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Authors

Rahal, Harman K
Tabibian, James H
Issaka, Rachel
et al.

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Diversity, Equity, and Inclusion in Gastroenterology and Hepatology: A Survey of Where We Stand

Harman K. Rahal, MD^{1,2,3,*}, James H. Tabibian, MD, PhD^{3,4,*}, Rachel Issaka, MD^{5,6}, Sandra Quezada, MD, MS⁷, Darrell Gray II, MD, MPH, FACP⁸, Sophie Balzora, MD, FACP⁹, Liu Yang, MD, MPH^{1,3}, Jayraan Badiee, MPH^{1,3} and Folasade May, MD, PhD, MPhil^{1,3,10,11}

INTRODUCTION: In the setting of increasing attention to representation in medicine, we aimed to assess current perspectives of racial and ethnic workforce diversity and health care disparities among gastroenterology (GI) and hepatology professionals in the United States.

METHODS: We developed and administered a 33-item electronic cross-sectional survey to members of 5 national GI and hepatology societies. Survey items were organized into thematic modules and solicited perspectives on racial and ethnic workforce diversity, health care disparities in GI and hepatology, and potential interventions to enhance workforce diversity and improve health equity.

RESULTS: Of the 1,219 survey participants, 62.3% were male, 48.7% were non-Hispanic White, and 19.9% were from backgrounds underrepresented in medicine. The most frequently reported barriers to increasing racial and ethnic diversity in GI and hepatology were insufficient representation of underrepresented racial and ethnic minority groups in the education and training pipeline (n = 431 [35.4%]), in professional leadership (n = 340 [27.9%]), and among practicing GI and hepatology professionals (n = 324 [26.6%]). Suggested interventions were to increase career mentorship opportunities (n = 545 [44.7%]), medical student opportunities (n = 520 [42.7%]), and program and professional society leadership roles for underrepresented racial and ethnic minority groups (n = 473 [38.8%]).

DISCUSSION: Our survey explored imperative and timely perspectives on racial and ethnic representation and health equity among professionals in GI and hepatology. The findings should inform future interventions to address workforce diversity and establish priorities toward improving health equity, ultimately serving as a springboard for professional societies, academic institutions, and other organizations that aim to increase diversity, equity, and inclusion in our field.

SUPPLEMENTARY MATERIAL accompanies this paper at <http://links.lww.com/AJG/C666>

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INTRODUCTION

Our nation has been reminded repeatedly of the pervasiveness of racial and social injustice. This injustice and repeated acts of prejudice nationwide have led to multiple responses, including the 2020 reinvigoration of the Black Lives Matter movement and sometimes uncomfortable conversations about race and racism in

the United States. In this context, there has also been a reassessment of racial and ethnic representation in the biomedical sciences, including gastroenterology (GI) and hepatology (1,2).

Despite some progress over the last several decades to improve gender representation in GI and hepatology, there have been fewer strides forward for traditionally underrepresented racial

¹Department of Medicine, David Geffen School of Medicine, University of California–Los Angeles, Los Angeles, California, USA; ²Karsh Division of Gastroenterology and Hepatology, Cedars-Sinai Medical Center, Los Angeles, California, USA; ³Vatche and Tamar Manoukian Division of Digestive Diseases, David Geffen School of Medicine, University of California–Los Angeles, Los Angeles, California, USA; ⁴Division of Gastroenterology, Department of Medicine, Olive View-UCLA Medical Center, Sylmar, California, USA; ⁵Clinical Research and Public Health Sciences Divisions, Fred Hutchinson Cancer Research Center, Seattle, Washington, USA; ⁶Division of Gastroenterology, Department of Medicine, University of Washington School of Medicine, Seattle, Washington, USA; ⁷Department of Medicine, Division of Gastroenterology and Hepatology, University of Maryland School of Medicine, Baltimore, Maryland, USA; ⁸Division of Gastroenterology, Hepatology and Nutrition, College of Medicine, the Ohio State University, Columbus, Ohio, USA; ⁹Division of Gastroenterology and Hepatology, NYU Langone Health, New York, New York, USA; ¹⁰UCLA Kaiser Permanente Center for Health Equity, Jonsson Comprehensive Cancer Center, University of California–Los Angeles, Los Angeles, California, USA; ¹¹Division of Gastroenterology, Department of Medicine, Veterans Affairs Greater Los Angeles Healthcare System, Los Angeles, California, USA. **Correspondence:** Folasade P. May, MD, PhD, MPhil. E-mail: fmay@mednet.ucla.edu.

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*Harman K. Rahal and James H. Tabibian share co-first authorship.

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and ethnic groups. The Association of American Medical Colleges defines *underrepresented in medicine* (UIM) as “those racial and ethnic populations that are underrepresented in the medical profession relative to their numbers in the general population.” (3) These groups have traditionally included Latino (i.e., Latino/a/x), Black (or African American), Native American (namely, American Indian, Alaska Native, and Native Hawaiian), Pacific Islander, and mainland Puerto Rican individuals (3). Several studies have demonstrated the benefits of a diverse physician workforce and workplace, including increased patient satisfaction, disease-specific knowledge, and adherence to medical recommendations (4,5) when providers and patients have racial, ethnic, and/or linguistic concordance (6). UIM individuals bring underrecognized perspectives to the workplace and to scholarly activities and are more likely to engage in health equity research, work in underserved communities and in areas where access to care is poor (4,5), and mentor students and trainees who are also from UIM backgrounds (7).

