Since January 2020 Elsevier has created a COVID-19 resource centre with free information in English and Mandarin on the novel coronavirus COVID-19. The COVID-19 resource centre is hosted on Elsevier Connect, the company's public news and information website.

From Intention to Action: Operationalizing AGA Diversity Policy to Combat Racism and Health Disparities in Gastroenterology

In 2016, the American Gastroenterological Association (AGA) codified its commitment to diversity, equity, and inclusion (Figure 1)[1,2] through the adoption of its organizational Diversity Policy.[3] Developed in collaboration with the AGA Diversity Committee, the policy establishes that the AGA aims to "reflect the interests of the diverse patient population we serve" and that the AGA is "committed to the "promotion of diversity within the practice of gastroenterology and in the individualized care of patients of all backgrounds," the "recruitment and retention of GI providers and researchers from diverse backgrounds," and the "elimination of disparities in GI diseases through community engagement, research and advocacy." Four years after the crafting of that policy, the AGA bolstered that commitment by condemning racism, bigotry, and discrimination in a Joint GI society statement with the American Association for the Study of Liver Diseases, American College of Gastroenterology, and American Society for Gastrointestinal Endoscopy.[4] The statement was in direct response to both the systemic racism laid bare by George Floyd's death at the hands of a white police officer and also to the burgeoning coronavirus disease-19–related racial health disparities.[5] Although the AGA had previously established diversity, equity, and inclusion as a major pillar of its organizational vitality, in the wake of these recent events, the specific inclusion of anti-racism initiatives is imperative to eliminate health care disparities and promote diversity within the practice of gastroenterology. Although AGA leadership and staff felt that they had been paying close attention to diversity issues, they deemed it essential (as detailed in this Commentary) to not only undertake a self-reflection in terms of its past and current initiatives, but also to establish a major equity initiative to further convert intentions to actions.

Diversity, Equity, and Inclusion

Membership

The AGA has >16,000 US and international members who span the spectrum of academia, trainees, private, federal, and community-based practice; and industry. Its leadership is composed of both professional staff and volunteer members who serve on 18 committees (https://gastro.org/committees/). Of the 64% of full AGA members who have provided race and ethnicity information, approximately 11% are underrepresented minorities. Underrepresented minorities include American Indian/Alaskan Native, Black/African American, Hawaiian/Pacific Islander, and Hispanic/Latinx[6] and comprise 0.2%, 4.6%, 0.03%, and 6.0% of the reporting AGA full members and 0.4%, 6.1%, 0.7%, and 6.4% of the reporting AGA trainee members, respectively (Table 1 and Table 2). Underserved communities additionally include those with disabilities and those who are economically disadvantaged. Although the AGA underrepresented minority representation mirrors the national GI underrepresented minority percentages, these numbers have plateaued over the past decade and remain well below the expected 30% based on national underrepresented minority population data when comparing 2010 and 2020 census data (Table 1).[7]

The AGA Governing Board includes 13 members who are charged with developing the AGA's strategic plan. The board is committed to making a significant impact on the goals enumerated in the AGA Diversity Policy and works with the AGA professional staff, a diverse staff of 101 employees, 30% of whom are underrepresented minorities, to achieve those aims (Table 3). Eighteen percent of the governing board are underrepresented minority members. Among AGA committees, underrepresented minorities volunteer on 12 of 18 committees, accounting for 13% of AGA committee participation (Table 3). Among these committees, the Diversity and Government Affairs Committees have the highest underrepresented minority representation. The AGA has been tracking diversity on committees since before the inception of the appointments committee in 2011. To further ensure that all ethnicities are appropriately represented within the leadership structure, in 2016 the Diversity Committee implemented an annual assessment of all committees. Although members may opt out of disclosing race/ethnicity information, data are now available for 75% of committee members (Table 2).

The Diversity Committee (formerly the Underrepresented Minorities Committee) has been in existence since 1993. The committee helps the AGA to address challenges with health care access and use among diverse patient populations inclusive of racial, cultural, religious, sexual orientation, gender, disability, age, and economic diversity. The committee also advocates for the inclusion, advancement and recognition of members from underrepresented groups in all AGA activities. The AGA disbanded this committee and the Women's Committee (which focuses on the promotion and advancement of women members of the AGA and women's health issues) for a 3-year period from 2005 to 2008 until AGA task forces recommended their re-establishment, thus demonstrating that even well-intentioned organizations can contribute to actions that may perpetuate inequity. The Diversity Committee has since created and supported several organizational initiatives to drive its core values of diversity, equity, and inclusion to the forefront. Examples include sponsorship of initiatives involving unconscious and implicit bias, gastroenterological (GI) care for the immigrant population, and increasing the diversity of the GI pipeline for

