” Likewise, to Sydney, workplace inclusion strategies must “[teach people in the majority], whether it's White, whether it's cis gender, whether it's Christians, whoever your majority is, teaching them how to be effective champions for change”. Deandre’s view is that when those employees with more advantaged identities act as “sponsor[s],” “champions and allies,” it has the potential to really impact organizations... in terms of their culture.” Sydney also touches on the issue of creating cultural value: “the first step in being a champion is making sure the door's open. The second step in being a champion is making sure the people outside of the door are invited into the room. Once you have folks in the room, you want to offer them a seat at the table. Once they have a seat at the table, you want to make sure that their voice is heard. That last step is kind of the one where, in my experience, White people get into trouble” because they are not aware of how their habits of communication are a part of the dominant culture. As a result of lacking awareness of how White people recreate cultural domination through communication patterns, “[White employees] often not listening or leveraging [non-dominant] perspectives and voices in... decision making” (Sydney).

Robin also mentions the importance of “not just jumping in with the answer all the time,” although to them, the cognitive-behavioral aspect of White allyship is only one

element. Robin explained that two other critical elements were one, emotional - “to understand my own emotional triggers, to understand the emotional triggers of others and to be able to effectively have conversations about those emotions” - and two, “ontological” - “what's the filter that we're using to perceive what's going on and how does that filter guide what we see and what we react to?” The filter of race being the most salient for the interview topic, Robin used the example of “Black Lives Matter.” Black Lives Matter were words chosen by activists seeking to expose and end the current and historic overuse of deadly force by the police against African Americans. But, because of the typical White ontological filter, “most people actually don't understand why it's important to focus on race as a way to address some of the issues... It just feels like [‘Black Lives Matter’ replaces] one bigotry with another bigotry.” (Robin). This view stems from a lack of “understanding the long term negative impacts of racism and the need to do some correction or reparations to that” (Robin).

Participants were pleased to describe organizational allies that seemed to truly embrace diversity, equity, and inclusion. Beyond “sponsorship” and “allocating resources,” numerous participants felt very pleased when White leaders would “bring up these issues without a diversity officer in the room” (Jamie, Deandre, Oakley). For Jamie, a White leader at her organization demonstrated his commitment through repeatedly telling a personal story about a workshop demonstrating, in a real time exercise, how representational diversity at the team level results in higher performance. Likewise, Lane and Marques both lauded the ability of students with racial advantage to be “vulnerable” by sharing personal, authentic stories regarding the relevant topics of diversity and inclusion. Emery went further and described

their own efforts to show allyship by admitting they did not have answers and felt “confused” in the face of the work to creating more racial equity in the workplace.

In contrast to a focus on social and psychological dimensions of supporting inclusion strategies, Lonnie focuses on White engagement with the mission of health equity:

“I’m delighted to tell you that champions on this campus, people who have made a deep professional commitment to improve healthcare, have done so by targeting improvement for all... they’re saying, “If we are indeed promoting health and targeting healthcare, if we are to do our job wisely, effectively, we need to embrace everyone.”

Organizational strategies and interventions to support White engagement.

In response to my direct questions about engaging White people in workforce inclusion in healthcare, participants responded at the interpersonal level and the organizational level. At the organizational level, participants logged at least 25 mentions of organizational strategies. I have covered the most mentioned strategies here in two categories: strategic frame and communication and leadership strategies. Since there was significant overlap in mentions between the categories, I have not provided a table breaking down the specific category.

Strategic frame and communication.

Participants revealed their strategic frame, or central argument for pursuing diversity and inclusion in the workplace, either explicitly by directly addressing the issue, or implicitly through their word choices and their choice of subject matter. I divided the participants’ responses regarding this subject into three ‘cases’: the healthcare quality case, the business case, and the social justice or anti-racist case. In practical usage, these cases overlap and

numerous participants reported using several cases. Additionally, several participants were quick to point out, as Francis mentions, “the strategy should speak to all groups.” Therefore, there is significant overlap between participant responses that were specific to engaging White employees and those that were not.

Given the industry focus of this study, it is logical that the healthcare quality frame was prominent in at least eight participants’ responses. Healthcare quality involves increasing equity of care and lessening “gross disparities” such as “black patients get referred for cardiac testing at rates [far less] frequently as White patients do” and “black women’s mortality rate, in... child [birth] at four times [that of] White women (Francis, Dionne). Zari and Lane stressed the connection between educating clinicians in inclusive behaviors and increasing quality of care overall. Lane also discussed his mission to “claim ownership of [medical student] wellness” in order to train doctors who were capable of delivering compassionate care. Despite the immediate importance of increasing healthcare quality, for some participants, achieving health goals was dependent on stressing the strategic business reasons for diversity and inclusion work. Jo states, “I choose to approach this from a business perspective, as opposed to a social perspective.” and Lonnie’s view is that, despite the critical importance of addressing healthcare disparities, the business case has not been “stated loudly or often enough.” Lonnie later re-states their case, “One part of that greater good is the importance of health equity for all. Hard to argue with that. But an even more compelling, more pragmatic greater good is the business model must continue to be changed.”

Despite the importance of the business drivers and healthcare imperative for workplace inclusion, participants also recalled the fundamental issues of justice around the work. Robin commented that, just because bias is a universal human experience, “that doesn't

mean that I'm not very cognizant of the fact that from a societal standpoint systemically there's certain people as groups that have suffered more than others.” Dionne wants to reduce the sense that White people are being singled out by getting to

a clarifying moment where we talk about how we're talking about a system here, and it's a system that's been in place for hundreds of years... we're in this societal milieu, where we've all been programmed with these implicit rules. And what we want to do is make those rules explicit, so that we can all examine whether things are fairly distributed based on them or not, and then work towards making things fair and equitable so that we are a more just society.

Whether using the social justice case, the business case or the healthcare case, participants mentioned the importance of communication and messaging about their inclusion strategies. Deandre's comments on the subject are apt:

I think it's figuring out what is important to [people with multiple privileges], and how to package something in a way that people will hear beyond those layered identities. It's sort of audience management, if you will. Because I think that's a pretty critical piece, I've had to do a lot of thinking about, as we share information within our organization, how do I share this information with different subgroups? That might be education level... My message tends to be a little bit different with our provider groups versus our medical assistant groups. Medical assistants are going to skew younger in age, typically don't have the same level of formal education.

Provider groups, higher education, higher income, maybe a little bit further removed from the communities that we're serving. I think the messaging and packaging piece becomes really important to be able to speak to what's important to them, but weave

in sort of where the opportunities to start kind of redirecting and creating some new expectations that make sense to folks.

Oakley wanted to do a better job in communication with “dominant group” members “crunching the [recruitment] numbers we realize that we didn't do a good job with our attendance of White male students for example.” Emery also stressed the importance of finding out the ‘WIIFM’, or ‘what’s in it for me’: “what incentivizes you? What motivates you? How do you want to be seen?” Oakley also mentions WIIFM: “learning to the... what's in it for me kind of approach and understanding where folks are coming from, what leverage you need to think catalyze and it's going to be different for different folks and maybe the messaging a little bit different for different audiences.” Sydney and Robin mentioned another key principle of communication to engage Whites: defining terms. Both participants discussed the pitfalls of using terms like ‘diverse populations’, ‘inclusion’, and ‘minority’ without properly defining them in such a way as to avoid exclusionary language.

Leadership strategies

Communication would be just one aspect of the many leadership activities that participants mentioned in their responses. Participant discussions of leadership occurred throughout the interviews, but in particular to the questions directly asking about White engagement in workplace inclusion. Given that White individuals make up a majority of senior leaders in healthcare overall, many of the responses to these questions could be construed as referring to engaging White *leaders*, such as the c-suite positions, or White *employees overall*, whatever their level or function. Participants also discussed *their own* leadership strategies in carrying out a diversity and inclusion agenda that engaged White employees.

