Reflective Letter: A Great Semester

Wayne State University

Dear Professor Kustarz,

 Thank you for a great semester. It has been a pleasure being in English 3010: Intermediate Writing. This has been a tremendous learning experience for me which has allowed me to take my writing abilities to a whole another level and prepare me for the future. Prior to this class, I hadn’t taken an English course or any courses which required writing essays since my freshman semester which is almost two years ago. Especially being a Biology major and having a schedule mainly of science courses, prior to this class, I hadn’t had much writing experience and lacked knowledge of writing and research in my discipline of medicine and science.

Before being enrolled in this class, the concept of writing an essay itself was the typical five paragraph essay with intro, three body and conclusion. So, before the semester started, although I wasn’t sure of what to expect, I wanted to take this class to improve my writing skills and learn about the type of writing that is done in research and medicine. Also, I wanted to use this class as an opportunity to explore my discourse community of emergency medicine. This was the perfect time to do so, because when this semester started, I was hired as a research assistant in the Emergency Medicine at Henry Ford for a research on Diversity, Equity and Inclusion. Not having known much about research or diversity, equity and inclusion; I used this class as an opportunity to learn about this and apply my knowledge to my work as a research assistant.

Throughout the semester, this class has taught me a lot of skills and given me a chance to learn and explore not only my discourse community of emergency medicine but also other discourse communities such as writing, and others shared by my classmates. More specifically, I have learned and developed a strong foundation in the objectives of reading, writing, research and reflection. This will be the focus for the rest of this reflective letter as I go in more detail of what I learned in each discipline, the changes in my own writing and research practices throughout the semester and its connection to this course’s learning objectives.

**Reading**

 When it comes to reading and developing skills in this discipline, the one assignment that helped me the most with this is the genre analysis. Reading thoroughly was very important during this assignment to analyze the genre of peer reviewed articles in the discourse communities of writing and emergency medicine. This assignment taught me a lot about writing in my discourse community and in the community of writing. The two articles that I had to read and analyze were “Rhetorical Reading Strategies and Construction of Meaning” for the writing discourse community and “Interventions to Improve Health Outcomes for Patients with Low Literacy A Systematic Review” for emergency medicine community. The analysis of these articles, through the development of good reading skills, taught me how to search for and take note of key things with writing in my community such as the use of passive voice, APA formatting, clear concise writing and organization of sections and subsections. More importantly, I learned the importance of these writing style choices. For example, as mentioned in my genre analysis, “Organization is very important with having sections and subsections that also make the articles easier to navigate through. This aligns with the goals of emergency physicians who are required to be able to act and diagnose quickly in stabilizing patients and referring them to the appropriate department. Having a clear organization in an article allows physicians to quickly acquire the information needed” (Name, p.12). Vice versa, for the writing discourse community, key things are MLA formatting, less organization, active voice which is important in this community because members value the freedom to write freely.

 By learning to read to analyze writing in my community, this practice was very important with future assignments, like the literature review where I had to analyze more articles in my community and ultimately writing my own research proposal following the formatting and organization typical of my discourse community of emergency medicine physicians. From what I have learned with this discipline, it aligns very well with English 3010 learning outcome of being able to “Analyze genres from the student’s discipline or profession, including their associated discourse community, audience(s), rhetorical situations, purposes, and strategies” (Kustarz, syllabus).

**Writing**

 As for the discipline or the learning outcome of writing in English 3010, the assignment for which the goals of this outcome were displayed the best was the Research Proposal. The research proposal was a tough writing process with a lot of components to it and took a lot of varied ways for it to meet the expectations or requirements of the assignment. One of the things that I struggled with in the beginning but taught me an important skill was having to modify the literature review to make it a part of the research proposal. This taught me to tailor and condense the literature review to fit the research proposal, keeping what is important for research proposal, not what was important in the literature review assignment. This editing process is shown on pages 14-24 of this paper which include the literature review paper and then pages 29-31 which show the modified lit review as a section within the research proposal.

Producing this text also reinforced what I had learned from the previous objective of reading; which taught me how writing in the discourse community is concise and straight to the point and is well organized. This is evident in the research proposal which is organized into headings of literature review (sub headings of diversity in healthcare, equity in healthcare, and inclusion in healthcare), methods and discussion. The research proposal also connects with the learning outcomes of writing by the strategy of ending the introduction with an outline for the rest of paper, which is in enough detail to tell the readers exactly what the rest of the paper includes. This skill is highlighted in the research proposal as “For this research proposal, the information is divided in the following sections: First, the literature review discusses the research of the authors and articles mentioned above. This is split into further sections; titled: diversity in healthcare, equity in healthcare, and inclusion in healthcare. Second, in the methods section, I will discuss implementing the mentorship programs and testing their effectiveness through surveys which will further divide students into groups for a case study. For the EQUIP Intervention, I will discuss the staff education through workshops and testing the effectiveness through pre- and post-surveys. …….” (Name, p.29).

Overall the research proposal reinforced what we had learned all semester long and taught me how to really put together this text using my developed skills and abilities to read and analyze texts, compose and use strategies to condense texts to fit requirements, creativity to propose a research which is missing in my community and using evidence to illustrate the importance of the research.

**Research**

 Along with the learning objectives within reading and writing, research was an important component of this class. This class taught me a lot about conducting primary and secondary research. Secondary research was evident in every writing essay in this class and one of the things that I got better and better as the semester went on was navigating thru databases to find articles. For me, this was a very important skill that I learned, as before this class, I had rarely even used the Wayne State library database. Also, for conducting research, starting off the semester with doing the research guide assignment was very helpful. For example, in the research guide, I had identified the following common databases in my discourse community; Academic Emergency Medicine (AEM), Wiley Online Library, PubMed, Cochrane, Science Direct (Name, p. 45). Learning about these databases in the beginning of the semester was very helpful because this gave me a platform to find articles for other projects throughout the semester for which I often used Wiley Online library, and PubMed. The research guide also had us do primary research through the interviews; I really enjoyed this as I was able to learn a lot from Dr. Caldwell who is an emergency medicine doctor. For conducting the interview, it also taught me that sometimes you have to seek out multiple sources when doing primary research as one resource might not necessary give you the information you wanted or desired. This happened to me as for the interview, I actually conducted two interviews because the first doctor I had interviewed didn’t give as detailed answers as Dr. Caldwell did.

 Overall, I learned a lot about conducting research and the assignments done in this class reinforced the learning objective of research very well which is to “write research genres, use research methods, and conduct primary and secondary research to produce an extended research project relevant to the student’s discipline or profession” (Kustarz, Syllabus).

**Reflection**

 Lastly, for reflection; it’s the skillset of being able to evaluate one’s own writing. Refection is very important in writing and is something that we constantly had to do in this class. This includes writing multiple drafts and re-evaluating each time in order to improve the writing. However, sometimes, reflection can be tough feedback as it was in my situation for mapping out my literature review. For the literature review, we had to do a road map as one of the last brainstorming activities in class for which we were start off with our research question then branch off to the main body paragraphs and list the two sources that will be used for each topic. When I was doing this road map, I actually struggled to map it out and list off the sources for each section to connect everything I wanted to include in my essay. Based on this struggle and tough reflection, I had to realize that my literature review research question was simply too specific. So, I had to make the tough choice of changing my question from “What are health inequities and interventions to reduce inequities in healthcare” to “What are the ways of increasing diversity, equity and inclusion in healthcare” (Refer to images on p. 48-49). This was a tough choice in the beginning because it meant I had to do more research and find more sources, but it all paid off at the end with a wonderful final composed text of the literature review. Through this process, I learned the importance of reflection and being able to critique your own writing.

 Through this course and the learning outcomes within reading, writing, research and reflection, this has been a great semester which has taught me a lot. This course truly exceeded my expectations and I am excited to take what I have learned out to the real world and have a chance to apply my writing skills within my discourse community of emergency medicine.

