Diversity and Inclusion

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The future success of organized Emergency Medicine, the Michigan College of Emergency Physicians (MCEP), and the practice of emergency medicine are dependent on the embracing, promotion, and facilitation of cultural diversity and inclusion. The American College of Emergency Physicians (ACEP) Board of Directors has recognized this and developed a strategic plan to promote and facilitate diversity, inclusion, and cultural sensitivity. ACEP Immediate Past President, Dr. Rebecca Parker, MD, FACEP hosted a summit in April 2016 and appointed a diversity and inclusion task force. Since that time, Annals of Emergency Medicine published an article highlighting research that shows that diversity and inclusion improves patient care, increases patient and provider satisfaction, and may even financially benefit organizations and companies. ACEP also has a Diversity Leadership Task Force to help broaden the diverse representation among ACEP leadership. This has the potential to engage new members, develop new leaders, and utilize the current expertise for mentorship of underrepresented groups. ACEP will be looking to engage the specialty of emergency medicine on diversity and inclusion, identify obstacles to advancement in the specialty related to diversity and inclusion, and highlight the effects of diversity and inclusion on patient outcomes.

A hard look at the statistics reveals there is much work to be done in the arena of diversity of inclusion as it applies to organized emergency medicine. 45% of medical school students are women and 44% are minorities. 38% of emergency medicine residents are women and 34% are minorities. However, within ACEP, women represent 25% of active members, 27% of ACEP Councilors and only 12.5% of ACEP board members. With respect to minorities the numbers are far worse, with the percentage of active ACEP members being only 1% Black and 1.5% Hispanic. Minorities represent less than 1% of leadership positions within ACEP. There is clearly an enormous opportunity for improvement.

MCEP has benefited from the leadership of strong women over the past quarter century. Our late Chief Executive Officer, Diane Kay Bollman, was a mentor to many, men and women alike, including our current office leadership, Executive Director Belinda Chandler, CAE, and Assistant Executive Director Christy Snitgen. The college has benefitted greatly from the leadership of Past Presidents, Dr. Constance Doyle, MD, FACEP, Dr. Kathleen Cowling, DO, FACEP, Dr. Melissa Barton, MD, FACEP, and Immediate Past President Dr. Larissa Traill, MD, FACEP. While I do not have statistics regarding women and minority involvement in MCEP, by gestalt I fear they are not much different from ACEP's demographics and there exists a large opportunity to promote and facilitate diversity and inclusion at the Michigan chapter level as well. I challenge myself, and our Michigan chapter membership, to be innovative in our approach to promoting and facilitating diversity and inclusion within our chapter and measuring our successes and challenges. I do not expect things to change overnight; however, I think the time is now to start

this discussion, seize the opportunity and meet the obligation we have to our specialty and to our patients.

The House of Medicine is behind the curve compared to other industries in the promotion and facilitation of diversity and inclusion. Organized medicine leadership and the medical work force are predominately white and disproportionately men. Most large US cities have populations where the minorities are the collective majority. The Institute of Medicine identified the underrepresentation of minority clinicians as a contributing factor to health care disparities in our country: As emergency medicine providers, many of us are witness to these healthcare disparities prevalent in minority populations ranging from uncontrolled hypertension and chronic renal failure to higher infant mortality and teen pregnancy rates. Researching the root causes for these healthcare disparities are prime opportunities for the advancement of emergency medicine and patient care overall. I have to look no farther than my respected colleague at Henry Ford Hospital, Dr. Martina Caldwell, MD to see the innovative approaches she has taken to address the disparities in women's reproductive health in Detroit. She has employed cutting edge research techniques including qualitative interviews of patients to understand their views with regard to contraceptive methods. Understanding cultural differences is a first step in the delivery of quality patient care.

Diversity and inclusion is also connected to other persistent challenges we face as a medical community: health disparities and unconscious bias. Regardless of our race, gender or other unique identities we all have an unconscious bias that may affect our patient care. We must acknowledge this bias and strive to mitigate this as we embrace diversity and inclusion in emergency medicine. MCEP has ample opportunity to engage new members from the medical student to the practicing physician, develop new leaders, and nurture creativity of thought. We must embrace the conversation and need for diversity and inclusion. We must commit leadership and mentoring opportunities to underrepresented groups. We must also expand our educational efforts to include cultural competence and acknowledgement of unconscious bias. The culmination of these efforts will afford the opportunity for emergency medicine to continue to lead within the House of Medicine.