



A path forward: underrepresented in medicine—gastroenterology

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The American Society for Gastrointestinal Endoscopy (ASGE) recognizes and values the importance of an inclusive environment in our field for our patients and colleagues. This includes embracing diversity, equity, and inclusion (DEI). By valuing these core principles, the organization prioritizes initiatives and education that promote excellence in patient care, member experience, training, and innovation. DEI principles are at the center of the society's efforts to support members and the patients we serve.¹ Recently, there has been more public discourse questioning the value of diversity and inclusion in the United States. Some argue that DEI principles discriminate against groups of people. This perspective may be due to a misinterpretation of how we should effectively integrate these principles into many aspects of our professional lives. These principles allow the opportunity for qualified individuals who may not have been considered for a role because of bias or lack of exposure to decision makers with strong social capital to be considered. Indeed, inclusion is an extremely complex framework, especially in the current climate. Given the current uncertainties, the ASGE and the authors believe that it is imperative for us as a community to continue our diversity, equity, and, most importantly, inclusion conversations to continue to drive on the path toward excellence. Therefore, we developed a series of white papers to provide an understanding of the key issues, offer solutions, and highlight the society's progress in addressing issues related to enhancing DEI.

This article, the first of the series, will focus on underrepresented minorities (URMs) in gastroenterology (GE). The Association of American Medical Colleges currently defines individuals underrepresented in medicine (URiMs) as "those racial and ethnic populations that are underrepresented in the medical profession relative to their numbers in the general population."² Historically, Hispanics, Blacks, American Indians, and Alaskan Natives have been considered URMs in science and engineering.³ Currently, the health care workforce in the United States does not reflect the diversity of our population, and this contributes significantly to health care disparities and health inequity.¹ For example, in the 2022 to 2023 U.S.

medical school year, Blacks made up only 10% of the matriculating students, whereas they made up 14.4% of the country's population.^{4,5} Similarly, Hispanics made up 12% of total matriculants to medical school and made up 19.1% of the U.S. population.^{4,6} Recognizing that undoing the impact that systemic racism has had on many communities is a monumental effort, we will attempt to provide strategies and possible solutions to overcome some of these challenges in GE practices. This article will explore the status of URMs in GE, the benefits to patient care, and strategies that ASGE is promoting to overcome challenges that contribute to the underrepresentation of some groups in the field of GE.

Foundationally, diversity involves incorporating people from different ethnic/racial and socioeconomic backgrounds, genders and sexual orientations, age, religion, or disability. Equity addresses the inherent imbalances among people with the principles of fairness and justice. However, equity is not the provision of the same to all but rather, acknowledges a long history of unequal access for marginalized groups and allows for adjustments to facilitate equal access to opportunities.⁷ Most importantly, inclusion is creating an environment in which diverse groups feel they are accepted, respected, and valued. Building and sustaining a sense of inclusion allows everyone to be creative, innovative, and contribute to the shared initiatives of any organization or community.

In the coming decades, the United States is expected to become much more diverse.⁸ The overall racial and ethnic diversity of the United States increased between 2010 and 2020.⁹ According to data from the U.S. Census, Whites (alone) made up 72.4% of the population in 2010 and dropped to 61.6% of the population in 2020.⁹ The 2020 Census showed an increase in the Hispanic or Latino population from 50.5 million (16.3%) in 2010 to 62.1 million (18.7%) in 2020.¹⁰ The Black or African American population (alone) was 38.9 million (12.6%) in 2010 and 41.1 million (12.4%) in 2020. In 2020, the American Indian or Alaska Native population accounted for 3.7 million (1.1%) of the population compared with 2.9 million (0.9%) of the population in 2010. The 2020 Census identified 689,966 (0.2%) of people

as Native Hawaiian and Other Pacific Islander, which was up from 540,013 (0.2%) in 2010. During the 2020 Census, over half of Native Hawaiians and Other Pacific Islanders identified with more than 1 race, and when including this group, they totaled about 1.6 million people (0.5%) of the total population.¹⁰ The Asian population made up 19.9 million (6%) of all respondents in 2020, compared with 14.7 million (4.8%) in 2010. Furthermore, minority populations make up the majority in California, Hawaii, and New Mexico in the most recent census.¹⁰ The 2020 Census showed that the percentage of people who reported multiple races was 10.2%, which increased from 2.9% in 2010—the largest change when compared to all the racial groups. These data also suggest that no one racial group will be the majority by 2045; therefore, the United States will effectively become a country of minorities.¹⁰