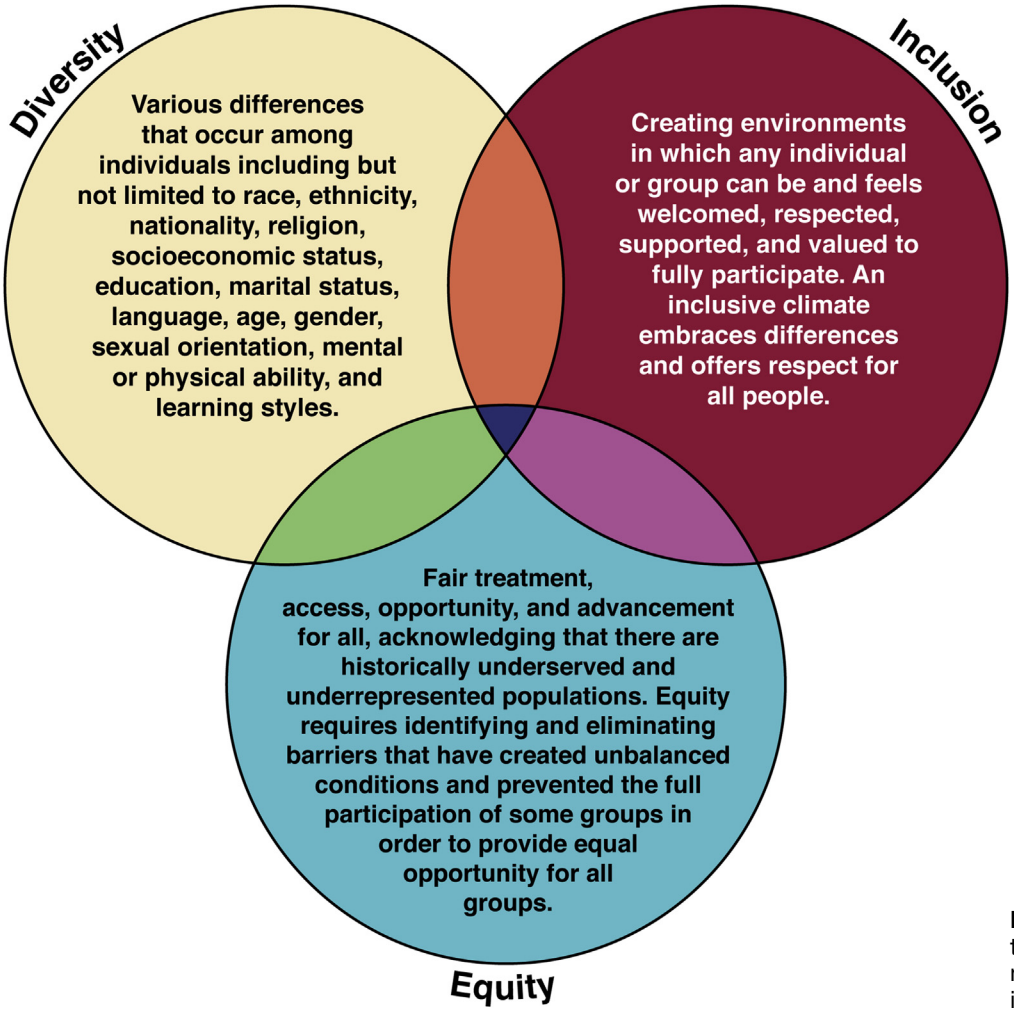

Figure 1. American Gastroenterological Association definitions of diversity, equity and inclusion.[1,2]

fellowship training and society leadership positions. The current Diversity Committee has 4 main initiatives: (i) improving the collection of demographic data from both AGA members-at-large and committee members; (ii) using AGA communication outlets to educate members about GI health disparities and unconscious/implicit bias; (iii) creating the first of its kind repository of renowned underrepresented minority GI physicians and scientists to be used by the AGA committees when seeking mentors, speakers, and nominations for committees and potential awards; and (iv) increasing the visibility of GI disparities research during the annual Digestive Disease Week (DDW) conference through dedicated e-Poster sessions and poster tours. The Diversity Committee also sponsors an annual symposium at DDW, with past symposia topics including unconscious and implicit bias, diversity in GI research, and GI care for the immigrant population.

Recruitment and Retention

The national proportion of only 11% underrepresented minority GI physicians reflects a striking contrast with the racial and ethnic diversity of the patient populations we serve. This racial and ethnic disparity among GI physicians also exists for the GI pipeline of medical student and GI trainees.[7,8] In a 2019 DDW Diversity Committee symposium and follow-up article, Carethers et al[7] highlighted our current state whereby both the tributaries that produce future gastroenterologists and the systems that support the retention of underrepresented minority gastroenterologists have been unable to increase GI underrepresented minority representation to a level commensurate with population demographics. In fact, GI fellowship applications by underrepresented minority residents have been decreasing over time. Some strategies that may mitigate these trends include programs designed to specifically recruit underrepresented minorities to the field of GI, increasing mentorship opportunities, and integrating cultural humility curricula.[7]

The AGA has had several programs to help expand the pool of underrepresented minority students, GI trainees, and GI research; to promote the retention of underrepresented minority AGA members; and to create a diverse leadership within the AGA. Examples of these initiatives include the following. (a) The Investing in the Future Program, a now discontinued program

Table 1. Racial and Ethnic Demographics of AGA Members and US Gastroenterologists

	AGA Full Members 2010 (US)		AGA Full Members 2020 (US)		US Gastroenterologists 2010 (US)[a]		US Gastroenterologists 2018 (US)[b]		US Population (%)	
Race and Ethnicity	n	%	n	%	n	%	n	%	2010[c]	2020[d]
American- Indian/ Alaskan Native[e]	8	0.2	13	0.2	8	0.07	15	0.12	0.7	0.7
Black/African American[e]	161	3.7	283	4.6	431	3.9	563	4.4	12.3	12.3
Hawaiian/Pacific Islander[e]	1	0.02	2	0.03	N.A.	N.A.	9	0.07	0.2	0.2
Hispanic[e]	211	4.8	370	6.0	717	6.5	847	6.6	16.4	17.8
Asian	925	21.13	1773	28.8	2538	22.8	3552	27.8	4.7	5.4
Multiracial	—	—	—	—	—	—	144	1.1	2.0	2.4
Other	—	—	—	—	305	2.7	123	0.96	0.2	0.2
White	3071	70.2	3725	60.4	7112	64	7527	58.9	63.7	61.1
Total reporting	4377	53.5	6166	64.2	11,111	84.1	12,780	—	n.a.	n.a.
Total URM	381	8.7	668	10.8	1156	10.4	1434	11.2	29.6	31
Not reporting	3798	46.5	3440	35.8	2099	15.9	—	—	n.a.	n.a.
Total	8175	100	9606	100	13,210	100	—	—	309.4 M	322.9 M