There is a vital need to increase workplace diversity, inclusion, and equity in medicine. The Intersociety Group on Diversity (IGD), established in 2020 by the American Association for the Study of Liver Diseases; American College of Gastroenterology; American Gastroenterological Association; American Society for Gastrointestinal Endoscopy; and the North American Society for Pediatric Gastroenterology, Hepatology and Nutrition, is one product of this movement. The objectives of this intersociety collaboration are to increase diversity, equity, and inclusion in the membership and leadership of GI and hepatology national societies and eradicate health disparities in the patients served by members of these 5 national societies (8). In partnership with the IGD, a group of investigators from the University of California–Los Angeles (UCLA) developed a 33-question cross-sectional survey (see Supplementary Material, Supplementary Digital Content 1, <http://links.lww.com/AJG/C666>) for GI and hepatology professionals, with the overall aims to determine perspectives of current racial, ethnic, and gender diversity within GI and hepatology; to assess current views on interventions needed to increase racial, ethnic, and gender diversity in the field; and to collect data on the experiences of UIM individuals and women in our field.

This article summarizes the survey participants’ demographic and professional characteristics and perspectives on racial and ethnic diversity and health care disparities in GI and hepatology. Our ultimate goal was to inform future discussions, initiatives, and interventions that improve representation in the GI and hepatology workforce and, in turn, improve patient and provider satisfaction and health outcomes.

METHODS

Study population

The study population included GI and hepatology medical professionals (i.e., MD, MD/PhD, DO, NP, and PA) in the United States who were members of at least 1 of the 5 national societies that comprise the IGD. For the purposes of our study, *Latinx* is a gender-neutral term that is an alternative to *Latino* or *Latina* and refers to any individual of Latin American descent (9).

Survey development

Survey development began with the UCLA researchers (H.R., J.T., L.Y., F.M.) in August 2020 and was informed by a literature review of publications related to racial, ethnic, and gender diversity in GI and hepatology. This team then partnered with the newly

developed IGD, at which time, IGD co-authors (R.I., S.Q., D.G., S.B.) provided input to meet the diversity, equity, and inclusion goals of the multiple GI and hepatology national societies. All of the UCLA and IGD investigators (7 female, 2 male) had university-based academic backgrounds, but there was an effort to include items and response categories appropriate for individuals in private practice. The survey was pilot tested for comprehension, readability, and timing and edited to incorporate suggested changes.

The final electronic survey instrument included 33 questions; 32 were multiple-choice and 1 was a free-text item. Multiple responses were allowed for many of the questions, and there was an option to include alternative responses as free text under “other.” There were 7 thematic modules (Figure 1) for the survey items: (i) demographic information, (ii) career and clinical practice characteristics, (iii) perspectives on racial and ethnic diversity in GI and hepatology, (iv) perspectives on gender diversity in GI and hepatology, (v) experiences as a UIM individual (if applicable), (vi) experiences as a female individual (if applicable), and (vii) health care disparities in GI and hepatology. Participants were also able to provide free-text comments at the end of the survey. The survey took approximately 10–15 minutes to complete (based on pilot testing). We summarized the results from modules 1, 2, 3, and 7.

Data collection

We distributed surveys between December 8, 2020, and January 4, 2021, through online intersociety listservs that enabled us to reach members of all 5 national GI and hepatology societies. Members of each society received an initial e-mail invitation to complete the survey and 4 reminder e-mails during the study period. In addition, each medical society, members of the IGD, and the UCLA investigative team used social media platforms to encourage GI and hepatology society members to complete the survey.

Data analysis

We collected and organized survey data via Research Electronic Data Capture software. The team statisticians (L.Y., J.B.) completed descriptive statistics and cross-tabulations to summarize frequencies of responses and evaluate demographic characteristics, clinical and leadership roles, workplace satisfaction, and changes perceived necessary for improvements in workforce diversity and disparities overall and by race and ethnicity. The study was reviewed and approved by the UCLA Institutional Review Board (IRB #20-001770).

RESULTS

Survey response

We distributed a total of 28,085 e-mails with surveys and received 1,219 responses, for a 4.3% response rate. However, we were not able to account for individuals who are members of more than 1 society or who received the survey more than once in this calculated response rate, due to the societies’ desire to maintain the confidentiality of society membership. For this reason, the true response rate is likely higher than 4.3%. The Association of American Medical Colleges estimated that there were 15,469 practicing gastroenterologists in the United States in 2019 (most recent estimate), and if we use this value as the number of potential participants, the survey response rate is estimated at 7.9% (10).

