Communication from the ASGE Membership and Diversity Committee

SPECIAL ARTICLE

Diversity in gastroenterology in the United States: Where are we now? Where should we go?

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The term *diversity* has many definitions that have continued to evolve and expand over time. At its core, diversity is "a concept that encompasses acceptance and respect. It means the understanding that each individual is unique, and recognizing individual differences."[1] Nowhere is diversity more apparent today than in our changing healthcare system. Given improved access to healthcare provided through healthcare reform and the rapidly changing demographics of the U.S. population, it is expected that the U.S. healthcare system will continue to become more diverse in the future. However, the U.S. healthcare workforce does not mirror the population that it serves, a disparity that is most glaring in medical specialties including gastroenterology. It is well understood that promoting diversity among the healthcare workforce is essential to improving the quality of care for all patients.[2] For example, by developing a more diverse workforce we can enhance the healthcare we provide to our changing population in a number of important areas: (1) increasing care in underrepresented communities, (2) improving familiarity with the cultural customs, values, and behaviors of our patients, (3) promoting research in healthcare disparities, and (4) cultivating mentors for future healthcare providers.[3]

The following review critically examines healthcare disparities in medicine and gastroenterology and reviews a number of initiatives that the American Society for Gastrointestinal Endoscopy (ASGE) has undertaken to help address these gaps. This review also will highlight future directions that the ASGE is addressing and upon which the ASGE is embarking.

TRENDS IN DIVERSITY FOR MEDICINE AND GASTROENTEROLOGY

Diversity of race and ethnicity is woven into the fabric of the United States. The breadth of this diversity is due in large part to immigrants who have migrated from all over the world to the United States. Initially, large waves of European immigrants in the 18th through mid-20th centuries influenced every aspect of U.S. culture, from politics to art. However, there has been a recent shift in this influence because of changing immigration patterns. Over the last 3 decades there has been a rapid and steady inflow of immigrants from Latin America and Asia who have now made the United States an even more ethnically diverse society, which, in turn, has had important implications for healthcare.[4]

In light of its ethnic mélange, in the 1970s, the U.S. government began creating and executing policies directed toward providing equal and adequate healthcare for all. However, many of these policies have been unsuccessful at increasing the diversity of the healthcare workforce and ensuring equal care for all racial groups in the United States. For instance, members of racial and/or ethnic minority groups continue to be underrepresented in the healthcare workforce.[5] This lack of representation has a number of consequences for healthcare in underserved communities. For example, minority healthcare professionals are more likely to practice in minority and medically underserved areas[6,7] as well as understand behaviors and social norms of underrepresented groups, which, in turn, can aid in patient adherence and compliance with medical treatment. Furthermore, minority healthcare professionals can serve as role models for future healthcare workers.

In addition to there being a lack of diversity in the healthcare workforce, underrepresented minority patients do far worse on a number of healthcare quality measures. In particular, minority groups are more likely to experience difficult physician-patient communication, feel disrespected by the healthcare system, and are more likely to experience barriers in obtaining healthcare insurance.[8] Moreover, even when healthcare resources are geographically accessible, language and cultural barriers create additional problems and limitations for minority populations.[9]

As a major medical specialty society, the ASGE is aware of the role that gastroenterology and specifically gastrointestinal endoscopy play in the overall digestive health of the U.S. population. To bridge the gaps in healthcare that

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prevail for underrepresented minorities, the ASGE sought to better understand the impact of racial and sex diversity on GI healthcare disparities. Along these lines, the ASGE conducted a survey in 2012 to assess ASGE membership with regard to member self-identification. In examining these survey results, a number of concerning trends were observed. First, the percentage of underrepresented minorities in gastroenterology was incredibly low, with Hispanics, African Americans, and American Indians and/or Alaskan Natives comprising <10% of practicing gastroenterology providers (Fig. 1). Second, just 1 in 10 gastroenterologists in the United States are women. Similar data have been reported from other gastroenterology societies, with little change over the last decade.[10] These results highlight the large gap that continues to exist with respect to racial and sex diversity within the field of gastroenterology.

A critical mechanism to address GI healthcare disparities as well as improve the diversity among gastroenterologists is to enrich the diversity among gastroenterology trainees. Training a more diverse pool of well-qualified gastroenterologists, in terms of providing more culturally appropriate curriculum, providing a variety of diverse clinical experiences, and increasing the diversity in fellowship classes is integral to this enrichment. Small improvements have been noted in terms of increasing sex and racial diversity among gastroenterology fellowship programs in recent years, but more work is needed in this arena. A number of important benefits would be realized by creating a more diverse gastroenterology workforce; such benefits would include strengthening provider-patient communication and relationships, enhancing patient compliance with provider treatment recommendations, and improving healthcare outcomes among patients from different backgrounds.