Six participants described the importance of organizational leaders, White and otherwise, incorporating workplace inclusion goals into the organizational strategy. This allowed the inclusion leader to “embed” their activities into other functions in order to reach various audiences, including White employees (Francis). Further, leaders spur action on the inclusion strategies by “[encouraging their] team to... align in support of those strategies” (Deandre). To at least three participants, this strategic commitment is best matched by a monetary one: “I think where the rubber meets the road is money. We have seen, I have seen commitment from our leadership. Essentially [we were] an office of one person before my arrival and we're now soon to be six folks” (Oakley). To Participants 4 and 15, these types of commitment are evidence that the leader, White or otherwise, had adopted values in alignment of an inclusive workplace. To Robin, another critical starting point is creating the vision and the ‘north star’: “What are we trying to create? What's the vision of the organization that we want to create? What does that look like? And I mean in detail.”

Another indicative behavior mentioned by at least five participants was setting real targets for diversity goals. Jo lauded the efforts of one organization “to tie diversity objectives to performance and to bonus so that your diversity objectives are a part of your bonus.” Likewise, Francis recommends “[tying] inclusion goals to individuals from a monetary standpoint and it's a performance-based thing. If we want to transform the organization, you write it into policies or procedures, you write it into performance and you assess behaviors”. Sydney describes the enormous leadership value of their (White) CEO’s leadership of diversity & inclusion:

[they] really set the tone and it is communicated and pushed down. So [they] are holding [their] executive teams accountable for creating diverse and inclusive

workspaces. That's being done through our internal policies and procedures, so that's kind of the system change that [they have] influence over... So since [they have] been in [their] role, we've seen a 71% increase in minority executives. They're doing the same thing with the board, which is kind of a tricky dance.

At least four participants addressed the leadership behavior of partnering with other White colleagues and middle managers to achieve inclusion outcomes. Jo, cognizant that “middle management can implode any project,” recommends that the “CEO lead a team of talented executives...including some really talented middle managers across the organization.” Harper, a mid-senior inclusion leader, was on the receiving end of this sort of attention from a C-suite leader who actively sought her counsel, which prompted the reflection, “To me, that's a really beautiful example of ways that White people can engage in this work. It's just reaching out.” After assembling their teams, Sydney saw success when the C-suite leader “[held their] executive teams accountable for creating diverse and inclusive workspaces.” In praise of similarly bold leadership, Deandre reported seeing model White leaders “pushing back on resistance in a way that people of color may not.” Deandre also was one of three participants to mention sponsorship as a critical White leadership activity. This was described in the form of workplace inclusion leaders sponsoring White participation in their diversity councils (Robin) and White leaders developing people of color leaders broadly in the organization (Deandre, Oakley).

Summary of Findings

Chapter 4 presents the findings from 16 interviews of leaders in healthcare delivery organizations and consultants from February to April, 2019. These leaders hailed from academic medical centers, non-academic health systems, community health systems, and

independent organizations. Demographically, based on my independent assessment and participant self-assessments of social identities, showed a relatively diverse cohort in terms of race, gender, class, and many other dimensions. This diversity was confirmed and enhanced by the participants' personal narratives of becoming a leader in healthcare workplace inclusion. With their own identities as a backdrop, the participants then explained their approaches to identity, commonality and difference. While most participants expressed the view that difference must be highlighted and managed, several participants advocated for downplaying difference in favor of the commonalities of organizational mission, professional training, or the human condition of bias. The participants then described their overall approaches to promoting workplace inclusion. These approaches were both interpersonal and organizational, and were highly heterogeneous. The interpersonal themes were the authentic, felt experience of inclusion, the importance of relationships and empathy, and the concept of belonging. Organizational themes included training, holistic and aligned strategies, using science and data, inclusion as a cultural project, diversity recruitment and retention, professional and general educational strategies, using goals and targets, and focusing on the business case for workplace inclusion activities.

When it came to the central subject of this study, the effective engagement of White people, I focused on three major sub-themes: the participants' reactions to my research topic, interpersonal issues surrounding White engagement, and organizational strategies. Nine participants expressed neither support nor concern for the research, four participants expressed support, and three participants expressed a concern or objection. Among the interpersonal issues of White engagement, participants commented on the exceptionality of Whiteness in specific and racial identity in general, perception of challenges in White

engagement, psychological safety, and development of positive identities, relationships, and White ally behaviors. At the organizational level, participants provided varying perspectives on how their framing and communication strategies might engage White employees in workplace inclusion. Specifically, participant responses reflected three cases: healthcare, business, and social justice. This Chapter concluded with participants' thoughts on which leadership activities, both by themselves and by senior organizational leaders, might result in effectively engaging White people in creating a more inclusive healthcare workplace.

CHAPTER 5

INTERPRETATION OF FINDINGS

“Here’s my new business case for diversity, equity and inclusion in healthcare: When we don’t get [it] right in our hospitals, in our clinics, in our coverage policies, and in our communities, people die.”

- Shamayne Braman, Director of Diversity and Inclusion at HealthPartners, 2018

“White people...have quite enough to do in learning how to accept and love themselves and each other, and when they have achieved this — which will not be tomorrow and may very well be never — the Negro problem will no longer exist, for it will no longer be needed.”

James Baldwin in *The Fire Next Time*, 1963

Introduction

Chapter 5 provides an interpretation of the findings from interviews with 16 healthcare leaders and consultants regarding the effective engagement of White people in workplace inclusion strategies. The first section of the chapter is an interpretation bounded by the concepts presented in Chapter 2, the Review of Literature. These bounded interpretations include the sub-topics of response to the research, interpersonal strategies for White engagement, and organizational strategies for White engagement. The second section presents conclusions, which include a summary of interpretations - key insights for practitioners - and a personal reflection.

Interpretation of Key Findings

This interpretation examines the key interview data in light of the concepts presented in Chapter 2, the Literature Review. I divide this section into four sub-sections: response to the research topic regarding the focus on Whiteness, response to the research topic regarding

diversity approach, interpersonal issues of engaging White people in workplace inclusion, and organizational strategies for promoting engagement of White people in workplace inclusion. At the close of each section, I suggest implications for practitioners.

Response to the Research Topic and Whiteness

Based on the research process and findings, there was significant support for the research topic among participants. I reached out to 23 people requesting a one-hour interview, with no enticement other than the participants' involvement with the research, and I received 17 affirmative responses, a 74% positive response rate. Sixteen of the 17 eventually scheduled and attended the interview with me. If there was significant opposition to the research project or how I framed it, it would be hard to discern from the ease of the recruitment process. Once the interviews were conducted, the findings showed that nine (9) neither expressed support nor objection for the research and four (4) of the participants expressed support. Therefore, 13 of the 16 participants did not express an objection or concern.

However, there were three participants who did express an objection or concern and these responses provide critical insights into the dynamics of diversity approach and race. Zari expressed that they were not "comfortable" with the title of the research specifying a 'White' racial designation: "I think that certainly these days we think more about ancestry as opposed to White and Black. So ancestry would be I think a better term because certainly, there's only one human race..." "Overall, this sentiment connects to work by Stevens (2008), Plaut (2011), and Apfelbaum (2016) that showed the critical importance of language in workplace inclusion.

Further, Zari's assertion that "these days we" do not use 'White' connotes a belief that using racial language is a thing of the past, at least in the realm of workplace inclusion. Lonnie's assertion that my use of 'White people' in the research topic was "inflammatory" also expresses this view. The idea that, in order to transcend racism, we need to remove 'White' from communications stands in contrast to the view of Critical Race Theorists, Whiteness scholars, and observers such as Coates (2015), who argue that not discussing race amounts to collusion with systemic racism (Frankenberg, 1993; Helms, 1995; Hooks, 1995). That Whiteness should not be discussed by Whites and non-Whites alike is a central tenet of institutionalized Whiteness (McIntosh, 1988; Helms, 1990; Painter, 2011; Lipsitz, 2018). As described in Chapter 2, 'White' communicates a social process and social position of an individual relative to the current and historic economic, legal, and political domination of non-White people, otherwise known as White Supremacy. This system of White domination was intentionally developed and fostered by particular White people who stood to benefit from it (Painter, 2011; Coates, 2015). Indeed, the very existence of diversity, equity, and inclusion work in healthcare owes its existence, in part, to the gross, persistent health disparities, and disparities in care received, between White and non-White individuals. (Lipsitz, 2018).