Sincerely,

Student Name

Genre Analysis: Writing Studies and Emergency Medicine Discourse Communities

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 Abstract

This paper aims to identify, analyze, and reflect on the major writing conventions used in two scholarly articles from the different discourse communities: Writing Studies and Emergency Medicine. The similarities and differences between the two help identify the variation in writing styles, demonstration of goals and values of discourse communities through writing and understanding discourse communities and professional genres.

*Keywords:* Discourse Community, Writing Studies, Emergency Medicine, Health Literacy Interventions, Rhetorical Reading Strategies

Genre Analysis

 A discourse community is a group of individuals who share common goals, values and methods of communication. We are all part of one or many discourse communities whether it is through school, work, clubs, organizations or sports. No matter what community you are part of, it is important to understand an essential method of communication: writing. In this paper, we will be understanding writing through the genre of peer reviewed articles in the discourse communities of Writing Studies and Emergency Medicine. For the Writing Studies discourse community, we will be using the article “Rhetorical Reading Strategies and Construction of Meaning” from *College Composition and Communication* published by the National Council of Teachers of English. For the second article for Emergency Medicine discourse community, we will be using the article “Interventions to Improve Health Outcomes for Patients with Low Literacy A Systematic Review” from *Wiley Online Library* published by Agency for Healthcare Research and Quality. These two articles represent writing well in their discourse communities and share many similarities and differences in terms of major writing conventions, the alignment of goals and values with writing, and the genre of peer reviewed articles; all which will be presented through identification, analysis and reflection.

**Identification:**

 In the article “Interventions to Improve Health Outcomes for Patients with Low Literacy A Systematic Review” by Michael Pignone and his colleagues, there are many major conventions that are common in writing within the Emergency Medicine discourse community. One of the common components of this type of writing is an abstract which serves as a summary and overview of the article’s purpose, importance, research design, results and conclusion. In the article “Interventions to Improve Health Outcomes for Patients with Low Literacy A Systematic Review”, the abstract is divided into the following parts: objective, data sources, study selection, data extraction, data synthesis, conclusion and key words. Following the abstract, the article is organized into main sections of methods, results, discussion, and references which are easily identified by the bolded headings. Within each main section, the writing varies in length and is divided up into sub sections.

 One other feature that is common in literature within this discourse community is the use of passive voice. Along with the passive voice, the writing uses the first- and third-person point of view. Although majority of the article is in third person, first person is used when describing how the articles and literature were selected for review in the methods section. Another notable component includes use of a table to summarize the results. In the article, this is illustrated by the table titled, “Studies Examining the Effect of Interventions for Patients with Low Literacy.” The table included variables such as study design, literature measure, type of intervention, and outcome description. Each of the variables is described in detail under the section: Study Characteristics.

Normally writing in this community can include primary or secondary research; however, this article is different as it only contains secondary research. This is because the article itself is a systematic review. A systematic review aims to summarize the results of many studies in health care regarding increasing health literacy and presents the effectiveness of each intervention. Thus, this systematic review analyzes work done by other professionals in the community. Because of the vast secondary research, there are a lot of sources used which are cited under references. Lastly, this article like majority of literature in the medical discourse community uses APA or AMA guidelines.

 On the other hand, in the article “Rhetorical Reading Strategies and the Construction of Meaning” by Christina Haas and Linda Flower, there are many similarities and differences in major conventions that compare literature within the Writing Studies and the Medical discourse communities. Unlike the article by Pignone, there is no designated abstract; however, the introduction in the article “Rhetorical Reading Strategies and the Construction of Meaning” does include a summary, purpose, and other information which is typically mentioned in an abstract as well. Following the introduction, the article splits into main sections indicated by the headings: What is Good Reading, Strategies for Constructing Meaning, and Role of Rhetorical Reading. Unlike the medical discourse community article, there are no sub sections. However, indentations are used for a clear division of the information.

As for other features of the article, one major difference from the Pignone article is the use of active voice. The active voice is shown by the authors performing the action or experiment and speaking from experience. Conversely, the writing in Emergency Medicine research typically uses passive voice. Another difference between the two articles is that Hass and Flower’s use both primary and secondary research. The secondary research is used by the authors in the beginning to establish their research and provide background information. While primary research is done through the think-aloud method, a method the authors used to watch readers make meaning of the text through different personal strategies.

 The formatting style is also different between the two as Hass and Flower use MLA guidelines. Regardless of the differences, there are some similarities such as use of additional tools like figures and tables to display the results. In both cases, this presents the results in a concise understandable way to the audience and illustrates importance of visual representation. Lastly, both articles represent common goals of their discourse communities very well which is illustrated in the next section under analysis.

**Analysis:**

 The major writing conventions used in the article “Interventions to Improve Health Outcomes for Patients with Low Literacy A Systematic Review,” represents the different values or goals of the discourse community of Emergency Medicine physicians. One such convention is use of an abstract which allows readers to quickly decide whether the article is worth the read or important to them. This suggests the value of selection and time. As a physician, there are thousands of articles that may relate to a topic of interest; so, it is important to be able to avoid wasting valuable time navigating through different articles and select with ease through reading the abstract.

Along with the abstract, organization is very important with having sections and subsections that also make the articles easier to navigate through. This aligns with the goals of emergency physicians who are required to be able to act and diagnose quickly in stabilizing patients and referring them to the appropriate department. Having a clear organization in an article allows physicians to quickly acquire the information needed. This also goes well with the writing itself within the article which is concise, straight to the point and avoids any jargon not relevant to the field. This type of organization, writing style and use of abstract resembles typical scientific papers which shows the relationship between the scientific community and medical physicians; who both value education and advancement in the field of science and medicine.

As for the formatting style itself, APA style is typical because it provides clear standards for scientific research and writing. Other than APA, AMA can be used as well. Other features of the text include passive voice and secondary research. Passive voice is typical in this type of writing. Regarding secondary research, not all emergency medicine physicians conduct their own research, so it is important for them to be able to depend on other professionals in the field for certain information. Within this community, it is also expected that the writing has well supported scientific findings and experiments which are properly cited to show credibility. This analysis shows the value of credibility, selection, time, concise writing, clear standards and secondary research in aiding physicians in providing the best healthcare possible.

 The article by Pignone and the article “Rhetorical Reading Strategies and the Construction of Meaning” both represent their discourse communities very well. For the article by Haas and Flower, some notable things include lack of abstract and less subsections. This illustrates a less strict type of writing in this community and shows the value of freedom of writing without being constricted within smaller sections. Along with this, this type of writing uses more transitions between paragraphs and transitions to change topics of discussion; this creates a flow in the article that makes the writing easier to understand. This is different than the article from Pignone which lacks focus on transitions and is more concise and straight to the point.

Another notable difference is formatting style itself which is MLA. MLA is the standard and common for writing about language and literature, arts, humanities, and some sciences. This shows the value of having standards set in this community which allow members of the community to be able to easily navigate through the writing and find the information needed. As for the data and support, Hass and Flower’s article uses both primary research and secondary research. The article also uses a 1st person point of view which puts an emphasis on credibility of the authors and presents a well-supported study. Having well supported and researched studies is valued in both discourse communities. This analysis of Writing Studies discourse community shows members value of freedom of writing, some standards and use of well supported studies in their goals of aiming to improve reading and writing of college students.

**Reflection:**

 Through this genre analysis, I have gained a better understanding of not only how writing is conducted within different discourse communities but also how the genre of peer reviewed articles is shaped. It shows how within the genre, articles have similarities and differences which are influenced by one’s discourse community. This is important in understanding writing conventions to communicate effectively and accordingly to the expectations of one’s community. Overall, being interested in the discourse community of Emergency Medicine, this genre analysis has helped me understand that each discourse community has its own values, goals and agendas which are reflected through writing.