Module	Theme	Survey item content
Module 1*	Demographic information	<ul style="list-style-type: none"> • Sex • Age • Race • Ethnicity • Location most lived • Language proficiency
Module 2*	Practice and clinical practice characteristics	<ul style="list-style-type: none"> • Duration of practice • State or territory • Work setting • Titles • Subspecialty or focus • Tenure status • Leadership roles in institution/practice • National society involvement • Leadership roles in national societies
Module 3*	Perspectives on racial and ethnic diversity	<ul style="list-style-type: none"> • Current satisfaction at workplace • Improvements would like to see in the workplace • Barriers in the workplace • Interventions needed in the workplace • Cultural competency training • Change over time in the field relative to other specialties • Impact on patient care • Impact on research • Least diverse subspecialties
Module 4	Perspectives on gender diversity	<ul style="list-style-type: none"> • Interventions needed in the workplace • Change over time in the field • Impact on patient care • Least diverse subspecialties
Module 5	Experiences as a UIM (if applicable)	<ul style="list-style-type: none"> • Unjust instances
Module 6	Experiences as a female (if applicable)	<ul style="list-style-type: none"> • Unjust instances
Module 7*	Health disparities in GI and hepatology	<ul style="list-style-type: none"> • Interventions needed

*Indicates module for which results are presented in this manuscript

Figure 1. Thematic modules and items included in the survey. GI, gastroenterology; UIM, underrepresented in medicine.

Demographic characteristics of participants

The majority of participants self-identified as male ($n = 760$ [62.3%]), and non-Hispanic White individuals ($n = 568$ [48.7%]) were the largest racial and ethnic group. The largest age group represented was 31–40 years ($n = 301$ [24.7%]). UIM participants self-identified their race and ethnicity as follows: 10.6% Latinx ($n = 128$), 9.1% non-Hispanic Black ($n = 109$), and 0.2% non-Hispanic American Indian or Alaska Native ($n = 2$). More than 75% of participants lived the majority of their lives in the United States (Table 1).

Professional practice characteristics

A majority of survey participants ($n = 654$ [53.9%]) worked in an academic setting, followed by private practice ($n = 437$ [36.0%]). The most common subspecialty focus was general GI ($n = 728$ [59.7%]), followed by hepatology ($n = 171$ [14.0%]). Notably, there was nearly equal representation from all career stages, from clinical training (GI fellowship) through more than 35 years of practice. Self-reported society membership was 64.1% for American Gastroenterological Association; 59.8% for American College of Gastroenterology; 48.8% for American Society for Gastrointestinal Endoscopy; 19.9% for American Association for the Study of Liver Diseases; and 13.1% for North American Society for Pediatric Gastroenterology, Hepatology and Nutrition (Table 1). Of note, 44.5% of participants in academia were female, compared with only 23.6% in private practice. Racial and ethnic groups had similar representation in academia and private practice: non-Hispanic White, 54.6% vs 58.3%; non-Hispanic

Black, 11.7% vs 8.1%; non-Hispanic Asian, 27.8% vs 24.1%; and Latinx, 10.3% vs 12.3%, respectively.

Perspectives on current racial and ethnic diversity in GI and hepatology

The majority of participants were very satisfied ($n = 423$ [34.8%]) or somewhat satisfied ($n = 465$ [38.2%]) with the current level of racial and ethnic diversity in their workplace. Conversely, 16.6% ($n = 202$) were unsatisfied and 8.1% ($n = 98$) were very unsatisfied. Satisfaction with racial and ethnic diversity varied by race and ethnicity. Although 77.7% ($n = 455$) of non-Hispanic White participants were very satisfied or somewhat satisfied with the current level of diversity at their workplace, 63.3% ($n = 69$) of non-Hispanic Black and 23.4% ($n = 30$) of Latinx individuals were somewhat or very unsatisfied.

Satisfaction also varied by age and practice type, but, notably, not by leadership status. Of participants 50 years or older (52.5%), 77.3% were very satisfied or somewhat satisfied with the current level of diversity at their workplace, compared with 68.8% of participants younger than 50 years. Of participants in private practice (36.0%), 80.3% were somewhat or very satisfied by the level of workplace diversity. However, of participants in academia (53.9%), 68.7% were somewhat or very satisfied. Of participants in leadership positions, 75.5% were very satisfied or somewhat satisfied with the level of diversity, compared with 70.0% in nonleadership positions. When we considered the race and ethnicity of participants in leadership positions (60.4% were non-Hispanic White, 12.4% were Latinx, 6.6% were non-

Table 1. Demographic and professional career characteristics of survey participants (n = 1,219)

Characteristic	n	%
Demographic		
Age		
21–30 y	43	3.5
31–40 y	301	24.7
41–50 y	232	19.1
51–60 y	273	22.4
61–70 y	245	20.1
71–80 y	88	7.2
80+ y	29	2.4
Prefer not to answer	6	0.5
Not reported	2	—
Gender		
Male	760	62.5
Female	437	35.9
Other (transgender, agender, genderqueer, nonbinary)	7	0.6
Prefer not to answer	13	1.1
Not reported	2	—
Race and ethnicity		
Non-Hispanic White	586	48.7
Non-Hispanic Asian/Native Hawaiian/Pacific Islander	271	22.5
Hispanic	128	10.6
Non-Hispanic Black	109	9.1
Non-Hispanic other	40	3.3
Non-Hispanic American Indian or Alaskan Native	2	0.2
Prefer not to answer	68	5.7
Not reported	15	—
Geographic area		
United States	952	78.3
Outside the United States	257	21.1
Prefer not to answer	7	0.6
Not reported	3	—
Professional career		
Time in practice		
Currently in training	124	10.2
5 y	153	12.6
5–10 y	168	13.8
11–15 y	104	8.6
16–20 y	116	9.5
21–25 y	140	11.5
26–30 y	134	11.0
31–35 y	95	7.8