Because of the changing demographics, it is imperative in all fields of medicine, including GE, that the diversity of the field reflects the diversity of the country's population. GE is a competitive specialty with few URM physicians.¹¹ In 1980, approximately 4% of GE physicians were from underrepresented groups.¹ Even though greater than one-third of the U.S. population is classified as an URM, only 9.1% of fellows and 10% of GE faculty identified as traditionally underrepresented in 2018 to 2019.¹² The GE match data from 2022 to 2023 by race/ethnicity (alone or in combination), with a total of 1677 trainees, showed that American Indian or Alaskan Natives were 3 of 1677 (0.2%), Black or African American 100 of 1677 (6%), Hispanic or Latino 138 of 1677 (8.2%), Native Hawaiian or Other Pacific Islander 2 of 1677 (0.1%), Asian 526 of 1677 (31.4%), White 600 of 1677 (35.8%), Other 67 of 1677 (4%), and Unknown 2 of 1677 (0.1%).¹³ These percentages illustrate that the GE workforce does not reflect the current diversity within the U.S. population and little progress has been made over the last 4 decades.¹³

Data from cross-sectional analysis of 117,589 Press Ganey surveys submitted after outpatient visits across various medical specialties at the University of Pennsylvania Health System showed that higher Press Ganey survey scores were associated with racial and ethnic concordance between the patient and physician.¹⁴ Through the Press Ganey survey, patients answered questions across 6 domains, including access, moving through visit, experience with nurse/assistant, experience with care provider, personal issues, and overall assessment. The primary outcome was based on the score for the “likelihood of recommending this care provider to others” question in the care provider domain. The study found that 87.6% of physicians from racially/ethnically concordant patient–physician pairs received the maximum score, whereas only 82.1% of physicians from discordant pairs received the maximum score, which was statistically significant.¹⁴ This may be because patients can identify more closely with a provider who looks

like and/or has had similar life experiences as them. Studies on the benefits of diversity have demonstrated that students who attend medical schools with significant minority student body compositions (at least 10% URM population and 36% nonwhite population) gain greater exposure to various ethnicities and feel more prepared to treat minority populations.¹⁵ Because it will take many years to achieve a health care workforce reflective of the population we serve, cultural competency training would benefit all physicians.

In addition, studies have shown that racial and ethnic minority patients are more likely to receive inferior care than their White counterparts.⁹ As it relates to colon cancer screening, patients with poor health care access and patients who do not receive a physician's recommendation for colon cancer screening are less likely to undergo screening.¹⁶ Several studies have shown that Black patients are more likely to develop and die from colon cancer than White patients.¹⁷ As much as a 28% difference in incidence of advanced colon cancer between Blacks and Whites has been demonstrated, which, in turn, accounted for more than 60% of the difference in mortality.¹⁸ It is imperative that we intentionally work to increase the GI workforce diversity. Indeed, minority health care professionals are more likely to practice in underserved areas, thus improving health care delivery and patient outcomes in this population.¹⁹ This, in turn, potentially leads to an overall healthier population and reduced burden on the health care system.^{17,18}

Furthermore, minority patients tend to score lower when it comes to health care quality measures. One study, published by the Agency for Healthcare Research and Quality, found that Black populations received worse care than White populations for 43% of quality measures, American Indian populations received worse care than White populations for 40% of quality measures, and Hispanic populations received worse care than non-Hispanic White populations for 36% of quality measures.¹⁰ One reason may be that they are more likely to have negative experiences with physician–patient communication.²⁰ Minority patients also often face language and cultural barriers during their visits, leading to miscommunication regarding treatment.²⁰ In addition, the patient's symptoms and needs may not be completely understood, leading to worse health care outcomes. Furthermore, minorities are more likely to confront barriers in obtaining health insurance, which can cause delays in care. A lack of employee-associated health insurance is a well-known barrier to receiving care.²¹ Social determinants of health, such as a lack of generational wealth, inability to afford nutritious foods, or access to safe spaces for exercise, drive poor health outcomes and the perception of the “noncompliant” or “nonadherent” patient.²² All these factors can be traced back to systemic racism, which allows health disparities and inequities to persist.²²