References

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Literature Review: Diversity, Equity, and Inclusion in Healthcare

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Abstract

This literature review aims to discuss the importance of diversity, equity, and inclusion in healthcare with a focus on interventions or ways to increase diversity, equity, and inclusion. The literature review considers many scholarly articles that all share similarities and differences in creating a diverse healthcare workforce, equal healthcare by reducing inequities and including people from all backgrounds to create an inclusive environment.

*Keywords:* Diversity, Equity, Inclusion, Healthcare, Interventions, Literature Review, Health Professions, Education

Diversity, Equity, and Inclusion are very important keywords in healthcare, yet they are often misunderstood and overlooked. Under the context of this literature review, diversity is focused on creating a healthcare workforce of leaders from different racial and ethnic backgrounds, socioeconomic status, belief systems, and the environment. In the article, "The Case for Diversity in The Health Care Workforce,” the authors Jordan J. Cohen and his colleagues discuss the importance of diversity in advancing cultural competency, increasing access to high-quality healthcare services, strengthening the medical research agenda, and ensuring optimal management of the healthcare system (Cohen, 2002). The reasons for having a more diverse workforce are endless; starting with cultural competency, as Cohen (2002) states, “most physicians and healthcare professionals who are unmindful of the potential impact of language barriers, various religious taboos, unconventional explanatory modes of disease, or traditional “alternative” remedies are not only unlikely to satisfy their patients but, more importantly, are also unlikely to provide their patients with optimally effective care” (p. 92). Along with this perspective of improving care through cultural competency, diversity creates leaders in the workforce who are representatives of the diverse population and can bring forth issues such as limited health care access for minorities. Also, having leaders from different backgrounds strengthens health care by having a pool of medically trained executives and public policy makers who can contribute to the government efforts of the medical research agenda, and can ensure optimal management in tackling health issues (Cohen, 2002).

As for health equity, it is about creating opportunities for everyone to receive equal and fair care no matter what their race, ethnicity or social level is. In doing so, first, there needs to be an understanding that "Health inequities are socially constructed, unjust, and avoidable differences in health and well-being between and within groups of people" (Browne, 2015, p.2). The key word that stands out is avoidable differences, which is why it is important for members in healthcare to be educated and trained to understand the population they are serving and to provide better care.

Lastly, within the context of this paper, inclusion is including a diverse population for feedback on health care issues, research studies, clinical trials, and advancements. Inclusion is important because excluding people due to their race, color or ethnicity creates issues such as health inequities and marginalization of patients. Also, if you leave people out of health studies or trials, then it creates advancements or results that don’t include the whole population. This not only presents a credibility issue but also presents false results of clinical trials as effective treatments which can lead to many problems.

Despite understanding the importance of diversity, equity and inclusion in healthcare, the question is how we can increase or promote these things. This is the focus of this literature review, which after the analysis of many peer-reviewed scholarly articles, discusses ways of increasing diversity, equity and inclusion in healthcare. The paper is split up in three sections: diversity in healthcare, equity in healthcare and inclusion in healthcare. The first section discusses changes in K-12 educational systems, providing more education resources and increasing the knowledge of healthcare career opportunities to create diversity in the workforce. The second section discusses promoting equity through the EQUIP intervention which focuses on staff education and organization level changes and reducing inequities through the understanding of disability and mental health. Lastly, the inclusion in healthcare section discusses promoting inclusion through active recruitment of all members including minorities, partnerships with local community and understanding unconscious biases that may cause exclusion.

Diversity in Healthcare

As the United States population becomes increasingly diverse, it is important that the workforce in healthcare represents the general population in terms of race, ethnicity, and socioeconomic background (Valentine, 2016). According to the article “Improving Diversity in Health Professions” by Dr. Valentine, in 2016, “Whites comprised 72% of the US population, yet they represented more than 80% of the healthcare professionals. While Asian Americans were well represented in health careers, the representation of African Americans, Hispanics, and Native Americans were much lower. When combined, these groups represented over 30% of the USA population, yet these minorities were well under-represented among physicians, registered nurses, dentists, pharmacists, and allied health care professionals” (p. 137). The lack of diversity in healthcare is an important problem to be addressed. Although there are many ongoing efforts to increase diversity and representation of minorities in healthcare, this section discusses changes in K-12 educational systems, providing more education resources and increasing the knowledge of health career opportunities among minority groups.

 Since the Supreme Court’s 1978 decision in Bakke, which offers the legal basis for using race and ethnicity as one factor among others in selecting applicants from a common pool, college admissions have done a great job in finding candidates in the field of science and medicine from diverse backgrounds (Cohen, 2002). Although, this has helped increase diversity to some degree; more work needs to be done beyond just the admissions. According to the article, “The Case for Diversity in The Health Care Workforce”, in order to get more students to pursue medical school and healthcare, there needs to be a focus on changing the K-12 education systems to provide students from all populations an opportunity to equal education and preparation to pursue their field of choice. Such changes in the educational system must start with holding states accountable for race-based inequities and making policies that link professional and teaching hospitals with local schools and the community (Cohen, 2002). To help with this change and reform, there are many organizations such as National Association for the Advancement of Colored Persons’ (NAACP’s), Minority Medical Education Programs (MMEP), and others who work hard for such goals. Some educational changes include making sure that schools in low-income and under-represented communities are receiving enough funding, especially, so they can have the basic resources of advanced technology, up to date textbooks, libraries, and adequate qualified teaching staff. For this to happen, there needs to be more funding dedicated to the educational system to give every child an opportunity for equal education. As Cohen mentions, if there can be equal access of education for all sectors of our population, there is no doubt that the composition of medical school students and health care workforce would be more diverse (Cohen, 2002). Along with minorities, changes in the education system would be beneficial for all aspects of the USA economy, as there would be a greater pool of candidates from all backgrounds who are involved in health care, policy making, medical advancements, and leadership roles towards creating an innovative and culturally competent workforce.

 In another article, “Improving Diversity in the Health Professions”, Dr. Valentine also agrees that changes to the educational system need to be made including more resources for academic preparation. Even though the high school graduation rates for minorities have increased, low-income students and students of color still lack the resources, such as SAT or ACT prep classes, tools, and knowledge of applying to colleges and furthering their education. The lack of preparatory tools explains why when it comes to competitive tests such as SAT and GRE, African Americans, Hispanics, and Native Americans tend to score lower than Whites or Asian Americans (Valentine, 2016). To help with this issue, there need to be more resources such as free SAT prep classes or workshops for the process of applying to college incorporated in all high school curriculum. With the resources, it will give more students from all races and ethnicities to have an equal opportunity to not only pursue healthcare but pursue any field of choice.

Along with providing additional resources in education, another challenge is the limited knowledge of health career opportunities among economically disadvantaged students and students of color (Valentine, 2016). This can be overcome by incorporating mentoring programs and summer programs to help raise awareness of health careers. Also, mentoring programs will allow students to have the guidance to pursue careers in healthcare. For this cause, a lot of colleges can host “shadow days” or “science fairs” which allow students from local middle schools and high schools to explore college life in a health program to increase their knowledge and exposure to health careers. Through the coordinated efforts of changing K-12 education systems, providing more resources to students, and creating opportunities to increase knowledge of health careers, there will be more diversity in healthcare in creating leaders that understand language barriers, cultural biases, and racial and ethnic disparities.

Equity in Healthcare

As mentioned in the introduction,

*“Health inequities can be understood as socially constructed, unjust, and avoidable differences in health and well-being between and within groups of people. These inequities structure patterns of individual ill health and population-level morbidity and mortality rates. Equity in health is, therefore, a social justice goal focused on pursuing the highest possible standard of health and health care for all people, paying attention to those at greatest risk of poor health, and considering broader socio-political and economic influences on health and access to care” (Browne, 2015, p. 2).*

From this, it is important to understand that health inequities are avoidable and are rooted in social injustices. To deal with this issue, this section discusses the EQUIP intervention and reducing inequities through the understanding of disability and mental health.

