Black voices in gastroenterology and hepatology

Joan A. Culpepper-Morgan, Alexandra Guillaume, Jeremy Louissaint and Renee Williams

Abstract | The Association of Black Gastroenterologists and Hepatologists (ABGH) was established to improve health equity in Black communities and to provide academic and social support for Black gastroenterologists and hepatologists. In this Viewpoint, four members of ABGH (early career, mid-career and late career) discuss their route into gastroenterology and hepatology, how academia and medicine can promote inclusivity and equity, and their advice to Black students interested in a career in medicine or science.

What made you choose gastroenterology and hepatology?

Joan A. Culpepper-Morgan. When I graduated from medical school, I thought that I would practice general internal medicine and grow old with my patients. I came to gastroenterology out of fear. We were warned that with the advent of diagnosis-related groups internists would starve and only specialists would thrive. Gastroenterology was the closest specialty to internal medicine and it included procedures that were fun and challenging as well as complex and fascinating diseases such as tropical sprue.

Alexandra Guillaume. I had an early penchant for learning about nutrition and gastrointestinal illnesses as a result of my cousin's experience with Crohn's disease. During medical school I learned of the multiple subspecialties within gastroenterology that offered great versatility in scope of practice. I realized this field kept me highly engaged with patients when managing both acute and chronic gastrointestinal illnesses, and became absorbed in learning the technical skills of endoscopic procedures. I enjoy the variety of medical personnel we get to work with in a team-based fashion.

Jeremy Louissaint. I was drawn to hepatology during medical school. Hepatology offered a fascinating mix of pathophysiology, team-based multidisciplinary care and an ability to perform diagnostic and therapeutic procedures. What cemented my decision to pursue hepatology was a fortunate opportunity to shadow a transplant hepatologist during my last year as a medical student. Rounding with this attending hepatologist was critical to my career trajectory for two major reasons. First, it provided first-hand experience that my love for the study of liver disease extended beyond the textbooks and into clinical practice. Providing clinical care to patients with a diverse spectrum of liver disease was rewarding and clinically challenging. Second, this hepatologist (Dr Alyson Fox), the leader of the team, was a person from a group under-represented in medicine. In gastroenterology, only 10% of faculty are from under-represented groups and an even lower proportion are Black[1,2]. As I reflect on where I am now in my early career, I remain convinced of the power of that moment, when someone who looked like me with similar prior experiences as me was also a direct example of the exceptional clinician I wanted to be.

Renee Williams. My path to gastroenterology was not straightforward. My initial plan when matriculating to medical school was to become an obstetrician–gynaecologist; I was inspired by my mother who was a nurse and also a midwife in Jamaica, West Indies. However, when I went on the wards I quickly realized that obstetrics and gynaecology was not appropriate for me and my interest instead turned to internal medicine, with plans to become a primary care doctor. My interest in gastroenterology did not fully manifest until I was a third-year resident, which was in part due to my mentor Dr Fritz Francois, the current vice dean of NYU Langone Health (NYULH), New York, USA. Interestingly, during residency I always enjoyed and sought out opportunities to participate in procedures. I remember speaking with a faculty member about my intentions to practice primary care: he looked at me and said, "You won't be happy as a primary care doctor, you enjoy procedures too much". My decision to apply to fellowship occurred during my third year, when I realized I wanted a procedural field that enabled me to have a longitudinal relationship with patients. To that end, I did work as a primary care physician while applying for fellowship. To be honest, it was the best decision I ever made, and it led to the very fulfilling and satisfying career that I currently enjoy.

What challenges and opportunities have you encountered in your career so far?

J.A.C.-M. Opportunities have often come at a cost. Like many a Black child of the 1960s, I was one of a select few who were plucked from their segregated schools and bussed into a white neighbourhood for elementary school education[3,4]. My South Bronx school was thus depleted of their most talented and gifted and, as a later consequence, atrophied and closed. My new school thrived, as did I, and provided a rich curriculum that would subsequently see me pass the entrance exam for The Bronx High School of Science. I also learned how to function as the lone Black person in a white space, a vital skill in a majority white country. Unfortunately, these programmes no longer exist and Black enrolment in New York's specialized high schools is a fraction of what it was[5].

After high school, I attended Smith College, an all-women's Seven Sisters college in Massachusetts. Smith cemented in me the academic confidence that would not be shaken by the men who would assume by my mere presence that I was a double affirmative action imposter[6]. Thus, high

school and college were about acquiring the armour needed for the next battles. The summer of my junior year I attended The Travelers Summer Research Fellowship Program at Weill Cornell[7]. There I was exposed to bench research and the language of clinical medicine, a language as foreign to me as any I had ever heard. I bought my first medical dictionary and endeavoured to learn how to communicate. That summer gave me an important head start and reinforced my love of science and investigation. I ultimately graduated from Weill Cornell Medical College with the Ivy League branding that would always quiet those who would undermine my confidence and say I did not achieve success legitimately.

This is the faulty logic of a biased system that does not want to let you in the room and when you work hard to get there tells you that you must have stolen someone's spot. Your goals are limited before you start. I was told in residency that I was smart enough to be considered for Chief Resident but in the same breath told that no Black woman would ever be a Chief Resident at that institution. Those numbers continue to challenge, and the selection process continues to be opaque[8,9]. One study notes that although 31.5% of the US population are under-represented minorities (URM), only 18.1% of medical students and 9.7% of Internal Medicine clinical faculty are URM[10]. I recall being recruited because a department wants 'diversity' and then being underpaid for years, because, like many young female attendings, I had no idea how to assess and demand wage equity. I had no idea of what my labours were really worth.