M, million; N.A., non-available; n.a., not applicable; URM, underrepresented minorities.
[a]From the AMA Physician Masterfile, December 31, 2018.
[b]AMA Physician Characteristics and Distribution in the United States, December 31, 2010. Percentages are of total reporting.
[c]The percentages add to 100.2 owing to approximation. The 2010 census data were obtained from: https://data.census.gov/cedsci/table?q=United%20States&g=0100000US&tid=ACSDP1Y2010.DP05.
[d]The percentages add to 100.1 owing to approximation. The 2020 census data are an estimate and were obtained from: https://data.census.gov/cedsci/all?q=ZCTA5%2012020&hidePreview=false&tid=ACSDP5Y2018.DP05.
[e]Underrepresented minorities (first 4 rows).

owing to cessation of funding focused on exposing underrepresented minority medical students to the field of gastroenterology and engaging them in summer research opportunities. This program is likely to restart via a generous gift from an AGA member. (b) The Future Leaders Program, an organizational leadership development and mentorship program available to all AGA members that also aims to identify and provide opportunities for underrepresented minority members. (c) The Fostering Opportunities Resulting in Workforce And Research Diversity (FORWARD) program, an ongoing National Institutes of Health–funded R25 leadership development program for underrepresented minority AGA members. Investing in the Future Program (I and II) were R25 National Institutes of Health–supported programs that started in 2001 in collaboration with American Society for Gastrointestinal Endoscopy. Underrepresented minority medical students and residents were introduced to gastroenterology through presentations, hands-on endoscopy simulations and 8- to 10-week long summer research opportunities. Through this program, AGA members performed outreach to >2300 students spanning 7 institutions and 19 regional and national conferences. The FORWARD Program is the newest AGA initiative established in 2019 for underrepresented minority AGA members who wish to participate in a structured active mentorship program that helps to develop leadership, research, and management skills, and affords networking opportunities to promote investigational or leadership careers in academic medicine. These programs, although important and worthy of support, are by themselves insufficient to reverse the trends in recruitment and retention of underrepresented minority AGA members.

Research, Scholarship, and Honorific Awards

The AGA has proudly supported many research, scholarship, and honorific awards since its inception. The AGA research portfolio has included $12 million of Research Foundation funding from 2016 to 2020. Eleven percent of AGA awards were competitively awarded to underrepresented minority members (excluding abstract and travel awards) amounting to approximately 15% of AGA Research Foundation funding. Currently, there are no underrepresented minority–specific research

Table 2. Racial and Ethnic Demographics of AGA Trainee Members, 2020

	AGA Trainee Members			
	2010[a]		2020[b]	
Race and Ethnicity	n	%	N	%
American-Indian/Alaskan Native[c]	2	0.2	4	0.4
Black/African American[c]	48	4.7	64	6.1
Hawaiian/Pacific Islander[c]	0	0	7	0.7
Hispanic[c]	48	4.7	67	6.4
Asian	387	37.8	451	43.2
White	538	52.6	452	43.2
Total reporting	1023	81.3	1045	74.5
Total URM	98	9.6	142	13.6
Not Reporting	235	18.7	357	25.5
Total	1258	100	1402	100

URM, underrepresented minorities.
[a]As of July 2010.
[b]As of July 2020.
[c]Underrepresented minorities (first 4 rows).

award mechanisms within the AGA, although such awards did exist in the past. Honorific awards (ie, distinguished recipient awards) were received by 10% of underrepresented minorities over the same time period. Among them are 2 Distinguished Clinician Awards, 2 Distinguished Mentor Awards, and 1 Distinguished Achievement Award in Basic Science.

The main venue to showcase the scholarship of AGA members is DDW,

Table 3. Racial and Ethnic Demographics of AGA Staff and Committee Members, 2010 and 2020

	AGA Staff				AGA Committee Members	
	2010[a]		2020[b]		2020[b]	
Race and ethnicity	n	%	n	%	n	%
American- Indian/Alaskan Native[c]	0	0	0	0	1	0.5
Black/ African-American[c]	19	22.9	25	24.8	13	6.0
Hawaiian/Pacific Islander[c]	0	0	0	0		0
Hispanic[c]	3	3	5	5.0	13	6.0
Asian	2	2.4	6	5.9	52	24.1
White	59	71.1	65	64.4	114	52.8
Other	—	—	—	—	23	10.6
Total reporting	83	100	101	100	216	
Total URM	22	26.5	30	29.7	27	12.5
Not Reporting	0		0		72	
Total	83		101		288	

URM, underrepresented minorities.
[a]As of July 2010.
[b]As of July 2020.
[c]Underrepresented minorities (first 4rows).

the largest GI conference in the world, attracting >14,000 attendees per year. Although 10% of the AGA members are underrepresented minorities, only 5% of DDW speakers are underrepresented minorities. This differential may reflect what has been recently termed the "diversity–innovation paradox in science" in which underrepresented minority groups are less likely to receive academic recognition for their research contributions despite innovating at higher levels than their majority counterparts.[9] This paradox again highlights a systemic need for alternative and additional approaches to encourage and sustain underrepresented minority engagement and leadership in research and discovery as an integral component of the AGA's mission.