 In the article, “EQUIP Healthcare: An overview of a multilevel intervention to enhance equity-oriented care in primary health care settings” by Annette J. Browne, the focus of the intervention is on staff education and changes on the organizational level. The intervention was evaluated at multiple primary health care clinics in CANADA that serve the majority of clients who are affected by structural inequities, systemic racism and discrimination, and forms of violence (Browne, 2015). The core of the intervention is contextually tailored care which is care focused on the local population at service (Browne, 2015). In order to provide contextually tailored care, Browne believes it must start with staff education. Staff in healthcare must be educated on not only equity-oriented care in general but also cultural safety which involves understanding interpersonal and institutional racism and injustices (Browne, 2015). Furthermore, staff must be educated and practice facilitation on trauma- and violence-informed care which focuses on forms of violence and trauma in providing physical and emotional support to patients dealing with such issues (Browne, 2015). The staff can be educated on these topics through workshops and Indigenous Cultural Competency (ICC) program (Browne, 2015). The ICC program serves to increase knowledge of diverse cultural groups and effects of racism and stereotyping in healthcare. Staff education on these topics is often limited so it is important to incorporate this strategy in all healthcare settings in promoting equity. In addition, hospitals and clinics can form groups such as Diversity, Equity, and Inclusion committees which allow members of the medical staff to come together and discuss these issues in developing a better understanding of the society. This is an essential part of delivering equal care and while staff education is important, it is not enough on its own to deal with inequities in healthcare.

 Along with staff education, there need to be changes at the organizational level. These changes include organizational structures, practices, and policies to enhance equity-oriented care (Browne, 2015). To make these changes, there needs to be better communication between clinical administrators and managers with physicians and other medical staff to understand what resources can help the population at service. In addition, basic changes can be made such as: adopting waiting room environments to be welcoming to families, developing and integrating harm reduction strategies into clinical programming and care which includes developing supports to address any trauma experienced by the patients or the staff (Browne, 2015).

 While the EQUIP intervention is a great step in the direction towards equity, there are some components discussed by the authors, N. and B. Nakkeeran, in the article “Disability, mental health, sexual orientation and gender identity: understanding health inequity through experience and difference” which are not given emphasis in the EQUIP intervention. These components include giving importance to disability and mental health to reduce inequities. Disability and mental health are two major problems in our society which are often neglected and not given enough attention. As Nakkeeran (2018) mentions, disability patients are often “Discriminated in the form of rude behavior, verbal abuse, bullying, delay in providing treatment or nor respecting their privacy and dignity” (p. 11). To help with this, as mentioned for the EQUIP intervention, staff need to be educated on dealing with disabled people being careful not to hurt their self-esteem or make them feel unwelcomed. More than staff education, healthcare facilities must be designed to accommodate disabled individuals. This includes having ramps and equipment of aid such as wheelchairs in all hospitals and facilities. Another problem with disability is that it is often excluded from medical insurance coverage or contributes to higher premiums (Nakkeeran, 2018). This is an issue on which human resources and representatives need to come together and offer some leverage in health insurance which will allow all people to receive equal treatment.

 Along with disability, mental health is a major issue especially considering mental health concerns are often neglected or people with such problems don't seek help. The number of people affected by mental disorders is astonishing as Nakkeeran (2018) mentions, “In any given year, globally, approximately 30% of the population is affected by mental disorders, of which over two-thirds remain untreated or under-treated. Approximately 14% of the global disease burden is from common mental disorders, and this proportion is only likely to increase” (p.13). With such numbers, matters are made worse due to the government simply not dedicating enough funding for mental health services. With this, it is important to raise awareness for mental health and continue to bring the problem to attention in front of policymakers to incorporate for agencies and facilities that can provide help to patients with mental problems. In addition, it is important as a society to encourage people to get help if needed.
 Although both authors Nakkeeran and Browne share some different factors in increasing equity in health care, they both believe in educating staff and getting attention to make changes on the organization level.

Inclusion in Healthcare

 Along with diversity and equity, inclusion is very important in healthcare. One major area where inclusion is lacking is research in healthcare. As mentioned by Kassandra Alcaraz in the article, “The CONNECT Framework: a model for advancing behavioral medicine science and practice to foster health equity,” the exclusion of diverse populations in research and clinical trials limits our results and understanding (Alcaraz, 2016). For example, “failure of racial/ethnic minority women to enroll in large numbers in clinical trials of cancer may leave unanswered important questions related to racial disparity in cancer survival. In addition, in one clinical trial in which tamoxifen (Nolvadex) was found to reduce breast cancer by nearly 50% in high-risk women, Black American, Asian American, Latino, and other groups made up only about 4% of participants" (Alcaraz, 2016, p. 29). Such studies and clinical trials in healthcare are not acceptable if they don’t include groups from all backgrounds. Inclusion can be promoted through active recruitment, partnerships and understanding unconscious biases that may cause exclusion.

 As Alcaraz mentions, researchers must be the ones to make the effort of inclusion. This may include providing incentives for participation or understanding that factors such as lack of transportation or family responsibilities that may play a role in recruiting members from vulnerable communities. Efforts in recruitment include developing recruitment plans and recruiting via locally-relevant channels such as radios, partnerships with trusted local organizations and leaders and leveraging local social networks (Alcaraz, 2016). Another problem in creating inclusion in research or medical trials is the language barrier. This can be overcome by having a diverse staff that is able to translate or communicate effectively. In addition, documents may need to be made in multiple languages to accommodate patients with such barriers.

 With inclusion, another article called “Effective diversity, equity, and inclusion practices,” by Gurwinder Gill, mentions the role of unconscious biases that create exclusion. This is a unique perspective that considers that all humans engage in conscious and unconscious processes based on images stored in memory (Gill, 2018). In addition, Gill (2018) mentions “Unconscious bias affects healthcare providers every day; it can reduce the quality of care and increase errors. And that there are higher levels of racial bias among clinicians directly linked with biased recommendations” (p.197). To help with this, the article discusses the Osler’s DEI strategy that focuses on self-awareness, self-reflection, and reduction of bias, perceptions, and assumptions (Gill, 2018). In addition, focusing on cross-cultural communication which is communication with others to understand cultural differences, and beliefs can help create an inclusive environment with the core values of compassion, empathy, and understanding.

To conclude, the importance of diversity, equity and inclusion is well known in healthcare, but it is time to act in making these three things the fundamentals of proving care. The ways highlighted in this literature review should serve as a starting point to create a diverse workforce, understand inequities and promote an inclusive environment for all in providing the best healthcare possible. However, the quest for diversity, equity and inclusion doesn’t end here. Even though the strategies or ways highlighted in this literature review were effective in their perspective populations of study, there is still more work to be done. There need to be more major hospitals and healthcare facilities to incorporate diversity, equity, and inclusion interventions and report their effectiveness. The ways of testing the effectiveness are yet to be confirmed but shall soon be brought to attention.

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Research Proposal: Diversity, Equity and Inclusion in Healthcare

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Abstract

This research proposal aims to present a study to test the effectiveness of interventions that increase diversity, equity and inclusion in healthcare. Along with the methodology and discussion of the study proposed, this paper discusses the importance of diversity, equity and inclusion and considers many scholarly articles that share similarities in creating a diverse healthcare workforce, equal healthcare by reducing inequities and including people from all backgrounds to create an inclusive environment.