Table 1. (continued)

Characteristic	n	%
35 y	174	14.3
Prefer not to answer	9	0.7
Not reported	2	—
Subspecialty (not mutually exclusive)		
General GI	728	59.7
Advanced/interventional endoscopy	189	15.5
Hepatology (including transplant hepatology)	171	14.0
Inflammatory bowel disease	149	12.2
Pediatric GI	131	10.8
Gastrointestinal motility and functional disorders	85	7.0
Research (nonclinical)	59	4.8
Gastrointestinal nutrition	42	3.5
Pediatric hepatology	35	2.9
Other	120	9.8
None	14	1.2
Prefer not to answer	8	0.7
Primary workplace setting		
Academic	654	53.9
Private practice	437	36.0
Other	99	8.2
Industry	14	1.2
Prefer not to answer	9	0.7
Not reported	5	—
Workplace leadership position		
President, chief executive officer, or chief medical officer	45	3.7
Chair of department	54	4.4
Dean, associate dean, assistant dean of medical school	11	0.9
Chief of division (gastroenterology, gastroenterology and hepatology, hepatology)	115	9.4
Partner in private practice	179	14.7
Director or associate director of residency or fellowship program	77	6.3
Other division leadership (director of research, center director, director of inflammatory bowel disease, quality director)	186	15.3
Group practice director	59	4.8
Other	96	7.9
Not applicable; I do not hold a leadership position at this time	577	47.3
Society leadership (not mutually exclusive) ^a		
American Association for the Study of Liver Diseases	242	19.9

Table 1. (continued)

Characteristic	n	%
American College of Gastroenterology	29	59.8
American Gastroenterological Association	781	64.1
American Society for Gastrointestinal Endoscopy	595	48.8
North American Society for Pediatric Gastroenterology, Hepatology and Nutrition	160	13.1
Other	110	9.0
Prefer not to answer	15	1.2

GI, gastroenterology.
^aSociety leadership roles included committee or subcommittee members, committee or subcommittee chair, and governing board.

Hispanic Black, 24.3% were non-Hispanic Asian, and 0.2% were non-Hispanic American Indian or Alaska Native), 77.5% of non-Hispanic White participants, 33.3% of non-Hispanic Black participants, 83.1% of Latinx participants, and 80.3% of non-Hispanic Asian participants in leadership roles were somewhat satisfied or very satisfied with the level of diversity at their workplace.

A large proportion of participants (n = 561 [46.0%]) responded “I don’t know” when asked to indicate the subspecialty area (e.g., general GI, advanced endoscopy, pediatric hepatology, pediatric GI, and basic science research) within GI and hepatology with the least racial and ethnic diversity. Approximately one-quarter of participants (n = 312 [25.6%]) selected advanced endoscopy. Conversely, pediatric hepatology was perceived as the subspecialty area with the most racial and ethnic diversity. A large proportion of participants (n = 553 [45.4%]) reported that the number of UIM individuals in their workplace should increase. However, there was also a large group of participants (n = 490 [40.2%]) who did not feel that the number of UIM individuals should increase within their workplace.

Reported barriers to increasing racial and ethnic diversity in GI and hepatology

The most frequently reported barriers to increasing racial and ethnic diversity in GI and hepatology were insufficient representation of racial and ethnic minority groups in the educational and training pipeline (n = 431 [35.4%]), insufficient racial and ethnic minority group representation in professional leadership (n = 340 [27.9%]), and insufficient racial and ethnic minority group representation among practicing GI and hepatology professionals in the workplace (n = 324 [26.6%]) (Figure 2). Most participants (n = 723 [59.7%]) expressed that they felt racial and ethnic diversity had increased over the past 5 years, compared with a smaller group (n = 241 [19.9%]) who felt that there was no substantial change.

Interventions to increase racial and ethnic diversity and to address health care disparities in gastroenterology and hepatology

More than 40% of participants (n = 545 [44.7%]) felt that future efforts to improve racial and ethnic workforce diversity in GI and hepatology should include an increase in career mentorship opportunities for UIM individuals. Additional recommendations were to increase medical student opportunities (n = 520 [42.7%]) in GI and hepatology and to increase UIM representation in training programs and professional society leadership (n = 473 [38.8%]) (Figure 3).

Participants reported that several strategies could be adopted by national societies and academic medical centers to improve health equity for clinical outcomes, including increasing UIM mentorship programs (n = 688 [56.4%]); increasing undergraduate pipeline science, technology, engineering, and mathematics programs for UIM undergraduate students (n = 625 [51.3%]); increasing UIM representation in leadership in national societies (n = 553 [45.4%]); and developing national and local policies to improve health care access and delivery in medically underserved communities (n = 508 [41.7%]) (Figure 4).

