A Model Partnership: Mentoring Underrepresented Students in Medicine (URiM) in Emergency Medicine

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David Reed Nguyen Anderson, EMT-B  
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100% Groups

Alvarado Emergency Medical Associates  
Beach Emergency Medical Associates  
Centinela Freeman Emergency Medical Associates  
Central Coast Emergency Physicians  
Chino Emergency Medical Associates  
Coast Plaza Emergency Physicians  
Corona Regional Emergency Medical Associates, Inc.  
Emergency Medicine Specialists of Orange County  
Glendale Adventist Emergency Physicians  
Hollywood Presbyterian Emergency Medical Associates  
Huntington Park Emergency Physicians  
Los Alamos Emergency Medical Associates  
Maui Memorial Emergency Medical Associates  
Montclair Emergency Medical Associates  
Napa Valley Emergency Medical Group  
Newport Emergency Medical Group Inc  
Orange County Emergency Medical Associates  
Pacific Coast Emergency Medical Associates  
Pacific Emergency Providers APC  
Pacifica Emergency Medical Associates  
Redondo Emergency Physicians  
San Dimas Emergency Medical Associates  
Shasta Regional Emergency Medical Associates  
Sherman Oaks Emergency Medical Associates  
Tarzana Emergency Medical Associates  
Temecula Valley Emergency Physicians  
Valle Presbyterian Emergency Medical Associates  
Vituity Emergency Medicine Advocacy Physicians  
Vituity Idaho-LLP  
West Hills Emergency Medical Associates
UNEQUAL USE OF FORCE BY POLICE DEPARTMENTS IS JUST ONE SYMPTOM OF SYSTEMIC RACISM. SYSTEMIC RACISM HAS BEEN PART OF THIS COUNTRY’S HISTORY SINCE ITS FOUNDING AND SUCH A LARGE TOPIC CAN BE OVERWHELMING TO ADDRESS. IT IS OFTEN UNCLEAR WHAT ROLE WE CAN PLAY IN INSTITUTING CHANGE OR WE MAY EVEN FEEL THAT WE CANNOT COME UP WITH THE RIGHT WORDS TO START THE CONVERSATION. THIS CAN FEEL PARALYZING AND OFTEN LEADS TO SILENCE. I RECENTLY HAD A HEALTHY CONVERSATION WITH A COLLEAGUE, ON MANY THINGS AND THIS TOPIC ALSO CAME UP. THEY ASTutely REFLECTED THAT SILENCE CAN EASILY BE INTERPRETED AS BEING COMFORTABLE WITH THE STATUS QUO.

Therefore, my goal is to keep the momentum going and continue the conversation because I am not comfortable with the status quo. If we don’t, we will once again find ourselves in situations where privilege and biases lead to power being abused with the worst possible outcome: the loss of human life.

I in no way claim to be an expert on this topic. But I am a learner, and I am open to the journey of improvement. In the end, I hope each of you will commit to the same.

Even when we start invoking actual change, outcomes can feel slow. This can be incredibly frustrating to emergency physicians who are accustomed to a “fix it now” mentality. But these are just barriers to the outcome we want. While we need to acknowledge them, the barriers should not stop us. We owe it to George Floyd’s daughter, who should be able to say every day, “My Daddy continues to change the world.”

The Big Three.

Diversity, inclusion, and equity have been part of a growing movement for several years now. In 2016, ACEP, at the request of then President-Elect Becky Parker, created a Diversity & Inclusion Task Force. Former California ACEP staff member, Ryan Adame, had the honor of being asked to serve as the only chapter staff person on the Task Force. Many companies and organizations throughout the country began similar discussions. But, after the death of George Floyd and the summer of large and diverse Black Lives Matter protests across the world, every organization focused on the three words that quickly became the buzz: Diversity, Inclusion, and Equity. On the initial pass, it is easy to assume that the three are like dominos. Accomplish diversity, and the other two automatically fall into succession. I have made this assumption myself. It was not until I was doing research for this article that I realized how flawed this initial presumption is.

Each can be independent of the other, and only when there is a conscious effort to focus on all three topics is when the sweet spot of intersection is achieved. But, to understand how they fit together, it is important to understand how they stand as independent ideas.
Diversity

When discussing diversity, there are two key fundamentals that we all know but probably quickly forget. First, no individual is diverse. Second, any organization that is composed of more than two individuals is, by definition, diverse. Individuals are like snowflakes and no two are completely identical. Diversity can only be measured as it relates to component bodies of a group, organization, or ecosystem.

Each individual brings a difference in thought that is shaped by their experiences and identity. These may be related to race, gender identity, age, sexual orientation, religious preference, nationality, language, geographic, or cultural background. While their experiences and identity may be unique to them, they are normal. As Sara Saka, Founder and CEO of Fumunity, explains, when an individual is referred to as “diverse,” implicit bias can result in the person not being thought of as part of the dominant, socially accepted, privileged, or in affect “normal” class. Examples of current dominant and privileged class include, but are not limited, to male, white or light skinned, straight, able-bodied, English speaking, and educated. When someone is labeled as “diverse,” this may unintentionally uphold the stereotypes we are trying to end.

Therefore, when discussing diversity, it is only appropriate to evaluate the relational makeup of the body by the individuals it is composed of. Too often statements will be made that an organization is “not diverse.” But that statement is ambiguous as to what context diversity is being evaluated. Without context, it remains difficult to address the underlying issue.

For example, let’s compare two examples of a team of five emergency medicine physicians. Team A contains three white males, one white female, and one Hispanic female. Team B has one white male, two black females, one Hispanic female, and one Asian male. Without a qualifier as to how diversity is being measured, it is easy to conclude Team B is more diverse than Team A. By default, many of us will automatically use the lens of race and gender. But if we then knew the issue these teams are addressing was: “how to help emergency physicians at the start of the COVID-19 pandemic access childcare options as schools are shutting down,” this context changes based on the above demographics. What if I told you Team A are between ages 30 - 65 years of age and all have school age children from 5 to 18 years old and members of Team B are all over 70 years old and do not have children or have children who are adults? Now “diversity” changes context. Would Team A be better equipped to tackle this topic, despite their apparent lack of subjective diversity? Likely so, considering this scenario and the diverse range of school age kids and family units (single parent vs. joined, etc.) they represent.

The trick, of course, is to create an organization that has a wide range of diversity no matter how you evaluate it. Openly defining exactly what diversity means to a group can help create trust and communication from the get-go.

Inclusivity

While diversity is measured as a relation to a whole group, inclusivity is measured by each individual and how they relate to the group. It boils down to how welcomed and valued does that individual member feel in relationship to the organization? Another way of thinking of inclusivity is all people in the group feel welcomed to share their opinions and that they are being heard.

While diversity is easy to achieve as a metric and keep it static, inclusivity is more fluid and requires a constant commitment and plan to maintain it. From the previous example, even if an organization has a diverse group of parents of school age kids, they will not feel included in helping to develop the solution to the problem if they are often looked down upon for bringing up the challenges they face. To understand this, I want to highlight a standout example from an emergency physician group’s leadership during the pandemic. Their partners met virtually and created “breakout rooms” where those challenged by loss of childcare, for example, could gather and share best practices with each other, and also highlight these challenges to the leadership. In this way, physicians felt included in the problem-solving process and felt encouraged to share their struggles.
**Equity**

I am a non-white male who was privileged to grow up in an affluent middle-class neighborhood. I am ethnically and culturally East-Indian, often mistaken as Hispanic, especially living in Southern California. Based on this, I can quickly come up with a list of life moments where being of a darker skin tone created a challenge or disenfranchised me both professionally and personally. However, I can also think of moments where being an East-Indian male was considered a positive and resulted in some privilege. So, it is hard to say that I want to be treated “equally” to anyone, because that would again reinforce the stereotype that we should all be the same and I would lose what makes me unique and different. I do, however, wish to be treated with equity and I hope I can continue to promote opportunities of equity for others.

According to National Book Award-winning writer Ibram X. Kendi, who was a keynote speaker at ACEP 2020, inequity is fundamentally about policy that has the result of treating people differently, regardless of how well-intended the policy may be. Equity is about outcomes, not about effort or intent. In his book *How To be an Anti-Racist*, he says, “racial inequity is a problem of bad policy, not bad people.”

No matter how much work is done, barriers, biases, and stereotypes will continue to exist. One of the healthiest things I have noticed over this last year is the newfound focus on uplifting and recognizing groups that are being disenfranchised. Calling out privilege or biases helps us get closer to treating everyone humanely and fairly. It also makes it more likely that we will see potential inequity of the social, economic, or health policies we promote.

**How does CalACEP measure?**

I will start with the raw data on age and geography because ACEP has that data for all their members. As of January 1, 2021, 52% of our members were under the age of 40, with the largest age group being those in their thirties at 34%. More detail is shown in the “CalACEP Age Demographics” chart below.

In terms of geography, the region with the largest number of members is Los Angeles, followed by the Bay Area. The majority of our members live in Southern California.

ACEP asks members to self-report data on gender and ethnicity. Because it is self-reported, the data is less complete, but still useful. According to ACEP’s data, 2,179 CalACEP members identify as male, 1,128 identify as female, 2 members identify as other, and 188 have not submitted gender identity. Ethnic data is less complete than gender. Approximately one-third of CalACEP members have not reported ethnicity to ACEP. The following graph displays what data we have from ACEP.

The following is my personal perspective as I evaluate our organization and how we measure on the big three.