*Keywords:* Diversity, Equity, Inclusion, Research Proposal, Effectiveness, Interventions, Healthcare, EQUIP Intervention, CONNECT Framework, ICC Program, Mentorship Programs

Diversity, Equity, and Inclusion are very important keywords in healthcare, yet they are often misunderstood and overlooked. For diversity, it is all about creating a healthcare workforce of leaders from different racial and ethnic backgrounds, socioeconomic status, belief systems, and the environment. In the article, "The Case for Diversity in The Health Care Workforce,” the authors Jordan J. Cohen and his colleagues discuss the importance of diversity in advancing cultural competency, increasing access to high-quality healthcare services, strengthening the medical research agenda, and ensuring optimal management of the healthcare system (Cohen, 2002). The reasons for having a more diverse workforce are endless; starting with cultural competency, as Cohen (2002) states, “most physicians and healthcare professionals who are unmindful of the potential impact of language barriers, various religious taboos, unconventional explanatory modes of disease, or traditional “alternative” remedies are not only unlikely to satisfy their patients but, more importantly, are also unlikely to provide their patients with optimally effective care” (p. 92). Along with this perspective of improving care through cultural competency, diversity creates leaders in the workforce who are representatives of the diverse population and can bring forth issues such as limited health care access for minorities. Also, having leaders from different backgrounds strengthens health care by having a pool of medically trained executives and public policy makers who can contribute to the government efforts of the medical research agenda, and can ensure optimal management in tackling health issues (Cohen, 2002).

As for health equity, it is about creating opportunities for everyone to receive equal and fair care no matter what their race, ethnicity or social level is. In doing so, first, there needs to be an understanding that "Health inequities are socially constructed, unjust, and avoidable differences in health and well-being between and within groups of people" (Browne, 2015, p.2). The key word that stands out is avoidable differences, which is why it is important for members in healthcare to be educated and trained to understand the population they are serving and to provide better care.

Lastly, inclusion is including a diverse population for feedback on health care issues, research studies, clinical trials, and advancements. Inclusion is important because excluding people due to their race, color or ethnicity creates issues such as health inequities and marginalization of patients. Also, if you leave people out of health studies or trials, then it creates advancements or results that don’t include the whole population. This not only presents a credibility issue but also presents false results of clinical trials as effective treatments which can lead to many problems.

 Despite understanding the importance of diversity, equity and inclusion in healthcare, one question is how we can increase or promote these things. Through the analysis of many peer reviewed scholarly articles, many effective ways were identified. One such way is discussed by the author Dr. Valentine, in the article “Improving Diversity in the Health Professions,” where she emphasizes the need of a focus on the educational system to give all kids an equal chance of pursuing medicine. In the educational system, Dr. Valentine focuses on providing more resources and raising knowledge of health-related careers in all schools especially those in inner cities or among minority students.

 Along with diversity, to increase equity in healthcare, the author Annette J. Browne in the article, “EQUIP Healthcare: An overview of a multilevel intervention to enhance equity-oriented care in primary health care settings,” emphasizes the importance of staff education on topics like trauma- and violence informed care, cultural views, effects of racism and stereotyping. Along with Browne, the authors N. and B. Nakkeeran in another article also emphasize staff education but on topics like disability and mental health.

 As for inclusion, the author Kassandra Alcaraz presents the CONNECT framework which promotes inclusion through active recruitment of participants from all races, backgrounds and socioeconomic status to make an effort as researchers to create an inclusive environment in healthcare. Along with the CONNECT framework, the author Gurwinder Gill, in the article “Effective diversity, equity and inclusion practices,” presents a unique factor of the impact of unconscious biases among physicians on the care of patients. For this, it is important to create a program or environment where physicians are more aware of such unconscious biases in order to give all patients an opportunity of equal care.

 Although such scholarly articles presented many effective ways which are described in more detail in the literature review section of this paper, a gap still exits. The gap or the problem is that even though the authors mentioned what needs to be done; the question is how effective it will be in truly increasing diversity, equity and inclusion in healthcare. So, it is important to test the effectiveness of the strategies mentioned by authors Dr. Valentine, Browne, N. and B. Nakkeeran, Alcaraz, and Gill; by implementing their research in a bigger sample of schools and hospitals and coming up with a way to test its effectiveness.

Hence, to test the effectiveness of the diversity, equity and inclusion interventions, I am proposing this research. The research will be implemented in many different cities in Michigan at various hospitals and schools. Furthermore, for diversity, this will include focusing on education by increasing the knowledge of health careers through a mentorship program between local high schools and hospitals. Along with the mentorship programs, for equity, the EQUIP intervention by the author Browne will be implemented with staff education through weekly workshops and meetings where staff will be educated on various topics. Lastly, for inclusion, through the CONNECT Framework mentioned in the literature review section of this paper, there will be active recruitment of participants from the local communities to attend focus groups where the members will be asked to share their thoughts and options on various topics. Also, there will be weekly focus groups between staff along with an online Indigenous Cultural Competency (ICC) program which will serve to increase the knowledge and awareness as well.

For this research proposal, the information is divided in the following sections: First, the literature review discusses the research of the authors and articles mentioned above. This is split into further sections; titled: diversity in healthcare, equity in healthcare, and inclusion in healthcare. Second, in the methods section, I will discuss implementing the mentorship programs and testing their effectiveness through surveys which will further divide students into groups for a case study. For the EQUIP Intervention, I will discuss the staff education through workshops and testing the effectiveness through pre- and post-surveys. Then, for inclusion, in the methods section, I will discuss implementing the CONNECT Framework and testing its effectiveness through focus groups along with surveying physicians to test the effectiveness of an online Indigenous Cultural Competency (ICC) program. Third, to end the paper with the discussion section, I will discuss the limitations and the benefits of this study.

**Literature review**

Diversity in Healthcare

As the United States population becomes increasingly diverse, it is important that the workforce in healthcare represents the general population in terms of race, ethnicity, and socioeconomic background (Valentine, 2016). According to the article “Improving Diversity in Health Professions” by Dr. Valentine, in 2016, “Whites comprised 72% of the US population, yet they represented more than 80% of the healthcare professionals. While Asian Americans were well represented in health careers, the representation of African Americans, Hispanics, and Native Americans were much lower. When combined, these groups represented over 30% of the USA population, yet these minorities were well under-represented among physicians, registered nurses, dentists, pharmacists, and allied health care professionals” (p. 137). The lack of diversity in healthcare is an important problem to be addressed. Although there are many ongoing efforts to increase diversity and representation of minorities in healthcare, this section discusses changes in the K-12 educational systems and increasing the knowledge of health career opportunities among minority groups.

 Since the Supreme Court’s 1978 decision in Bakke, which offers the legal basis for using race and ethnicity as one factor among others in selecting applicants from a common pool, college admissions have done a great job in finding candidates in the field of science and medicine from diverse backgrounds (Cohen, 2002). Although, this has helped increase diversity to some degree; more work needs to be done beyond just the admissions. According to the article, “The Case for Diversity in The Health Care Workforce”, in order to get more students to pursue medical school and healthcare, there needs to be a focus on changing the K-12 education systems to provide students from all populations an opportunity to equal education and preparation to pursue their field of choice (Cohen, 2002). Such changes in the educational system must start with holding states accountable for race-based inequities and making policies that link professional and teaching hospitals with local schools and the community (Cohen, 2002). Along with this, other educational changes include making sure that schools in low-income and under-represented communities are receiving enough funding, especially, so they can have the basic resources of advanced technology, up to date textbooks, libraries, and adequate qualified teaching staff. It must start with more funding dedicated to educational systems to give everyone an opportunity of equal education to increase diversity in healthcare in the long run. As Cohen mentions, if there can be equal access of education for all sectors of our population, there is no doubt that the composition of medical school students and health care workforce would be more diverse (Cohen, 2002). Along with minorities, changes in the education system would be beneficial for all aspects of the USA economy, as there would be a greater pool of candidates from all backgrounds who are involved in health care, policy making, medical advancements, and leadership roles towards creating an innovative and culturally competent workforce.