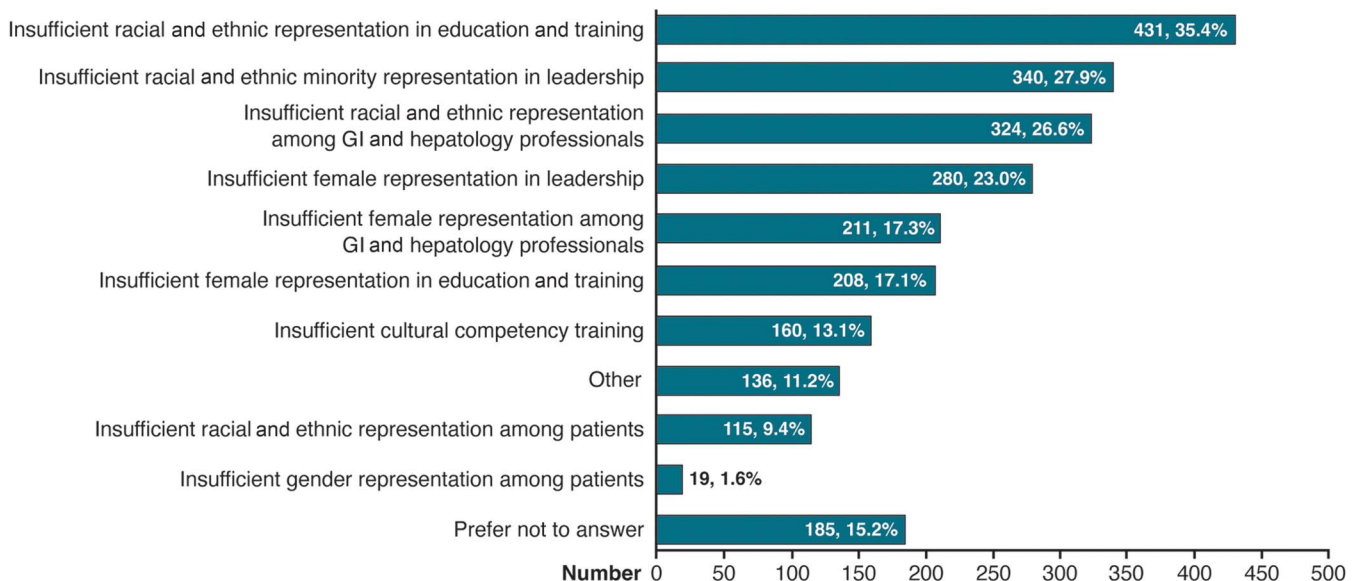


Figure 2. Perceived barriers to workforce diversity among GI and hepatology professionals. GI, gastroenterology.

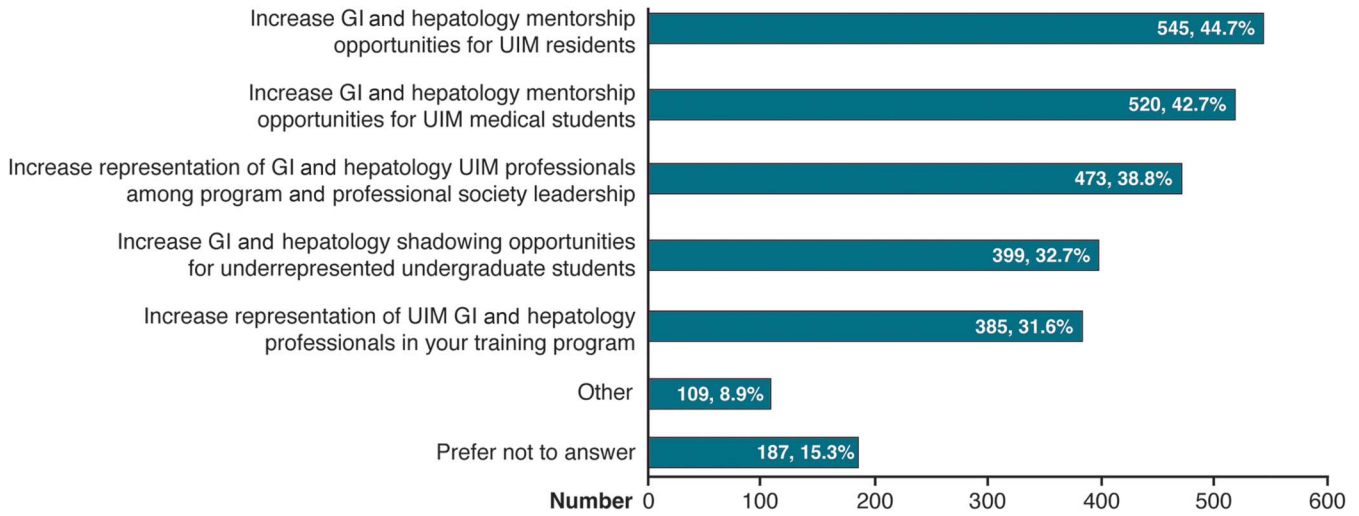


Figure 3. Perceived best interventions to improve representation of UIM individuals in GI and hepatology. GI, gastroenterology; UIM, underrepresented in medicine.

