INTRODUCTION

As the globalization of trade, technology, investment, and migration create a more diverse U.S. population, we are increasingly becoming aware of disparities in economics, health care, and human rights. Our nation was founded on the concept that “all men are created equal,” and equal treatment and equal access are the goals toward which we strive. Nowhere else in medicine is the commitment to equality as obvious as it is in emergency departments (EDs), where the sole criteria for moving to the front of the line is severity of illness. Other specialties now restrict the days and hours during which they are available to patients and tell their patients at discharge from the hospital to go the ED if they have any problems or concerns. Changes in the economy have resulted in a significant increase in the percentage of uninsured. Only the ED provides medical care 24 hours a day, 365 days a year for every patient with any complaint. As advocates for our patients, emergency physicians (EP) are at the forefront of the promotion of diversity and the elimination of disparities in health care, not just at home but throughout the world.

The definitions of some important terms, broadly and more specifically as they relate to emergency medicine (EM), will help provide a common understanding and language for the reader (Box 217.1). Awareness of the history of disparities in access to quality health care (Box 217.2), the benefits of clinical research (Table 217.1), and medical education and EM practice (Box 217.3) will create a contextual framework within which the reader can appreciate all that has been accomplished, as well as the tasks that remain, as we work toward the ideals of diversity and cultural competency.

IDENTIFYING ISSUES OF DISPARITY

In 2003 the Institute of Medicine (IOM) was charged by Congress to examine racial and ethnic disparities in health care. Their landmark report, “Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare,” brought the issue of health care disparities to national attention. The report concluded that “Racial and ethnic minorities tend to receive a lower quality of healthcare than non-minorities, even when access-related factors, such as patients’ insurance status and income, were controlled.” The report defined disparities as “racial or ethnic differences in the quality of healthcare that are not due to access-related factors or clinical needs, preferences, and appropriateness of intervention.”

According to the U.S. Census Bureau, there are currently more than 300 million Americans: 65% white, 16% Hispanic, 13% black, 5% Asian, and 1% American Indian. Yet according to a report by the American Medical Association, only 6.4% of practicing physicians are Hispanic and 4.5% are black. Recognizing the changing patient demographics and the unchanging demographics of the physician workforce, the Association of American Medical Colleges (AAMC) Executive Council adopted a definition of underrepresented in medicine (URM) as “those racial and ethnic populations that are under-represented in the medical profession relative to their numbers in the general population.” Before this, the AAMC used the term “under-represented minority,” which specifically targeted African Americans, Mexican Americans, Native Americans, and mainland Puerto Ricans. A much broader definition of diversity includes race, ethnicity, socioeconomic status, sexual orientation, religion, disability, age, language, and geographic diversity.

UNDERSTANDING CULTURAL COMPETENCY

Diversity and cultural competency have emerged as the two main forces for eliminating disparity in medicine. When
patients have contact with the health care system, they bring their culture and all that it encompasses, including their beliefs, values, identity, and links to the community. When people of different cultures and backgrounds come together, diversity is achieved. The Office of Minority Health (OMH) defines cultural and linguistic competence as “a set of congruent behaviors, attitudes and policies that come together in a system, agency or among professionals that enables effective work in cross-cultural situations.” The educational concepts for cultural competency are centered on the provider’s ability to acquire the knowledge, attitude, and skills necessary to elicit an explanatory model of illness from the patient and to incorporate it into the medical decision-making process. Ultimately, this concept empowers the physician to navigate the cross-cultural experience with any patient from any cultural background by enabling greater understanding of the patient’s perspective and social context. The OMH published their standards for culturally and linguistically appropriate services in health care in 2002. Another conceptual model by the Agency for Healthcare Research and Quality describes how integrating nine major cultural competency techniques can potentially improve the ability of physicians and health care systems to deliver appropriate services to diverse populations.