Publications

The AGA has five journals that it sponsors. During the past 5 years, AGA publications have featured several articles on diversity, equity and inclusion. AGA members have advanced this topic in the flagship journal, *Gastroenterology*,[7,10,11] and in *GI and Hepatology News, The New Gastroenterologist*,[12,13] and *AGA Perspectives*.[14,15] Although this is evidence of a growing commitment to diversity, equity, and inclusion within the AGA, this commitment has not extended to journal editorship. Of the 260 current journal editors and editorial board members among all AGA publications, currently only 6 (2.3%) are underrepresented minorities, compared with 3% in 2010. Correcting this limited underrepresented minority editorial board representation is of paramount importance for the AGA.

Racial Health Disparities

AGA-Sponsored Community Engagement and Member Education

Racial health disparities exist for a number of GI diseases and the AGA's Diversity Policy calls for their elimination. With minor exception, African Americans are most affected by these disparities in the United States. In fact, based on 2002 data, approximately 84,000 excess deaths could have been prevented if the mortality disparity between Black and Caucasian patients were eliminated.[16] Using colorectal cancer disparities in African Americans as an example, several strategies have been proposed, including improvement of patient access and provider education.[17] Although most of the AGA's activities on patient access occur through advocacy activities (detailed elsewhere in this Commentary), the AGA previously sponsored the Colon Cancer Roundtable designed to improve colon cancer screening rates in African Americans. Efforts in provider education have included the incorporation of racial/ethnic disparity data in GI clinical guidelines and a DDW session specifically focused on delivering culturally competent care. Attendees were encouraged to complete implicit bias testing as part of that session. The AGA also cosponsors with the American Society of Clinical Oncology, AstraZeneca, and the Society of Surgical Oncology an annual Gastrointestinal Cancers Symposium that focuses on the cancer care continuum that includes racial and ethnic differences in epidemiology, treatment, and survivorship. To date, however, there is no AGA-wide curriculum on health disparities or cultural humility.

Health Disparities Research

The numbers of GI researchers engaged in health disparities work has increased over time as evidenced by the number of DDW presentations. In 2017, the DDW Council adopted the Diversity Committee's recommendation to include a "Health Care Delivery, Disparities and Practice Management" track. In 2019, this track was renamed the "Healthcare Delivery, Disparities, and Quality" track, and has had a greater volume of programming in care delivery and quality compared with programming in GI health disparities. Although the Diversity Committee has remained consistent in its commitment to symposium planning for DDW, these symposia have had modest attendance.

Despite evidence for continued, systemic underrepresented minority racial and ethnic disparities in GI disease prevalence and outcomes, underrepresented minorities are also underrepresented in clinical research participation. During the Diversity Committee's sponsored symposium at the 2017 DDW "Closing the Data Gaps: Strategies to Recruit and Retain Diverse Patient Populations in Clinical Studies," AGA members initiated a discussion of some of the patient-, provider-, and system-level barriers that contribute to such low inclusion of underrepresented minorities in GI research. Although this conversation was critical, the AGA does not currently have specific mechanisms to improve underrepresented minority enrollment in clinical trials. This national crisis needs to be addressed as a priority.[18]

Advocacy

The AGA has a long track record of advocacy engagement on behalf of patients and members. The Government Affairs committee works to define the AGA advocacy priorities. Members and staff of this committee and members who participate in the Congressional Advocates and Young Delegates programs facilitate this advocacy work on state and national levels. Although not based on a race- or ethnicity-based platform, the AGA advocacy priorities include ensuring patient access to and coverage of specialty care, ensuring patient access to and coverage of evidence-based preventive screenings without cost sharing, and preventing insurers from discriminating on the basis of preexisting conditions. These fundamental differences in access often underlie racial health disparities. Unique among GI organizations, the AGA also has a nonpartisan Political Action Committee that actively supports candidates who support these advocacy efforts.

The AGA has long advocated for access to specialty care for patients. In the 1990s when managed care penetration restricted access to specialists like gastroenterologists, the AGA pushed for a patient bill of rights legislation to ensure patients were able to seek unfettered access to specialists. Since 2010, the AGA has advocated for