But the concerns and objections expressed by three participants make a distinction between strategic work to address disparities wrought by racism and using the language of race. Zari's preferred 'European American' seeks to remove the Whiteness from those individuals, who by accident of their skin color and other phenotype characteristics, are proffered with White privilege. Zari would likely agree with Lonnie when they argue that, in

order to transcend race, workplace inclusion leaders should remove, or at least “mute” racial designation:

... the whole point of the existence of diversity and inclusion initiatives is to mute, M-U-T-E, the significance of the self-assignment of race or ethnicity... As long as we continue to articulate race as a descriptor of those that are participating in improvement and quite frankly those that are targeted, we continue to end up with somewhat polarizing views...

Therefore, Zari nor Lonnie would not likely connect their concern with using the word ‘White’ with colluding with the system of White domination. However, their objection can reasonably be associated with the contemporary societal preference for keeping Whiteness, and White Supremacy, hidden from view. To these participants, avoiding the White racial designation in language, if not in dealing with racism-related issues, amounts to a practical choice to avoid inflaming racial tensions at the expense of their strategic goals. I imagine that, in a debate with Critical Race Theory scholars, these senior healthcare leaders might argue,

“OK, we understand, probably as well as anyone, how removing or softening racial designations might work to reinforce old patterns of discrimination. But we are tasked with an organizational project that strategically attacks sources of racial discrimination in the health system. In this context, what use is there to using ‘White’ or to calling attention to race if it will compromise the entire project? Further, if our interest is in engaging White people with diversity and inclusion work, why would we use a concept that is more likely to drive White people away than attract them?”

For, the healthcare insiders might claim, as Lonnie writes in his follow up email to me, “In nearly every public discourse, once race enters the discussion, all progress stops and acrimony begins (March 4, 2019)”.

In response, White privilege scholar DiAngelo might quote her work that demonstrated how ignoring Whiteness “reproduces the comfortable illusion that race and its problems are what “they” have, not us [White people] through coded language (1988, p. 55)”. Further, DiAngelo might argue, when trainers allow White privilege to ‘[remain] unnamed and explicitly denied’ in diversity education, this reinforces the very dynamics that create the need for such training (p. 64).

Response to Research Topic and Diversity Approach

Besides the issue of racial language, the support for, and the three objections or concerns with, the research topic speaks to a fundamental difference in diversity approach. Here I use Apfelbaum’s definition of diversity approach, which is ‘how diversity and social group differences are discussed’ in organizational and leadership communication (2016, p. 547). Diversity approach can be seen as an extension of Plaut’s work on diversity models, which are an organizing principles that guide how diversity strategies are presented and messaged (2011). Plaut’s work, in part conducted in a large healthcare context, compares the impact of the approaches ‘colorblindness,’ ‘multiculturalism,’ and ‘all-inclusive multiculturalism’ (AIM) on feelings of exclusion and likelihood of endorsing the diversity platform (2011). Apfelbaum’s work uses a series of experiments wherein subjects are given challenging work-like tasks after being exposed to the ‘value in equality’ and ‘value in difference’ approaches to diversity (2016). Taken together, Apfelbaum’s and Plaut’s work supports the idea that White employees, even when considering the overlay of gender,

interpret and process messaging about diversity differently from non-Whites. Further, these works support the ideas that diversity approaches trigger feelings of exclusion or inclusion, result in lower or higher endorsement of diversity and inclusion efforts, and negatively or positively affects performance of White employees. Apfelbaum's work also supports the hypothesis that the organizational context of perceived 'numerical inferiority' is a mediating influence the impact of diversity approach. Plaut and Apfelbaum's work implies that, in order to engage White employees in diversity and inclusion strategies, diversity approaches should use language that is all-inclusive of racial and ethnic background, includes a 'value in difference' approach (in addition to 'value in equality'), and is calibrated to the organizational context, particularly in regards to 'stereotype threat' levels relating to numerical representation of each group.

While the current study did not measure the effectiveness of various diversity approaches, the diversity approach construct is helpful in understanding the contrast between the support and concerns or objections expressed by the participants regarding the topic of White engagement. Quinn's concern with the primary research question, "I don't think [the work] is what White people do versus Asian people do or Black people do," is exemplary of a contrast in diversity approach as shown by Apfelbaum's (2016) research. Apfelbaum shows how a 'value in difference' approach is generally preferred by dominant group members (e.g. White men) because our representation concerns are low and the value in equality approach is preferred by non-dominant groups. I, a White man, developed a research topic that reflects a value in difference approach in that it explicitly calls out the need to value and manage the engagement of employees with White racial identity. Lonnie and Quinn, both non-White senior leaders in majority White organizations, signal that they prefer a value in equality

approach. As Lonnie comments, their preference is that communications intended to promote inclusion stress the “greater good in having [diversity and inclusion] efforts, that is what appeals to everyone....No one is going to lose their identity being engaged in diversity and inclusion, but everyone will seek what constitutes real value.”

To Lonnie, “real value” is the business case for diversity and inclusion in healthcare. To the extent that the business case is in conflict with the goal of racial justice, this connects to the work of Mease (2016) regarding the ongoing ‘discursive’ conflict between the goals of ‘social justice,’ which include ending race-based oppression writ large, and goals of organizational performance. Thus, while advocates of the social justice case for workplace inclusion may prefer directly addressing Whiteness in order to reduce its pervasive, if unintentional, cultural impact, leaders such as Zari, Lonnie, and Quinn might prefer to assiduously avoid using racial language that implicitly link White employees to ongoing racial inequity in order to achieve, or at least not subvert, their strategic goals.

Interpersonal Aspects of White Engagement in Workplace Inclusion

The interview responses regarding interpersonal aspects of White engagement dealt with the exceptionality of White employees in relation to workplace inclusion, challenge or lack of challenge of White engagement, psychological safety, and positive development of identity, relationship, and White allyship. Here I review each interpersonal issue in turn, considering how they relate to the ideas presented in the Literature Review.

Exceptionality of White employees’ engagement in workplace inclusion.

Save for three responses to the contrary, a majority of participants generally supported the idea of White employees being exceptional in how they needed to be managed. This exceptionality included opportunities such as Whites’ ability to “establish cultural

norms” and outsized “potential to really impact the organization,” “whether they know it or not” (Emery and Deandre).

These interview results regarding the exceptionality of engaging White people in workplace inclusion demonstrated numerous theoretical concepts from the Literature Review. Both the work of management-oriented scholars Plaut and Apfelbaum and the Critical Race Theory and Whiteness scholars such as Helms, DiAngelo, and Spanierman support the overall notion that employees with White racial identity, due to their position in the dominant racial hierarchy, are exceptional in relationship to workplace inclusion strategies.

Challenge or lack of challenge of White engagement.

Seven participants also described White exceptionality in terms of particular challenges to realizing the benefits of their outsized influence. Six participants mentioned White employees feeling, or acting as though they felt, excluded from workplace inclusion activities. The reasons provided for exclusion were “the diversity conversation was aimed at White people [in a negative way],” exclusionary language such as using “diverse” to mean non-White, and a lack of connection between workplace inclusion efforts and Whites’ “vested self-interest” (Robin, Emery, and Oakley). Participants mentioned the challenges of “having to be gentle” with Whites (Finley), Whites taking the existence of racism as a personal attack (Emery) and White disbelief in their societal advantage, regardless of gender or class status (Emery, Dionne and Finley). Not insignificantly, numerous participants noticed that these challenges were heightened by the current political and social “climate” since the 2016 presidential election. In contrast to other participants’ experience of

challenges, Lonnie “was pleased to report” and “delighted” that White engagement in diversity, equity, and inclusion work was strong in diversity-related programs and activities.