Beyond the changes suggested by Cohen, with the K-12 education systems, there is a major challenge that needs to be overcome in order to truly increase diversity in the workforce. That challenge is the limited knowledge of health career opportunities among economically disadvantaged students and students of color (Valentine, 2016). This can be overcome by incorporating mentoring programs and summer programs to help raise awareness of health careers. Also, mentoring programs will allow students to have the guidance to pursue careers in healthcare. For this cause, a lot of colleges and hospitals can host “shadow days” or “science fairs” which allow students from local middle schools and high schools to explore life in a health setting to increase their knowledge and exposure to health careers. This further relates to the point made earlier by Cohen that a link between professional and teaching hospitals with local schools and the community is important for efforts toward increasing diversity. Through these coordinated efforts of changing K-12 education systems and creating opportunities to increase the knowledge of health careers, there will be more diversity in healthcare in creating leaders that understand language barriers, cultural biases, and racial and ethnic disparities.

Equity in Healthcare

As mentioned in the introduction, it is important to understand that health inequities are avoidable and are rooted in social injustices. To deal with this issue, this section discusses the EQUIP intervention and reducing inequities through the understanding of disability and mental health.

 In the article, “EQUIP Healthcare: An overview of a multilevel intervention to enhance equity-oriented care in primary health care settings” by Annette J. Browne, the focus of the intervention is on staff education. The intervention was evaluated at multiple primary health care clinics in CANADA that serve the majority of clients who are affected by structural inequities, systemic racism and discrimination, and forms of violence (Browne, 2015). The core of the intervention is contextually tailored care which is care focused on the local population at service (Browne, 2015). In order to provide contextually tailored care, Browne believes it must start with staff education. Staff in healthcare must be educated on not only equity-oriented care in general but also cultural safety which involves understanding interpersonal and institutional racism and injustices (Browne, 2015). Furthermore, staff must be educated and practice facilitation on trauma- and violence-informed care which focuses on forms of violence and trauma in providing physical and emotional support to patients dealing with such issues (Browne, 2015). The staff can be educated on these topics through workshops and Indigenous Cultural Competency (ICC) program (Browne, 2015). The ICC program serves to increase knowledge of diverse cultural groups and effects of racism and stereotyping in healthcare. Staff education on these topics is often limited so it is important to incorporate this strategy in all healthcare settings in promoting equity. In addition, hospitals and clinics can form groups such as Diversity, Equity, and Inclusion committees which allow members of the medical staff to come together and discuss these issues in developing a better understanding of the society.

 While the EQUIP intervention is a great step in the direction towards equity, there are some components discussed by the authors, N. and B. Nakkeeran, in the article “Disability, mental health, sexual orientation and gender identity: understanding health inequity through experience and difference” which are not given emphasis in the EQUIP intervention. These components include giving importance to disability and mental health to reduce inequities. Disability and mental health are two major problems in our society which are often neglected and not given enough attention. As Nakkeeran (2018) mentions, disability patients are often “Discriminated in the form of rude behavior, verbal abuse, bullying, delay in providing treatment or nor respecting their privacy and dignity” (p. 11). To help with this, as mentioned for the EQUIP intervention, staff need to be educated on dealing with disabled people being careful not to hurt their self-esteem or make them feel unwelcomed.

 Along with disability, mental health is a major issue especially considering mental health concerns are often neglected or people with such problems don't seek help. The number of people affected by mental disorders is astonishing as Nakkeeran (2018) mentions, “In any given year, globally, approximately 30% of the population is affected by mental disorders, of which over two-thirds remain untreated or under-treated. Approximately 14% of the global disease burden is from common mental disorders, and this proportion is only likely to increase” (p.13). With such numbers, matters are made worse due to the government simply not dedicating enough funding for mental health services. With this, it is important to raise awareness for mental health and continue to bring the problem to attention in front of policymakers to incorporate for agencies and facilities that can provide help to patients with mental problems. In addition, it is important as a society to encourage people to get help if needed.
 Although both authors Nakkeeran and Browne share some different factors in increasing equity in health care, they both believe in educating staff and getting attention to make changes.

Inclusion in Healthcare

 Along with diversity and equity, inclusion is very important in healthcare. One major area where inclusion is lacking is research in healthcare. As mentioned by Kassandra Alcaraz in the article, “The CONNECT Framework: a model for advancing behavioral medicine science and practice to foster health equity,” the exclusion of diverse populations in research and clinical trials limits our results and understanding (Alcaraz, 2016). For example, “One clinical trial in which tamoxifen (Nolvadex) was found to reduce breast cancer by nearly 50% in high-risk women, Black American, Asian American, Latino, and other groups made up only about 4% of participants" (Alcaraz, 2016, p. 29). Such clinical trials in healthcare are not acceptable if they don’t include groups from all backgrounds. Inclusion can be promoted through active recruitment, partnerships and understanding unconscious biases that may cause exclusion.

 As Alcaraz mentions, researchers must be the ones to make the effort of inclusion. This may include providing incentives for participation or understanding that factors such as lack of transportation or family responsibilities that may play a role in recruiting members from vulnerable communities. Efforts in recruitment include developing recruitment plans and recruiting via locally-relevant channels such as radios, partnerships with trusted local organizations and leaders and leveraging local social networks (Alcaraz, 2016). Another problem in creating inclusion in research or medical trials is the language barrier. This can be overcome by having a diverse staff that is able to translate or communicate effectively. In addition, documents may need to be made in multiple languages to accommodate patients with such barriers.

 With inclusion, another article called “Effective diversity, equity, and inclusion practices,” by Gurwinder Gill, mentions the role of unconscious biases that create exclusion. This is a unique perspective that considers that all humans engage in conscious and unconscious processes based on images stored in memory (Gill, 2018). In addition, Gill (2018) mentions “Unconscious bias affects healthcare providers every day; it can reduce the quality of care and increase errors. And that there are higher levels of racial bias among clinicians directly linked with biased recommendations” (p.197). To help with this, the article discusses the Osler’s DEI strategy that focuses on self-awareness, self-reflection, and reduction of bias, perceptions, and assumptions (Gill, 2018). In addition, focusing on cross-cultural communication which is communication with others to understand cultural differences, and beliefs can help create an inclusive environment with the core values of compassion, empathy, and understanding.

 In improving diversity, equity and inclusion in healthcare, the research and ideology by the authors mentioned above serves as a good foundation and a step forward. But it is time to put these things in action and test their effectiveness. To do so, I have come up with a plan of implementation that is detailed in the methods section below.

**Methods**

For diversity, equity and inclusion; the study will be conducted at Henry Ford hospitals in ten different major cities in Michigan which include Detroit, Ann Arbor, Grand Rapids, Lansing, Flint, Kalamazoo, Saginaw, Dearborn, Traverse City and Livonia. Having the study conducted at ten different cities allows for a bigger sample size which will further allow us to compare the results with previous studies done which are mentioned in the literature review. One of the problems with the studies mentioned in the literature review section is that the research was conducted at very few hospitals which limits our understanding about the effectiveness of each intervention mentioned to increase diversity, equity and inclusion in healthcare. Along with having a bigger sample size, the ten cities were chosen based on the population; for this study we want to include and gather data from people of all backgrounds, ethnicities and socioeconomic status which allows us to do so through this set up. Furthermore, for this study, it is best to partner up with Henry Ford hospitals due to the established Henry Ford Diversity, Equity and Inclusion committee at the Detroit hospital which is newly founded but needs direction to further their work making this a perfect opportunity for a partnership.

 In order to increase diversity in the workforce, there needs to be a focus on the education system. One of the problems that was mentioned in the study by Dr. Valentine, in the article “Improving Diversity in the Health Professions,” was a lack of knowledge of health-related careers among minority groups. One way to tackle this problem is through mentorship programs. Each Henry Ford hospital will partner with local high schools especially in inner cities for the mentorship program which will run for six months. Through the mentorship program, kids will have an opportunity to attend medical school and hospital tours, seminars which panels of doctors and other healthcare professionals, and participate in workshops teaching important skills such as CPR. In addition, each high school student who is a junior or senior will be partnered with one medical student from the medical school affiliated with the hospital. Through this buddy program, students will have an opportunity to seek advice and ask questions to medical students through email, cell or in person as preferred between the two buddies. The goal with this mentorship program is to see how effective it is to increase diversity in the workforce.