One of things I have been most impressed with at CalACEP is that we have always had a focus on ensuring diversity, in many different contexts, on our Board and among our leaders. We haven’t always
gotten it right, but we try, and we never stop reexamining and striving to improve. While our Board is currently composed of individuals from a variety of gender, ethnic, age, geographic, and group perspectives, I feel we have been lacking in two areas specifically. From a race perspective, our Board is visibly lacking the perspective from our black emergency medicine colleagues. While I have unfortunately been called a terrorist and told to go back to my country (for the record I was born in Rochester, NY), I know I cannot understand what it feels like to be perceived as the “affirmative action admission” to medical school or what the bedside experience is for black emergency physicians practicing in EDs serving predominately white communities. In addition, physicians from many EM groups have served on the CalACEP board over the years, there has never been a physician practicing with the Southern California Permanente Medical Group. By constantly assessing our gaps, we can continue to reach out to and inspire members to run for the Board.

Ultimately, the composition of the Board is up to you, our members. I encourage you to reflect on what gaps you see on the Board and what you want it to look like. I encourage you to run for the Board and to motivate others to do the same. I encourage you to participate in the Board election; your vote matters and you can make a difference. A few elections have come down to less than ten votes for the final spot on the Board. Help shape the organization’s Board to reflect the diversity important to you.

I also feel proud that we generally do a good job with inclusivity on our Board. Board members feel like they have a voice and can be heard, and we make a conscious effort to invite the perspectives of all Board members, even when some would initially prefer to stay quiet and observe.

However, I feel this inclusivity is much less strong when it comes to our larger membership. Of our 3,400+ members, frequently we notice only about 10% are actively engaged in Chapter events. While all members benefit from the Chapter activities, often I am approached by CalACEP members who have great ideas that have the potential to benefit all of us. However, many are hesitant to share their perspective beyond a private conversation. Therefore, it has been my objective during my presidency to continue to ensure that each of you feel encouraged and welcomed to share your perspectives and ideas beyond a private conversation. Therefore, it has been my objective during my presidency to continue to ensure that each of you feel encouraged and welcomed to share your perspectives and ideas beyond the behind-the-scenes conversations at CalACEP Board of Directors, committee, or workgroup meetings. While the pandemic unfortunately eliminated in-person meetings, one of the advantages has been the ability to meet virtually. This eliminated the time and financial barrier that precluded many members from attending the in-person Board meetings in Sacramento. I encourage each of you to take advantage of the virtual aspects of our CalACEP gatherings and listen in on the meetings we run and issues we face. Colleagues have dubbed it the “Gulati Challenge.” You can just listen if you would like, but by the end of the meeting I hope you will have commented on an item or voiced your opinion. You are welcomed to turn on your camera and come off mute.

Evaluating how CalACEP measures in equity is probably the hardest for me to answer. I believe we must continue to pause and consider how each discussion, action, policy, or vote is impacting each aspect of our membership. All the policies we adopt as a Board and a Chapter are intended to be equitable. But, as discussed above, inequality is about outcomes, regardless of intent. Sometimes an unintended consequence reveals itself in time. However, because we think we are being fair when we adopt the policies, it becomes inherently difficult to see an unequal result. This is why inclusion is so important. As an organization, we need you to help us see where we have fallen short and what we need to reexamine. Email us, call us, let us know what we aren’t seeing. Help us continue to grow. It is my sincere hope that you will engage with us, now and over the course of your career, and provide us the feedback we need to have a vital, diverse, inclusive, and equitable organization.

A year may have passed since the tragic death of George Floyd, but our work must go on with the same urgency that people felt a year ago. It is a journey that may have different highs and lows, but one that we must continue, even if we don’t have all the answers. We can improve the lives of all emergency medicine physicians and our patients, especially those who for too long have not had the voice and justice they deserve.

REFERENCES
While much of the world has come to a halt due to the COVID-19 pandemic, advocacy in the California State Legislature continues to move ahead. Things look a lot different than they used to: meetings are held over Zoom, there will be fewer committee meetings, and advocates cannot just drop by a Legislator’s office to talk about an important issue, among many other changes. In 2021 the Chapter is sponsoring two bills: AB 451 by Assembly Member Joaquin Arambula, MD and AB 685 by Assembly Member Brian Maienschein.

**AB 451 (Arambula) – Emergency Mental Healthcare Access**

AB 451 is the reintroduction of our 2017-18 and 2019-20 sponsored legislation, by the same number, that was defeated in 2018 and held due to COVID-19 in 2020.

As you know, after an evaluation by an emergency physician, and treatment of any other emergency medical conditions, some patients need additional psychiatric services not available at that hospital and require transfer to a psychiatric hospital to receive a higher level of mental health care. Unfortunately, patients encounter several barriers to getting this care. AB 451 seeks to remove one of those barriers.

Chapter members report that psychiatric hospitals routinely ask for the insurance status of a patient before determining if they will accept the transfer, even though in some instances this violates current law. In other instances, EMTALA does not apply. Similar to EMTALA, California law ensures that everyone who comes to an emergency department (ED) is treated for their emergency medical condition, regardless of their ability to pay. Because not all hospitals have the capability – due to lack of available specialists or capacity - to treat every condition, this law also requires hospitals to accept transfers of patients with emergency conditions from another hospital. Hospitals are expected to accept an appropriate transfer of an unstable patient and cannot ask about payment until the patient is both medically and psychiatrically stabilized. However, this law does not apply to stand-alone psychiatric hospitals that do not have EDs. AB 451 ensures that standalone acute psychiatric hospitals accept transfers under the same conditions as other hospitals and prohibits financially screening patients before accepting them.

**AB 685 (Maienschein) – Health Care Service Plans: Reimbursement.**

To save money, some payers routinely and arbitrarily “downcode”, the claim to a level 3 or 4 and pay at the lower level. Some payer software systems appear to do so based on automated criteria such as final diagnosis, but other reasons are unclear. These downcoding patterns are arbitrary because they involve no review of the medical record documentation.

Based on confidential information provided by emergency physician groups, dozens of payers downcode more than 10% of claims with some payers downcoding as many as 69% of all claims. When these claims are appealed, the downcoding is overturned on average 60% of the time with some payers being overturned 98% of the time. The cost to dispute these claims is approximately $30 per claim. Because of this cost, not all groups appeal downcoded claims. The average underpayment is $190, resulting in millions of dollars of losses to the emergency care safety net that should be going to increased staffing and patient care.

While legitimate disputes over coding will always exist, routine and arbitrary downcoding as a cost-savings measure should not be sanctioned as it delays payment and shifts the cost to emergency physicians to appeal appropriately coded claims. AB 685 would require health plans and insurers to have a board-certified emergency physician review a claim before it can be downcoded.

At the time this article was written, AB 451 (Arambula) and AB 685 (Maienschein) were awaiting their first committee hearings and the California ACEP Board had not yet finalized the organization’s positions on other legislation.

California ACEP continues to monitor and review legislation throughout the year as bills are amended. The Chapter will keep you up to date on our sponsored bills and other important legislation impacting emergency physicians during the 2021-22 Legislative Session.

If you have any questions about the legislative or regulatory process, feel free to contact us at info@californiaacep.org.
He came in by ambulance short of breath. He was already started on CPAP by EMS. Still, he was clearly working hard to breathe. He looked sick. Uncomfortable. Scared.

As we got him over to the gurney and his shirt off to switch to a hospital gown, we all noticed the number of Nazi tattoos. He was solidly built. Older. His methamphetamine use over the years had taken its usual toll and his teeth were all but gone.

The swastika stood out boldly on his chest. SS tattoos and other insignia that had previously been covered by his shirt were now obvious to the room.

“Don’t let me die, doc.” He said breathlessly as the respiratory therapist (RT) switched him over from CPAP by EMS to our mask and machine. I reassured him that we were all going to work hard to take care of him and keep him alive as best as we could. All of us being a team that included a Jewish physician, a Black nurse, and an Asian respiratory therapist.

We all saw. The symbols of hate on his body outwardly and proudly announced his views. We all knew what he thought of us. How he valued our lives. Yet here we were, working seamlessly as a team to make sure we gave him the best chance to survive that we could. All while wearing masks, gowns, face shields, and gloves. The moment perfectly captured what we are going through as healthcare workers as this pandemic accelerates.

We exist in a cycle of fear and isolation. Fear of getting sick on the front lines. Fear of bringing a virus home and exposing our families. Fear of the developing surge of patients. Fear of losing our colleagues. Fear of not having what we need to take care of patients. Isolation because we do not want to be responsible for spreading the virus, knowing that we are surrounded by it on a daily basis. Isolation because no one else can truly understand this feeling, these fears, and the toll of this work. But we soldier on.

Unfortunately, society has proven unwilling to listen to the science or to our pleas. Begging for people to take this seriously, to stay home, wear a mask, to be the break in the chain of transmission. Instead, they have called the pandemic a hoax, called us liars and corrupt, told us we are being too political by worrying about patients dying and trying to save lives. They have stopped caring about our lives, our families, and our fears, worried only about their own.

He was already on high respiratory support and still working hard to breathe so I asked him about his code status and if he would want to be intubated, knowing that was all but inevitable and before the hypoxia made him more confused and unable to answer. He said that if a breathing tube were the only way he could survive, he wanted us to do everything we could. So, we would. We were out of other options by this point, so we prepared.

I have faced these situations countless times since medical school. Not the intubation - which is routine at this point for me and my team. The swastikas. The racist patients. Every single time I feel a bit shaken, but I went into this job wanting to save lives and every single time I have been able to smoothly and quickly move through those emotions to do so. “They came here needing a doctor, and dammit Taylor, you’re a doctor” is a mantra I have repeated to myself when I feel like my empathic core wanes.