The findings in regards to challenge or lack of challenge to engaging Whites in workplace inclusion correspond to numerous theories described in Chapter 2. Whites’ perception of exclusion from inclusion strategies corroborates Plaut (2011)’s finding that White employees in a large healthcare organization were significantly more likely to associate the legacy conception of multiculturalism with exclusion. This finding was directly corroborated by numerous independent studies (Shelton, 2013; Witt/Keifer, 2017) and work by Aysola (2018) in her narrative study of workplace inclusion in an academic medical center: some Whites reported feeling excluded from diversity and inclusion efforts.²⁷

McIntosh’s work on White privilege and DiAngelo’s work on White fragility (see also Sue 2010) connects with numerous challenges mentioned by participants of the current study, principally Whites disbelieving societal advantage and having heightened sensitivity to race-related topics. To these scholars, the White beliefs and behaviors that challenge workplace inclusion mentioned by participants follow from an interpersonal agenda, however unconsciously it is carried out, of avoiding personal responsibility for engaging in new behaviors that expose racial inequity, reduce White privilege, and support people of color’s leadership. Helms (1990) model of positive White identity also provides a useful perspective on the challenges of White engagement as fundamentally developmental behaviors,

²⁷ In the White Men’s Leading Through Diversity & Inclusion (WMLTDI) Study, a cross-industry study of 670 corporate leaders from 2012, 70% of White men and 60% of women and non-Whites were ‘not clear’ if diversity and inclusion work were intended for White men (Shelton 2013). The consulting firm Diversity Best Practices explained this phenomenon as ‘an unintended outcome of framing D&I’ as targeted to historically disadvantaged groups ‘is that the dominant employee group, white males, are often left out of the equation and therefore significantly less engaged in D&I efforts than their underrepresented colleagues’ (2013, p1).

something like the path to adulthood. The Helms model attributes these challenges to the emotionally rocky journey from ignorance of Whiteness through cognitive dissonance ultimately to a non-racist White identity. For example, when Zari and Dionne reported that some White workshop attendees denied the existence of white privilege, Helms would locate this behavior in the early ‘disintegration’ phase, when Whites are prone to ‘selectively attend to only the information that gives him or her greater confidence’ (1990, p. 59). Since Lonnie did not report these challenging behaviors, Whiteness scholars might surmise that Lonnie has found a strategic formula to counter the vagaries of White privilege in the workplace inclusion arena. Or, as pertaining to the Helms model, perhaps there is a critical mass of White colleagues of Lonnie who have progressed to the ‘immersion’ or ‘autonomy’ phases of positive White identity development.

Schein’s (2016) work on culture change also provides insight into the participant responses regarding the challenges of engaging Whites in healthcare inclusion strategies. The behaviors that Schein cites, such as denial, avoidance, and open resistance, can be seen as typically human responses to numerous fears that are triggered by any major change project, let alone one dealing with issues of diversity and inclusion. In Table 16 below, in an enhancement of Table 5 from the Literature Review, I list the fears sparked by learning from Schein (2016) with examples from diversity and inclusion work in a healthcare workplace setting. While participants may not have mentioned these fears verbatim, numerous participants, including Lonnie, Robin, Emery, and Francis address the overall issue of fear as a driver of challenging behavior.

Table 16: Schein's (2016) list of fears associated with learning anxiety during organizational change, with examples from healthcare diversity and inclusion (D&I) work

Fear	Description	Example from D&I work
Fear of loss of power or position	New learning may mean loss of status or power	Division chief learning a new interviewing process that is more bias-proof means she can hire fewer acquaintances within her social circle, meaning that her personal influence is diminished
Fear of temporary incompetence	Giving up old ways of doing things means giving up expertise; we know we will have to do things that we have not mastered yet	Chief Medical Officer is afraid of appearing incompetent as he learns to not interrupt women colleagues during senior leadership meetings
Fear of punishment for incompetence	If learning period results in mistakes or too long a duration, we fear productivity may be harmed, resulting in reprisal by management	Emergency department IT Manager fears that they will be sanctioned by management for slower response times due to incorporating a new, more inclusive structure for team meetings
Fear of loss of personal identity	If new learning requires us to take on a new way of being, we may not want be 'that kind of person'	Vice Chair of Curriculum for medical school sees that development of a new, more inclusive curriculum requires a deep appreciation for social issues that find politically unpalatable
Fear of loss of group membership	If new learning challenges shared assumptions of their group culture, changing those assumptions also may result in, or appear to result in, separation from the group	Medical technicians learning to speak up as active bystanders for elder patients fear that this will change how they are viewed by other technicians, who value 'keeping their head down' and 'focusing on the task at hand'

Psychological safety.

To mitigate the potential interpersonal challenges of White engagement, numerous (7) participants describe the importance of establishing psychological safety in workplace inclusion strategies and interventions. These spaces were to be free of “blame, shame, or guilt,” avoid sending the message that “White people are the enemy,” enabling employees to “be vulnerable” (Sydney, Francis, and Finley).

The theme of psychological safety in the interviews is addressed directly in chapter 2 as a key orienting theory for understanding White engagement in workplace inclusion.²⁸ Per Edmondson (2002) and Hackman and Lorsch (1987), creating psychological safety is particularly important for developing trusting relationships and learning new skills, two essential competencies associated with increasing a more inclusive workplace. In their responses, the participants also demonstrated understanding of the dark side of psychological safety in the workplace. That is, when fear is dominant, this sparks behaviors such as disengagement and resistance intended to shield employees from danger, both real and emotional (Kidder et al, 2004; Dollard and Bakker, 2010; Ross, 2018). As described above, Schein also discusses management of psychological safety at length in his recommendations for leading culture changes.

Positive development of identity, relationship, and White allyship.

Participant comments regarding White employees developing a positive identity, positive relationships, and effective interpersonal strategies for being an ally to workplace inclusion. To help employees reach these positive states, the senior leaders and consultants giving Whites a “bridge” or “[meeting] them where they are” to develop their own

²⁸ The 2012 WMLTDI Study calls out psychological safety as the number 1 finding: ‘There are safety concerns’ (Shelton, 2013, p. 6).

“appreciation and understanding” of inclusion issues and their relationship to them (Emery and Zari). Participants reported facilitating White employees or students to build “a set of competencies” for leading across boundaries and “bring [their] talents together” and “join forces” in service of “something beyond [themselves]” (Sydney, Emery, Lane, and Quinn). For those White employees seeking to move beyond the base level of involvement with workplace inclusion, participants described the desired behaviors of champions or allies. These ally behaviors ranged from “curiosity” and “[positive] body language” to “being willing to understand the life experience [of people of color] and “eliminating colorblindness” from their view of race and ethnicity (Lane, Finley, Zari, Dionne, Robin). Participants observed ally behavior when White leaders would “bring up these issues without a diversity officer in the room” (Jamie, Deandre, Oakley), showing vulnerability by telling personal stories of inclusion (Marques, Lane, Sydney), and embracing the notion that “if we do our job [as healthcare providers] wisely, effectively, [then] we need to embrace everyone” (Lonnie). Finally, Zari and Robin stressed that ally-like behaviors were part and parcel of White leaders actively embracing, respectively, a value system and ontology that supports greater inclusion in the workplace.

Whether participants focused on deeper psychological alignment or outward behaviors, their responses demonstrate numerous aspects of the scholarly work on positive identity development outlined in the Literature Review. As described by Dutton (2010), Wrzesniewski and Dutton (2001) and colleagues, an essential aspect of inclusive cultures is that they enable employees to achieve positive attributes such as goodness and worthiness. Participants 3’s and 4’s descriptions of allowing White employees, wherever “they are at”, to engage authentically with the work is a good example of enabling positive identity

development. Just as scholars theorize that positive identities enable the development of positive relationships, Lane, Deandre, and Lonnie all discuss how their inclusion strategies provide employees to build relationships across difference based upon achieving the higher goals of health equity and community engagement. Critically, as Ely and Roberts (2008) show, these project-based learning opportunities encourage transcendence of stereotypes while delivering lessons to participants in ‘simultaneity’ (intersectionality of social identities), intra-group relations, and diversity as an asset (p.176). Or, as Stevens and Plaut (2008) put it, positive relationships allow workers to ‘move beyond surface-level tactics to actively incorporate diversity into their work lives’ (p. 124). Given the alignment between positive identity development and inclusive behaviors, it is worth considering whether interventions that focus on the identification of difference, privilege and power are compatible with the positive organization model. The PRCE at Henry Ford Health System as described in Chapter 2 would be one such intervention (Holm et al, 2017).