Consistently, racial and ethnic diversity among health care providers was perceived to influence patient care. A majority of participants (n = 707 [58%]) indicated that increasing workforce diversity would impact patient care by increasing the willingness of racial and ethnic minority patients to receive medical care. Similarly, a large group (n = 542 [44.5%]) stated that increased UIM representation among providers would increase patient satisfaction with medical care. Nearly one-half of participants (n = 553 [45.4%]) felt that increased racial and ethnic diversity among practicing GI and hepatology professionals would increase research findings that improve health outcomes for patients from medically underserved backgrounds (Figure 5).

DISCUSSION

There is a paucity of data on perceptions of diversity and disparities in the GI and hepatology workforce, despite relatively stagnant UIM representation in GI and hepatology over the last decade. Given the importance and growing awareness of diversity, or lack thereof, we conducted a national cross-sectional survey-based study to examine current views on workforce diversity and health equity, assess potential interventions to address diversity and health inequities, and increase knowledge of the experiences of those underrepresented in GI and hepatology. Our survey is the first to explore recent perspectives on UIM representation and health equity among professionals in GI and

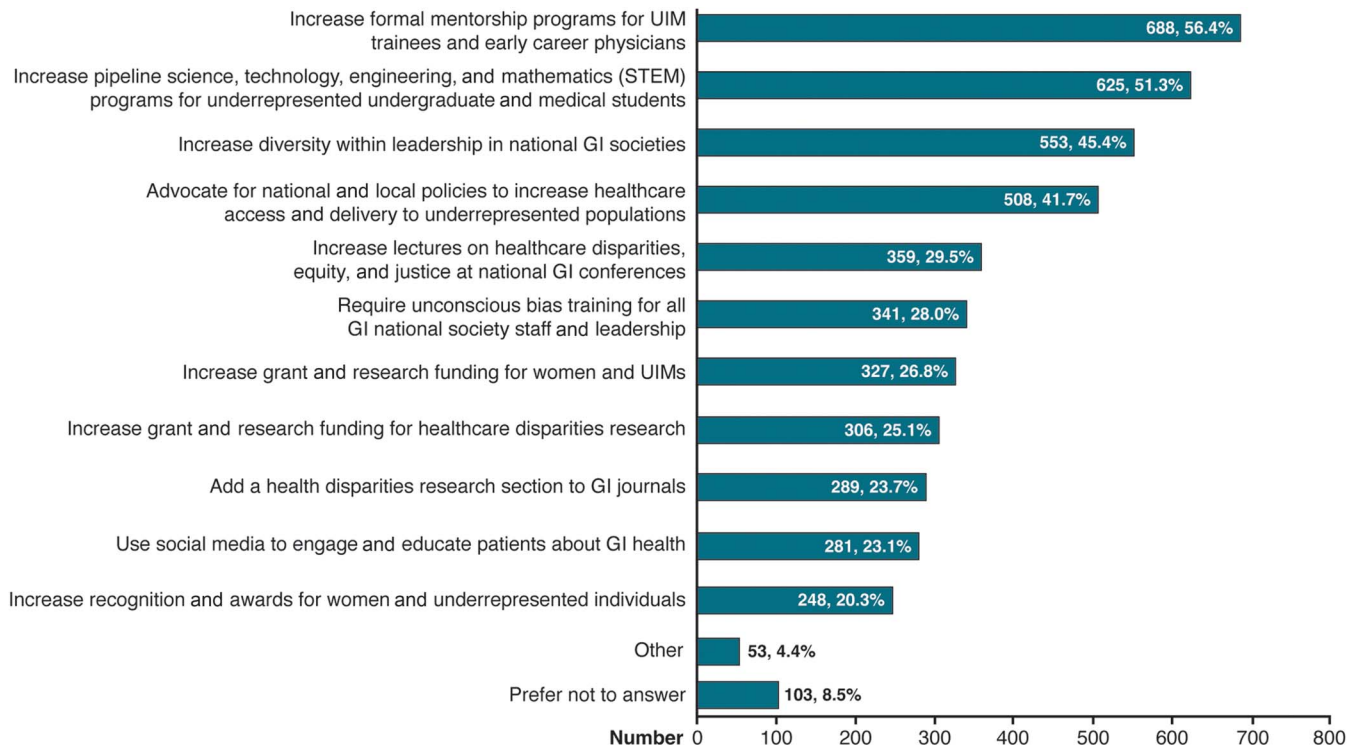


Figure 4. Perceived strategies to improve health equity/health disparities. GI, gastroenterology; UIM, underrepresented in medicine.

