The Role of Cultural Diversity Climate in Recruitment, Promotion, and Retention of Faculty in Academic Medicine

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BACKGROUND: Ethnic diversity among physicians may be linked to improved access and quality of care for minorities. Academic medical institutions are challenged to increase representation of ethnic minorities among health professionals.

OBJECTIVES: To explore the perceptions of physician faculty regarding the following: (1) the institution's cultural diversity climate and (2) facilitators and barriers to success and professional satisfaction in academic medicine within this context.

DESIGN: Qualitative study using focus groups and semi-structured interviews.

PARTICIPANTS: Nontenured physicians in the tenure track at the Johns Hopkins University School of Medicine.

APPROACH: Focus groups and interviews were audio-taped, transcribed verbatim, and reviewed for thematic content in a 3-stage independent review/adjudication process.

RESULTS: Study participants included 29 faculty representing 9 clinical departments, 4 career tracks, and 4 ethnic groups. In defining cultural diversity, faculty noted visible (race/ethnicity, foreign-born status, gender) and invisible (religion, sexual orientation) dimensions. They believe visible dimensions provoke bias and cumulative advantages or disadvantages in the workplace. Minority and foreign-born faculty report ethnicity-based disparities in recruitment and subtle manifestations of bias in the promotion process. Minority and majority faculty agree that ethnic differences in prior educational opportunities lead to disparities in exposure to career options, and qualifications for and subsequent recruitment to training programs and faculty positions. Minority faculty also describe structural barriers (poor retention efforts, lack of mentorship) that hinder their success and professional satisfaction after recruitment. To effectively manage the diversity climate, our faculty recommended 4 strategies for improving the psychological climate and structural diversity of the institution.

CONCLUSIONS: Soliciting input from faculty provides tangible ideas regarding interventions to improve an institution's diversity climate.

KEY WORDS: cultural diversity; academic medicine; ethnic minorities; recruitment; promotion.
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As the U.S. population becomes increasingly diverse, and as research links diversity in the physician workforce to improved access to care for minorities, academic institutions are challenged to increase the proportion of underrepresented racial and ethnic minorities among faculty.[1–3] Furthermore, ethnic minority faculty may serve as important role models and mentors to prospective minority trainees. However, racial/ethnic minority physicians are less likely to be satisfied with their jobs in academia,[4] and more likely to report experiencing ethnic harassment[5] and racial/ethnic bias.[6] Moreover, there are ongoing ethnic disparities in faculty promotion in academic medicine nationwide.[7] Academic medical institutions need innovative strategies to overcome these barriers to achieving workforce diversity. The Department of Medicine at Johns Hopkins University School of Medicine chartered the Diversity Council as a strategy to address recruitment and retention of underrepresented racial and ethnic groups in medical training programs (residency, fellowships) and faculty positions.

The Institute of Medicine defines the institutional climate for diversity as "the perceptions, attitudes, and expectations that define the institution, particularly as seen from the perspectives of individuals of different racial or ethnic backgrounds."[8] We examined our institution's diversity climate with regard to faculty recruitment, promotion, and retention to better inform the Diversity Council activities. Specifically, our objectives were as follows: (1) to explore the perceptions of majority and minority faculty regarding cultural diversity in academic medicine overall and at our institution and (2) to explore facilitators and barriers to success in academic medicine within this context.

METHODS

Study Design

We conducted focus group discussions with 3 groups: (1) physicians of different ethnic backgrounds (mixed group), (2) underrepresented minority physicians (URM group), and (3) ethnic majority physicians (majority group). We used the Association of American Medical Colleges' (AAMC) former definition of "underrepresented minorities" (African Americans, Mexicans, mainland Puerto Ricans, Native Americans) since the AAMC published its current definition after our study began.[9] Given the logistic difficulty of scheduling multiple focus groups with clinical faculty, we conducted one-on-one, in-depth, semi-structured interviews with faculty members who either did not have time to participate in focus groups or did not wish to share their experiences in group settings. We intentionally matched the study participants with racially

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concordant moderators and interviewers to create a comfortable, nonthreatening environment that would facilitate frank disclosure of faculty perceptions and experiences. There were two exceptions: (1) the focus group with physicians of different ethnic backgrounds had an African-American woman as a moderator, and (2) one interview with a Hispanic faculty had an African-American woman as the interviewer. We assigned participants to focus groups based on their self-identified race/ethnicity as listed by the Office of the Registrar. The Johns Hopkins Institutional Review Board approved this study.