To do this, the method employed will be a case study where students will be split into groups based on certain criteria: students will be surveyed before the mentorship program where they will answer whether their interested in medicine or health related careers. From there, after the six-month program, students will again be surveyed about their interest in medicine. Comparing the results from the surveys; students will be split in three groups: Group A will be students who were interested in medicine before the mentorship program, Group B will be students who were not interested before the mentorship program but changed their mind after the program, and lastly group C will be students who were neither interested before or after. Based on these criteria, students will be tracked to note which ones decided to pursue medicine in college. For this, taking time into consideration; only students who are juniors and seniors in high school will be selected and will be followed up with up to their sophomore year in college to see if they are still on the medical path. Through this, we should be able to tell how effective the mentorship program was in increasing the diversity in the workforce by tracking which students who ended up pursuing medicine in college due to their exposure from the mentorship program.

 For equity, the EQUIP intervention, mentioned by Browne in her article, will be implemented with a focus on staff education. This will be done through weekly workshops and meetings where staff will be educated on cultural differences, stereotypes, interpersonal & institutional racism, trauma and violence informed care, disability and mental health. To monitor the progress and efficiency of the EQUIP Intervention; each hospital will have a Diversity, Equity and Inclusion committee (DEIC) of senior physicians, policy makers, and directors of the EQUIP Intervention program. Note; this EQUIP Intervention and the committee will only be for the emergency department in each hospital. Here, the emergency department is specifically selected due to the lack of diversity in the emergency department workforce especially among physicians. Also, this choice takes into consideration the number of patients who go in and out of the emergency department on the day to day basis who are from different ethnicities, backgrounds and socioeconomic status. Furthermore, by starting off with implementing the EQUIP intervention in only one department; after a year, its effectiveness will be evaluated before expanding it to multiple departments within the hospital. This will also allow the DEIC committee to establish its roots and be able to guide other departments based on their experiences from the first year of implementation.

With the establishment in the emergency department, to test the effectiveness of staff education through the EQUIP Intervention; it will be done through surveys. Using pre- and post-surveys for the education workshops; staff will be asked both closed and open-ended questions. The closed ended questions will be more about testing the staff members’ knowledge regarding topics like cultural differences, racism, disability and mental health in healthcare. On the other hand, the open-ended questions will be more opinion based targeted towards questions which ask about tough topics like racism and discrimination. An example of one possible open-ended question is:

Discrimination can be in the form of rude behavior, verbal abuse, bullying, delay in treatment or not respecting a patient’s privacy and dignity (Nakkeeran, 2018). Based on this criterion, have you ever discriminated against a patient or seen another employee in this department do so? If so, was it done unconsciously or on purpose? Provide your answer in detail. Also, please refrain from mentioning your name or any other employee’s name for this response as this survey is anonymous.

 This is just one example of an open-ended question that could be asked. In general, by doing the survey before and after the educational workshops, it will be easy to identify any increases in knowledge, changes in opinion and understanding which will show the effectiveness of the EQUIP intervention. This will further help the staff provide better care and understand their patients.

 Next, for inclusion; the CONNECT Framework, mentioned by the author Alcaraz in the literature review, will be incorporated serving a purpose of better understanding the local community. This will be done through an active recruitment of participants for focus groups or round table discussions. To really recruit participants from all backgrounds, ethnicities and socioeconomic status; a more proactive approach will be used such as using social media and resources like radio shows to encourage people to attend. Also, there will be an incentive provided for each participant which will be a $10 gift card for their participation and contribution. In hopes of getting a large sample size, the target will be 1000 participants in each city over the course of a year which will provide a wide range of responses.

For each focus groups; participants will be asked about their opinions or experiences with how they have been treated by medical staff and doctors during their visits along with questions regarding diversity, equity and inclusion. This will include for example asking participants about the lack of minority physicians like Hispanics or African Americans in the emergency department and whether that makes a difference in their care. Additionally, participants will be asked to discuss and share any experiences about being discriminated against or treated poorly especially due to disabilities or mental health problems. Another purpose of these focus groups will be simply to understand the needs of the local communities and ask people about any additional services or programs that could be provided to better their care. This can be simple things such as hospitals having free seminars or events about nutrition, cooking healthier, importance of exercise, raising awareness of measures to reduce diabetes, teaching CPR and many other things of such nature to help educate the local population and really connect with the people.

To measure and record the data for the round table discussions; the conversations will be recorded and later transcribed without including names of the participants. This is to gather data about diversity, equity and inclusion in healthcare. Also, the transcriptions will be analyzed to identify common concerns or problems pointed out by participants in order to understand and reduce such issues. Doing such focus groups for at least a year will build better relationships with the community and encourage people to share their thoughts and opinions in improving healthcare so that everyone could have equal access to healthcare.

Along with the testing the effectiveness of the CONNECT Framework by analyzing the success of the focus groups, another program will be incorporated to promote inclusion. This will be an online Indigenous Cultural Competency (ICC) program which will be required for all physicians in the emergency department. The ICC program was mentioned by the author Browne as a resource to educate physicians about cultural differences and effects of racism and stereotyping in healthcare. However, this program will be altered to also accommodate the research done by Gurwinder Gill who discusses educating physicians on unconscious biases that play a role in evaluating and treating patients.

To test the effectiveness of the online ICC program, physicians will be given a short survey which will have close ended questions rating the effectiveness of the program. Also, there will be open ended questions asking physicians’ opinions on what they learned from the program or anything they were surprised to find out about their own unconscious biases.

**Discussion**

Through the methods discussed above; this study has some limitations but overall the benefits outweigh such concerns. Starting off with limitations for increasing diversity through mentorship programs, the main challenge with the method of the case study is keeping in touch with the students. The limitations here can be for example; when trying to follow up with the students after a year or after they are in college; students might not pick up or be hard to contact. So, this itself presents a challenge which can be tackled by following up with students periodically, so they don’t forget about the program. Another thing is the time constraint with the case study; just to have the results and even know if the mentorship programs are effective; it will take years as students need to be tracked from either junior or senior year in high school to sophomore year in college.

As for increasing equity through the EQUIP intervention, some limitations include problems with the surveys. Some staff members might not take it seriously or leave certain parts of the survey incomplete. This can lead to some skewed data but in general; staff need to be encouraged to give honest detailed feedback and complete participation. The participation can be another issue for which staff might not want to participate or attend the educational workshops as it adds additional things to their agenda. But for this, the best way would be to make it a requirement for all staff instead of it being voluntary and really convey the benefits of the workshops to the medical staff.

For inclusion and running focus groups, one of the challenges is recruiting participants from all backgrounds, ethnicities and socioeconomic status. For inclusion, this is a problem that researchers often face of recruiting participants but by taking an active approach of advertising through social media and even radio shows, it will make it easier. Also, providing incentives such as gift cards can be another way to encourage more people to participate. Along with recruiting, another limitation could be getting people to voice their opinion or thoughts on topics that can be uncomfortable for certain people to talk about such as discrimination and racism. For such concern, it is important to make the environment for the focus groups as welcoming as possible and really encourage participants to voice their own honest opinions and not worry about being judged or looked down upon.

While these are just some limitations, additional problems and concerns can always come up while putting these methods into action, but that is why every hospital will have a Diversity, Equity and Inclusion committee (DEIC) in charge of all the operations and making sure everything runs smoothly. Also, by starting off with this research being only in the emergency department for first year, this will make it easier when expanding the research to other departments within the hospitals once we are able to find out how effective these interventions are.