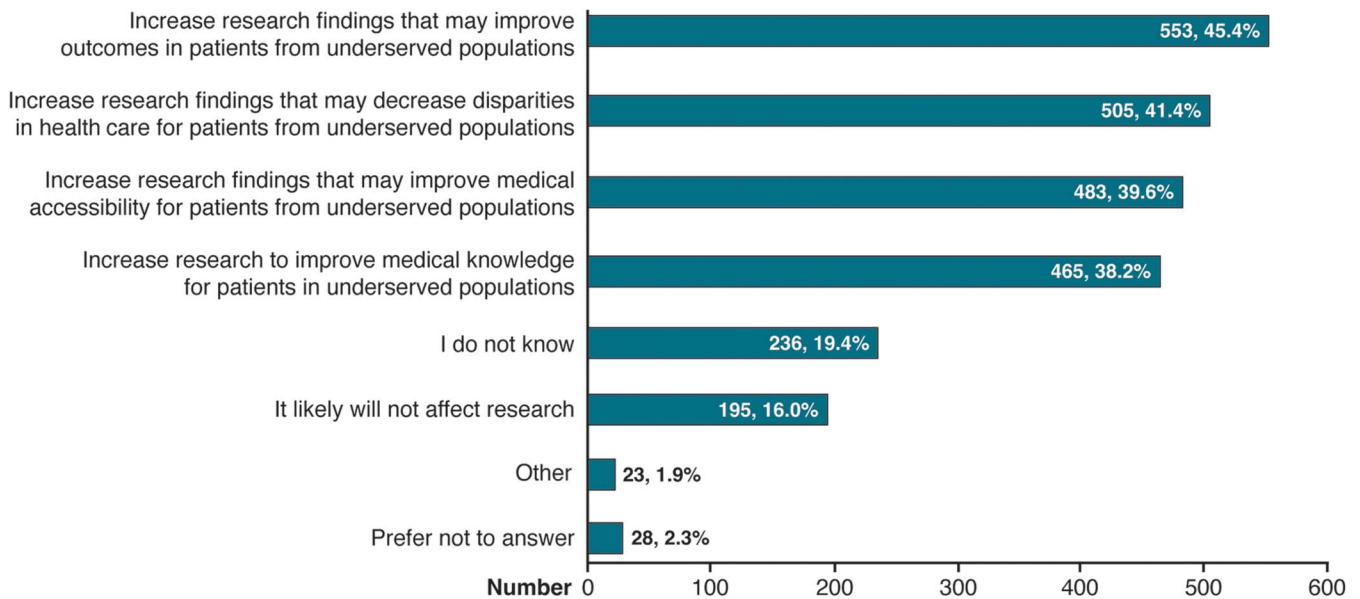


Figure 5. Perceived impact of increasing representation of UIM individuals on basic and clinical research. UIM, underrepresented in medicine.

hepatology and highlights that to improve workforce diversity and address health disparities in our field, a necessary first step may be to better demonstrate why these factors must be a critical priority.

Based on data published by the Accreditation Council for Graduate Medical Education, the percentage of fellows in GI and hepatology who are UIM has remained low at 9.0% since 2011 (11). Although this trend among GI and hepatology fellows is not reassuring, it correlates closely with UIM representation among internal medicine residents. In addition, the proportion of UIM academic faculty has never exceeded 10% at each academic rank and, more concerning, there has been a decline in the proportion of UIM individuals at junior academic faculty positions in recent years (12). Within academic GI and hepatology divisions, similar patterns are noted—only 9% of US academic gastroenterologists identify as UIM and there has been little change in the proportion of UIM individuals within GI and hepatology divisions over the last decade (12). Potential contributors to these observations may be lack of racial and ethnic diversity in the medical training pipeline, nondiverse leadership, bias, racial discrimination, and the notion that UIM physicians may be less likely to promote themselves or be promoted (13).

We found that despite the well-recognized scarcity of UIM individuals in GI and hepatology, only a small proportion of survey participants (one-third or fewer) felt that racial and ethnic representation was insufficient in the educational and training pipeline, among practicing professionals, or in GI and hepatology leadership. When asked to report their current level of satisfaction with workplace diversity, nearly three-fourths of participants stated they were somewhat or very satisfied, and a majority of participants (59.7%) felt that racial and ethnic diversity has increased over the past 5 years, despite data supporting the contrary.

Notably, there was also a discrepancy between the large number of participants who were satisfied with the level of diversity in their workplace and the large number who indicated that interventions are needed to improve diversity and

equity. Although these findings appear contradictory, they are not mutually exclusive. It is possible that the participants felt satisfied with the level of diversity, yet thought that it could be further improved. Of those who reported they were very satisfied (34.8%), 10.4% indicated that interventions are needed to improve diversity and equity. Of those who reported that they were somewhat or very satisfied (73.0%), 42.6% indicated that interventions are needed to improve diversity and equity. The finding may also reflect the large proportion of survey participants in leadership positions who were non-UIM (60.4%) and rated satisfaction high (77.5%). It may be the case that non-UIM leaders (overrepresented in our sample) who help shape the demographic composition of their workplace were or felt obligated to report content with the degree of diversity, but are also aware of the need for increased diversity.

There are a number of benefits to a more diverse GI and hepatology workforce. The current racial and ethnic composition of the GI and hepatology workforce does not reflect the population of patients served or the current matriculants in medicine (14,15). Provider-patient concordance studies have demonstrated that patients value commonality with their physicians on the dimensions of race and ethnicity, as well as language. This patient preference underscores the need to recruit and train a more diverse cohort of trainees into GI and hepatology fellowships if the desired goal is to optimize patient care and combat health disparities (16). Cultural understanding impacts a patient's perspective of their health and influences expression of symptoms and concerns, which may improve provider diagnostic accuracy and treatment recommendations (13). Patients may also be more inclined to adhere to treatment recommendations when their provider is from a similar background (17,18). As there are several conditions in GI and hepatology with disparities in incidence, treatment, and outcomes, representation of UIM individuals is critical to address health disparities (19,20). UIM physicians are also more likely to work in medically underserved communities where access to care is poor (21,22). Hence, diversifying GI

and hepatology becomes important not only for making the subspecialty a more equitable profession but also for the quality of health care provided to our patients across the country (23).