**BOX 217.1 Definitions**

*Culture*: Customary beliefs, social forms, and material traits of a racial, religious, or social group; also, the characteristic features of everyday existence shared by people in a place

*Disparity*: Lack of parity, the state of being dissimilar or unequal

*Diversity*: Inclusion of different types of people in a group or organization

**Table 217.1 History of Disparities in Research**

<table>
<thead>
<tr>
<th>Event</th>
<th>Description</th>
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<tbody>
<tr>
<td>Nazi human experimentation:</td>
<td>Josef Mengele, MD, was one of the notorious physicians who performed burning, boiling, freezing, beating, hanging, and poisoning experiments on human prisoners of war who were predominantly racial and ethnic minorities in Europe.</td>
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<tr>
<td>1938-1945</td>
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<tr>
<td>Tuskegee Study of Untreated Syphilis in the Negro Male: 1932-1972, Taliaferro Clark, MD</td>
<td>The U.S. Public Health Service conducted a study on the natural course of syphilis in black males; they were often not informed of their diagnosis and were deliberately prevented from seeking and obtaining treatment, even after penicillin became widely available.</td>
</tr>
<tr>
<td>Willowbrook: 1963-1966</td>
<td>Saul Krugman, PhD, deliberately infected mentally handicapped children with hepatitis B virus to study the effects of gamma globulin on the disease.</td>
</tr>
<tr>
<td>Nuremberg Code: 1948</td>
<td>It arose from the trials of Nazis for crimes against humanity and addressed consent by and protection of subjects of human research.</td>
</tr>
<tr>
<td>Belmont Report: 1979</td>
<td>Boundaries were established between practice and research and basic ethical principles of human research.</td>
</tr>
</tbody>
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**BOX 217.2 History of Health Care Disparities**

1619-1865: Contaminated drinking water led to frequent outbreaks of disease among slaves. Slaves develop a system of care involving indigenous herb root doctors and midwives.

1824: The Bureau of Indian Affairs is established and provides limited health care to Native Americans on reservations.

1852: The first hospital for the care of blacks is opened: Jackson Street Hospital, Augusta, Georgia.

1862: The only government-funded hospital for blacks, Freedmen’s Hospital in Washington, DC, is established.

1948: Executive Order 9981 mandates the integration of Veterans Administration hospitals.

1955: The Indian Health Service is commissioned.

1964: Executive Order 11,292 mandates the integration of federal Medicaid and Medicare payments will be denied to segregated hospitals.

1965: The Johnson administration announces that federal Medicaid and Medicare payments will be denied to segregated hospitals.

1990: A metaanalysis of 485 articles confirms that migrant health care is confined almost exclusively to charity migrant clinics and virtually nothing is known about the health status of the workers.

2004: At every age, blacks have higher blood pressure than nonblacks.

2005: A total of 16.5% of American Indians, 10.4% of Hispanics, and 6.6% of whites are diabetic.

2006: African Americans are more likely than whites to die of coronary artery disease. They and Hispanics are less likely to be offered bypass or angioplasty. Blacks have worse cancer survival rates, are more likely to undergo amputation for complications of diabetes, and are less likely than whites to be referred for transplant evaluation. Hispanics and Native Americans are least likely to be offered cholesterol management services.

2009: Of all patients in whom human immunodeficiency virus infection was diagnosed this year, 52% were black.

2010: Twenty percent of the population lives in rural areas, where only 9% of physicians practice.
Over the course of time there has been an evolution in the education and assessment of cultural competency in undergraduate and graduate medical education. The Liaison Committee on Medical Education has codified the following criteria: “Students must demonstrate an understanding of the manner in which people of diverse cultures and belief systems perceive health and illness and respond to various symptoms, diseases, and treatments.”

Similarly, the Accreditation Council for Graduate Medical Education (ACGME) has defined its competency standards within two of the six core competencies: patient care and interpersonal communication skills.