Policies that provide true safety nets and incorporate more diversity in health care represent strategies to reduce GE-related health care disparities and foster health equity. Improving health care workforce diversity may lead to improving the quality of care for minority patients, primarily through increasing access to care by community physicians of diverse backgrounds and addressing health care disparities within local communities. Improving diversity in GE can be addressed by the creation of pathway programs, targeting school-aged children up through postgraduate training. Increasing the prevalence of URiMs in GE may also promote research in health care disparities and inequities frequently encountered by the respective underrepresented groups.^{1,23} Similarly, compulsory implicit bias training at all health care organizations would help to not only identify biases but also to provide the educational literacy necessary to mitigate them.

In terms of funding sources for initiatives to reduce disparities in health care, the National Institute on Minority Health and Health Disparities (NIMHD) is an example of one organization that may prove an important partner for GE by providing significant funding to institutions and practitioners. It had an allocated budget of \$391,586,000 for fiscal year 2022.²⁴ Each year, NIMHD provides several active funding opportunities nationwide for individuals participating in disparities research. However, there is now uncertainty for funding, given the proposed funding freezes. There are also local funding sources available to support this work. One example is Blue Cross Blue Shield of Massachusetts, which announced in December 2021 that it would donate \$25 million to health care disparities work, given the findings of health care inequity across its members in that state.

Engagement and outreach with minority communities is 1 way to facilitate a better understanding of their needs. In 1 study, 11 community listening sessions were conducted, and qualitative content analyses were conducted to identify common themes. In this study, the following themes were identified: uncertainties of minorities around research participation, ineffective communication regarding research findings, and the need for more cultural competence training/humility among research teams. The findings of this study highlight the importance of outreach to minority communities to increase participation in clinical research with the goal of reducing health disparities.²⁵

ASGE UP TO THE CHALLENGE: BUILDING PATHS FOR DEI

Part of ASGE's commitment to research in DEI is reflected by supporting grants like the Diversity and Inclusion Research Award, which awards \$50,000 over 2 years. Since 2007, the ASGE has also offered 2 \$1000 Diversity awards per year for research focusing on GE disease in underserved or underrepresented populations.

In addition, the ASGE successfully launched the inaugural Elevate Retreat: Positioning Physicians Underrepresented in GI for Success in the summer of 2023. This retreat provides a weekend of learning, coaching, and networking for early-career gastroenterologists who are URiM. Participants learned career advancement strategies, developed leadership skills, incorporated tools to balance career and life choices, and expanded their networking circles.²⁶

ASGE's Colorectal Cancer Screening Project, funded by a grant from Exact Sciences, is dedicated to developing a financially sustainable model to ensure that minority and underserved patient populations with positive stool-based colorectal cancer screening tests receive timely follow-up colonoscopy. ASGE is proudly at the center of an integrated effort, involving health care systems, health care professionals, legislators, regulators, advocacy organizations, patients, and community leaders, to provide education, patient navigation, and outreach to underserved communities.²⁷

In addition to monetary support in the form of grants and awards, the ASGE is heavily invested in education and community outreach. During Digestive Disease Week (DDW) 2023-2024, the ASGE Diversity and Inclusion Committee conducted half-day programs at local high schools to introduce students to the specialty of GE. The programs included hands-on experience with GE procedures and equipment, colonoscopy education, and GE trivia. ASGE provided networking opportunities and prizes for the students and volunteers. This is a popular program that we look forward to taking on the road each year at DDW. Other examples of ASGE's outreach efforts include the clinical skills workshop presented at the Latino Medical Student Association National Conference in 2023-2025 and a hands-on endoscopy session at the Association of American Indian Physicians Annual meeting in 2024. Students were educated about the field of GE and participated in a "Basics of Endoscopy" skills session on porcine models. In addition, ASGE began collaborating with Healio, a health care communications company, in 2022 to deliver a DEI in GE educational video series.²⁸