In the realm of engaging White employees in workforce inclusion, the development of positive identities and relationships can be seen as synonymous with development a White ally identity. Helms’ (1995) non-racist White identity model provides a foundational perspective on White allyship as a developmental process. Within Helms’ framework, the instances of defensiveness and sensitivity mentioned by participants and cited by McIntosh (1988) and DiAngelo (2011) can be viewed not as permanent conditions of Whiteness but as early stages in a well-understood psychological process: the breaking down old identities and cognitive-behavioral patterns and the building up of new ones.

White allyship, as in definitions by Tatum (2007) and Spanierman (2017), is an aspirational construct that involves a White individual who transcends racism by

‘understanding that it is possible to use one’s privilege to create more equitable systems,’ continually self-reflects on their own position vis-a-vis racism, and engages in actions that disrupt racism and support the leadership of people of color (Spanierman and Smith, 2017, p. 608 - 609). In their citations of behavior such as sponsoring leadership of people of color (Deandre), speaking up for workplace inclusion in the absence of a diversity and inclusion leader (Oakley), and actively reaching out to hear and incorporate the perspective of people of color (Harper), the interviewees provided some evidence of ally-like behaviors at their institutions.

Organizational Strategies for Engagement of White People in Workplace Inclusion

In addition to the interpersonal aspects of the research topic, the interviewees provide valuable insights into organizational strategies that they believe promote workplace inclusion, including the engagement of White employees in the work. In Chapter 4 - Findings, I divided the organizational strategies into two categories - strategic frame and leadership activities. Here I explore the implications of each by reviewing the categories in turn and how they relate to the ideas presented in Chapter 2, Literature Review.

Beyond diversity approach: strategic frame.

The participants’ strategic frame for promoting workplace inclusion was influential in how they approached the question of effective engagement of White employees. I define strategic frame as the central argument for pursuing greater inclusion in the workplace. The interviewees revealed their frames either explicitly by directly addressing the issue or implicitly through their choices of words and subjects. I divide the participants’ comments into three major strategic frames: the healthcare quality case, the business case, and the social justice case. In practical usage, the frames overlap and participants use numerous frames.

Additionally, several participants clarified that their approach was meant to “speak to all groups” (Francis) rather than just White colleagues.

When thinking about effective engagement of Whites in workplace inclusion, participants discussed two dimensions healthcare quality: one, in terms of promoting health equity and lessening disparities and two, in terms of professional medical training to ensure equitable care. Regarding overall health equity, at least eight participants explicitly used this mission-driven argument to appeal to White employees. Participants mentioned “gross” health disparities such as “Black patients get referred for cardiac testing at rates [far less] frequently [than] Whites” (Francis) and “black women’s mortality rates in... [childbirth] at four times that of White women” (Dionne). Others, particularly Zari and Lane, focused their comments on embedding the inclusion agenda into clinical training to promote healthcare quality. Despite the clear necessity to communicate the healthcare quality case, at least two participants professed an overall allegiance to the business case for engaging Whites, and particularly White senior leaders, in the inclusion agenda. Lonnie summed up this sentiment: “One part of that greater good [of diversity and inclusion work] is the importance of health equity for all. Hard to argue with that. But an even more compelling, more pragmatic greater good is [that] the business model must continue to be changed.” While the business case and healthcare case appeal to organizational and professional priorities, participants’ adherence to the social justice case was apparent in their choice of words and subject matter. Examples include, “there’s certain people as groups that have suffered more than others (Robin)” and “a system that’s been in place for hundreds of years... with implicit rules (Dionne)”.

This debate over how to strategically frame workplace inclusion to engage White people was given scant attention in the Literature Review. However, Mease’s (2016) work on

the ‘discursive conflict’ for diversity consultants is directly applicable. Mease identifies the divergent goals of social justice, which include ending race-based oppression, and the goals of organizational performance, which are financial and operational - defined within the walls of the institution. These divergent goals are evident in the participant responses regarding the effective engagement of White employees. On one hand, the more social-justice oriented participants may prefer, or even insist, upon directly addressing Whiteness in order to reduce its largely hidden but pervasive impact on organizational cultures. On the other hand, the participants favoring the business and healthcare quality cases expressed a preference for addressing racial politics obliquely. While Mease does not propose a specific answer to this ‘conflict’, her recommendation for effective management of it involves identifying common goals and ‘both - and’ strategies that fulfill social justice and organizational priorities.

Plaut and Apfelbaum’s work on diversity models and diversity approaches is adjacent to the debate around strategic frames. While Plaut and Apfelbaum’s work dealt with “how diversity and social group differences are discussed” (Apfelbaum, 2016, 547), the three strategic frames explicated by participants operate at a more strategic level. Plaut and Apfelbaum’s audience is primarily designers of communication strategy for diversity and inclusion whereas the participants’ strategic frames address a C-suite audience. Plaut and Apfelbaum dealt with the “how” of diversity approach while many of the senior healthcare and consulting leaders were focused on the “why” of workplace inclusion. Nevertheless, both levels of inquiry apply to the project of engaging White people in that they represent choices that workplace inclusion leaders must make regarding explanation of both the “why” and the “how” of their work to various audiences.

Leadership activities as leading organizational change.

The interviews of 16 organizational leaders and consultants resulted in rich data regarding effective leadership activities in the management of workplace inclusion. My questions regarding engaging White individuals elicited responses that referred to engaging White leaders or White employees, whatever their level or function. Participants also discussed their own leadership activities. Chief among these activities was embedding workplace inclusion into the larger strategy of the organization and matching the strategic commitment with financial backing. These activities signal evidence that a leader is aligned with the values and overall perspective of the diversity and inclusion functional leader. Aligning values is just a starting point for creating a shared vision that resonates with the key stakeholders, particularly White leaders who may not fully grasp their vested interest in diversity and inclusion strategies. Participants stressed the importance of pushing action down through the organization by encouraging their teams to align. There were numerous participant citations of the beneficial effects of senior leaders tying diversity objectives to performance and to financial outcomes, as well as writing inclusion-friendly policies and procedures. Beyond these operational activities, numerous participants mentioned the use of relationship-building as critical for winning White engagement. This relationship-building could be partnering with colleagues, sponsoring the leadership of people of color, or actively recruiting the perspectives of White middle-managers on the diversity leadership committee. Participants saw effective White leaders use these relationships to establish accountability push back on resistance. The leaders' relationships enabled another key activity in the workplace inclusion project: strategic communications. Participants commented on the need

to tailor specific messages for organizational groups, including those with White majorities and avoiding language that may be exclusionary.

When considered as a whole, the findings on leadership activities support the overall contention that promoting workplace inclusion in healthcare cannot be confined to a particular functional area. Rather, creating a more inclusive workplace is an organizational change project involving both cultural and technical aspects, of which engaging White leaders and employees is one part. Therefore, as described in the Literature Review, the change management model of Hiatt and Creasey (2012) and the work of Schein (2016) on culture change are apt for better understanding the leadership activities of workplace inclusion.

As described in the review of literature, change management experts Hiatt and Creasey (2012) lead research and training at ProSCI, an independent, science-driven organization dedicated to the practice of change management. The last six ProSCI longitudinal studies on the best practices in change management (2018, 2016, 2014, 2012, 2010, 2008), have found that the existence of a highly engaged executive sponsors is the number one predictor of successful organizational change (Creasey and Hiatt, 2019). In the interviews, there were numerous mentions that relate to executive sponsorship in the current study. Sydney's comments about their CEO are exemplary:

[they] really set the tone and it is communicated and pushed down. So [they] are holding [their] executive teams accountable for creating diverse and inclusive workspaces. That's being done through our internal policies and procedures, so that's kind of the system change that [they have] influence over... So since [they have] been

in [their] role, we've seen a 71% increase in minority executives. They're doing the same thing with the board, which is kind of a tricky dance.

Participants also discussed roles of executive sponsors that mirror Hiatt and Creasey's (2012) guidance that sponsors must authorize the change, build coalitions to rally support and mitigate resistance to the change, and communicate directly about the change (p. 12).