As I stepped out of the room to gear up for a high-risk procedure and grab equipment, I checked my PPE. I had my N95, face shield, gown, and gloves. Was I safe? Was my team safe? I pause to check and make sure I had all my equipment and backups if needed. I run through the meds and plan with the nurse and RT. I pause. I see the SS tattoo and wonder what he might think about having a Jewish physician taking care of him now, or how much he would have cared about my life if the roles were reversed.

For the first time, I recognize that I hesitated, ambivalent.

The pandemic has worn on me, and my mantra is not having the same impact in the moment. All this time soldiering on against the headwinds, gladiators in the pit.

And I realize that maybe I’m not ok.

Dr. Nichols is a CalACEP Board Member. Prior to that he was the CalACEP Advocacy Fellow.

This article was adapted from the following Twitter thread: https://twitter.com/tnicholsmd/status/1333391178738274305
I have been to the hospital countless times over the last few years, and you are the first Black doctor that I have met to take care of me. Thank you for being here.” He was a young Black male paralyzed from the waist down after a gunshot wound to the spine. He had been in and out of the hospital due to complications from his paraplegia. He was trying to get his life together, but reoccurring and new obstacles prevented him from achieving the life he wanted.

I felt a mix of emotions, unsure whether to feel pride or disappointment in what he told me. I said, “You’re welcome,” and told him I was doing the best job I could, yet I left his room slightly disheartened. Cognitively, I knew that I was among an incredibly small minority of physicians at my hospital and in medicine overall, but hearing his words sparked a better understanding of how important my role as a Black male physician is in emergency medicine and in my community.

One of the attributes that attracted me to emergency medicine was the opportunity to care for patients from all walks of life, no matter their ethnicity, religion, or economic class. As a Black physician, I especially took pride in caring for members of my community, a group that is often underserved. It is well documented that medically underserved populations have increased trust in physicians who are underrepresented in medicine, increased adherence to physician recommendations, and even decreased hospital and ED utilization.1

Despite the growth of emergency medicine as a field, we have had lower application rates from women medical students and students underrepresented in medicine than expected from the general population.2 One documented reason for the lack of diversity in the emergency medicine applicant pool is the lack of diversity among emergency medicine faculty. Currently, approximately 10 to 15 percent of EM faculty are underrepresented minorities.3 As a trainee, I felt fulfilled by the patients who received our care but often discouraged by the lack of emergency medicine mentors with whom I had shared experiences.

WHAT WE CAN DO

For our specialty to diversify its physician pool, it is imperative to understand the challenges underrepresented minorities face in medical school matriculation and the factors that motivate interest in emergency medicine. Quantitative and qualitative research cataloging the obstacles to medical school matriculation for minorities includes, but is not limited to, a disproportionate number of minorities educated in school districts with fewer resources, lack of positive role models or sponsors, barriers from bias and stereotyping, the financial cost of higher education, poor socialization to the pre-med process, and a dearth of visible underrepresented minorities in medicine.4 A recent study also showed that lower interest in emergency medicine was independently correlated with sex and ethnic or racial profile. The odds of underrepresented students in medicine planning careers in emergency medicine were 32 percent lower than their majority peers.
Age, level of indebtedness, plans to practice in an underserved area, and advice from mentors were shown to be positive predictors of emergency medicine interest.5

I am all too familiar with the obstacles that many minority students face, but I was fortunate to have supportive mentors to help guide me along a path toward medical school and a career in emergency medicine. The data are clear. Emergency physicians who are underrepresented minorities in medicine can have an enormous impact on the trajectory and talent acquisition pipeline of minority students. But we can’t do it alone.

Acknowledging the consequences of underrepresentation in emergency medicine, the Society for Academic Emergency Medicine and ACEP have included diversity and inclusion in their mission goals.1 In 2008, the Council of Emergency Medicine Residency Directors provided national expert recommendations to address the diversity gap in emergency medicine. Unfortunately, these recommendations have not been sufficiently adopted across residency programs. Common reasons include a lack of dedicated resources in some cases, and diversity not even being a priority in others.6 Identifying local faculty members who can lead these efforts is crucial, as is compensating them for their time, just like any other leadership role.

Our country’s demographics are rapidly changing, and our specialty needs to start better mirroring our patient populations. Recent events and tensions have especially highlighted the importance of equity, diversity, and inclusion in medical education and training in emergency medicine. To create change, medical school and residency program leadership across the country needs to engage and make this a priority. Numerous authors, workgroups, and organizations have provided tactics for addressing this issue, including:

- Underserved community outreach and engagement
- Creation and participation in pipeline activities to increase the proportion of underrepresented students, trainees, and faculty
- Holistic review when screening applicants for medical school and residency selection
- Promotion of cultures that nurture productive conversations about diversity
- Strategic recruitment and retention of underrepresented students, trainees, and faculty 4,7,8

As a physician of color, I embrace my responsibility to do what I can to reach these goals. For these goals to be accomplished, there must be buy-in from everyone and I invite all of my colleagues to join in this pursuit. This is not only for the benefit of our specialty but most importantly to provide the best care possible to every single one of our patients, regardless of who they are.

REFERENCES


On December 14, Sandra Lindsay, a nurse at Long Island Jewish Medical Center, was the first person in the United States to receive the Pfizer COVID-19 vaccine following its FDA approval a few days prior. Dr. Michelle Chester administered the vaccine. Photos of the event have circulated print, digital, and social media. In the setting of the devastation that the coronavirus pandemic has had on marginalized communities, the visual of a Black female nurse receiving the vaccine from a Black female physician is powerful. But, it also feels disingenuous.

Equitable access to the vaccine for the communities most impacted by the disease is critically important, but will be difficult to actualize given the current state of our healthcare system, which has seeded mistrust within communities through years of racist practices while currently lacking the representation needed to address the most pressing questions of this community.

The mortality rate from COVID-19 in Black, Indigenous, Latinx, and Pacific Islander communities has been roughly three times higher than in non-Hispanic White populations. This inequity is not explained by biological differences alone, but rather influenced by social and structural determinants of health like economic deprivation and systemic bias. As such, and to mitigate further harm to these communities as the pandemic progresses, a case has been made to prioritize access to the vaccine based on their risk factors as well as the unjust burden of disease felt by minoritized Americans, many of whom are also essential workers. But when will members of these communities receive their vaccines?

Given their risk of exposure and value to local communities and economies, essential workers will be among the first in line for the coronavirus vaccine. Yet, only a subset of essential workers have been prioritized to have access to the vaccine in the first phase: the healthcare workforce. It is reasonable that, given limited doses of the vaccine, the vaccine should be made available to healthcare providers and staff who directly interact with the sickest COVID-19 patients. However, while Black, Latinx, and Indigenous people together represent more than one-fourth of the US population, they make up 42% of the essential workforce, comprise less than 9 percent of nurses and 6 percent of physicians. Diversity among other healthcare occupations including pharmacists, respiratory therapists, and health technologists, is similarly lacking.
Despite earnest efforts to prioritize vaccine access for marginalized communities, the exclusion of racial and ethnic minorities from the healthcare workforce has significant implications for who has the earliest opportunity to receive the vaccine during this most pressing third wave of the pandemic. That is to say, structural barriers that exclude members of communities of color from entering the healthcare workforce are, in doing so, also excluding members of these communities from gaining access to the first phase of vaccination.

But the impact of this lack of representation in the healthcare workforce may have even more insidious downstream effects. As we approach vaccination of the general population, there is concern that vaccine hesitancy may lead to suboptimal uptake in already marginalized communities. Healthcare has a long history of violence against structurally vulnerable communities, not the least of which is exemplified by the Tuskegee experiment and present-day inequities in maternal mortality, and the fear of medical institutions by some members is valid. Why should anyone have faith in a system which has not yet earned the trust necessary to accept treatment at face value?

Millions of Americans of color have flocked to social media looking for answers from influencers, bloggers, and healthcare providers alike. Some of our colleagues have called upon community leaders and celebrities to reassure Black Americans that the vaccine is safe. These phenomena serve to illustrate that, in healthcare, people of color do not see a system which represents them or works for them. Some of this is due to how our system works, some due to who is part of it, while some is the result of years of communal mistrust. Greater racial concordance is certainly part of the solution, but for the same reason that our patients avoid the healthcare system, so do many would-be healthcare practitioners who do not feel welcome in healthcare. We are generations away from actualizing the goal of a more representational healthcare system. But, we cannot afford to wait.

What we are watching is a system at work that, despite the interest in change and justice, relies on public policies, institutional practices, cultural representations, and other norms that work in various ways to continue to reinforce and perpetuate racial inequity. This is, in fact, the definition of “structural racism.” We want to provide better care, but we lack the tools necessary to fulfill our promise. The coronavirus vaccine is itself a case study of how intent and initiative may not result in the outcome of interest; not due to personal biases but rather systems that limit the effectiveness of our medicine and harm the communities we serve.

The photo of Dr. Chester and Ms. Lindsay presents a powerful paradox. It is an image to which we can and should aspire. Equal access to the vaccine for the communities most impacted by the virus is a step toward health equity. However, health justice necessitates the much more challenging project of constructing a healthcare landscape in which members of marginalized communities see themselves fully integrated, feel safe and empowered, and are valued - not just in photos but in everyday practice.

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Growing up, I would always be mad at my immigrant father when he told me to put my head down, not make any waves, and shoulder past any indignities hurled at me. I saw it as fundamentally unfair. We would end up in yelling matches over it.