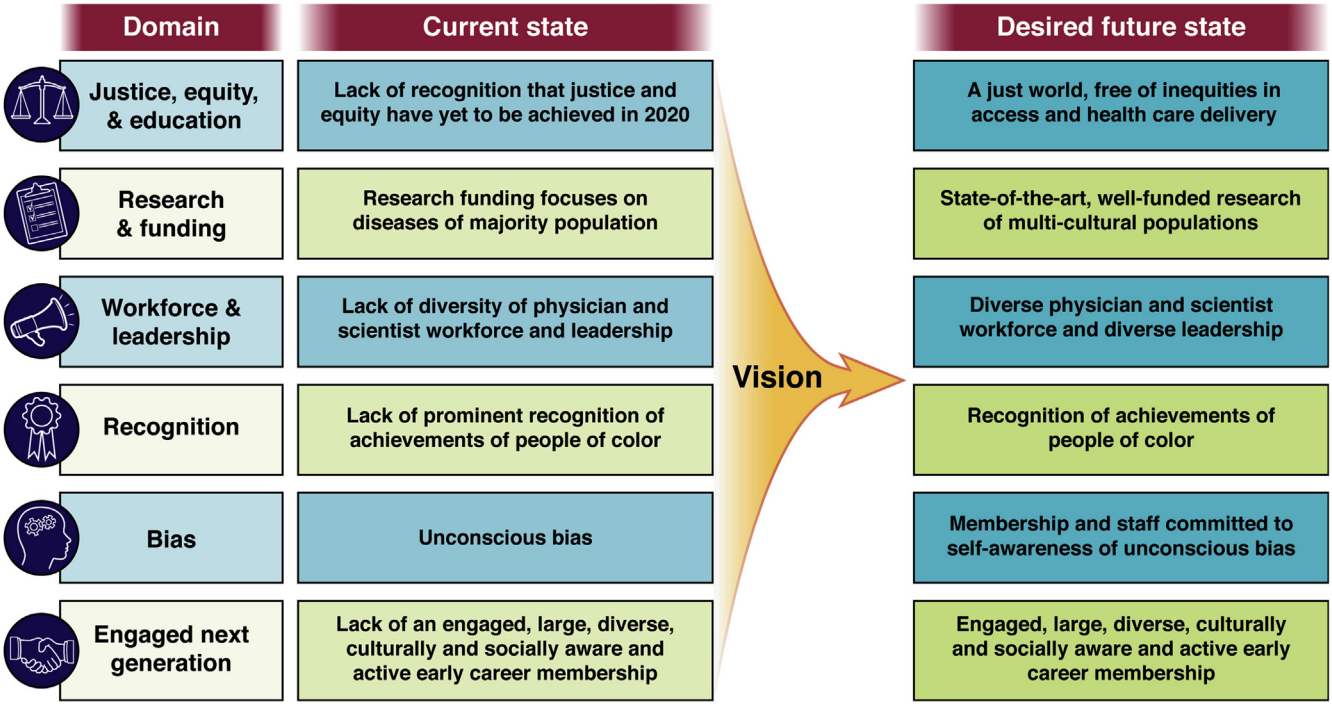

Figure 2. Schematic representation of the American Gastroenterological Association (AGA) Equity Task Force's Assessment of the Current State of the AGA and Vision for the Future.

fixing the screening colonoscopy "surprise billing" practice for Medicare patients wherein a patient is charged the rate of a therapeutic colonoscopy if during a screening colonoscopy a polyp is removed. More recently, the AGA has been advocating for Congress and the Centers for Medicare and Medicaid Services to ease administrative burdens for prior authorization and other use management policies that restrict timely access to care for patients. These policies have a disproportionate impact on minority communities, given the higher rates of uninsured and underinsured patients in these communities and the potential for delayed or unfunded care.

In addition to the Colon Cancer Roundtable discussed above in this article that addressed the higher incidence of colorectal cancer and lower screening rates in African Americans, AGA advocates have worked with Representative Donald Payne Jr. (D-NJ), a member of the Congressional Black Caucus whose father died of colorectal cancer and who authored H.R. 1570, the "Removing Barriers to Colorectal Cancer Screening Act" that would fix the screening colonoscopy cost-sharing problem. Together with the Congressional Black Caucus, the AGA has also collaborated on raising awareness of health disparities and the need to increase minority participation in clinical research, especially in areas like liver disease and hepatitis C, which have significant racial and ethnic disparities. This latter collaboration resulted in AGA members meeting with the US Food and Drug Administration (FDA) at the 2016 AGA–FDA Office of Minority Health Meeting. The meeting resulting in the FDA agreeing to (1) share information with the AGA about FDA grants through their Broad Area Announcement process, (2) provide the AGA with more information about existing regulatory science fellowship programs in which the FDA participates, (3) send information about how the AGA could subscribe to the FDA's hepatitis listserve, and (4) share information with the AGA about the FDA Advisory Committee participation and how AGA members could get involved. The AGA, in turn, agreed to (1) actively communicate upcoming guidelines, clinical practice updates, position papers, and white papers to FDA staff and (2) explore opportunities to host educational programs on regulatory science with FDA input.

Anti-racism as a Strategy to Promote Diversity, Equity, and Inclusion and Decrease Disparities in GI Diseases

The recent unjustified killings of Breonna Taylor, George Floyd, and many other African Americans have heightened our national awareness of longstanding, systemic racism against African Americans and its related health inequities. Despite many gains made in the last 50-plus years toward increasing equity in health care and digestive diseases, as of today, priorities of the AGA have not adequately kept pace with the rapid and significant demographic changes in the United States. Nor have they kept pace with the diverse, evolving needs in research, education, clinical care, and community engagement. The gap between societal health care needs and delivery in the United States is also reflected globally.

On June 2, 2020, leaders of the AGA, American Association for the Study of Liver Diseases, American College of Gastroenterology, and American Society for Gastrointestinal Endoscopy adopted an anti-racism policy that condemns "racism, bigotry and discrimination based on race, religion, gender, country of origin and sexual orientation." The 4 GI societies pledged to "continue to advocate for diversity in our staff and governance, grant awards to research health care disparities, ensure quality care for all and work tirelessly to reduce inequalities in health care delivery and access."[4] Here, we use this platform to delineate specifically how the AGA as an organization plans to engage anti-racism as a mechanism to go beyond its mission of "empowering clinicians and researchers to improve digestive health" toward reducing the effects of structural racism on health inequities and promoting equity for all.

Defining Anti-racism for the AGA

Anti-racism is an intentional set of behaviors and policies that work to combat racism, which can be defined as the rules, practices, and customs that permeate societal systems.[19] Although diversity, equity, and inclusion are necessarily components of successful anti-racism strategies, these 3 terms and anti-racism are not equivalent, because diversity, equity, and inclusion represent outcomes, whereas anti-racism strategies lead to these desired outcomes. We have elected to undertake the following framework to ensure long-term success in incorporating anti-racism as a cross-cutting actionable strategy to bolster diversity, equity, and inclusion within our organization and in much broader terms within the field of gastroenterology. We additionally commit to using this framework to improve the care of the diverse groups of GI patients we serve.