Examples included senior leaders "embedding" or "mainstreaming" workplace inclusion into the larger strategy of the organization (Francis; Zari) and matching the strategic commitment with "dollars" and "financial sponsorship" (Oakley; Lonnie). Robin, echoing Hiatt and Creasey, argue that change leaders can directly impact employees' awareness of the need to change by communicating "the vision of the [more inclusive] organization that we want to create.... And I mean in detail." Harper and Quinn underline the benefits of building relationships throughout the organization, which echoes the ProSCI recommendation that effective executive sponsors must build coalitions. In the case of creating a more inclusive workplace, building coalitions across boundaries of positional power, function, and social identity are key. Participants reported strong leaders as using these relationships to establish "accountability" (Sydney) and even "push back on resistance in a way that people of color may not" (Deandre).

Beyond sponsorship, another critical part of the ProSCI change management playbook is strategic communication and understanding the dynamics of "senders and receivers" (Hiatt and Creasey, 2012). Numerous participants reported striving to connect with audiences, the receivers of information) with divergent goals, places in the hierarchy, and professional training. Deandre discusses their efforts to understand their receivers: "my message tends to be different with provider groups versus our medical assistant groups... [I

want] the messaging and packaging... to be able to speak to what's important to them." At least four others mention the importance of leaders to master art of finding the WIIFM ('what's in it for me?') of different audiences. Just as the participants described the importance of knowing their various audiences, including White employees, and tailoring messages to suit them, so too do Hiatt and Creasey recommend knowing the WIIFM of all major functions involved in a change. In the case of messaging for majority White groups, this might include knowing how, as Emery says, those with White racial identity can grasp their "vested self-interest" in creating a more inclusive workplace.

Schein's work on leadership of organizational culture change also provides a helpful lens for viewing the participants' comments regarding leadership activities for promoting workplace inclusion. In his recommendations for change leaders, Schein's (2016, pps. 328 - 385) cites numerous activities that were directly mentioned by participants during the interviews:

- Providing a compelling vision for the change (Robin)
- Providing formal training around activities associated with the change (Oakley)
- Involve the learner in managing their own informal learning (Lane)
- Train relevant "family" groups and teams (Deandre)
- Removing barriers and building new support systems and structures (Francis)
- Redefining concepts to help new beliefs and values take hold (Quinn)
- The change goal being defined concretely (Lonnie)
- Developing new standards of evaluation (Jamie)

These include steps associated with creating both psychological safety and organizational mechanisms to shepherd the organization through culture change. Participants

also reported their appreciation of leaders modelling the changes desired in the workplace inclusion culture (Sydney, Harper). In sum, Schein's approach to leading culture change lends support to the findings regarding leadership activities that promote workplace inclusion in general and engagement of White employees in specific.

Conclusions

In this capstone paper, I have explored the topic of effective engagement of White employees in healthcare workplace inclusion from multiple perspectives. In some ways, my use of an interdisciplinary approach reflects the core learning goal of the Organizational Dynamics program at the University of Pennsylvania. In my January 2016 foundations class, Professor Janet Greco demonstrated this perspective-taking ability by taking out a Ziploc bag of eyeglasses – some big, some small, some tinted brown, some green, some clear. In turn, Dr. Greco put each pair of glasses on to demonstrating how the various 'lenses' on organizational life change one's view of reality. Her lesson was that Organizational Dynamics practitioners needed to understand and be facile with numerous conceptual lenses in order to help leaders arrive at better conclusions, get unstuck, innovate, and grow. In this study, I also used many lenses. There was the personal (researcher) lens, the healthcare lens, the historic lens, the academic lens, and the practitioner lens. I examined the interpersonal and organizational perspectives. I probed the subject in terms of the value of appreciating difference and that of uniting behind common goals. There were many more perspectives – too many to name!

However important the value of this exploration, the reader may be wondering what to do with all these perspectives. Therefore, the final question that I will answer is, "So what?" While my answer will not be a prescription to the reader, I will offer a few

suggestions. In conclusion to this chapter and to the capstone project, I have summarized the implications of the results and synthesized them to produce four key insights for practitioners. Following that, I provide a narrative description of a personal realization regarding the limits of good intentions in creating a diverse and inclusive research project.

Summary of Implications: Key Insights for Practitioners

In this study of effective engagement of White employees in healthcare inclusion strategies, I conducted a review of academic literature, interviewed 16 practitioners assembled and analyzed the results, and interpreted the results through the lenses of the reviewed literature. The interpretation of findings have resulted in four key insights for practitioners. Each insight is followed by suggested actions for practitioners. Also in this section, I cite non-academic but reputable sources of knowledge regarding engaging Whites in diversity and inclusion work.²⁹

Insight #1.

While the subjects of racism, Whiteness, and White Supremacy are highly relevant to the project of workplace inclusion in healthcare, there is disagreement among practitioners on whether, and how, to discuss these issues directly. These disagreements somewhat correspond to differences in participants' 'insider' and 'outsider' status and racial identity.

Some participants, especially high-level, established leaders in academic medical centers with non-White racial identities, see far more costs than benefits to directly addressing these issues. Other participants, particularly either consultants or mid-upper tier leaders with White and non-White identities, were either neutral or saw more benefits than costs to directly addressing racism, Whiteness, and White Supremacy. However, the

²⁹ For non-academic studies of engagement of White people in workforce inclusion, see Shelton (2013), Diversity Best Practices (2013), Witt/Keifer (2015), and White Men as Full Diversity Partners (2018).

mediating influences of insider and outsider status and racial identity on participant views were not consistent.

Therefore, my suggestion is that both ‘insiders’ (practitioners employed at healthcare organizations) and ‘outsiders’ (consultants) of both White and non-White racial identities continue the dialogue regarding the best ways to approach these issues with the goal of establishing common ground and common practices. Next steps may be

- conducting a national quantitative survey of both insiders and outsiders on their approaches to racism, Whiteness, and White Supremacy
- facilitating both intra-group and inter-group dialogue on this topic at industry and academic conferences

Insight #2.

The optimal mode of diversity approach (how diversity is discussed) for Whites and non-Whites varies based on a complex combination of factors, particularly the various groups’ perceived ‘stereotype threat’ based upon numerical representation in the organization and their intersectional identities relative to the White male power structure.

As many participants reported, either explicitly or implicitly, their communication strategies must, at least most of the time, speak to employees with one voice. However, the research on diversity approach shows that word choice and frequency matter in how Whites and non-Whites respond. But these preferences are not entirely reliable and shift based upon each group’s dynamic perceptions of relative power and influence. The dynamic nature of perceptions of power are particularly important given the United States’ epic demographic shift from a White majority to a non-White majority.

Therefore, I suggest that participants:

- Assess the relative numerical representation of each major social identity group at their organization and sub-units; survey the groups to clarify their levels of ‘representation-based concerns,’ otherwise known as ‘stereotype threat.’
- Generally, use a ‘both-and’ approach to messaging - incorporating both a ‘value in equality’ message and a ‘value in difference’ message. Below are definitions of each.
 - Value in Equality: ‘A value in equality approach affirms that group membership will not be an obstacle to career opportunities and advancement, and that all employees are judged equally and fairly based on their skills, qualifications, and effort’ (Apfelbaum 2016, p. 2).
 - Value in Difference: ‘A value in difference approach advocates for the importance of creating a workplace environment that appreciates (and is inclusive of) social group differences’ (Apfelbaum 2016, p. 2).

Insight #3.

Because there are particular patterns of beliefs, emotions, and behavior associated with the White encounter with inclusion initiatives, and given this group’s current outsized influence in the healthcare workplace, gaining a better understanding of how to support positive, non-racist White identity development would be a worthy investment of resources.

This insight is derived from what participants discussed and what they did not discuss. While several participants did discuss an awareness of supporting White engagement, many did not. While some expressed an understanding of the particular psycho-

social challenges involved with the White encounter with workplace inclusion, many did not. Of those that did understand the challenges, very few participants conceived of the challenges as stages in a developmental process for Whites grappling with their social identity. While some expressed an awareness of the developmental process, most participants' comments did not reflect a sophisticated understanding of non-racist White identity development or allyship. Participants did report deployment of effective strategies for inter-group engagement in mission-driven practicum projects in health equity and community health. However, they did not report providing White employees with an intra-group opportunities to develop non-racist identities and build positive relationships.