However, especially over the past year, I've understood more and more why he would tell me that. He's seen that putting your head down is the way for minorities to move forward to "get ahead." He's seen that we have different rules to play by.

Being Asian American is complicated.

My parents were immigrants, here to chase that "American Dream" - that dream that if you work hard, you'll be fairly rewarded and can become successful. Admittedly, my parents have done well, starting here with a few dollars in their pocket and a dream. Their hard work has helped me become the doctor I am today.

And as part of their struggle to make it here in America, they were shown that to be safe - to get ahead - they had to try to assimilate, to try to play "the game".

However, that game in America has been fundamentally unfair for a long time.

The "model minority" myth is disastrous for everyone. Asians are weaponized as what people of color in America can strive for "if you just work harder." But do you know what comes with that? Internalized racism. Guilt to speak up about racism if we've become successful. It comes with fear to speak out and risk being that troublesome individual, threatening the success we've tried to build.

The myth ignores all the Asian Americans who are struggling to get by and forgets that we're not monolithic. The myth makes it so that there is a fear of speaking out about racism towards us, because "it's not as bad as other races have it."

The "game" - the American Dream - has us pitted against each other to try to get by. Individual freedom at the expense of others.
The model minority myth also comes with the marginalization of racism directed towards Asian Americans. It comes with the lack of others stepping in to recognize and help fight out against racism directed at us.

It’s great that recently, #StopAAPIHate and #StopAsianHate are trending. But, why so late, especially with the rise of Xenophobia over this past year? Will it actually translate into action? Why did it take 6 Asian women dying by a single individual to spur on the movement?

Throughout my life, I have experienced plenty of “benign” racism - nonviolent racism that I often shrug off. I’ve had patients tell me that, “If I had a nice Asian wife like you, I would never need to come to the hospital because you’d be submissive and take care of my every need.”

However, over the past year, I’ve been in situations where I have had violent racism directed toward me while I’ve been trying to administer care as a physician. In one situation, I was scared for my life, legitimately worried that a patient would grab my scalpel and stab me.

Sure, battling COVID in the emergency department has been tiring, and being worried I’d bring COVID home to my family has been stressful.

But COVID never scared me as much as these violent racist encounters have. In those situations, I’ve had people of color offer to step in, to help me out - because they know what it’s like to feel scared and threatened by racists. But you know who didn’t step in, during those crucial events? People of privilege and power.

I could not transfer the care of this patient to the other people of color for fear that this patient would hurt them too. I continued to care for this violent individual because I didn’t have the words to tell the people in power that I couldn’t do it, other than jokingly saying “I’m scared for my life.” In the moment, I couldn’t say, “I need you to do this for me. I can’t do it.”

I didn’t have the words because in healthcare we promise to take care of all people, knowing that despite their mental illness, medical illnesses, racism, etc. we still have a duty to give care.

Plus, as a model minority and a female, I had to live up to the expectation that we can handle anything and be successful. As a model minority, racism against us “isn’t as serious.” So, I followed my father’s experiences and advice and put my head down, brought in a security guard, and administered care. I’m sure my father would never want me to be in danger, but that is the struggle minorities deal with so often. We worry that our shortcomings will reflect badly on our race, our gender, or our identity. We take on the abuse so as to not be seen as a problem.

This is NOT an indictment of the individual places I work - there are many great allies and we’re working as a community to be better when it comes to being anti-racist. But my story is a greater commentary on what I’ve seen on our societal level. Those of privilege and power - whether it comes from their skin color, their job title, their seniority, their social standing - often time fail to recognize the power they have if they offer to help. Ever since, I’ve been working in my community to be better about speaking up, when I have the bandwidth to do so. I invite you to speak up as well.

Do you want to truly be anti-racist and help the minorities around you? Step out of your comfort zone. Show up. Step in.

Don’t know how? That’s okay. Support your colleagues by learning. Look up “Guide to Bystander Intervention” and start there. You will make medicine that much safer and open the door to more diversity.

Dr. Yap is a PGY-3 and the Immediate Past President of CalEMRA.

She would like to acknowledge her father, who is truly one of the most giving, loving humans she knows - even if he’s not the best at verbally saying it.
While the United States population is becoming more and more diverse, diversity within the physician workforce continues to lag significantly. There is clear evidence supporting diversity in medicine: it improves population health, increases innovation, and advances research and infrastructure to better care for the medically underserved. Despite several initiatives, there has not been any significant impact to sustainably enhance representation in medicine.¹

For one, as a first-generation physician, my circuitous path in medicine has led me to question whether or not I belong in this field. I later learned that this is called the imposter syndrome. Imposter syndrome is not unique to underrepresented in medicine (UiM), although our experience is intensified. The lack of role models along the way who can normalize the struggles of medical school and residency training reinforces this feeling of “otherness.”

Imposter syndrome has been detected more commonly among women in medicine. One study found that female medical students were twice as likely than their male counterparts to experience imposter syndrome. More concerning, imposter syndrome is associated with symptoms of burnout.² A similar finding showed female residents reporting significantly higher imposter syndrome, which correlated with higher levels of burnout, especially among senior residents.³

Imposter syndrome is not unique to trainees. Attending physicians also experience being an imposter, often during career transitions including starting a new job or a new role.⁴ Imposter syndrome leads to an aversion to taking risks, indecisiveness, and even procrastination for fear of failing.⁵

How does one overcome imposter syndrome? Simply put, it’s not that easy. While self-compassion allows us to practice self-kindness instead of self-judgment, the nature of medicine is that of volatility, uncertainty, complexity, and ambiguity (VUCA). Providing formal mentorship creates a supportive environment that helps normalize many challenges physicians who are UiM commonly experience.⁶ Unfortunately, just like no amount of resilience-building initiatives can overcome inefficiencies of practice that lead to physician burnout, no amount of self-improvement, introspection, mentorship, and sponsorship can overcome structural challenges in medicine.

The VUCA environment fosters self-doubt and undermines confidence. One detrimental manifestation of this internal struggle is through microaggressions, which are subtle slights and insults. Microaggressions are a frequent “othering” experience for UiM, further preventing one’s sense of belonging. Microaggressions, when added to implicit or unconscious bias, exacerbate one’s imposter syndrome.

It is important to acknowledge that we all have our own biases and having them does not automatically make us racists. Unchecked, however, these biases have significant downstream adverse effects and may manifest as racist decisions.

Bias starts early in our development, and in medical school, it is commonly seen in evaluations. Even after controlling for USMLE Step 1 scores and other factors, underrepresented minorities were more likely to have lower clerkships grades.⁷ Deeper investigation on the descriptive narratives of evaluations showed that words such as “exceptional,” “best,” “outstanding,” and “bright” were more likely to be seen in White students.⁸ It has also been revealed that racial and ethnic disparities exist in membership to the Alpha Omega Alpha Medical Honor Society.⁹

At the residency level, one study compared gender differences in achievements in milestones in emergency medicine across 8 programs. They found that while both genders achieved similar milestones during the first year of training, by the third year of residency, male residents received higher evaluations than their female counterparts.
in all sub-competencies reviewed. This gap translated into a difference of 3 to 4 months of additional training, despite no difference in actual training exposure.10

Another study highlighted one potential explanation upon evaluating the written qualitative feedback attached to the ACGME milestones. They found that female residents were more likely to receive strong criticism than male residents. Furthermore, when male residents struggled, they were more likely to receive consistently clear feedback from various attending physicians on areas they need to improve.11

Attending physicians are also not immune to implicit bias in medicine. As academic rank increases, unfortunately, women become more underrepresented despite two decades of women comprising half of all medical school graduates. According to the 2019 ACGME data, while 35% of EM residents are female, only 27% pursue an academic career with only 16% being represented at the chair level. The numbers while 35% of EM residents are female, only 27% pursue an academic program director at Stanford Emergency Medicine. He serves as the co-chair of the ACGEP/EMRA Diversity Mentoring Initiative. 

Dr. Alvarez, is a clinical assistant professor and the assistant residency program director at Stanford Emergency Medicine. He serves as the co-chair of the ACEP/EMRA Diversity Mentoring Initiative.

Imposter syndrome, microaggressions, and bias all affect one’s sense of belonging. Their cumulative effects curtail decades-long efforts to advance diversity in medicine. Belongingness is critical for inclusion. Only when we truly see diversity as a key to excellence rather than merely another metric in our dashboard will we finally improve representation in medicine. ■

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I was sitting at Starbucks with my mentor, a laptop between us open to a spreadsheet of residency programs. There were so many to choose from and I had no idea how to narrow my list. We discussed private versus county, large cities versus small towns, three year versus four year, and then he said, “consider if you want to be the only Indian in the program”. That comment surprised me. I had no column in my spreadsheet for diversity. Perhaps it’s privilege or naivety (or a combination of the two), but I had never thought to consider race or gender when making my career goals. I grew up in one of the most diverse cities in the country and my medical school’s emergency department has residents and attendings of all backgrounds, with the leadership mirroring this diversity. This isn’t to say I’ve never been exposed to others’ stereotypes. As a member of an all-female trio of my collegiate EMS leadership, I had to convince my male colleagues that a group of women could keep the system operational. In medical school I’ve had patients request I do not follow them because they did not want to be treated by a terrorist. While these comments irritated me, I was able to move past them and never thought that ‘female’ or ‘Indian’ would be labels that defined my career.