Study Setting and Population

To be eligible, study participants had to be full-time tenure track physician faculty with clinical appointments in the Johns Hopkins University School of Medicine at the rank of Associate Professor or lower. We excluded tenured faculty (Professor) to minimize the influence of senior faculty and institutional leaders who might have made junior faculty uncomfortable sharing sensitive information. In June 2003, among 1,265 physician faculty, we recruited participants via e-mail letters sent to 240 ethnic majority faculty (randomly sampled among 605 eligible) and 89 ethnic minority faculty (oversampled all eligible minorities).

Conduct of Focus Group Sessions and Interviews

Experienced moderators/interviewers underwent a 60-minute training session with study investigators to review the moderator/interviewer guide and clarify key study questions. Focus group discussions occurred in office building conference rooms on campus, while interviews occurred in the participant's office. At the start of each session, all study participants signed informed consent forms and completed a 9-item demographic survey. The focus groups lasted approximately 2 hours. The interviews lasted 30 to 45 minutes. All sessions were audiotaped. We offered a $25 honorarium to each study participant.

To orient study participants to issues unique to working in academic medicine, moderators asked participants to review and critique handouts (created by study investigators) depicting the links among factors with a documented impact on professional satisfaction and success in academic medicine.[10–17] The focus groups and interviews proceeded with a general discussion of these factors. The faculty members were then asked a series of open-ended questions about the facilitators and barriers to success and professional satisfaction in academic medicine within the context of cultural diversity. Specifically, participants were asked to reflect upon the advantages or disadvantages in the workplace, underrepresentation of minorities in academic medicine, and any manifestations or experiences of bias as detailed in Table 1. All study questions were pilot tested for meaning with 5 faculty members from the Department of Medicine.

Data Analysis and Development of Taxonomy

Audiotapes of focus groups and interviews were transcribed verbatim, masking names of participants, clinical departments, and names of individuals that were mentioned. We identified the participants speaking on the audiotapes as URM male or female or majority male or female for focus groups and interviews conducted with URM or majority faculty, respectively. Speakers from the mixed focus group were identified as mixed group male or female. Two study investigators (U.S.-born African-American; foreign-born white) independently read each transcript in its entirety, manually marking distinct comments that were felt to represent discrete thoughts or themes. The two investigators met to adjudicate minor differences in choices of themes and where the relevant comments began and ended. A third investigator (foreign-born African-American) then adjudicated the remaining differences between the primary reviewers regarding one major theme that was not elicited by study questions (strategies for improving diversity). The resulting comments were separated into categories with thematic labels based on the actual words used by participants. These categories were used to develop a final taxonomy.

RESULTS

Forty-five faculty out of 329 possible participants expressed an interest in participating in the study. We successfully scheduled 3 focus groups (17 participants; 5 to 7 faculty per group) and 12 interviews (9 URM, 3 majority; 6 males, 6 females) prior to reaching theme saturation (at which point, we discontinued recruitment efforts). For those who did not participate, the most common reasons cited were scheduling conflicts. Most nonparticipants were surgical specialists or faculty with heavy clinical duties. Table 2 shows the characteristics of the study participants. All topic-specific comments were categorized into 5 broad domains, which are shown in Table 3 and discussed below.