AGA Anti-racism Framework

Adapting an organizational anti-racism framework established by the National Juvenile Justice Network,[20] the AGA leadership recognizes that a commitment to anti-racism requires that the AGA: (1) establish organizational readiness through self-assessments of its anti-racism activities and anti-racism institutional culture, including an evaluation of the racial diversity of the membership and leadership; audit of resource allocation for prior anti-racism programming and initiatives; and an analysis of the past and ongoing alliances with racially diverse organizations; (2) develop leaders who receive formal instruction in diversity, equity and inclusion, cultural humility, unconscious bias, and anti-racism; (3) commit to educating and engaging membership and stakeholders in anti-racism efforts; (4) commit to coalition building with other organizations who are working toward incorporating anti-racism as a strategy to improve diversity and reduce disparities; (5) perform a financial and resource audit to identify current resources that can be applied to new initiatives and develop a plan for fundraising for initiatives that cannot be accommodated with current resources; and (6) establish an interval assessment to permit determining how we have done and to assess the need for any calibration of efforts and resource allocation.

Informed by the results of this self-assessment and the need to develop concrete and actionable strategies and tactics, the AGA has established the AGA Equity Project, led by the AGA Equity Task Force (https://gastro.org/aga-leadership/initiatives-and-programs/aga-equity-project/). The Task Force was established June 12, 2020, and was charged with developing a vision of equity for the organization overseeing AGA initiatives designed to make this vision a reality. The Task Force proposed a vision to "achieve equity in digestive health and eradicate disparities in digestive disease" focused on the following six domains: (1) justice, equity, and education (2) research and funding, (3) workforce and leadership, (4) recognition, (5) unconscious bias, and (6) engagement of the next generation (Figure 2).

The following is a preview of the Task Force's assessment of the current state, and its vision for each domain.

Justice, Equity, and Education. Many individuals have assumptions (we believe incorrect) that justice and equity for all have already been achieved in 2020, resulting in general assumptions that racism, discrimination, and bias do not exist on personal or systemic levels, and thus there is no current need for a solution or paradigm change. We envision a just world free of health disparities in digestive diseases and free of inequities in access and effective health care delivery.

Research and Funding. There is greater emphasis on funding and prominence of research that focuses on GI diseases that primarily affect the majority population, and a relative lack of funding and research that advances the science of health care disparities and scientific understanding of diseases most prevalent in minority populations. We envision state-of-the-art and well-funded research that aligns with the realities of the current multicultural patient population and disease states to achieve health equity for all.

Workforce and Leadership. The physician and scientist workforce does not mirror the diversity and shared experiences of the increasingly diverse patient population. Moreover, the diversity achievements in institutional leadership structures have insufficiently addressed equity attainment. The lack of diverse representation in leadership leads to a more limited voice and modest influence to appreciate and resolve systemic and structural changes, hence progress toward achieving greater organizational diversity has been impeded. Although contentment leads to complacency, diversity could breed more diversity. We envision a world where it is expected and normal that both members and society leadership structures are diverse, and people of color and women are routinely included in organizational decision making.

Recognition. There is a relative lack of prominent recognition of the achievements of people of color in science and medicine that inspires the next generation of minority physicians and scientists to enter and advance within the field of digestive diseases. We envision the recognition of accomplishments of diverse leaders in

Anti-racism resources for gastroenterologists

1. **Diversity within U.S. gastroenterology physician practices: the pipeline, cultural competencies, and GI societies approaches.** Carethers JM, Quezada SM, Carr RM, Day LW. Gastroenterology. 2019; 156:829–833.
2. **Diversity in GI training: a timely goal.** Quezada SM. GI and Hepatology News, September, 2017. https://www.mdedge.com/gihepnews/article/156095/diversity-gi-training-timely-goal
3. **Reducing colorectal cancer risk among African Americans.** Kupfer S, Carr RM, Carethers JM. Gastroenterology. 2015; 149:1302–1304.
4. **Improving diversity and inclusion in GI.** Anyane-Yeboa A, Balzora S, Gray DM. Am J. Gastroenterology. 2020; 115:1147–1149.

Anti-racism resources

1. **A provider's handbook on culturally competent care.** Kaiser Foundation Health Plan, Inc. 2003. http://residency-ncal.kaiserpermanente.org/wp-content/uploads/2018/12/African-American-Handbook.pdf
2. **Harvard implicit bias training.** Project Implicit. https://implicit.harvard.edu/implicit/takeatest.html. 2011.
3. **Checklist for white allies against racism.** ttps://web.cortland.edu/russellk/courses/hdouts/raible.htm. 2001.
4. **The racist patient.** Jain SH. Ann Intern Med. 2013; 158:632.
5. **Accommodating bigotry.** Lane-Fall M. JAMA. 2014; 311:39–140.
6. **Harassment and discrimination in medical training: a systematic review and meta-analysis.** Fnais N, et al. Acad Med. 2014; 89:817–827.
7. **Implicit attitudes and beliefs adapt to situations: a decade of research on the malleability of implicit prejudice, stereotypes, and the self-concept.** Dasgupta N. Advances in Experimental Social Psychology. 2013; 47:233–279.
8. **Unequal treatment: confronting racial and ethnic disparities in health care.** Institute of Medicine (US) Committee on Understanding and Eliminating Racial and Ethnic Disparities in Health Care. Smedley BD, Stith AY, Nelson AR, editors. Washington (DC): National Academies Press (US). 2003.
9. **Diversity and cultural competence in health care: a systems approach;** Dreachslin JL, Gilbert MJ, Malone B. John Wiley & Sons, 2012.
10. **Systemic racism and US healthcare.** Feagin J, Bennefield Z. Soc Sci Med. 2014; 103:7–14.
11. **Racism in healthcare: its relationship to shared decision-making and health disparities: a response to Bradby.** Peek ME, Odoms-Young A, Quinn M, Gorawara-Bhat R, Wilson SC, Chin MH. Soc Sci Med. 2010; 71:13–17.
12. **How academia should respond to racism.** Gray, DM, Joseph JJ, Glover AR and Olayiwola JN. Nature Reviews: Gastroenterology & Hepatology. 2020; 17:589–590.
13. **The not-so-silent killer missing in medical-training curricula: racism.** Walters FP, Anyane-Yeboa A, Landry AM. Nature Medicine. 2020; 26:1160–1161.
14. **Good for us all.** Issaka RB. JAMA. 2020; 324:556–557.
15. **Academic medicine and black lives matter: time for deep listening.** Yancy CW. JAMA. 2020; 324:435–436.