I spent more time looking at the resident facesheets of the programs I was interested in. Of course there were exceptions, but the majority of faces I saw amongst the faculty, residents and my co-applicants were white; and males often outnumbered females. In fact, I remember a co-applicant who came up to me during a pre-interview social and said, ‘I’m so glad I am not the only person of color at this interview!’ I began to ask about diversity at each interview, and most acknowledged that this was an area the program was working on. However, one person told me, ‘I’ll be honest, if diversity is important to you this program probably isn’t for you’. This was an off-hand comment to a question the interviewer was likely not prepared for, and I hope was not truly indicative of the program leadership’s perspective. Nevertheless, it was hard to overlook.
It’s been nearly five years since I wrote the article printed above and, in that time, I have finished my emergency medicine residency training and am currently in fellowship. These have been a tumultuous five years, and the topics discussed in the ACEP Diversity Summit have unfortunately proven to be evergreen. After I was approached regarding the possibility of re-printing this article for Lifeline, I reread these words and remember the earnest sentiment in which they were written. Despite my optimism and the efforts outlined above, not much has changed in the make-up of the specialty. Many Black physicians continue to be pushed out of the workforce. Descriptions of racism in the workplace, from patients, colleagues, and superiors are well documented, and even more reports have come to light since the killings of George Floyd, Ahmaud Arbery, Breonna Taylor, and other Black individuals.

In response to the Black Lives Matter protests this summer, many medical institutions issued statements denouncing racism, including ACEP: “Racism is a social determinant of health. The structural racism we are witnessing nationwide undermines the health of individuals, families and communities we serve”. While important, these statements are just the first step. If we hope to address structural racism as a social determinant of health, we must also take steps in our capacities as individuals, physicians, and members of health care institutions, to eliminate racism within our walls. We must center, believe, and stand by our colleagues when they describe how racism impacts them. We must examine how each of our policies and practices impact the lives of those who identify as Black, Indigenous, and/or People of Color (BIPOC). Then, we must tear down and re-write those that cause harm. For if we cannot address racism in our own institutions, how can we expect our patients to believe our efforts in the community are sincere?

As an Indian woman in emergency medicine, I am still a minority in this specialty. My experiences with racism and inequity are not the same as those experienced by my BIPOC colleagues. While one groups’ experience is no more or less urgent to address than another’s, by joining together to support the BIPOC community, we will undoubtedly make strides in the advancement of equity for us all. I have and I will undoubtably continue to make mistakes in my allyship efforts. What defines us, however, is not the mistakes, but instead is how we acknowledge, apologize and learn from them. It is time for each of us to be, as President Obama said, “the ones we’ve been waiting for…the change we seek”. ■
Medical school was the first time in my career I was openly gay, but it was not without my own share of personal and professional fears that I might potentially be at a disadvantage because of it. It would be another two years before the landmark Supreme Court case Obergefell v. Hodges even guaranteed same sex couples the right to marry. It would be another half a decade until the Court extended Title VII of the Civil Rights Act to include protection for sexual orientation and gender identity. Needless to say, we have made significant social progress within the realm of LGBTQ+ rights since my first day in anatomy lab, but we still have a way to go. It was difficult sometimes to look around during my medical training and not have other gay or queer physicians within my institution who I could identify with. I realized early on that having a mentor in medicine was important and, through my involvement in organized medicine, I was able to network and find others who have navigated the waters of being out in medicine before me who have helped me throughout my training.

Even amongst individuals as educated as physicians and health care providers, I still experienced my own fair share of subtle discrimination—from changes in attitude from doctors or nurses when I made a comment in clinic that identified me as queer, to confusion during residency interviews when I talked about my partner who I was couple’s matching with. I consider myself fortunate to have been at training programs that supported me regardless of my sexual orientation, but I know there are others who have been significantly less fortunate than I have.

As emergency physicians, we have the opportunity to treat patients from all backgrounds, including vulnerable and underserved populations. However, as the patients we care for have continued to grow increasingly diverse, the composition of the workforce within medicine has lagged far behind. It has been well demonstrated that physicians who identify as underrepresented minorities in medicine work in medically underserved areas more frequently than their counterparts. Working alongside providers from different backgrounds also increases education and understanding of the many barriers people may face within healthcare.

The importance of encouraging more diversity within medicine, as well as more extensive education and training on how to care for patients who identify as sexual or gender minorities, should not be understated, especially as emergency physicians. Many patients who identify as LGBTQ+ may avoid regular care out of fear of discrimination and utilize emergency departments for a majority of their health care needs. As emergency providers, we serve a critical role in helping our patients navigate the difficulties within our own healthcare system and, by providing culturally sensitive care, we can positively impact the health of LGBTQ+ patients who come through our departments.
Even in 2021, data on LGBTQ+ individuals is limited at best. Sexual orientation and gender identity questions are not routinely asked by state and national reporting agencies and the LGBTQ+ community has historically been undercounted by the U.S. Census Bureau. Data on individuals who identify as a sexual or gender minority may also be limited partially out of concern that reporting could result in retaliation from employers and peers. However, research has shown that LGBTQ+ Americans face disturbing health disparities, including higher rates of hypertension in gay and bisexual men, higher rates of heart disease among lesbian and bisexual women, and significantly increased risk of suicide in LGBTQ+ youth, particularly in transgender men and women.3

Historically, we as clinicians have had little formal training in topics relating to LGBTQ+ health. A 2011 study of medical schools published in JAMA found that students receive approximately five hours total of LGBTQ-related content in their education, with almost a third of schools incorporating no content at all.4 Additionally, a 2019 study conducted by the Council of Residency Directors (CORD) in Emergency Medicine found that over a third of emergency medicine residents felt neutral to very uncomfortable addressing the needs of LGBTQ+ patients.5 This gap in knowledge creates significant barriers to caring for our patients and can further harm members of these communities. More than half of transgender patients in a survey by the National LGBTQ Taskforce reported having to teach their health care providers about transgender care.6 Even worse are the reports of patients who have encountered significant discrimination by providers or even refusal of services outright, particularly Black LGBTQ+ and transgender patients.7

It is important to incorporate education on sexual and gender minorities within all aspects of medical education to encourage cultural competency on this topic among emergency providers. This includes training at all levels, from medical school to residency and continuing medical education (CME). Even more important is to encourage efforts to increase diversity within our field and support our LGBTQ+ colleagues who are leading those efforts. This is a way to serve not only as advocates for our community and our colleagues, but to be on the forefront of all the changes we are seeing within our society.8

If you are interested in finding out more about providing culturally competent care to LGBTQ+ patients, visit: www.lgbtqiahealtheducation.org.

The Joint Commission has also published a Field Guide for LGBT patients: www.jointcommission.org/lgbt/.

For institutions seeking to incorporate LGBTQ-centered education, the AAMC created a resource that key stakeholders can use to guide curriculum changes: https://store.aamc.org/implementing-curricular-and-institutional-climate-changes-to-improve-health-care-for-individuals-who-are-lgbt-gender-nonconforming-or-born-with-dsd-a-resource-for-medical-educators.html.

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Dr. Pattison is the 2020-21 CalACEP Advocacy Fellow and previously served as CalEMRA President and a voting member of the CalACEP Board of Directors.
A MODEL PARTNERSHIP:
Mentoring Underrepresented Students in Medicine (URiM) in Emergency Medicine

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INTRODUCTION: Creating a racially and ethnically diverse workforce remains a challenge for medical specialties, including emergency medicine (EM). One area to examine is a partnership between a predominantly white institution (PWI) with a historically black college and university (HBCU) to determine whether this partnership would increase the number of underrepresented in medicine (URiM) in EM who are from a HBCU.

METHODS: Twenty years ago Emory Department of Emergency Medicine began its collaboration with Morehouse School of Medicine (MSM) to provide guidance to MSM students who were interested in EM. Since its inception, our engagement and intervention has evolved over time to include mentorship and guidance from the EM clerkship director, program director, and key faculty.

RESULTS: Since the beginning of the MSM-Emory EM partnership, 115 MSM students have completed an EM clerkship at Emory. Seventy-two of those students (62.6%) have successfully matched into an EM residency program. Of those who matched into EM, 22 (32%) have joined the Emory EM residency program with the remaining 50 students matching at 40 other EM programs across the nation.

CONCLUSION: Based on our experience and outcomes with the Emory-MSM partnership, we are confident that a partnership with an HBCU school without an EM residency should be considered by residency programs to increase the number of URiM students in EM, which could perhaps translate to other specialties. [West J Emerg Med. 2021;22(X)X–X.]

INTRODUCTION

Creating a racially and ethnically diverse workforce remains a challenge for medical specialties, including emergency medicine (EM). In 2008 a set of recommendations designed to augment physician diversity in EM was published; however, a recent study suggested that these best practices have not been widely implemented. The pilot intervention in this study included three strategies focusing on a scholarship-based externship, a funded second-look event, and increased involvement of underrepresented in medicine (URiM) faculty in the interview and recruitment process. In response to these findings, a group of emergency physicians with a focus on and expertise in diversity and inclusion reconvened in 2018. The group identified several strategies to recruit diverse applicants into EM. Among the most commonly discussed strategies was visiting elective clerkships for URiM students. These programs have proliferated in the last decade, with over 30 such programs in EM identified in 2018. However, as of this writing there has been limited data to suggest that the extent of impact of these URiM dedicated programs.

The challenge faced by EM residency directors in recruiting diverse applicants is in large part a reflection of the number of URiM within undergraduate medical education (UME). In a recent survey, 35% of program directors reported that the small pool of URiM applicants was the greatest barrier to recruiting a diverse class of residents. However, there are a small number of medical schools with a higher representation of URiM students; most prominent of these are the historically black colleges and universities (HBCU). Based on a recent Association of American Medical Colleges (AAMC) data set, there are only three HBCU medical schools: Howard University College of Medicine; Meharry School of Medicine; and Morehouse School of Medicine.

