



Choosing Wisely

By Joel Moll, MD, FACEP

It's an exciting time of the year for academic emergency medicine. Department chairs and medical directors are receiving faculty applications from residents and fellows. Program directors are sorting through a sea of applicants for residency and fellowship training. It's the life cycle of academic emergency medicine and it is exciting because it is about the future, about possibilities, and about dreams. Decisions made in the fall of 2017 will have long-reaching and lasting impact on our departments, our programs, our specialty, and our patients, so it's important to choose wisely.

Last year I wrote about a diverse and inclusive match—diversity in every sense of the word and inclusion of all into the house of medicine. Diversity and inclusion is especially important in emergency medicine where we take care of a mélange of people from a multifaceted society, often on the worst days of their lives. We in emergency medicine have a special responsibility to be skilled in taking care of all patients, especially the vulnerable. Despite the reality that our patients may sometimes not share our values, experiences, or backgrounds, we want to be empathetic physicians who deliver high quality care. The Institute of Medicine (now called the National Academy of Medicine) in a 2001 publication, [Crossing the Quality Chasm: A New Health System for the 21st Century](#), defined six domains of health quality, one of which is equity.

To be equitable, we must be familiar with and knowledgeable of those who are different from us and whose experiences differ from our own. Such knowledge and familiarity has been shown in numerous studies to increase understanding and competency when caring for patients and working with colleagues dissimilar to us. We must go beyond merely applying our own references and experiences to others; we must proactively seek out this familiarity and knowledge, otherwise they will likely elude us. Simply being equal in our consideration of our different patients,

different learners, or different colleagues is not a clear, straight path toward diversity and inclusion in emergency medicine. We must go beyond equal consideration and be equitable in our quality of care.

I first became involved with diversity and inclusion efforts in 1979, when I was appointed to the human relations committee at my newly formed, recently integrated junior high school in Ohio. I remember thinking, "all we have to do is treat everyone the same." My experiences soon demonstrated to me the problem with that assumption. I went from a conservative, white, German family, into a world where I was in the minority. My classmates and school leaders were primarily African-American or Latino and many of them became my friends and mentors—sometimes to the dismay of my extended family. Although I might not have understood it at the time, I now realize that I was fortunate to have had the experience of being exposed to these differences. This exposure stimulated my intellect and my ethos—not just toward diversity, but in all ways. As I progressed into a similar high school environment, and then on to college, this smorgasbord of experiences was defining in my life. Thus, when I hear that discussions on diversity and inclusion are not needed, or even appreciated, and that we should simply "treat everyone the same," I think back to what might have happened had I not been exposed to people different from myself. Comparing others to myself and evaluating them through that lens, is not being equitable. Human tendency is to seek those who are like us. In the past year, I have reflected with sadness and sometimes horror, on the divisions, hateful speech, and violent events that surround us. Clearly, exposure to the diversity of humanity is needed. After all, it's hard to hate people you've grown to know and understand. The driver of the car that killed a peaceful protestor in Charlottesville lived in the same area where I grew up, yet he clearly did not have the same experiences as I.

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In medicine, studies have shown that having diverse and inclusive faculty, learners, and patients positively benefits a medical practice. Providers deliver and patients judge care to be more inclusive, competent, and equitable when diversity training and exposure to diverse people groups and experiences is provided. Corporate studies have found the health of companies and communities are positively impacted by a diverse and inclusive climate. Yet we must not rely on equality alone. Implicit bias remains a strong opponent of change and growth in an American culture that is rapidly becoming more diverse and more complicated. Unfortunately, our colleagues and learners in medicine are not necessarily keeping pace. We cannot continue to apply our personal frames of reference, USMLE scores, and research expectations to everyone we meet and expect to adequately reflect our patients in our learners, our colleagues, or our profession. It's not about politics or affirmative action, it's about our personal perspective and the breadth of humanity.

Women, underrepresented minorities (URMs), LGBT (lesbian, gay, bisexual, transgender), those suffering economic hardship, or with disabilities, have experiences worth sharing—and even celebrating—in emergency medicine. And certainly, that is just the start. We all have gifts to bring forward. Those gifts are different for each of us and therefore cannot and should not be ranked against one another, nor judged in simple measures of equality. Sharing our gifts through our diversity of life references and experiences creates a whole that is greater than the sum of our individual parts—and that benefits us as a society and as a profession. As you review applications this season, whether for faculty, fellows, or residents, ask if you are being equitable, not equal. Are you choosing wisely? ▶

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