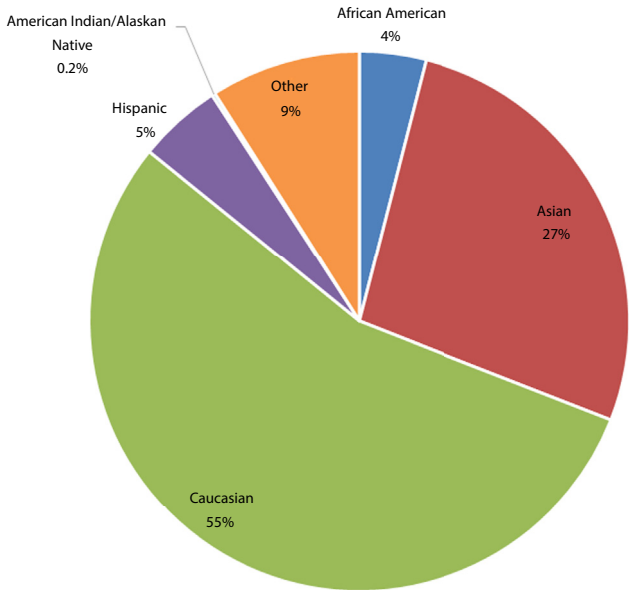

Figure 1. Racial distribution among ASGE members (self-identified).

ASGE DIVERSITY SURVEY RESULTS

After assessing the diversity of its membership, the ASGE then conducted a survey of its practicing gastroenterologists and trainee members in 2013 in order to gain a better understanding and awareness of current gastroenterologists' perceptions of diversity (Table 1). The survey was sent to 7408 ASGE members, of whom 169 responded (2.3% response rate). Among respondents, 85.5% were practicing members, and 14.5% were trainees, with the largest group of respondents between the ages of 34 and 44 (29.6%).

The survey clearly illustrated that many members were unaware of the ASGE's efforts at improving diversity in the field of gastroenterology. Among respondents, only 55.7% were aware that the ASGE had a Diversity Committee. Furthermore, respondents had little knowledge of initiatives led by the committee: only 14.0% were aware of the ASGE Diversity Initiatives Web page, 27.3% were aware of the Gastroenterology Women's Coalition, and 39.1% were aware of the annual Digestive Disease Week (DDW) diversity reception. When asked about knowledge of existing ASGE patient resources geared toward women and minorities, few respondents were aware of guidelines on racial and/or ethnic issues in endoscopy and pregnant and/or lactating women. Lastly, more than three-quarters of respondents were not aware that a quarter of ASGE's course directors and faculty are female or members of an underrepresented minority group.

Despite an overall lack of familiarity with the ASGE Diversity Committee functions and initiatives, when members were asked whether the ASGE does enough to increase diversity in the field of gastroenterology at this time, the majority agreed that the ASGE does do enough. When questioned about what efforts, programs, and initiatives related to minorities or sex they would like the ASGE to support in the future, their comments varied from promoting women in gastroenterology and increasing endoscopic screening programs in minority populations to increasing diversity within ASGE leadership positions.

WHY DIVERSITY MATTERS

Physician diversity benefits healthcare on multiple levels. First, studies have shown that medical students who attend allopathic medical schools with a racially and ethnically diverse student body gain greater exposure to racial and ethnic differences and feel more prepared to care for minority populations.[11] Second, minority physicians are more willing to practice in underserved communities where access to healthcare is limited.[7,12-15] Third, diversity among healthcare providers also impacts the physician-patient relationship. When given the option to choose, patients prefer to receive healthcare from an individual of similar racial or ethnic background and report greater satisfaction with their care.[6,16] Also, sex

TABLE 1. Characteristics of the respondents for the American Society for Gastrointestinal Endoscopy diversity survey

Demographic	No. (%)
Age, y	
<34	22 (13.0)
34-44	50 (29.6)
45-54	44 (26.0)
55-64	39 (23.1)
≥65	14 (8.3)
Sex	
Male	116 (68.6)
Female	53 (31.4)
Race	
White	96 (56.8)
African American/Black	17 (10.1)
Asian	41 (24.3)
American Indian/Alaskan Native	0
Other	15 (8.9)
Ethnicity	
Not Hispanic	146 (86.9)
Mexican, Mexican American, Chicano	3 (1.8)
Puerto Rican	7 (4.2)
Cuban	0
Other Hispanic or Latino origin	12 (7.1)

concordance between patients and physicians is linked to medical decision making and better treatment of chronic diseases like diabetes, hypertension, and obesity.[17-19]