These institutions represent 2.4% of United States medical schools yet have 14% of all Black medical students in the US. Further, the mission and culture of these institutions generally emphasize care for the underserved and other principles of equity and justice that are considered to be core values of EM. The challenge, however, is that none of these institutions has an academic EM department or EM residency training program. This poses a significant barrier in recruiting students at HBCU medical schools who are interested in EM. In addition

Population Health Research Capsule

What do we already know about this issue?
Emergency medicine (EM) continues to have difficulty creating a racially and ethnically diverse workforce.

What was the research question?
Does a structured partnership between an EM residency and a historically black college and university (HBCU) medical school result in more underrepresented medical students in EM?

What was the major finding of the study?
A partnership between an EM residency and an HBCU medical school can help to increase the number of underrepresented in the field of EM.

How does this improve population health?
Partnerships like this can help to improve patient health outcomes, address healthcare disparities, and advance health equity.
to not having easy access to EM advisors or mentors during the critical stages of the application process, students at HBCU medical schools may not have the same exposure to EM during the foundational early years of medical school, when a student’s choice of residency training/specialty is often considered and in some cases, solidified.

Morehouse School of Medicine (MSM), a HBCU school in the city of Atlanta, does not have an academic EM department or residency training program and has more students that are URiM than the average US medical school. Founded in 1975, MSM has a student population that currently identifies as approximately 70% URiM. Another medical school in Atlanta, Emory University School of Medicine, has a large academic EM department and residency training program. Emory EM has had a nationally recognized history of supporting diversity and inclusion in EM with key URiM faculty publishing one of the first papers on how to improve diversity in EM.\(^1\) For the past 20 years there has been a meaningful partnership between MSM and the Emory Department of Emergency Medicine. Begun initially as an informal interaction, over the course of 20 years this relationship has flourished and become a more structured partnership that has resulted in significant outcomes with regard to matching MSM EM students.

### METHODS

In 1999 the Emory Department of Emergency Medicine began its collaboration with MSM to provide guidance to MSM students who were interested in EM. At the onset of this collaboration, it was primarily the EM clerkship director who provided more mentorship and group activities. Since then, the program has expanded to include engagement of more Emory EM faculty and residents. Every MSM student who expresses interest in EM can meet with the faculty leadership in Emory EM. This includes the clerkship director, assistant clerkship director, program director, and associate/assistant program director, as well as other EM faculty. In addition, there continues to be an increased effort to engage URiM faculty as mentors and role models for URiM students. These relationships incorporate shadowing opportunities, assistance with career decisions, guidance for planning away rotations, fourth-year scheduling, application assistance, interview guidance, and when requested by the student, help with their rank list decisions.

In addition, an Emory EM faculty member serves as the faculty advisor for the MSM EM interest group, and the interest group is also assigned a senior EM EM resident liaison. One key component of this partnership is the equitable treatment within EM of MSM and Emory medical students regarding opportunities and exposure. This includes the guarantee that MSM students, like Emory students, are given priority to the EM rotation in high-yield months. To evaluate the proportion of matches before and after the partnership, we submitted data to a regression using a beta distribution and a logit link. The change following 1999 was analyzed using a linear spline with a single knot at 1999. We conducted analyses using R v 3.5.1, R Core Team (R Foundation for Statistical Computing, Vienna, Austria)

### RESULTS

MSM had its first student match into EM in 1985. Since the beginning of the MSM-Emory EM partnership in 1999, 115 MSM students have completed an EM clerkship at Emory. Seventy-two of those students (62.6%) have successfully matched into an EM residency program. Of those who matched into EM, 22 (32%) have joined the Emory EM residency program with the remaining 50 students matching at 40 other EM programs across the nation. To compare the proportion of MSM students who matched into an EM residency before vs after the MSM-Emory EM partnership, we conducted a linear spline in a beta regression. The significance level was assigned to alpha of 0.05. The spline in the regression was significant (odds ratio [1.10], 95% confidence interval, 1.01 – 1.20, P = .03). This finding indicates that the proportion of EM matches began to increase following the 1999 partnership.

MSM has undergone a period of rapid expansion in terms of class size. To control for this expansion, we also assessed the MSM-Emory EM partnership with regard to the percentage of total MSM students who matched into EM each year. Before the partnership, the average percent of the total MSM class matching into EM was 3.01%. Since the inception of the partnership, the total percent of the class matching into EM is 6.65%, which represents an increase of 121.20%. We performed descriptive analyses to further assess the match outcomes of the partnership as it progressed. Specifically, in the last six years (2012-2018), the mean candidates matching per year increased from 2.07 to 5.67. In the most recent two years of the partnership to date (2017-2018), the average number of EM matches was 9.0, which represented 15.79% and 11.84% of the total MSM senior class, respectively. This two-year period coincided with the period during which an Emory EM faculty member became adjunct faculty at MSM, and the EM rotation was certified as a senior elective, thus allowing this rotation to count toward required graduation credits. Further, over the last 10 years, MSM has matched at least one student to EM every year, which represents a notable increase over the 10 years prior.
DISCUSSION

Over the past two decades, a successful partnership has developed and matured between the Emory Department of Emergency Medicine and MSM, resulting in a significant increase in the number of MSM students matching into EM. An increase in the diversity of residents and emergency physicians has been a goal for the Academy for Diversity and Inclusion in the Society for Academic Emergency Medicine, the premier organization for academic EM.12

Emergency physicians are at the forefront of patient care, and increasing the number of emergency physicians to align with the population we serve is a desired goal.13-15 For example, in 2017 there were 83,968 residents in US and Canadian allopathic medical schools, of whom only 13.67% classified as URiM.16 During the same period, out of 7136 EM residents only 4.42% of these identified as Black. This is clearly a significant disparity given that in the 2017 Census, 13.4% of the US population identified as Black.17

This level of disparity is especially problematic in a racially diverse city such as Atlanta, since previous literature consistently indicates that patient outcomes and satisfaction are improved when a patient and his or her physician share a racial and/or ethnic background.6,13,18-20 From its inception the MSM-Emory EM partnership has been intentional about closing this gap and has seen positive results. Since the partnership began, MSM has seen over twice as many students matched into EM or her physician share a racial and/or ethnic background.6,13,18-20 From its inception the MSM-Emory EM partnership has been intentional about closing this gap and has seen positive results. Since the partnership began, MSM has seen over twice as many students matched into EM and matured between the Emory Department of Emergency Medicine and MSM, resulting in a significant increase in the number of MSM students matching into EM. An increase in the diversity of residents and emergency physicians has been a goal for the Academy for Diversity and Inclusion in the Society for Academic Emergency Medicine, the premier organization for academic EM.12

In addition to continuing mentorship, application preparation, and previously noted activities, in 2017 an Emory emergency physician, who was the MSM EM faculty advisor, officially became adjunct faculty at MSM. Also, in that same year, MSM certified the Emory EM subinternship/clerkship as a senior selective, thus ensuring that it became part of the core curriculum for EM-bound and/or interested students who elected to take the rotation. Notably, in this same year, 15.79% of the MSM graduating class matched into EM, which is above the national average of the percent of US medical graduates matching into EM that year (9.16%).21

In our study there were 43 students enrolled in our EM elective who did not match in EM. We do not have details regarding their confidential rank list order or subsequent career choices. This missing data only strengthens our conclusion that our partnership was successful since we likely underestimated the number of students impacted by our mentorship who either ranked EM but matched in other specialties, or within several years were able to switch into EM.

This type of partnership requires a culture, climate, and commitment in diversity and inclusion for all students who have an interest in EM. Based on the success of the MSM-Emory EM partnership, we propose a multilayered approach to successful matching in EM residency programs for HBCU schools without an EM residency. Mentorship has been demonstrated to be a significant factor in URIM residency applicants being able to identify with a residency program; as such, mentorship has been maintained as the cornerstone of this partnership.8 Specifically, key aspects of this partnership include a dedicated group of Emory EM faculty and staff who provide the needed advising, mentoring, administrative support, and teaching throughout the MSM student’s years in medical school. From the perspective of a non-HBCU medical school, partnering with HBCU schools without a residency program in EM is an opportunity to increase URIM in EM and advance diversity and inclusion in the field.

Initiatives to increase URIMs in EM, including a paid elective, a funded second look and URIM involvement in recruitment, focus on later stages of a student’s decisionmaking process. Our focus is on a close relationship between an academic EM department and URIM students from a partner school to nurture an early interest in EM. As this relationship, mentoring, and advising continues throughout their medical education the opportunity of matching in EM is improved. Our holistic approach to EM mentorship for the MSM students has resulted in positive match outcomes exceeding national norms. We hope that the MSM-Emory EM partnership can serve as a model for other residency programs that value diversity and desire to increase the diversity of their residency classes in other specialties in medicine.

LIMITATIONS AND FUTURE DIRECTIONS

The program we describe has some identified areas for growth. First, although we discussed the many benefits of increasing URIMs in EM residency programs, we do not specifically describe the racial or ethnic demographics of the MSM students matching into EM. Over the course of the Emory-MSM relationship, specific racial and ethnic data was not collected, and doing so retrospectively would have been complex. It should be noted that although on average 70% of MSM students identify as URIM, MSM also accepts and trains non-URIM students who have benefitted from the Emory-MSM partnership. Future analyses on this partnership would benefit from additional information specific to race/ethnicity and also socioeconomic status.
Additionally, as this is a single institutional program, the statistics are limited by sample size and meant to be descriptive only. With the increasing numbers of students contemplating EM as a career and ultimately applying for residency, as well as the increasing complexity of the application process, we recognized the need to better formalize our partnership and provide a structure for interested medical students throughout all years of medical school. In the last two years, for example, structured “EM bootcamp” sessions which include simulations, application discussion, and rotation preparation, have been instituted prior to the start of fourth-year subinternship rotations.