Dimensions of cultural diversity

Study participants noted that some dimensions of cultural diversity are invisible (religion, sexual orientation), while others are visible (race/ethnicity, gender, foreign-born status). Moreover, they believed that visible dimensions of diversity were more subject to bias and stereotypes:

> I think it's probably trivial because [religion], unlike foreign-born status, ethnicity, and race and gender, you can hide it. I mean you can use it, you can expose it selectively . . . (Majority male)
>
> Unless I identify myself as a gay man, which until I tell you that, you don't know, I may have to stand and listen to somebody say things that are very derogatory about me and others that, in polite company, they wouldn't do for a person whose diversity is outwardly visible. (Mixed group male)
>
> Race is a social construct and there are sort of two aspects of it. One is how do you identify yourself, which you can decide, but the other is, what does somebody say when they walk in the room and look at you . . . (Mixed group male)

Table 1. Key Focus Group and Interview Questions

(1)	Can you think of daily practices (in the workplace) in which advantages or disadvantages may occur within an academic setting?
(2)	Why do you think racial and ethnic minorities are underrepresented in academic medicine?
(3)	Why do you think they are underrepresented at Johns Hopkins?
(4)	What are your personal experiences as well as observations of manifestations of bias/disadvantages in academic medicine related to race/ethnicity?
(5)	What are your personal experiences and/or observations of bias in academic medicine based on religion or foreign-born status?
(6)	Are any of the factors discussed unique to Johns Hopkins School of Medicine?

Table 2. Characteristics of the Study Participants

	N=29
Age (years)	33 to 50 (range)
Gender	
Female	11
Male	18
Ethnicity	
African American	13
Asian	2
White	11
Hispanic	3
Foreign born	10
Faculty rank	
Instructor	3
Assistant professor	18
Associate professor	8
Career track	
Basic researcher	7
Clinical researcher	9
Academic clinician	5
Clinician educator	6
Other	2
Clinical departments	
Anesthesia	2
Dermatology	1
Medicine	9
Neurology	4
Oncology	1
Pediatrics	6
Psychiatry	3
Pathology	2
Physical Medicine and Rehabilitation	1

Table 3. Taxonomy of Themes Regarding Faculty Perceptions of the Diversity Climate in Academic Medicine

Dimensions of Cultural Diversity
Visible dimensions
Race/Ethnicity
Foreign-born status
Gender
Invisible dimensions
Religion
Sexual orientation
Under-representation of Minorities in Academics
Few in numbers at all levels of training
Lack of prior educational opportunities
Poor recruitment efforts
Educational debt or lack independent wealth
Advantages and Disadvantages in Workplace
Related to race or ethnicity
Minority intraracial networking not possible
Lack of acknowledgment or invisible to colleagues
Derogatory statements about minority patients
Related to gender
Women assigned extra responsibilities
Related to race and gender
Minority females more disadvantaged
Related to foreign-born status
Visa status impacts grant funding
Lack of leadership support for promotion
Related to professional relationships
Informal networking
Mentorship
Manifestations of Bias in Academic Medicine
Related to race or ethnicity
Disparities in recruitment efforts
Disparities in promotion criteria
Disparities in leadership behavior toward faculty
Differential scrutinizing of professional competence or credentials
Related to foreign-born status
Disparities in recruitment efforts
English language dysfluency
Suggestions to Improve Diversity Climate
Increase self-awareness of attitudes
Leadership making diversity a priority
Increase diversity in leadership
Increase diversity of faculty/staff

Reasons for Underrepresentation of Minorities in Academic Medicine

The participants identified several potential explanations for underrepresentation of minorities in academic medicine. The most common reasons stated were that the environment is not welcoming and that minorities lack role models or mentors with whom they can identify:

> With numbers comes comfort, and if you're gonna be the only one there, I think it's gonna be much more uncomfortable than if you're joining a group of, you know, ten or fifteen, even if it's in a large sea of people. (*URM female*)

> There aren't very good role models for minority physicians in academic medicine. There are very very few and very far between, I mean, they're almost nonexistent. (*URM male*)