Finally, to be impactful in breaking down the many barriers that still exist for the URiM, we must be unified in our goals and efforts for change. ASGE is excited to be an integral member of the Intersociety Group on Diversity (IGD). The IGD is a group composed of members of the ASGE, American College of Gastroenterology, American Gastroenterological Association, and the North American Society of Pediatric Gastroenterology, Hepatology, and Nutrition. The mission of the IGD is to address issues related to DEI collaboratively across all major GE and hepatology specialty groups. Diversifying the GE physician workforce is truly an essential step to improve care delivery and achieve equitable health outcomes for patients.

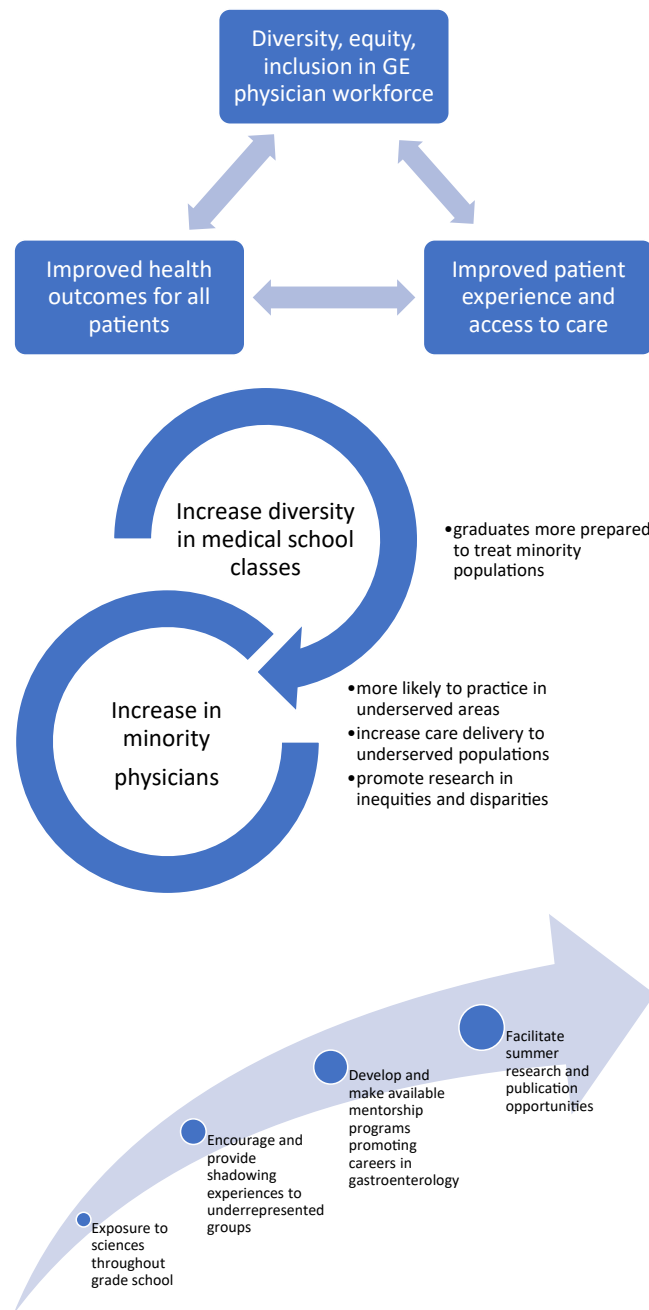


Figure 1. ASGE Pathways for Diversity. ASGE, American Society for Gastrointestinal Endoscopy.

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Abbreviations: ASGE, American Society for Gastrointestinal Endoscopy; DEI, diversity, equity, and inclusion; DDW, Digestive Disease Week; GE, gastroenterology; IGD, Intersociety Group on Diversity; URIMs, individuals underrepresented in medicine; URM, underrepresented minorities.

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