It is important to note that recognition of healthcare disparities has spawned improvements in medical care. Since 1999, the Agency for Healthcare Research and Quality has produced an Annual Report aimed at improving quality and reducing disparities in healthcare. In 2013, their annual report highlighted that several noteworthy disparities continue to worsen for underrepresented minorities, including late diagnosis of breast cancer in African American women aged ≥40 years as well as lower rates of colorectal cancer screening either by colonoscopy or sigmoidoscopy in low income, Hispanic, and American Indian and/or Alaskan Native adults aged ≥50 years.[20] Additionally, the report highlighted that African Americans have an increased risk of developing and dying from colorectal cancer compared to other racial groups in the United States. A better understanding of these disparities has sparked the development of innovative programs to address them. One such example is that using culturally and/or ethnically similar patient navigators can help to increase colorectal cancer screening in underrepresented minorities.[21]

Last, a number of clinical guidelines have factored race and ethnicity into their recommendations. A recent practice management update has suggested that different management strategies may need to be considered for African American and Latino patients with respect to hepatitis C (HCV) treatment and colorectal cancer screening.[22] To address HCV care disparities among African Americans, recommendations have included a call for greater educational outreach to providers and patients, increased underrepresented minority participation in clinical trials, and improved access to treatment and liver transplantation.[23] Along these lines, the ASGE has highlighted expert opinions that suggest African Americans should begin colorectal cancer screening at an earlier age of 45 years.[24,25] Additionally, the ASGE has recently published recommendations for gastric and colorectal cancer screening based on race and ethnicity as well as specific disease states.[26] Nonetheless, although strides have been made in recognizing and addressing some disparities, more work is needed. Other specialties and primary care are farther along than gastroenterology in the incorporation of race and ethnicity into their management guidelines, highlighting the continued work that needs to take place in gastroenterology.

ASGE DIVERSITY INITIATIVES

Given the lack of both racial and sex diversity in gastroenterology, the ASGE has been committed to a number of initiatives over the years to reduce such disparities. We wish to highlight several of these programs.

Investing in the Future program

Investing in the Future is one of the most successful programs aimed at increasing underrepresented minorities in gastroenterology. The *Investing in the Future* program is a collaborative initiative between the ASGE and the American Gastroenterological Association Institute (AGAI) that began in 2011 with the support of a grant from the National Institutes of Health. It is intended to inspire and encourage medical students and internal medicine residents of underrepresented backgrounds to consider specializing in gastroenterology. There are 2 key components of the program: a presentation on the field of gastroenterology by a gastroenterologist or gastroenterology fellow from an underrepresented group followed by an opportunity for students to participate in a hands-on endoscopy simulation led by local gastroenterologists. Both components are aimed at introducing students to the field of gastroenterology and highlighting the need for diversity. To date, more than 18 *Investing in the Future* programs involving more than 1700 students have been conducted throughout the United States, both at medical schools, such as Howard University College of Medicine, Meharry Medical College, Texas Tech University, and the University of Puerto Rico, and at national conferences, such as the Latino Medical Student Association,

Association of American Indian Physicians, and Student National Medical Association.

Although it is still too early to determine the success of the program as measured by the number of underrepresented students matriculating into gastroenterology fellowships, student enthusiasm and feedback indicate that students have been encouraged to consider a career in gastroenterology.

Women and gastroenterology leadership

Women constitute only 13%[27] of practicing gastroenterologists in the United States. Although the number of women enrolled in training programs has steadily increased, more work is needed to promote sex diversity. On this front, the ASGE has been engaged in a number of important projects. The first is the Gastroenterology Women's Coalition, which represents a collaboration of 4 gastroenterology societies: ASGE, AGAI, American Association for the Study of Liver Diseases, and North American Society for Pediatric Gastroenterology, Hepatology and Nutrition. This collaboration focuses on identifying and addressing issues related specifically to women.