Figure 3. Anti-racism resources for American Gastroenterological Association (AGA) members and staff.

the organization. In addition, we envision that all leaders will recognize, inspire and cultivate the next generation of prominent, diverse leaders.

Unconscious Bias. Unconscious bias leads to negative outcomes for minorities, women, and other marginalized groups in health care settings. This contributes to health disparities in which these groups experience inequities in the provision of and access to health care. Like the broader health

care community, and any one of us, digestive disease specialists possess unconscious bias and can benefit from training in unconscious bias awareness as well as training in social determinants of health. We envision an engaged AGA membership and staff educated about unconscious bias and committed to the eradication of racism and prejudice toward patients, colleagues, and others they work with in their communities.

Engagement of the Next Generation. We believe that there are missed opportunities to increase diversity and move toward equity through expansion of early career membership and increasing inclusion of diverse early career members to carry, enhance, and lead the field and its future. We envision an engaged, diverse, culturally and socially aware, large, and active early career membership that leads the field through this and the next decade.

The AGA Equity Task Force will now further develop concrete, actionable multiyear strategies within each of the 6 domains to create a roadmap for achieving the vision of the AGA Equity Project, as implemented by multiple AGA existing committee structures and the AGA membership at large. These recommendations will be embedded in the AGA Strategic Plan, and codified into AGA doctrine so that they withstand transitions in AGA leadership. The AGA further commits to assessing and sharing the success of these initiatives with its members and the GI community at large. The AGA will establish its anti-racism and equity initiatives expeditiously, recognizing that some efforts can be initiated by the end of 2020. Others will require more time. Although our challenges are formidable, they are not insurmountable with a concerted, multiyear effort through the AGA Equity Project that involves our entire community.

A Plea to AGA Members

As physicians, scientists, health providers, and trainees in our communities, we have an obligation to address health disparities and the social problems of longstanding, systemic racism and discrimination. We tend to look for avenues to affect change in the provision of health services or through research into the effects of treatments and access to care that impact social and racial disparities. However, our role and power extend beyond that of providing clinical care, carrying out research, or training. For example, medical practices are small businesses within their communities. We are community educators, employers, and business neighbors. We can proactively seek the opinions and ideas of our African American and other underrepresented minority patients to specifically address their needs. Medical practices can improve the representation of underrepresented minorities amongst the physicians, advanced practice providers, and practice management, and within their own leadership teams. Groups can create opportunities for leadership roles and should include succession planning to achieve racial diversity. When a practice has a need, recruitment of African American and other minority candidates should be pursued through strategic advertisement and networking. Mentoring, career development, and leadership training are also necessary to increase diversity at the executive level.

As academic gastroenterologists, we have the ability to ensure that our teams are racially and ethnically diverse; and that we specifically reach out to underrepresented minority communities to diversify our clinical and research teams. We can lobby our leadership to promote more diversity within our own divisions and departments, ensure diversity in the invited lectureships and on academic committees, and improve our interactions with patients of racially and ethnically diverse backgrounds.

As employers, we can impact our community beyond our ability to provide medical care. In an open discussion, physicians and staff members can acknowledge and address racism and discrimination. We should seek to improve opportunities for advancement and education for African American and other underrepresented minority employees through mentorship programs, sponsored education, and work–study support, all of which can make meaningful differences in the lives of our employees and their families. We have the ability to provide summer jobs for their children to further their learning, promote interest in health care careers, and offer scholarships where needed. We must begin early to create a pool of candidates that will increase the number of GI physicians from underrepresented minority populations. Combating racial disparities must be a guiding principle for the enlightened gastroenterology practice. We have a network of contacts in our businesses and amongst our patients that can be used to support initiatives that combat racial health care disparities and racial inequalities. We can provide support and guidance to our colleagues who similarly want to effect change.

Finally, although GI as a specialty has successfully started to bend the gender gap, we have not succeeded in attracting underrepresented minorities into our fellowship training and nurturing them into leaders within our profession. This concerning trend is particularly worrisome for Black/African American men. We need to understand what it will take to attract more underrepresented minorities to the field of GI and to our practices, partner with groups who have been successful in recruiting underrepresented minorities to their specialties, and collaborate with groups whose primary missions are dedicated to recruiting and developing underrepresented minority GIs.

Although we have a lot of work to do, we also want to highlight a few examples of how AGA members are already working toward solutions in their own communities.

1. Members are building trust in underserved communities through direct clinical outreach programs and partnerships with free clinics to provide GI specialty care.

2. Members have developed public service announcements and educational seminars on the importance of colorectal cancer screening targeted to underserved communities.