### BOX 217.3 History of Disparities in Medical Education

1783: Dr. James Durham, a former slave, becomes the first African American physician. He sets up practice in New Orleans after apprenticeship training.

1837: Dr. James McCune Smith is the first African American to obtain an MD degree. He has to go to the University of Glasgow to do so. He sets up practice in New York City.

1847: Dr. David J. Peck is the first African American to graduate from a U.S. Medical School (Rush Medical College).

1849: Two African American men receive MD degrees from Bowdoin College, Maine.

1850: There are 13 African American doctors: 9 in New York City and 4 in New Orleans.

1857: Dr. Elizabeth Blackwell becomes the first woman to graduate from a U.S. medical school and founds the New York Infirmary for Women and Children.

1867: Dr. Blackwell founds the Women’s Medical College of Pennsylvania.

1868 and 1876: Eight Negro medical schools were established, but only two are still open: Meharry, Tennessee (1876), and Howard, Washington, DC (1868).

1889: Dr. Susan La Flesche Picotte is the first American Indian woman to earn an MD degree; she receives it from the Women’s Medical College of Pennsylvania.

1890: There are 909 African American doctors, as compared with 1734 in 1900 and 4500 in 1960.

1891: Dr. Daniel Hale Williams opens the first black-owned hospital (Provisional Hospital in Chicago).

1905: Being denied membership in “mainstream” medical associations, Dr. Williams establishes the National Medical Association.

Even though access to care has improved remarkably for racial minorities over the past 2 centuries, it is important to realize that they “are disproportionately affected by multiple barriers to care: financial, linguistic, cultural, logistical, organizational, institutional and systemic. Disturbingly, providing disadvantaged populations with adequate access to care may not be sufficient to eliminate racial/ethnic disparities in health.”

In the Health Disparities and Inequities Report of 2011 by the Centers for Disease Control and Prevention, minority groups were overrepresented in every diagnostic category monitored except suicide and drug-induced death, where whites prevailed. To highlight the importance of patient-centered, culturally competent care, the AAMC developed the Tool for Assessing Cultural Competence Training (TACCT), which provides a framework for designing, implementing, and integrating an effective cultural competency educational program. The TACCT is a self-administered assessment tool that can be used to identify the strengths and weaknesses of a program’s educational curriculum. ACGME’s Toolbox of Assessment Methods is an excellent resource that includes assessment methods and references to articles where more in-depth information can be found. The design, implementation, and assessment of effective cultural competency curricula must be flexible, be tailored to the institution, maximize existing resources, and be linked to a data collection component to measure and monitor for success.

The 2003 Academic Emergency Medicine national consensus conference “Disparities in Emergency Health Care” went further by addressing issues of unconscious personal bias, disparities profiling, and the need for epidemiologic and clinical research directed at making an impact on outcomes and improving physician-patient communication.

### MOVING TOWARD JUSTICE IN RESEARCH

Several particularly shocking acts of injustice and abuse in clinical research (see Table 217.1) culminated in governmental intervention to protect the human rights of research subjects. In the United States, the Belmont Report remains the standard by which institutional review boards (IRBs) ensure that subjects of human research are treated with respect for persons, beneficence, and justice. The report states that “injustice arises from social, racial, sexual, and cultural biases institutionalized in society. Thus, even if individual researchers are treating their research subjects fairly, and even if IRBs are taking care to assure that subjects are selected fairly within a particular institution, unjust patterns may nevertheless appear in the overall distribution of the burdens and benefits of research.” Theoretically, diseases that predominantly affect racial and ethnic minorities and low socioeconomic groups should have the same opportunity to be studied as diseases predominantly affecting males, whites, and the middle class. In recent decades there has been concern regarding the lack of inclusion of women as subjects of research and barriers and describe the different levels of commitment required throughout the organization.