Another reason that study participants cited for underrepresentation is lack of prior educational opportunities:

> In terms of race, it's simply an opportunity difference . . . recruitment, at least, is probably the function of prior productivity, track record, which is, in the early stages of a career, are all gonna be dependent on where you went to school. Who you had an opportunity to work with, which is a function of did you have money to go to a good school and train. (*Majority male*)

> Another is that they may not have had exposure early on, you know, to research and writing publications . . . early enough so that it would come easy to them. (*URM female*)

Yet another reason study participants believe minorities are underrepresented is poor recruitment efforts, which many participants attributed to prejudice against racial minorities and/or lack of leadership commitment to minority recruitment:

> . . . [N]o matter what you say, I mean people have prejudices, and they tend to choose people who are like them, and there's no question that . . . people who decide . . . belong to a certain category. (*Majority male*)

> There are no African Americans in the residency class, which is unusual. I think this just represents a change in the leadership in the residency training program . . . in the previous leadership, there was awareness of the need to train more African Americans given the nature of this community. (*URM female*)

Finally, the study participants identified educational debt as a major deterrent to pursuing academic careers:

> When you talk about people saddled with massive quantities of debt . . . regardless of race . . . a lot of them will go private practice-type employment opportunities . . . (*Mixed group male*)

Advantages and Disadvantages in the Workplace Attributed to Diversity Climate

The faculty identified advantages and disadvantages in the workplace that they attributed to one's race/ethnicity, gender, and foreign-born status. For example, with respect to race, networking opportunities seem to be limited for minorities:

> I think you almost need a critical mass to have an effective network, and unless you have that critical mass of people, there's no minority-specific networking possible. (*Mixed group male*)

Minorities also report concerns about being invisible to their colleagues if they are not wearing their white coats:

> When I take off my white coat . . . I'm invisible to some people. So, it's those types of things which I'm blatantly aware of . . .. (*URM male*)

Another challenge that minorities may face is trying to decide when to confront bias and stereotypes in the workplace without negatively impacting their career development at an institution:

> . . . when you think about practices that may or may not impact your career development, I think you have to kind of choose your battles very selectively because you'll be confronted with topics of conversation and points of view that can be very viscerally offensive. I mean whenever I hear people talk . . . about we are all going to STD [clinic], that's where you can recruit large numbers of African Americans, and when I hear that, it's offensive. (*Mixed focus group; female*)

With respect to gender, some study participants reported that women are sometimes given more responsibilities than men:

> . . . it's easy for women to be given that 'cause, you know, we're more likely to go along with the program . . . I've had a recent experience where . . . I finally sort of put my foot down and questioned certain things . . . the response that I got . . . it's a very negative response . . . (*URM female*)

Others expressed concerns about the disadvantages of being both female and minority:

> So, I think in terms of your everyday work, patient care and interactions that may be a little difficult and is worse in the beginning . . . as people get to know you, they become a little less gender conscious and color conscious. And they then start feeling you more as a colleague. But in the beginning, it's very hard, very hard. (*URM female*)

Some study participants also identified major disadvantages for foreign-born faculty in academic settings with regard to grant funding and leadership support for professional advancement:

> The research allocation for me . . . has been a problem because I'm not a U.S. citizen . . . I cannot blame the institution for not trying to be more forthcoming at getting my immigration situation status fixed because . . . I'm not the only one . . . but it didn't help for me to get visas . . . (*URM female*)
>
> . . . I had to go and tell my division chief . . . that if he didn't promote me to assistant professor, I was leaving . . . When my file went to the Promotions Committee, they jumped me all the way . . . from instructor to assistant, unanimously . . . But he never proposed me for promotion . . . I always assumed that that was . . . because I was a foreigner. (*URM female*)

The faculty also identified sources of advantages and disadvantages that relate to access to informal professional/social relationships and mentoring:

> I've heard about members of my department who get together and socialize. They drink together, and they hang out . . . when I heard that that kind of thing was going on a regular basis, I thought, gee, you know, that probably makes it a lot easier to, you know, get things done when you're really "palsy" with the chairman. (*URM female*)
>
> . . . it's not just that I've had good mentorship . . . I think the person who I connected with as a mentor was somebody who was a very strong institutional leader who has achieved a lot of things, both inside and outside of the institution, and helped me to see and grasp things even when I thought that they were beyond what I was able to do. (*URM male*)

Manifestations of Bias Attributed to Diversity Climate

The faculty reported having observed or experienced bias in recruitment efforts for faculty, fellowship, and resident physician appointments. Most comments related these observations or experiences of bias to race/ethnicity and foreign-born status. They described subtle and blatant acts of bias:

> Because that [bias] can express itself so subtlety. . . there can always be justifications made for picking one candidate over another because . . . we're very fortunate here that we do get really phenomenal candidates, and so I think it would always be easy to justify why this person was picked . . . (*Majority male*)
>
> There were two of us, two underrepresented minorities applying for jobs, we were told, point blank . . . there are no positions . . . And there was one other person who was with us who got a position . . . they still hired this one person who was obviously . . . not underrepresented minority at all. It was interesting that in the space of two weeks, all of a sudden, there's a position. (*URM female*)
>
> I have been called . . . to explain why don't I have more American trainees . . . . it was an awkward place to be in, to try to explain something that I wasn't sure I needed to be explaining. (*Mixed group female*)

Faculty also expressed concerns about potential disparities in the promotion process depending on whether or not they viewed promotion as an objective or a subjective process:

> Whereas, promotion, and you work with the person or you know him for a longer time. You know what they've achieved and you can change your mind about potential prejudice that you've had about [them]. (*Majority male*)
>
> There was somebody who got promoted around the time that I got promoted but . . . had accomplished substantially less than I had, and, but got promoted ahead of me. I always felt like I had . . . I better work harder than the other people because I just have to do that in order to be successful. (*URM female*)
>
> And if anything, if there was, for example, an ethnic or racially underrepresented [minority], he is more likely to be promoted. (*Majority male*)

Both minority and foreign-born faculty reported feeling as though their professional competence is questioned by their colleagues or that they have to justify their credentials to others:

> They would have never gone through all those channels with any of my other colleagues. It's because I was a woman . . . an African American . . . They would have never challenged . . . a majority physician's judgments like that. (*URM female*)
>
> I'm obviously running the cases, and one of the community doctors . . . walked in and asked me who I was and then proceeded to ask where I went to medical school . . . I didn't want that to be the issue that placed me in an okay box . . . But those are the kind of things that you have to experience again and again . . ., and it does define kind of how you kinda feel about the social dynamics of your workplace. (*Mixed focus group; female*)

Some minority faculty expressed concerns about leadership commitment to helping minority faculty be successful in academic medicine:

> The leadership may have low expectations of achievement but may want you around to sort of like, say, "Oh, yes, we have black faculty here," you know, and not really helping people to achieve. (*URM female*)

Foreign-born faculty noted that having a foreign accent is a frequent source of scrutiny:

> Actually, I take that sometimes with a joke, and I say, "Well, I am attending and I have this and this and this experience." . . . It's very upsetting when somebody questions you because . . . you have an accent. (*URM male*)

Notably, language dysfluency may negatively impact important career advancement opportunities for foreign-born faculty:

> [L]anguage definitely plays an important role . . . you're not gonna [be] invited to meetings and/or asked to give talks, so it definitely hampers your ability to get promoted. (*Majority male*)

Suggestions for Improving the Diversity Climate

The study participants' suggestions for improving the diversity climate in academic medicine fell into 4 main strategic areas: (1) increase faculty members' and leadership awareness of their own attitudes and behavior, (2) increase institutional leadership commitment to improving the diversity climate, (3) increase diversity in the institutional leadership, and (4) increase the number of faculty and staff who may identify with the diverse patient population.