Therefore, my suggestion is that practitioners partner with experts on White ally development to better understand the issues and promising strategies for fostering positive, non-racist White identity in a workplace setting. These strategies may include

- Working with senior leaders to infuse a positive identity development model into all leadership development activities
- Working with senior leaders to embed best practices for positive identity development into middle managers' training
- Provide opportunities for inter-group relationship building through
 - mission-driven activities that brings together White and non-White groups
 - facilitated workshops providing opportunities to appreciate both commonality and difference (see Creary, 2019)
- Provide opportunities for intra-group relationship building for White employees, including
 - White ally groups can be organized internally or externally

- Education about a developmental model for becoming an effective ally; use positive role models, make available numerous, concrete examples of effective White ally behavior, and present the likely challenges along the way, both personally and interpersonally.
- Provide ‘practice fields’ and coaching by expert facilitators³⁰

Insight #4.

Framing workplace inclusion work as an organizational culture change project has strong potential to assist practitioners in creating a winning strategy, and in effectively engaging White leaders and employees as a part of that strategy. In particular, this frame could be helpful for inclusion leaders seeking to help White employees feel included the work.

This insight is derived from the many connections between the participants’ descriptions of their work and well-established models of organizational culture change. Some participants appeared to make this connection to culture change, grasp its significance, and understand its implications. The concept of organizational culture change provides clear direction to leaders’ management of interpersonal dynamics, such as psychological safety, and organizational dynamics, such as executive sponsorship. Additionally, thinking of workplace inclusion as culture change captures the inherent difficulties and dangers of intentionally seeking to alter the shared assumptions of various work subcultures. White employees represent one such subculture and, whether it is visible to them or not, their shared assumptions align with the dominant work culture at most healthcare organizations.

³⁰ The consulting firm White Men as Full Diversity Partners (2018) (WMFDP) provides one model for holistic leadership development for White men’s engagement in diversity and inclusion. They focus on leadership development through coaching and intra-group dialogue.

This means that any significant culture change in healthcare organizations will involve changing, at least in part, assumptions and norms of a White work culture.

Therefore, my suggestion is that practitioners view their work overall, and the project of engaging White leaders and employees specifically, as organizational culture change. The following suggestions are based upon best practices for culture change, as mentioned by participants and from the literature:

- Partner with colleagues and consultants to create an organizational change plan that seeks to effectively manage psychological safety for all stakeholder groups
- Educate, train, and manage the executive sponsor as the most important aspect of the workplace inclusion strategy
 - Given its importance, the executive sponsor is ideally the CEO of the organization. In 2016, Cardinal Health named its Chairman and CEO, a White man, to lead its diversity council (Diversity Best Practices, 2017)
 - Besides simply authorizing and allocating resources to the change, the executive sponsor must
 - Actively and visibly be involved in the change campaign from beginning to end
 - Build powerful coalitions of the willing and help manage resistance
 - Communicate directly to employees about change; specifically the business case
 - Utilize external consultants with specific expertise. One model is White Men as Full Diversity Partners' (WMFDP) 'Pathways to Full Inclusion' (see Figure

5 below), which focuses on developing executive sponsorship in order to impact the culture of inclusivity:

Figure 5: WMFDP's 'Pathways to Full Inclusion' process (2018)



- Develop a sophisticated and detailed strategic communications plan that includes
 - Do not discuss workforce inclusion as culture change; instead, focus on the concrete behaviors that will be indicative that the change has been successful
 - Using language and a strategic frame (i.e. business case, healthcare case, social justice case) that will inspire and align change agents across the organization³¹
 - A detailed vision for the more inclusive organization and how this connects to the strategic frame mentioned above







³¹ The WMLTDI study's recommendation is to 'hone the business case and career advantage every day' (Shelton, 2013, p. 14)

- Understanding each audience's WIIFM, including White leaders and managers
 - Answer the most pressing concerns of many Whites about these issues, including this short list from the consulting firm Diversity Best Practices (2017, p. 6):
 - I want to be involved, but I'm not sure how to get involved
 - I am fearful of repercussions: what if I say something wrong?
 - Diversity is a zero-sum game, what's in it for me?
 - Why do I need to be engaged?
 - Enlist their support by showing how increased diversity & inclusion satisfies their self-interest (White Men as Full Diversity Partners, 2018)
- Support the executive sponsor to communicate the business case for the change and the possible impacts of not changing.
- Support middle managers to develop messages that speak to personal impacts rather than business impact
 - Provide objective data and feedback about competencies associated with inclusion.³²
 - Use of existing models of engagement such as Deloitte's six personas of strategic change (see Figure 6)

³² The WMLTDI study showed a significant gap between the self-assessed rating of White men leaders' diversity and inclusion skills and how others rated their skills. For example, White men rated themselves 45% positive effectiveness and others rated them as 21% positive (Shelton, 2013).

Figure 6: Deloitte's six personas of strategic change as applied to diversity and inclusion

(Bourke and Dillon, 2018)

					
Opposed	Unaware	Undecided: Anxious	Undecided: Fatigued	Supportive	Committed
A saboteur, deliberately undermining diversity and inclusion goals through words and actions	Concerned about how diversity and inclusion may impact him/her or colleagues	In the dark about diversity and inclusion, either because he/she has never read or heard about it or doesn't remember it	Once fired up about diversity and inclusion, now disengaged by the lack of progress	In favor of diversity and inclusion, but sees goal achievement as someone else's job	Takes personal responsibility for achieving diversity and inclusion goals

A Personal Reflection

I felt deeply invested in this capstone research project. Because of my deep personal investment in issues of race and organizational dynamics, the process itself triggered many interesting thoughts. Many of these moments of reflection were concerning how I, as a White man, as an activist, and as a scholar-practitioner was going about executing a project that hit so close to home. Below I describe one such reflection in which I find out the limits of awareness and good intentions in pursuit of greater diversity and inclusion.

In early March, I met with my advisor Harvey Floyd to discuss the struggles I had been having with the literature review. During our discussion, I was pleased to tell Harvey that I had successfully recruited a diverse cohort by race and gender that generally reflected the diversity of healthcare diversity and inclusion leaders. This felt like a repeat performance of the success I'd had in recruiting a diverse, excellent capstone team: my advisor was a fast-rising, mid-career, African American male coach and diversity consultant, and my reader was an advanced coaching practitioner, newly minted PhD, White female professor. But in the

course of my discussion with Harvey about the myriad ways I believed my Whiteness impacted the research, I felt a sinking feeling in my stomach. I realized that, while my 16-person cohort reflected the diversity of the 'D&I' function in healthcare, my first three interviewees were all White. This realization caused my mind to swirl with questions:

How did this happen? In my recruitment process, did I reach out to more White people in the beginning? Or was it because two of the three White people at the beginning were consultants, a professional status I myself coveted? Did I reach out in a more energetic way, with more touchpoints, or more frequency? If yes, then why was I more excited about interviewing White people? Or, if my recruitment was carried out in a racially equitable way, was it the *response that I received* from the prospective interviewees of White and non-White identities that determined the order of the participants? And, if it was the response that I received, then was it about me being White, was it about a topic that centered Whiteness, or a combination of the two? If I had been a person of color doing this research, would I have gotten a quicker response from people of color (Kenneth R. Rosso, personal reflection, circa March 7, 2019)?

And these questions sparked an even deeper thought: If I were a person of color, would I have taken on a research topic framed around the White experience of workplace inclusion at all? I had no firm answers to these questions. What I did know, however, is that I could not undo the past and replace any of those first three White participants with a person of color. What I could do was commit to changing my data analysis process and reporting to mitigate the potential impact on my research. When analyzing and presenting the findings, I made sure to vary the starting point from which I reviewed the data, participant-by-

participant. For, if I went from the ‘top’, or first interviews, each time, this would mean that the first three responses to each of 10 questions would come from a White participant. Instead, I varied my starting place - from the ‘bottom,’ the ‘middle,’ and the ‘top.’ Then, in Chapter 4, I committed to intentionally varying my choices of quotes between non-White and White participants. Lastly, I committed to revealing my process of self-discovery in the interpretation of my findings.