3. Members have partnered with local programs that provide access to healthy food options to

provide education on the importance of healthy eating.

4. Members have partnered with local high schools to provide mentorship programs for underrepresented minority students aimed at exposing them to careers in health care.
5. Small to medium sized business owners have partnered with their local Small Business Association to provide business mentoring and startup support to minority entrepreneurs business.
6. Members are engaged in business strategies to improve the economic development of minority communities.
7. Members are engaged in local advocacy to ensure education and health care equity.

The AGA vows to amplify the impact of our members who engage in anti-racism efforts as strategies to promote health equity and recommends several anti-racism resources (Figure 3).

Conclusion

The AGA is committed to move from intention to action in operationalizing our Diversity Policy toward a future state of anti-racism, equity, and inclusion. We choose to be among the leaders in health care organizations that work to stem the tide of systemic racism and its negative impact on the health of our patients and the lives of our members. We are confident that our equity task force's vision and plans for this future state will be achieved and will shift the culture of the AGA and of the field of gastroenterology toward one that reflects the gastroenterology patients we have the privilege to serve. We will also work closely with our sister societies on a parallel inter-GI-society effort called the "Intersociety Group on Diversity." As writer Ava DuVernay so eloquently stated, "When we're talking about diversity, it's not a box to check. It is a reality that should be deeply felt and held and valued by all of us."

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References

1. National Multicultural Institute. Diversity Terms, 2003. Available: https://our.ptsem.edu/UploadedFiles/Multicultural/MCRDiversityTerms.pdf. Accessed July 8, 2020.
2. UC Berkeley Initiative for Equity, Inclusion, and Diversity. Glossary of terms. 2011. Available: http://diversity.berkeley.edu/sp_glossary_of_terms. Accessed July 8, 2020.
3. American Gastroenterological Association Diversity Policy. Available: https://aga-cms-assets.s3.amazonaws.com/2020327173230—COM20-009%20AGA%20Diversity%20Policy.pdf. Accessed June 30, 2020.
4. Racism, social injustice and our pledge to lead change. Joint GI society statement from AGA, AASLD, ACG and ASGE. Available: https://gastro.org/news/racism-social-injustice-and-our-pledge-to-lead-change. Accessed June 30, 2020.
5. Gray DM 2nd, Anyane-Yeboa A, Balzora S, Issaka RB, May FP. COVID-19 and the other pandemic: populations made vulnerable by systemic inequity. Nat Rev Gastroenterol Hepatol 2020;17:520–522.
6. National Institutes of Health. Racial and Ethnic Categories and Definitions for NIH Diversity Programs and for Other Reporting Purposes. Available: https://grants.nih.gov/grants/guide/notice-files/NOT-OD-15-089.html 2015.
7. Carethers JM, Quezada SM, Carr RM, Day LW. Diversity within US gastroenterology physician practices: the pipeline, cultural competencies, and gastroenterology societies approaches. Gastroenterology 2019;156:829–833.
8. Day LW, Gonzalez S, Ladd AM, Bucobo JC, Pickett-Blakely O, Tilara A, Christie J. Diversity in gastroenterology in the United States: where are we now? Where should we go? Gastrointest Endosc 2016;83:679–683.
9. Hofstra B, Kulkarni VV, Munoz-Najar Galvez S, He B, Jurafsky D, McFarland DA. The diversity-innovation paradox in science. Proc Natl Acad Sci U S A 2020;117:9284–9291.
10. Lang L. Racial diversity among medical students may better prepare them for minority patient care. Gastroenterology 2008;135:1439.
11. Merchant JL, Omary MB. Underrepresentation of underrepresented minorities in academic medicine: the need to enhance the pipeline and the pipe. Gastroenterology 2010;138:19–26 e1–3.
12. Quezada SM. Diversity in GI training: a timely goal. GI and

Hepatology News. Parsippany, NJ: The New Gastroenterologist, Frontline Medical Communications Inc., 2017.
13. Badurdeen DPA, Malespin M, Oduyebo I, Quezada S, Stephen O. Promoting diversity through the AGA. Parsippany, NJ: GI and Hepatology News: The New Gastroenterologist Frontline Medical Communications Inc.
14. Gray D. Diversity in gastroenterology: purpose and progress. AGA Perspectives, 2017.
15. Munroe CA, Quezada SM, Lamousé-Smith E. The AGA Diversity Committee: opening up a conversation about unconscious bias in GI practice. AGA Perspectives, 2019.
16. Satcher D, Fryer GE Jr, McCann J, Troutman A, Woolf SH, Rust G. What if we were equal? A comparison of the black-white mortality gap in 1960 and 2000. Health affairs 2005; 24:459–464.
17. **Kupfer S, Carr RM**, Carethers JM. Reducing colorectal cancer risk Among African Americans. Gastroenterology 2015;149:1302–1304.
18. US Food and Drug Administration. Enhancing the diversity of clinical trial populations — eligibility criteria, enrollment practices, and trial designs guidance for industry; 2019. Available: www.fda.gov/regulatory-information/search-fda-guidance-documents/enhancing-diversity-clinical-trial-populations-eligibility-criteria-enrollment-practices-and-trial. Accessed July 6, 2020.
19. Understanding commonly used terms, ideas related to racism, injustice. Available: https://abc30.com/society/understanding-commonly-used-terms-about-racism-inequality/6248593/. Accessed July 1, 2020.
20. National Juvenile Justice Network. Moving a racial justice agenda: organizational assessment: are you ready?. Available: http://www.njjn.org/uploads/digital-library/westernstates3.pdf?phpMyAdmin=14730ab3483c51c94ca868bccffa06ef. Accessed June 25, 2020.

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