CONCLUSION

The Emory-MSM partnership has shown success in increasing the presence of underrepresented students in EM with targeted intervention/involve/efforts in the early stages of a medical student’s specialty selection process. This type of program, which mentors URiM students early and engages them in multiple aspects of the specialty and its application process, should be adopted by other HBCU medical schools and all US medical schools. Given the limited published data, previous attempts to increase URiM student interest in EM, while likely beneficial, were less effective than our broad-based approach, or at this juncture, are unknown. Based on our 20-year experience with the Emory-MSM partnership and our outcomes, we are confident that our approach is effective and that partnership with an HBCU school should be considered by residency programs to increase the number of URiM students in residency programs.

ACKNOWLEDGMENTS

We wish to thank Dr. Timothy Moran for his statistical assistance in the crafting of this manuscript. In addition, we would like to thank Nanette Rushing our Medical Student Clerkship Program Coordinator as well as the countless faculty, staff, and patients who have contributed to the students’ education.

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REFERENCES

Diversity is a fact.

Equity is a choice.

Inclusion is an action.

Belonging is an outcome.

- Arthur Chan -
DEAF AND HARD-OF-HEARING

Learners in Emergency Medicine

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DOI: 10.5811/westjem.2018.8.38550
Deaf and hard-of-hearing (DHoH) individuals over the age of 12 comprise 23% of the U.S. population, and over 500,000 patients use American Sign Language (ASL). Disproportionate to the general population, allopathic medical students with disabilities account for only 2.7% (1,547) of the total medical student population and only a fraction of these (38) are DHoH students. Medical schools may unintentionally discourage DHoH students from entering specialties such as surgery, obstetrics and gynecology (OB/GYN) or emergency medicine (EM) given the lack of knowledge regarding this population and the false belief that accommodations are not possible, too complicated, too costly, or that trainees are simply unable to perform the duties of a physician. A recent paper suggests that students with disabilities self-report being counseled out of subspecialties such as surgery, OB/GYN, and EM, while a 2013 study shows that the majority of DHoH physicians (68%) practice in primary care specialties, supporting the idea that the majority of DHoH physicians do not enter subspecialties. It may be that experiences in medical school and visiting rotations negatively inform students’ choices to forgo these specialties. Despite a growing interest in the experiences of DHoH students, there remains a dearth of information about the experiences of this population in subspecialty electives such as surgery, OB/GYN and EM. To our knowledge only one article exists that discusses a DHoH student’s experiences in an anesthesia rotation.

Researchers suggest that the inclusion of DHoH students, residents and physicians in the medical education continuum could offer multiple benefits to peers and patients alike including increasing disability awareness, improving interactions with DHoH patients and family members; building empathy for persons with disabilities; and promoting an accessible and supportive environment for patients and physicians, including aging physicians who experience hearing loss as part of natural aging. DHoH patients may benefit from improvements in knowledge, attitudes, and communication that results from teaching medical students how to work with interpreters specifically in emergency department (ED) settings where communication is central to patient outcomes. This is especially relevant for the DHoH population that uses ASL, as these patients are more likely to use the ED, when compared to the general hearing population. Disparities in healthcare and poorer outcomes exist for DHoH patients. Language-concordant patient-providers fluent in ASL may help reduce these disparities. For example, a 2011 study showed that ASL users who received primary care from ASL-using physicians were more likely to use preventive services. It may be that physicians skilled at creatively navigating diverse and alternative forms of communication are able to provide more informed care to DHoH patients.

While reduced healthcare disparities for patients and a commitment to social justice should drive the inclusion of DHoH students in medicine, recent court decisions have supported qualified DHoH individuals in the healthcare workforce noting that DHoH individuals are appropriate providers when properly accommodated. Despite the courts’ support of DHoH students and employees, and the greater focus on diversity and inclusion in medical education, there remains a great deal of stigma for DHoH individuals in medicine. For example, concern has been expressed regarding effective communication with DHoH students. However, communication between non-DHoH physicians and teams is of equal concern in medicine. Techniques including establishing set protocols, using a check-back process to verify communication, and communicating the plan to the team members have proven effective in reducing communication errors in EM. The same recommendations that guide hearing physicians also allow DHoH students to operate within a team and to provide excellent care to their patients. The addition of DHoH students in the ED may reduce common errors among all physicians through (1) a focus on accurate translation, (2) patient care diversity awareness, and (3) improved access to care through increased cultural competency in working with the DHoH population.

**CASE REPORT ON DEAF STUDENT IN EMERGENCY MEDICINE**

A deaf medical student completed a one-month visiting rotation in EM at a medical school in the Western U.S. The student had a history of...
using hearing aids, cochlear implants, communication access real-time transcription (CART), Cued Speech transliteration, and ASL interpreters (Table). With appropriate accommodations, the student performed well in undergraduate and graduate school. The student used designated healthcare interpreters (DI) – sign language interpreters linguistically specialized in working with healthcare professionals – throughout the clinical years in medical school and during the visiting EM rotation. The DIs were provided by the student’s home institution who maintained financial responsibility for the interpreting services and full access for the student’s educational experience.

APPLICATION AND DISCLOSURE OF DISABILITY
The student applied to the EM rotation through the Visiting Student Application Service. Once accepted, and two months prior to the start of the rotation, the student notified the school of the need for accommodations. The student’s designated interpreter contacted the institution’s Americans with Disabilities Act (ADA) designee to request accommodations and to provide guidelines and guidance for working with a deaf student. Two weeks prior to the start of the program, the program director and disability director provided a brief educational outreach to the ED staff, including techniques for working with deaf students in the clinical setting. The student and DI were invited to share their insights about working in the department at the conclusion of the rotation.

The ED setting presents challenges for all students, specifically a fast-paced and stressful working environment, interacting with patients speaking multiple languages, tight and noisy working spaces, witnessing trauma and overall loss of control in emergency situations. Yet the deaf student’s feedback about the rotation was positive. The student and DI noted the inclusiveness of the experience in this environment, including a respectful, responsive and communicative team. For example, hospital staff directly approached the student, not the DI, when they had questions about communication (e.g., inquiries about the amplified stethoscope). Educational materials and experiences for students in the program were equally accessible for the deaf student, and the program expressed genuine interest and excitement regarding the diversity the deaf student brought to their program.

MECHANISMS FOR INCLUSION
The program director welcomed the student and set clear expectations for the ED team. The DI was included in every interaction from orientation to patient care. Access to orientation items and to the virtual learning platform were completely accessible as a result of being addressed proactively with the program director, student coordinator, disability services office, and designated interpreter. By requesting accommodations and accessible materials two months in advance, the student ensured 1) the addition of captioning to instructional videos contained in online learning platforms, 2) complete scheduling of the DI for didactic and clinical activities, and 3) the development of specialized medical sign language for the rotation (for terminology not currently designated in ASL) in advance of the student’s arrival. This collaborative approach facilitated access to the program, normalized the presence of a deaf student, and contributed to an inclusive and nonmarginalizing experience. Once the rotation began, the student identified potential barriers to the rotation including having to use a phone for consults, learning new clinical skills under traditional instructional models, responding to codes, and navigating field experiences, all of which could be removed using accessible practices. Each area is addressed below.

POTENTIAL CHALLENGES FOR DHoH STUDENTS

PHONE CALLS
While phone calls in the ED were a challenge for the student, these barriers were easily addressed. For this rotation, the phone was frequently used to access the language interpreting line, consult with the pharmacy, specialist physicians, and the laboratory. To facilitate phone calls, the student used assistive devices including adaptive headsets and video relay service. A speakerphone function or a two-way headset was the chosen method for facilitating phone calls, with the DI on each call interpreting for the student. This was a productive and effective method for removing barriers in this setting. A quick and professional disclosure that the student was using an interpreter or relay service reduced potential confusion when the student’s gender did not match the voice of the DI, or if the receiving party was unfamiliar with communicating with a deaf person.

LEARNING PROCEDURAL SKILLS
The acquisition of procedural skills is an essential part of any rotation. Standard EM procedures range from laceration repairs and venipuncture to central line placement and endotracheal intubations. The traditional model of “see one, do one, teach one” whereby students watch a demonstration of a procedure, practice a mock simulation, and then demonstrate competency to a preceptor needed to be modified for the student. Typically, when demonstrating a procedure, the spoken instructions and demonstration often occurred concurrently. For a deaf student, it is difficult to simultaneously focus on both the spoken instructions and demonstration often occurred concurrently. For a deaf student, it is difficult to simultaneously focus on both the procedure and the interpreter to capture the instructions. In these situations, the student felt empowered to request that faculty discuss the procedure first, followed by a demonstration of the procedure and the interpreter to capture the instructions. In these situations, the student felt empowered to request that faculty discuss the procedure first, followed by a demonstration of the procedure to allow the student to view the interpreting of instructions before shifting to the demonstration. Allowing time for verbal instruction in advance of demonstration was necessary for the deaf student to have full access to the material. While this approach to teaching the material is necessary for the deaf student it can also increase retention for all students by tapping into multiple learning styles.