In addition to the benefits for patient care, UIM individuals broaden the scope of medical research, scholarly activity, and mentorship. UIM individuals are more likely to engage in health equity research and to conduct community-embedded interventions for conditions that disproportionately impact medically underserved populations (12). UIM individuals bring alternate perspectives to the workplace and to scholarly activities, and teams composed of diverse individuals operate with increased creativity and promote cross-cultural competence. UIM individuals are also more likely to mentor UIM students and trainees, creating new channels for mentorship for students and trainees of underrepresented backgrounds (5,24).

On the basis of our survey results, the most recommended interventions to increase racial and gender diversity nationwide among GI and hepatology professionals were to increase GI and hepatology mentorship opportunities for UIM residents, increase GI and hepatology mentorship opportunities for UIM medical students, and increase representation of GI and hepatology professionals from underrepresented backgrounds within program and professional society leadership. Previous literature has suggested the need to increase representation of UIM individuals in the training pipeline, and multiple national GI and hepatology societies, including the American College of Gastroenterology, American Gastroenterological Association, and American Society for Gastrointestinal Endoscopy, have consequently developed research and/or summer programs pairing researchers or professionals with undergraduate and medical students (12,25). The national GI and hepatology societies comprising the IGD may continue to be instrumental in implementing these strategies by creating formal, structured, and assigned mentorship and shadowing opportunities for UIM medical students and residents considering a career in GI and hepatology. Societies may also garner support for UIM GI and hepatology professionals interested in pursuing leadership roles in the national societies and in local settings, such as in training programs (e.g., program director), academic institutions (e.g., division chief), and clinical practice leadership (e.g., partner) (26). As proprietors of the GI and hepatology journals that determine educational content for professionals, the societies can also help to promote broad dissemination of research related to diversity and disparities and other intellectual content from UIM professionals. These examples are but a few of the many ways that gastroenterologists and hepatologists, medical societies, allies, and the IGD can serve collectively as important agents of change (27). By sharing our survey findings, we hope to underscore the need for more widespread education of GI and hepatology professionals and leadership regarding the lack of adequate UIM representation in our field.

There are a number of limitations to our survey and its findings. First, given that the survey was disseminated electronically, it may not represent the views of GI and hepatology professionals who do not have access to or use electronic communication. However, given the high use of electronic communication in the medical field, we believe that the impact of this potential limitation is likely minor. Second, there may be some responder bias given recent national events and pressures to align with or to not

align with themes and sentiments presented in the media. We suspect, however, that the anonymity and self-response nature of the survey maximizes likelihood of reliable participant responses. Responder bias may also exist due to overrepresentation of UIM individuals and of individuals in leadership positions. Approximately 11% of practicing gastroenterologists in the United States are from a UIM background, whereas nearly 19.9% of survey participants were UIM individuals (11). Third, we were unable to determine an exact survey response rate due to multiple society memberships and the desire of the societies to maintain confidentiality of members. Fourth, as Research Electronic Data Capture software does not prevent survey participants from completing a survey multiple times, multiple responses from 1 individual may have biased the results and response rate. An additional limitation may be an inability to explore the perspectives of mixed-race individuals.

Despite these limitations, our study has many strengths. It is the first of its kind to explore perspectives on race and ethnicity and diversity among practicing GI and hepatology professionals and to gain insight into interventions to increase UIM representation. The survey also provides information regarding current demographic and professional characteristics of a large, diverse sample of both adult and pediatric GI and hepatology providers in academic and private practice settings in the United States. Survey participants were racially and ethnically diverse, and notably, there was high representation of racial and ethnic minority groups and women among the survey participants. The demographic characteristics of the survey participants may reflect the importance and value this topic has for these groups. Nonetheless, 64.6% of survey participants reported not identifying as UIM, and the survey results reflect the non-UIM majority. Our survey also underscores the discrepancy in satisfaction with workplace diversity among GI and hepatology physicians by race and ethnicity: 63% of Black physicians were very or somewhat unsatisfied with workplace diversity, whereas 78% of White physicians were very or somewhat satisfied. Essentially, those not UIM and not necessarily impacted by a lack of diversity are less likely to see lack of diversity as an important issue.

The initial interest in undertaking this study was sparked by several national events in 2020 that highlighted racial injustices and health care disparities in the United States. The findings of this study help characterize the status quo, identify areas where workforce disparities are greatest, inform future interventions to address representation of UIM individuals, and establish priorities toward improving health equity. The results serve as a springboard for the 5 GI and hepatology societies within the IGD, academic institutions, academic and private practice leadership, and other organizations as they aim to increase diversity, equity, and inclusion in our field and eliminate disparities among the patients we serve.

CONFLICTS OF INTEREST

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