> It's very interesting to me how unaware we are of some of the things that we do . . . I think most people like to believe [that] they don't have that different behavior. It can be very hard when you identify that and you watch people go through that self-realization that maybe they have been . . . I think that external acknowledgment and a stated desire to want to . . . change that, would be very important to enhancing the diversity. (*Mixed focus group; male*)

> I mean, I could see the difference between our current chairman versus the previous one [in terms of] approach to perhaps different ethnic groups. (*Majority male*)

> As you go up the pyramid, the people up the pyramid have to be diversified as well. (*Mixed focus group; male*)

> We get a very diverse group of patient population coming through this place from all over—rural, urban, black, white, Hispanic, educated, non-educated, white collar, blue collar—and you need people who are gonna appreciate that this guy, . . . still has some value and has to be treated in a certain way. (*URM male*)

DISCUSSION

To our knowledge, this is the first qualitative study to explore in-depth the perceptions and attitudes of faculty regarding the impact of the diversity climate at an academic medical institution. Our focus group and interview discussions elucidate faculty beliefs about the diversity climate that may have been difficult to capture in previous survey studies.[4–6] In defining cultural diversity, study participants noted that visible dimensions (race/ethnicity, gender, foreign-born status) often provoke bias and cumulative advantages or disadvantages in the workplace that impact faculty recruitment, promotion, and retention.

We used Hurtado's framework for understanding diversity climate to help us interpret our findings. As illustrated in Figure 1, the diversity climate is influenced by an institution's historical legacy of inclusion or exclusion of minority students and faculty, and the institution's structural diversity (e.g. number of diverse students, faculty, and staff), psychological climate (e.g. perceptions of racial/ethnic tension), and behavioral dimensions (e.g. the quality and quantity of interactions across diverse groups).[18] Using this framework, we were able to better interpret study participants' perceptions and experiences with respect to visible dimensions of diversity to determine the impact on the diversity climate at our institution.

Both minority and majority faculty discussed the problem of underrepresentation of ethnic minorities in academic medicine. They agreed that ethnic differences in prior educational opportunities lead to disparities in exposure to career options, qualifications for training programs, and subsequent recruitment to training programs and faculty positions. This finding confirms a recent report that found that parental education and income has a profound effect on academic achievement in the early years of training and success thereafter.[19] While inadequate financial resources discourage all qualified students from pursuing a college education and then medical education, lower socioeconomic status is disproportionately present among African Americans and Hispanics.[20] Faculty comments in this domain are most relevant to *structural diversity* in Hurtado's framework.

Qualified candidates who make it through medical school may face additional race- or ethnicity-based challenges during the rest of their training and future employment. In our study, minority and foreign-born faculty report ethnicity-based disparities in recruitment to residency or fellowship programs and faculty appointments and subtle manifestations of bias in the promotion process. Previous studies that document disparities in faculty promotion substantiate this perception.[7,21] In contrast to minority and foreign-born faculty, some majority faculty in our study view promotion as an objective process; others suggest that efforts to increase promotions among minorities may be reverse discrimination. These types of diametrically opposed views may be divisive and negatively impact the *psychological climate* of diversity within an institution.

Regarding general experiences in academic medicine, minority faculty further describe *structural* barriers (poor retention efforts, lack of mentorship, and cultural homogeneity) that hinder their success and professional satisfaction after recruitment. This finding supports recent studies that reveal that racial or ethnic discordance or gender discordance between mentors and protégés may present unique challenges for individuals in these relationships.[22–24] In our study, the paucity of minority role models or mentors is perceived as a major barrier to recruitment and retention of ethnic minorities because it limits the number of visible faculty with whom they can identify with regard to socio-cultural issues.