CODES
During a code, communication is essential to ensure role expectations and the team’s approach to the case. When a deaf team member participates in the code they can easily follow their assigned role under the direction of the DI. Additionally, when deaf students become physicians and run a code they can develop strict communication protocols, ensuring that each team member understands designated hand signals. During this rotation, the student and the DI participated in several codes without incident. For each code, interpreter positioning...
was quickly identified and a line of sight was established to facilitate the student’s involvement and interaction with the code.

**FIELD EXPERIENCES**

As part of the rotation, the student was expected to complete a ride-along with emergency medical services (EMS). Excusing the student from field experiences had been the approach during other rotations; however, this program felt strongly that the student should engage in all aspects of the rotation and that the rotation should be fully accessible. The student and the DI were included in required field experiences, including the ride-along in the ambulance. Observing the EMS crew was the main learning objective of the experience. However, the crew was called to an acute incident during the ride-along that necessitated an all-hands-on-deck approach. The student was included in the response by using non-verbal communication (hand signals) and by handing appropriate supplies and pointing or guiding the student’s hands to the needed medical procedure. The DI facilitated verbal communication by establishing a position near the paramedic and emergency medical technician and interpreting essential instructions to the student.

The ADA was amended effective January 1, 2009, and new ADA regulations took effect March 15, 2011.26 In the most general terms, the amendments and regulations broaden the definition of a disability, lowering the burden of proof to establish oneself as a person with a disability. The law requires medical education programs, including undergraduate medical education (UME) and graduate medical education (GME) to engage in an interactive process (see Figure) with qualified individuals that includes a discussion about their disability-related needs. This process calls upon disability specialists, program directors and other identified stakeholders to investigate potential and reasonable accommodations that would allow equal access to the program. Appropriately responding to ADA requests for accommodation requires that UME and GME designees maintain a full understanding of federal regulations, are able to articulate the essential functions of their programs and have a command of reasonable and effective accommodations. This case study highlights the effective, respectful, and proactive process among the parties.

---

**TABLE.** Mechanisms for communication with deaf or hard of hearing students.

<table>
<thead>
<tr>
<th>Mechanism</th>
<th>Description</th>
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<tbody>
<tr>
<td><strong>AMERICAN SIGN LANGUAGE INTERPRETERS (ASL)</strong></td>
<td>A person trained in translating between a spoken and a signed language.</td>
</tr>
<tr>
<td><strong>DESIGNATED HEALTHCARE INTERPRETER (DI)</strong></td>
<td>A designated interpreter is a linguistically specialized sign language interpreter who works extensively with a deaf healthcare professional, making cultural and professional adaptations to the professionals’ career environment as appropriate.</td>
</tr>
<tr>
<td><strong>COMMUNICATION ACCESS REAL-TIME TRANSLATION (CART)</strong></td>
<td>A captioner (CART provider) uses a court reporting stenography machine, a computer and software to display everything that is being said, word for word. The text is displayed on a computer, television or projection screen.</td>
</tr>
<tr>
<td><strong>CUED SPEECH TRANSLITERATORS (CST)</strong></td>
<td>A visual mode of communication that uses hand shapes and placements in combination with mouth movements and speech to make the phonemes of spoken language visible.</td>
</tr>
<tr>
<td><strong>VIDEO RELAY SERVICE (VRS)</strong></td>
<td>Video Relay Service is a form of Telecommunications Relay Service that enables persons with hearing disabilities to utilize ASL to communicate with voice telephone users through video equipment, rather than through typed text. Video equipment links the VRS user with a TRS operator – called a communications assistant, or CA – so that the VRS user and the CA can see and communicate with each other in signed conversation.</td>
</tr>
<tr>
<td><strong>ADAPTIVE HEARING DEVICES</strong></td>
<td>A device that helps individuals with hearing loss or a voice, speech, or language disorder to communicate. (examples: Induction loops systems; FM systems, infrared systems; personal amplifiers, amplified stethoscopes, digital stethoscopes).</td>
</tr>
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**MECHANISMS FOR ENSURING COMPLIANCE WITH THE ADA**

**STEP 1:** Program and applicant work together to identify programmatic barriers and their impact on applicant’s ability to perform an essential function.

**STEP 2:** Determine whether or not the applicant can meet the essential functions of the program with or without accommodation.

**STEP 3:** Determine what, if any, accommodations are appropriate and reasonable to mitigate barriers to the program.

**STEP 4:** Determine whether or not a requested accommodation presents an undue hardship on the program.

---

**FIGURE.** Steps for engaging in the interactive process.
CONCLUSION

A number of methods exist that allow for the full inclusion of DHoH students in medical education including ASL interpreters, DI, Cued Speech transliterators, and adaptive hearing devices. DHoH students with appropriate accommodations, including assistive technology, are able to effectively follow procedural instructions, respond to codes, and respond to other environmental cues effectively, even though these tasks are communication-dependent.

Given the large number of people with hearing loss that affects communication access, it is critical that the growing number of DHoH physicians in the pipeline be well trained and positioned to provide effective, culturally sensitive care. This is especially critical when navigating the communication challenges in EM environments. As evidenced in this case study, the logistical hurdles to access for a deaf student in an EM rotation, and for DHoH students broadly, can be remedied with creativity, advanced planning, and the institutionalization of team-oriented learning environments that prioritize clear communication. This equips DHoH students to not only effectively handle a complex and diverse patient population, but also increases patient-provider concordance.

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Friday, September 10, 2021
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Samuel Lam, MD, MPH, FACEP was promoted to Clinical Professor of Emergency Medicine at the California Northstate University College of Medicine.

Jake Toy, MD received the Jean Hollister Contribution to Pre-Hospital Care Award from the Emergency Medicine Residents’ Association.

Benjamin Thomas, MD wrote the article “How to Reassure Black Americans That the Vaccine Is Safe” for the New York Times.

Gary Tamkin, MD, FACEP was nominated to serve as Vice Chair for the National Emergency Service Clinical Council.

Jessica Andrusaitis, MD started her fellowship in Multimedia Design Education Technology at University of California Irvine.

Lauren Van Woy, DO was matched at Rady Children’s Hospital, San Diego to do Pediatric Emergency Medicine.

Sophie Terp, MD; Elizabeth Burner, MD, FACEP; Madeline Ross, MD; Molly Grassini, MD; and Briah Fischer, MD published their paper “Deaths in Immigration and Customs Enforcement (ICE) detention: FY2018-2020”.

Kevin Durgun, MD will be starting the Global Health Fellowship at George Washington University in August.

June Gordon, MD was promoted to Assistant Professor at Stanford Emergency Medicine.

Mariame Fofana, MD and Ashley Rider, MD were named Outstanding Educators of the Month at Stanford Emergency Medicine.

Jonathan Hootman, MD received the Emergency Medicine Residents’ Association Critical Care Conference Scholarship.

Biosha Jones, MD is one of the Vice-Chairs for the Emergency Medicine Residents’ Association Diversity and Inclusion Committee.

Brian Chinnock, MD, FACEP; Mackensie Yore MD; Jessica Mason, MD; Leyla Farshidpour; and Jannet Castaneda published their article “Self-obtained vaginal swabs are not inferior to provider-performed endocervical sampling for Emergency Department diagnosis of Neisseria gonorrhoeae and Chlamydia trachomatis” in the Academic Emergency Medicine.

Bryn Eisfelder, MD received the Emergency Medicine Residents’ Association Chief Resident of the Year award.

Nicole Prendergast, MD and Henry Schwimmer, MD were awarded the Emergency Medicine Residents’ Association/ American College of Emergency Physicians Emergency Medicine Basic Research Skills Scholarship.

Roderick Fontenette, MD was inducted as a Fellow of Critical Care Medicine through the Society of Critical Care Medicine.

Cindy Chang, MD received the Emergency Medicine Residents’ Association Resident of the Year Award.

Let California ACEP know and we will include it in this new section of Lifeline. Tweet your accomplishment or post it on Instagram and tag @californiaacep or submit your accomplishments at: https://californiaacep.site-ym.comsurveys/?id=Accomplishments.
The California Emergency Medicine Advocacy Fund (CEMAF) has transformed California ACEP’s advocacy efforts from primarily legislative to robust efforts in the legislative, regulatory, legal, and through the Emergency Medical Political Action Committee, political arenas. Few, if any, organization of our size can boast of an advocacy program like California ACEP’s; a program that has helped block Medi-Cal provider rate cuts, lock in $500 million for the Maddy EMS Fund over the next 10 years, and fight for ED overcrowding solutions! The efforts could not be sustained without the generous support from the groups listed below, some of whom have donated as much as $0.25 per chart to ensure that California ACEP can fight on your behalf. Thank you to our 2019-20 contributors (in alphabetical order):

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If you would like more information or would like to submit a guest article, email info@californiaacep.org.

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Do you have an EM all-star hiding in your program and want to get their name out there? We’re looking for residents or medical students that deserve recognition!

Nominations can be submitted at bit.ly/nominate4calemra.

CORRECTION

In the Winter 2020 issue of Lifeline, two authors were left off the article “Telehealth Community Outreach Shows Promise of Virtual POLST Education for SNF Residents: Recruiting to Expand Participation”. Authors Caroline Etland, PhD, RN and Glenn Panzer, MD were omitted from the original publication. We apologize for the error.
For more information on upcoming meetings, please e-mail us at info@californiaacep.org; unless otherwise noted, all meetings are held via conference call.

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<td>Virtual</td>
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<td>Board of Directors Election</td>
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<td><strong>23rd at 9am</strong></td>
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<td><strong>30th</strong></td>
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<tr>
<td>Chapter Award Nominations Close</td>
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