With these decisions behind me, I continued interviewing and reading. Still, by mid-March, my struggles with the Literature Review were beginning to become an open emotional sore that impacted the rest of my life. I became more moody and made poor decisions at my workplace, one of which nearly cost me my job. I was moody and irritable with my children and wife. I even sensed that my advisor was a bit perplexed by my struggle. Finally, I decided to confine my survey of the literature to only scholarship that I felt *directly* addressed the issue of effectively engaging White people in diversity and inclusion. After combing through all of the 50+ articles at my disposal, I hit on two articles which reviewed five-studies each by Victoria Plaut and Evan Apfelbaum. Their work was well-cited and struck me as highly relevant, rigorous, extensive - each used a five-study series, collaborative - each listed five co-authors, and well-written. Moreover, I felt their angle on the topic was appreciative and focused on positive solutions rather than problems. Thankfully, this decision got me ‘unstuck’ and allowed me to proceed with the critical work of finishing interviews, assembling data, and interpreting the data.

Then, one day in early April, as I excitedly anticipated the writing portion of the project, my stomach once again got that sinking feeling. Upon searching for further background information about Victoria Plaut’s work, I came across her photograph on a

faculty profile. To my surprise, Plaut was White! Perhaps due to prior work she had done with Kecia Thomas, an African American scholar of diversity resistance, I had incorrectly assumed that she was Black. This assumption played into the narrative I had developed about my research being an endeavor that would, at least, *not recreate* historic patterns of marginalization of Peoples of Color scholarly voices. At best, I had hoped that my research would be considered anti-racist since I was turning a lens toward the oft-hidden impacts of Whiteness on workplace dynamics. I made an effort to include people of color in many of my But, since I knew Apfelbaum was White based on earlier digging, revealing Plaut's White racial identity was a major strike against my preferred narrative. For, now my Literature Review was starting by featuring two White-led research teams. Again, as earlier, my mind swirled with questions:

Since I had read and reviewed many articles by people of color, how had the research of two White people ended up being among the chosen few? Was it really the quality and relevance of the work that attracted me to it? Could this be explained by the overall dominance of Whites in academia, which would result in a far greater number of peer-reviewed work available for me to consider? Or perhaps the angle that they took on the material, and was this a decidedly 'White' angle, but I could not tell because White culture was invisible to me as a White person? Will my audience be able to tell and will it matter to them? And, how much do I think it matters that Plaut and Apfelbaum are White? For, if their work contributes toward a field whose goal, although usually unstated, is to create more diverse, equitable, and inclusive workplaces, a goal that helps people of color and other marginalized groups, how much *should* it matter that they are White (circa April 1, 2019)?

Like the many questions about my recruitment of participants, I had no clear answers. However, unlike my discovery that the first three interviewees being White, which was reviewing a past event that could not be change, my realization that my two most thoroughly-reviewed scholars were White created an opportunity for reparative action. I could re-write my literature review and include more scholarship from People of Color. Even if I was still featuring Apfelbaum and Plaut, I could place precede and follow their work with scholars of color.

But I did not take these actions. Why? Since the literature review had already given me so much difficulty and emotional turmoil, I was loath to reopen this can of worms. I was gaining confidence, but still staring down the barrel of a 100 page capstone paper that I had yet to begin and was due May 1, a month away. This paper was the final step in fulfilling my requirements for earning a Master's degree from an Ivy League institution. This is the Master's degree that I had worked on for six years as a middle-aged husband, father of two children under 10 years old, and full time employee. Would I be willing to set my process back in order to fulfill a commitment that I never made explicit to my capstone committee or the participant-partners, to ensure that more non-White voices were heard in the literature review? I am not proud of it, but the answer was no. I only hope that the benefits this paper provide to the advancement of workplace inclusion far outweigh any damage done by a Literature Review that centers a White perspective on the topic.

Perhaps my decision process is emblematic of cost-benefit decision processes that leaders make every day regarding promotion of workplace inclusion. To me, a White man, the costs of reopening the Pandora's Box of my literature review outweighed the possible benefits, either actual or perceived, in increasing the racial diversity of the referenced

scholarship. My story may underline the importance of advancing representational diversity to support an inclusive workplace in healthcare. My process shows that I, or any healthcare leader, cannot divorce my societal privileges, including and especially racial privilege, from the cost-benefit analysis of doing work to promote a more racially equitable world.

Therefore, increasing representational diversity to get more decision-makers who can represent black and brown interests is a critical part of promoting overall inclusion for the benefit of all employees.

However, this research paper would never had happened if I, a White man, was not engaged in a process of self-discovery by the leaders in my life. These leaders included friends and neighbors, bullies, teachers, activist leaders, supervisors, professors, and particularly co-counselors. They were both White and non-White, women and men, queer and straight, and any number of other social identities. They gave me support and love, challenge and push back, and so many ‘disconfirming’ experiences that helped me develop a positive non-racist White identity. I have been given space to have painful experiences and express my emotions. I have made huge mistakes and survived them. I still do make mistakes that, I have no doubt, perpetuate racial inequality and prejudice. I am a work in progress. However, I believe that the dedication, passion, and attention to quality of this research project demonstrates the power of helping White people to engage with creating a more equitable society.

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APPENDIX A

INTERVIEW AGENDA

[Enable Zoom Recording]

Thank you very much for agreeing to be a participant-partner of this research project regarding the effective engagement of White people in workplace inclusion strategies in healthcare delivery organizations. My use of the phrase “participant-partner” communicates my hope that you will get to contribute to and benefit from the research process.

Our one-hour qualitative interview session is being recorded and transcribed to aid data collection and analysis. I will also be taking handwritten notes. The data is confidential and your identity will remain anonymous throughout the research process.

There will be three main parts to the interview - one, getting to know you and your overall approach to promoting an inclusive workplace, two, hearing your thoughts about, and experiences with, engaging White people with this work, and three, a discussion about how you see this work evolving.

Do you have any questions before we begin?

[Part 1]

1. What does your typical work day look like?
 - What are your formal and informal responsibilities for promoting DEI?
 - About how long have you held this position/appointment?

2. What got you into the work of diversity, equity and inclusion?
 - What do you enjoy about this work?
 - What about the work has been challenging?
 - Could you tell me about a past experience that has been influential for you?

3. How would you describe your overall approach to promoting an inclusive healthcare workplace? (Prompt examples: unconscious bias or cultural competence)
 - a. Can you describe a recent example of this approach?
 - b. Would say your work focuses mostly on structural aspects of inclusion or interpersonal aspect?
 - c. What are you most proud of in terms of your work in this area?

Statement: Next, I will ask you about the social identities that you think are relevant to your work in this area. As you may know, social identities can be more visible like gender and race, or less visible such as place of origin or class background. For example, the identities

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that I believe impact my research include White, male, cis-gender, Jewish, raised middle class, and activist.

4. Which social identities do you feel most influence your work, and how others perceive your work, in promoting an inclusive workplace?

[Part 2]

5. How would you describe your approach in helping employees with various identities to think about their commonalities and what makes them different?
 - a. Can you think of an example?
6. When you think about effectively engaging White people in healthcare workplace inclusion strategies, what are some thoughts you have?
7. What behaviors would indicate to you that the White employees in your organization are fully engaged in helping create an inclusive workplace?
 - Can you think of any particular moments that stand out, either positively or negatively?
 - Can you think of any examples, either in your organization or another, when you felt that a White person was being effective in helping create an inclusive workplace?

[Part 3]

8. Based upon your experience and expertise, how might you recommend a new healthcare leader go about creating an inclusion strategy that fully engages White people?
9. How do you see the work of creating an inclusive healthcare workplace developing over the next 5-10 years?
10. What recommendations or resources might you have for me as I move forward in my research?
 - Do you have colleagues at other healthcare systems that you feel I should interview as a part of this study?
 - Are there any reports, websites, or other data you think I should see?

Thank you very much for your valuable time and attention. I will be in touch!