Why Diversity and Inclusion Are Critical to the American College of Emergency Physicians' Future Success

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To ensure the future success of our specialty and organization, the American College of Emergency Physicians' (ACEP's) Board of Directors is moving forward "to promote and facilitate diversity, inclusion, and cultural sensitivity" as an integral part of the ACEP strategic plan. As discussed below, fostering broad and inclusive participation in ACEP's efforts enhances the array of thoughtful and innovative ideas brought forth, mitigates unconscious bias, and directly increases the likelihood of future success for our College and specialty.

The United States has long been culturally varied and is becoming even more so today. Women now make up more than half of the population,[1] and America is becoming an increasingly racially and ethnically diverse society, as reported by the US Census Bureau.[2] Today, minority groups (ie, any group other than non-Hispanic white) compose approximately 38% of our population and are projected to become the collective majority as early as 2044.[2] Most large US cities, and some of the largest and fastest-growing states, have populations in which minorities are now collectively the majority, or will be in the near future.[3]

As a specialty, emergency medicine is in a unique position to serve this diverse population. For some of our nation's emergency departments (EDs), patients from minority backgrounds compose the majority of their patient visits. This trend will increase for the foreseeable future as the population diversifies.

Within the medical profession, however, organized medicine leadership and the medical workforce itself remain predominantly white and disproportionately men.[4] This is largely reflective of historical factors that determined who was allowed to attend medical school, train in residency programs, and practice medicine in our country.[5,6] There remains an unconscious bias toward white men as leaders or authority figures not just by white men but also by women and minority populations.[7]

In recent decades, women have increased their representation in medical schools and residency programs, in part because of innovative pipeline programs, regulatory changes such as Title IX, and directed diversity initiatives. In 1970, women composed only 7.6% of physicians.[8] Since 1995, however, 40% to 49% of medical school graduates have been women.[9] In the past year, just over 45% of all medical school students were women and approximately 44% were a minority race.[10] Progress may have stalled, though, because the number of underrepresented minorities has remained flat in recent years.[4]

Emergency medicine mirrors the same challenges facing medicine in general. Our specialty's workforce is changing, but slowly. In the past 20 years, the number of women in emergency medicine residency programs increased from 27% to a variable, but flat, 10-year average of 38.5% (personal communication, Earl Reisdorff, MD, American Board of Emergency Medicine). Additionally, during the past 2 decades, there has been gradual growth in the percentage of nonwhite physicians in emergency medicine residency programs (23% in 1997, to 29% in 2007, to approximately 34% at present) (personal communication, Earl Reisdorff, MD, American Board of Emergency Medicine).

Internal ACEP demographic information reveals similar diversity challenges. Women are substantially underrepresented, composing only 26% of the regular ACEP membership, 28% of committee members, 26% of committee chairs, and 27% of council members. The division is even greater in senior leadership positions, in which only 12.5% of the current board of directors and 19% of state chapter presidents are women. Blacks account for just 1% of our members and Hispanics 1.5% (personal communication, Debra Perina, MD, American College of Emergency Physicians). These groups have almost no

†All attendees are listed in the Appendix.

representation among ACEP leadership. When one further considers that our nation has even more religious, cultural, sexual, gender identity, and other forms of diversity—far beyond the obvious visual distinctions—it is apparent that the magnitude of the opportunity for improvement is enormous.

Embracing diversity and inclusion in the workplace and our professional societies can improve patient care.[11] The Institute of Medicine identified the underrepresentation of minority clinicians as a contributing factor to health care disparities in our country.[12] Increasing the number of women and minority clinicians in the ED can increase cultural sensitivity in the care of a diverse patient population.[12,13] Patients often are more comfortable communicating and interacting with physicians who more closely resemble them and share similar life experiences,[14] and this enhanced comfort can improve the patient experience, quality of care, and compliance with medical recommendations.[15-18]

Exposure to the profession of medicine in general, and emergency medicine in particular, should begin as early as possible, even in elementary school. Demystifying the profession, sparking interest, and promoting mentorship early is invaluable for young students to become physicians. Additionally, when young people from underrepresented populations see emergency physicians delivering compassionate, lifesaving care to all types of people, particularly when delivered by physicians of diverse backgrounds, they can better visualize themselves serving in those roles, thereby attracting them to our profession. Several pipeline programs in emergency medicine and through the Association of American Medical Colleges aim to diversify the physician and health care workforce.[19,20]

Diversity and inclusiveness are also good for business. Studies of corporations demonstrate that gender, racial, and ethnic diversity financially benefit companies.[21-23] For example, there is a correlation between a greater number of women in the leadership of a company (eg, when 30% or more of board members are women) and better financial performance and reputation of that company.[22] A strong reputation for inclusion also gives organizations an edge to attract and retain the best physicians and employees.[23] And diversity is more than just gender and racial identification. Geographic, educational, and other "hidden" differences can increase innovation.[24] Diversity leads organizations to overcome collective biases when they bring it into their discussions and fosters creativity of thought, collaboration, problem solving, and even expansion into new markets.[23]

ACEP has both an opportunity and obligation to lead this charge within the House of Medicine. Although there have been efforts by numerous medical and health-related associations, it is fair to say that most medical societies, including ACEP, have failed to achieve the desired outcome of a membership and leadership reflective of the society we serve. The establishment of the Academy for Diversity and Inclusion in Emergency Medicine within the Society for Academic Emergency Medicine is a notable exception.[25]

The value of diversity and inclusiveness for ACEP goes beyond its leadership. It will enhance the reputation of ACEP both internally and externally—within medicine, as well as with public policymakers, the media, and the public. A culture of diversity and inclusiveness will position ACEP for greater success both nationally and internationally. ACEP will better resonate with a broader audience and may have greater media opportunities. This approach will potentially attract, retain, and engage new members, develop new leaders, and build on the expertise of our current members. These factors are crucial for ACEP's long-term growth and stability.

ACEP's infrastructure supports numerous opportunities to foster diversity and inclusion. ACEP's meetings—some of the most widely attended in all of emergency medicine—have an incredible potential to reach emergency physicians and have a positive influence. More attention should be given to educational sessions that include health care disparity education and the effects of unconscious bias, highlighting the work of our members in this area.[26] In addition to receiving the world-class education, people attend ACEP meetings to network and connect with their peers. Expanding these opportunities improves the well-being and resiliency of our members while improving patient care.

Additionally, to advance clinical quality improvement in emergency medicine, ACEP has created its own qualified clinical data registry, the Clinical Emergency Data Registry. ACEP can create health-disparity-related quality measures for the Centers for Medicare & Medicaid Services Merit-Based Incentive Payment System and Alternative Payment Models to assist our departments and physicians in reducing disparities, increasing the quality of care, and further demonstrating the value of emergency medicine. For example, quality measures addressing differences between gender and racial groups in the amount and time to analgesia administration and the treatment of acute coronary syndromes would identify potentially correctable disparities within emergency care.

With a diverse and inclusive membership, represented by a more diverse leadership, ACEP can improve advocacy at the state and federal levels. As constituents elect increasing numbers of women and minorities to Congress and state legislatures,[27] we can make better connections with these politicians if our leaders, values, membership, and expertise reflect that same diversity. Additionally, we