### EXPLORING SOLUTIONS

The Sullivan Alliance, composed of former members of the IOM and the Sullivan Commission, a group commissioned by Duke University and the Kellogg Foundation to study diversity in the health care workforce, aimed to transform the health care workforce, targeted at the critical steps referenced by the Sullivan Alliance. Recognizing the challenges that medical schools and academic medical centers face when implementing the recommendations, the AAMC published several road maps that highlight some of the legal, practical, and subtle
The SAEM’s Diversity Statement asserts that “attaining diversity in emergency medicine residencies and faculty that reflect our multicultural society is a desirable and achievable goal. SAEM encourages all academic medical centers to recruit, retain, and advance a faculty reflective of the community served. SAEM encourages its members to respect, support, and embrace the existing cultural differences of its membership. SAEM encourages the development of didactic, educational, research, and other programs to assist academic emergency medicine departments to improve the diversity of their faculties and residencies.”

The American Academy of Emergency Medicine (AAEM) makes a statement on diversity within the AAEM and Emergency Nurses Association Joint Position on a Code of Professional Conduct by stating that “the ideal for emergency nurses and physicians is to practice in an optimal working environment where there is respect for diversity.”

In 2008, the Council of Residency Directors in EM convened the Promoting Diversity in Emergency Medicine Workgroup and, in 2009, published a set of primary recommendations, secondary considerations, and tools to help EM residency training programs and academic departments promote diversity.

**BARRIERS AND CHALLENGES**

EPs provide continuous care to patients from varying ethnic, cultural, and social backgrounds, frequently the most disadvantaged and vulnerable populations. The fast-paced and unpredictable clinical setting of the ED presents challenges that include time constraints, limited information, and inadequate resources. The health care team must establish rapport quickly and gain the trust of both patient and family. Patients who are acutely ill, sometimes with a language barrier, represent significant challenges for EPs and are at the highest risk of suffering from unconscious bias, disparities in care, and worse outcomes.

The major challenge to diversifying the physician workforce rests with the establishment of an educational pipeline, beginning in elementary school and continuing mentorship through residency training and on into faculty leadership roles. Barriers at the academic faculty level include inadequate recruitment efforts for qualified URM physicians and inadequate efforts toward retention and promotion.
and academic departments are often remiss by spending limited educational time devoted to cultural competency, which they may believe is not as important as clinical competency. Individual physicians may be resistant to acknowledging that disparities exist in their health care delivery or may be reluctant to admit to the possibility of subconscious bias.

**FUTURE DIRECTIONS**

Elimination of disparities and the development of a diverse, culturally competent workforce will require the collective effort of individual providers, EM residency programs, faculty practices, hospital administration, and medical school leadership in embracing the goals of delivering equal care to all. In closing the health care disparities gap, EM leaders and educators will play a critical role by recognizing disparity as an important issue in medicine and by developing methods of addressing the knowledge and attitudinal barriers that propagate the problem. As the population continues to become more diverse, we will need to quickly expand the professional pipeline from high school to faculty leadership positions to meet the public’s need. Development and implementation of cultural training that is compliant with the ACGME core competencies should provide our residency graduates with the skills that they need to be effective, culturally competent practitioners. Increasing workforce diversity and ensuring cultural competency are the most important strategies for eliminating racial and ethnic disparities in health care.

**REFERENCES**

References can be found on Expert Consult @ www.expertconsult.com.
REFERENCES

1. United States Bill of Rights (historical document).
44. Patient-physician concordance is a phenomenon by which patients prefer physicians who mirror their own cultural and ethnic backgrounds, values, and communication styles and express more satisfaction when cared for by doctors of their own race. The concept is described in many journal articles, such as Street Jr RL, O’Malley KJ, Cooper LA, et al. Understanding concordance in patient-physician relationships: personal and ethnic dimensions of shared identity. Ann Fam Med 2008;6:198-205.
46. AAMC diversity in the physician workforce: facts and figures. Table 9, p. 75. Available to AAMC members at https://members.aamc.org/eweb/upload/Diversity.