A second, recently initiated program is the Leadership Education and Development program, which is intended to provide young female gastroenterologists with the skills, training, and mentorship necessary to become leaders in gastroenterology. The first Leadership Education and Development program in 2014 was 18 months long and included 30 women from all over the United States who represented academic and private practice, urban and rural patient settings, and adult and pediatric practice. There were several components to the program. First, the program hosted several Web seminars for participants that focused on the art of peer review, time management, and career navigation. Second, the group met together at DDW, EndoFest, and at the ASGE Institute for Training and Technology where invited experts provided instructions on networking, budget preparation, meeting management, conflict resolution, and negotiating skills. Participants have provided strong feedback in support of the program, describing their experience as invaluable, and a new group of young women leaders began the program in 2015.

Mentorship program

In 2011, the ASGE launched the Mentorship Program. The program provides a forum by which trainees or young faculty can be matched with resourceful gastroenterologists around the country to advise them on various aspects of their careers. Those being mentored can select a mentor based on a number of criteria, including sex, ethnicity, location, or area of expertise. The program offers valuable support to trainees who are committed to advancing their careers and the field of GI endoscopy. The program has been widely popular and successful on a number of fronts. Over 80% of participating mentors and those being mentored reported their experience in the program as good or excellent, and the overwhelming majority stated that they would recommend the program to a colleague. Nearly 90% of those being mentored stated that they gained professionally from their relationship with the mentor.

Diversity awards and grants

To promote awareness of diversity as an area of research in gastroenterology, the ASGE Diversity Committee selects 2 recipients annually to receive the ASGE Diversity awards, which are presented during the ASGE Crystal Awards at DDW. Based on review of abstracts submitted to the ASGE for DDW, awards are presented for research that addresses healthcare disparities related to sex or race and/or ethnicity. Past recipients of the awards have addressed topics such as endoscopy in pregnant women, CAP-assisted colonoscopy in Hispanic patients, racial differences observed in segmental adenoma detection rates, and water exchange colonoscopy in women who received care at a Veterans Administration hospital.

Lesbian, Gay, Bisexual, and Transgender providers and patients in gastroenterology

Another important type of diversity is sexual orientation (eg, lesbian, gay, bisexual, and transgender [LGBT]). Little education or training is offered to U.S. medical students, medicine residents, or gastroenterology fellows on LGBT healthcare issues.[28,29] Such a lack of formal education may negatively impact the ability of practitioners to provide optimal GI care for LGBT patients. Presently, there is scarce information available on LGBT GI providers and LGBT patients with GI diseases. In fact, among the major medicine specialty societies, few address the LGBT population in their diversity initiatives. We believe the ASGE can and should become a leader in this area.

A number of steps should be taken by the ASGE to address these disparities. First, we need a better understanding of our LGBT membership. We should begin by determining the number of LGBT gastroenterologists who are ASGE members and solicit input on their needs and opinions. Such information can be used to inform institutional and programmatic decisions about the LGBT community in gastroenterology and, more specifically, the ASGE. Next, we should develop and implement programs to promote awareness of LGBT-related issues in gastroenterology. This type of promotion can take many forms, but an important start would be the discussion of LGBT-related topics through clinical symposia or special sessions at national, regional, and/or local meetings. Third, we should create opportunities for networking and professional development for LGBT members, which may be initiated by sponsoring LGBT functions at national meetings, including DDW. Finally, the Diversity Committee should continue to advocate for research pertaining to LGBT issues as they pertain to both gastroenterology providers and LGBT patients who experience GI illnesses.

Clearly more work is required in this area and it is one in which our specialty and the ASGE can become a leader through continued measured and sustained efforts.

CONCLUSION

Understanding and promoting diversity in medicine, specifically in gastroenterology, is essential to ensuring high-quality and equitable healthcare for all patients. Along these lines, it is crucial to have a diverse healthcare workforce to care for our changing patient population and to address the disparities that currently exist. The gastroenterology societies, including the ASGE, have recognized this as a priority and have begun to address such disparities. One priority must be a focus on increasing minorities and women not only within the field of gastroenterology but to ensure they have leadership positions in gastroenterology. To meet these challenges, the ASGE has been engaged in numerous initiatives over the years. These programs are aimed at students, trainees, and practicing gastroenterologists. Although more work is definitely needed, the foundation has been laid with the above-mentioned programs. Continued and sustained effort will expand these programs and help bridge the existing diversity gaps in our specialty.

DISCLOSURE

J. Bucobo is a consultant for Boston Scientific and a speaker for Cook Medical. All other authors disclosed no financial relationships relevant to this publication.

Abbreviations: AGAI, American Gastroenterological Association Institute; ASGE, American Society for Gastrointestinal Endoscopy; DDW, Digestive Disease Week; HCV, hepatitis C virus; LGBT, lesbian, gay, bisexual, transsexual.

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