Our study does have some limitations. First, we had a small sample size, and our sampling frame was based on one institution; therefore, the study results may have limited generalizability to other academic institutions. However, despite our small sample size, we achieved theme saturation. Second, our study may have selection bias. The faculty who responded to our e-mail recruitments may have had recent experiences of bias or disadvantages in the workplace and may have been looking for a venue in which to express their frustrations. Even so, the nature of qualitative studies is such that the perceptions of individuals who voluntarily share such information are represented. Another limitation is the possibility of response bias in that participants may not have felt comfortable expressing their true concerns in a focus group setting. However, this limitation is unlikely since many of the topics discussed in the focus groups were corroborated in the one-on-one interviews. Moreover, focus group and interview participants shared information and experiences that were extremely personal and sometimes emotionally charged.

Despite these limitations, our study has several strengths. Study participants came from a variety of backgrounds, which helped us to explore the institutional context of the diversity climate from different perspectives in an academic medical setting. Second, our findings substantiate and further describe faculty experiences of bias in academic medicine noted in previous survey studies. Third, as a result of their experiences, our study participants identified areas for future interventions that target the psychological climate and the structural diversity of the institution.

Our study identifies subtle disadvantages experienced by URM faculty, such as differences in social and networking

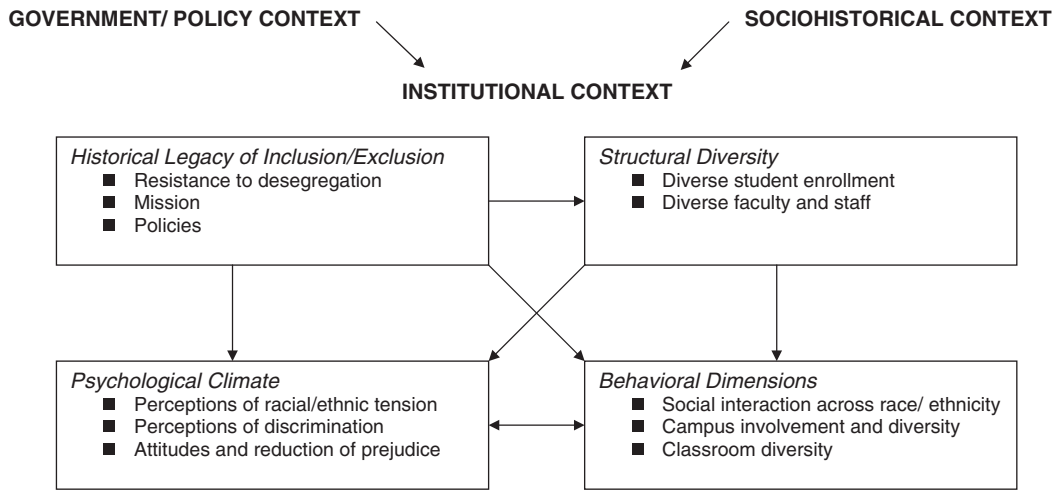

FIGURE 1. Factors influencing racial/ethnic diversity climate within an institution. *Source:* Hurtado et al.[18]

connections and unspoken biases, as well as overt factors that could affect recruitment and career advancement, such as overt expressions of bias, differences in prior opportunities, decreased availability of ethnic concordant role models and mentors, and being asked to fulfill socially responsible roles that may take time but not lead to academic advancement. Thomas has suggested that addressing an institution's diversity climate requires that: (1) the institutional culture encourages faculty to openly express their opinions and insights, (2) the institutional culture makes faculty feel valued, and (3) the institution incorporates faculty perspectives into the main mission and culture of the organization.[25] Our faculty suggest that our institution's diversity climate would be improved by increasing faculty member's and leadership's awareness of their own attitudes and behaviors, increasing institutional commitment to diversity, and increasing diversity among leadership as well as other faculty and staff. Soliciting faculty input regarding interventions to improve the diversity climate may increase the likelihood that an institution's efforts to increase diversity will be successful. Accordingly, we have developed a survey to quantify differences across race/ethnicity and nativity status in faculty perceptions of the diversity climate at our institution, to explore associations of these perceptions with academic success and professional satisfaction, and to help prioritize future activities of the Diversity Council.

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