Overall, as mentioned throughout this paper and discussed in many different scholarly articles, diversity, equity and inclusion are very important in healthcare. Beyond understanding the importance, we have to figure out effective ways for increasing diversity in the workforce, promoting equal care through equity and creasing an inclusive environment. Although such ways or interventions were discussed by many authors, through this research proposal, we will be able to really bridge the gap of the effectiveness of such interventions and provide a study that shows methods which are proven and work efficiently. This will benefit not only the discourse community of medicine and healthcare but also create a new discourse community in which members of healthcare, hospitals, teachers, schools, students and local community members are all interlinked and working together to increase diversity, equity and inclusion.

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Discourse Community of Emergency Medicine Physicians Research Guide

**Definition:** Emergency physicians are the leaders of the emergency department and function to treat patients with urgent life-threatening conditions. With the knowledge of prevention, diagnosis and management of urgent health issues, emergency physicians treat a variety of ailments from physical to behavioral disorders. Emergency physicians are required to act and diagnose quickly in stabilizing patients and referring them to the appropriate department.

**Membership Requirements:**

* Earn a bachelor’s degree preferably with a pre-med major
* Take the MCAT exam, attend interviews and get selected in an accredited medical school
* Complete medical school; during which members must pass the United States Medical Licensing Examination (USMLE) and score well to apply to emergency medicine residencies.
* Complete emergency medicine residency
* After residency, members can do a fellowship to specialize in an area of emergency medicine like medial toxicology, hyperbaric medicine or ultrasounds.
* Get licensed and certified to become eligible for practicing as an independent physician; emergency physicians must be certified by the American Board of Emergency Medicine (ABEM) or the American Osteopathic Board of Emergency Medicine (AOBEM) or an equivalent international certifying body recognized by ABEM or AOBEM
* Must maintain current emergency medicine knowledge and skills through independent study, continuing medical education (CME) activities and Maintenance of Certification (MOC) standards
* Should exhibit attributes of professionalism such as altruism, accountability, honor, integrity, respect and positive patient experience
* Should participate in medical staff and/or hospital affairs
* Should gain a working knowledge of national quality and performance measures and patient safety
* Must maintain knowledge of and compliance with major federal and state regulations that affect the practice of emergency medicine such as the Emergency Medical Treatment and Labor Act (EMTALA) and the Health Insurance Portability and Accountability Act (HIPAA) of 1996.

**Goals/Values:**

* According to Dr. Mahajan, a common goal all physicians share is to heal the sick, to do good for the patient and do no harm.
* More specifically for emergency medicine physicians, according to Dr. Caldwell, there are three common goals: identify and rule out any life threats, alleviate symptoms and direct patients to the correct department.
* Other goals include providing high quality care and making decisions in the best interest of the patient.
* Values shared by emergency physicians include being ethical, respecting patient privacy, treating patients with respect, courtesy, integrity and providing equal treatment to all patients no matter their background.

**Major Communication Practices and Mechanisms:**

* Verbal Communication with peers
* Communication and teamwork are very important in emergency care; this involves discussion with other physicians and the emergency care team. This includes communicating with emergency medicine technicians (EMT’s) to coordinate care for the patient before he or she even arrives at the emergency room. In the emergency department, patients are shared between physicians so as Dr. Caldwell mentioned, it is important that when a new doctor is coming on the case that you communicate expectations, the plan of treatment and other information pertaining to the patient.
* Written Notes
* Written notes pertaining to patient’s chief complaint, symptoms, background and other clinical notes are very important in aiding the communication process as when getting patients to the correct department of care; these notes are shared with the new specialist who will be taking care of the patient. Dr. Caldwell mentioned that when a patient is sent to a new department; she does a consultant with other specialist during which she shares her notes of care, what to anticipate and the plan of care. These notes are also inputted into EPIC which is an electronic health record system used.
* Email
* Email is a frequency used as well to stay in touch with colleagues, and get updates on things such as new treatments, events, hospital policies and conferences.
* Electronic Records
* Electronic Privacy Information Center (EPIC) is the electronic health record system that is used commonly. This allows for documentation and instant access to current records, pending tests, laboratory results, health background and outpatient or inpatient visit data from any of faculties. EPIC is also used to share notes and plan of treatment with the health care team. Physicians can also send messages directly through EPIC to communicate with others.
* Meeting of group of specialists as & when required
* On specific patient cases; group of physicians from different specialties might have to come together to consult and discuss the situation.

**Prominent Participatory Mechanisms:**

* Meetings
* Meetings with group of specialists as & when needed
* Weekly committee meetings to discuss certain issues, implementing required changes or discussing new policies.
* Seminars
* New Drug Seminars
* Continuing Medical Education (CME) Seminars
* Conferences
* Educational Conferences (covering latest advances in medical techniques)
* Society for Academic Emergency Medicine (SAEM) conferences (optional method for continuing medical education)
* Journals
* Annals of Emergency Medicine
* BMC Emergency Medicine
* Safety in Health
* Biological Procedures
* Databases
* Academic Emergency Medicine (AEM)
* Wiley Online Library
* PubMed
* Cochrane
* Science Direct
* Books
* Rosen’s Emergency Medicine: Concepts and Clinical Practice
* EKG Reference Guide

**Key Figures in discourse community:**

* Dr. Emanuel Rivers
* Local specialist in emergency medicine, critical care and internal medicine who has done extensive work and published in the field of shock, sepsis and resuscitation.
* Dr. Steven Bird
* President of Society for Academic Emergency Medicine (SAEM)
* Dr. Martina Caldwell
* Diversity, Equity & Inclusion Committee Co-Chair at Henry Ford hospital in Detroit.

**Topics of Discussion:**

* Medical insurance cover charges
* Interventions by insurance companies
* Co-Pay requirements for financial strapped patients
* New medical techniques and drugs
* Diversity, Equity, and Inclusion in health care
* Vulnerable communities
* Health inequities
* Cultural sensitivity in medical education and clinical practice
* Health Literacy

**Research:**

* Dr. Caldwell herself as an emergency medicine physician is co-chair of Diversity, Equity & Inclusion Committee which focus on research of diversity, equity and inclusion in health care. Dr. Caldwell is also involved in research that addresses health inequities in women’s reproductive health and preventive health care access.
* As for emergency medicine physicians in general, conducting research depends on the hospital they work at; In a lot of teaching hospitals that are partnered with medical schools, educational programs and research centers, research is more common for physicians and recommended. While in non-teaching hospitals; emergency medicine physicians conducting research is less common.

**Lexis:**

* In this discourse community, there is a use of a lot of medical terminology. Some terminology includes:
* Angioplasty: surgical procedure in which a small catheter with a balloon tip is threaded into the coronary artery. The balloon is then blown up to re-expand the clotted artery.
* Appendectomy: operation where infected appendix is removed.
* Arrhythmia: Occurs when the beat of the heart is no longer originating from the sinus node, and the rhythm is abnormal.
* Bradycardia: abnormally slow heart rate.
* Some examples of abbreviations:
* CC: stands for Chief complaint
* CBC: complete blood count
* DNR: do not resuscitate
* EKG: electrocardiogram
* MVA: motor vehicle accident

**Research Questions:**

1. How can we implement interventions in health care to increase diversity, equity and inclusion? Especially in Detroit, where in departments like emergency medicine; majority of patients are African American yet African American emergency physicians are very underrepresented.
2. Why is understanding cultural sensitivity and awareness important in clinical practice and medical education?
3. Why it is important to recognize health inequities and implement changes to help vulnerable communities in health care?
4. How can we increase health literacy and find the best way for doctors to give information to patients so that they understand it?

**Sources:**

Academic Emergency Medicine (AEM)

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Caldwell, Martina. Phone Interview. September 18, 2018.

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EKG Reference Guide

Emergency Medicine Terminology Website and Quizlet

Emergency Medicine Doctor Educational Requirements

Emergency Medicine Physicians Forum

Henry Ford Website

Mahajan, Swarn. Email Interview. September 15, 2018.

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Rosen’s Emergency Medicine: Concepts and Clinical Practice

Safety in Health

Science Direct

Society for Academic Emergency Medicine (SAEM)

Wiley Online Library