Patients perpetrated microaggressions by assuming stereotypes and revealing their biases. I found that some office patients would surreptitiously search for my medical diploma or ask me where I went to medical school. Hospital patients would assume that I came to clean the room or remove the food tray[11]. As a Black person in a white space these events undermine self-confidence and create 'death by a thousand cuts'. I have chosen to complete my career working in a Black space where I am not in danger of being questioned or doubted or that I belong. I just have to deliver the best medical care that I can.

Like friends, mentors come into your life for a season, for a reason, or for a lifetime. For a reason: one of my residency attendings recognized my curiosity about the biology of addiction and asked if I would like to do research in that field at The Rockefeller University. There I met my lifetime mentor who advised and taught me in all aspects of academe. Our relationship spanned over 30 years and afforded me innumerable opportunities to see and be seen. I learned how to write a CV, grant applications and papers. I was provided the opportunity to write book chapters and sit on committees. I was also protected in ways I did not know I needed. For a season: my Program Director taught me the art of paper submission and draft revision. He also allowed me to construct a unique 4-year fellowship with research at The Rockefeller University in addition to my home programme. For a season: my first boss who taught me how to run a fellowship and a department. In addition, he gave me the opportunity to organize local and regional conferences. For a lifetime: the young attending who encouraged my interests in HIV/AIDS research and nutrition support and who ultimately recommended me for my current position as Division Chief.

A.G. One of the challenges I experienced has been navigating the decision to remain as an attending at the institution where I trained for a gastroenterology fellowship at the start of my attending career. I chose to remain at my fellowship institution because I had developed a strong clinical rapport with the faculty and sought the opportunity to lead a cutting-edge motility centre under the guidance of a supportive division chief and team of faculty colleagues. However, during my first year as an attending, I found that transitioning into a leader was hard to achieve, particularly in the endoscopy suite. It was difficult to establish authority without the sense of imposter syndrome and the fear of being disliked. On the contrary, it appeared that other junior colleagues, particularly male colleagues, were given an early presumption of leader readiness and treated with more grace during early career shortcomings. With a strong desire for equity, I would identify and challenge such behaviours, but I was more often than not met with microaggressions and labelled 'demanding' or even 'angry'. This left me battling feelings of invalidation and in search of strategies and allies who would support and fuel my passion[12].

Fortunately, several of the opportunities I have encountered have come from this search. Through leadership training opportunities available to early-career attendings such as the American Society for Gastrointestinal Endoscopy's Leadership, Education and Development (LEAD) Program and the American College of Gastroenterology's Young Physician Leadership Scholars Program, I gained an ability to look at challenges from a more favourable perspective and clarify my vision as a leader. I learned to prioritize my development into a competent gastroenterologist over winning likes, and most importantly that leadership and authority cannot be implemented without first earning respect.

To date, the largest career opportunity I have had is an intimate involvement in the creation of the Association of Black Gastroenterologists and Hepatologists (ABGH), an organization dedicated to promoting health equity in Black communities, advancing science, and developing the careers of Black

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gastroenterologists, hepatologists and scientists.

J.L. There are, of course, traditional challenges in training, but there are also unique barriers faced by those under-represented in medicine. I, as have so many others, have experienced situations that seek to deteriorate principles of inclusion and falsely signal a lack of belonging. The spectrum of microaggressions and macroaggressions is wide, and, unfortunately, they do occur longitudinally across different settings (for example, classrooms and clinical interactions with peers and patients). There are also moments when achievements and awards are seemingly asterisked by others to suggest that race, not hard work and perseverance, was the basis of selection. Similarly, a sense of belonging is also diminished when statements of diversity are not matched by the actions necessary to achieve such goals. Perhaps for this reason, overcoming and disowning the idea and effect of imposter syndrome was one of my biggest challenges thus far. Imposter syndrome is often described and accepted in such a way as to seem innate to the minoritized individual, yet, in reality it is a consequence of repeated exposure to the aforementioned experiences that serve as external signals of exclusion and of not belonging in these spaces[13].

I have been fortunate to have experienced incredible opportunities as well. By far, mentorship has been most critical to my academic success and will continue to remain so. I challenged myself to learn the behaviours and skills of a mentee that display a commitment to and appreciation of the shared goals of the mentor–mentee relationship[14]. As a result, I journey on this academic medicine path surrounded by mentors — notably, Dr Elliot Tapper, Dr Anna Lok and Dr Elizabeth Verna — who have fiercely committed themselves to a shared vision of my academic growth and success. These mentorship relationships have opened countless doors that I have walked through confidently because of their encouragement and support.

R.W. Thinking back to early in my career, I think one challenge was learning how to socialize and connect with my classmates as a person from an immigrant background. If you're unable to connect with your colleagues on a social level, it potentially can adversely affect your career opportunities. There is a 2021 article in the *New England Journal of Medicine* that discusses code switching. Code switching is essentially adjusting your style of speech, appearance, behaviour and/or expression to optimize the comfort of others[15]. I'll be very honest, in my opinion some proportion of Black physicians code switch to fit in in their professional space. It's an unconscious thing that occurs; it's not something that you think about on a conscious level, it just happens. I want to clarify that I'm not speaking for all Black physicians, just a subset that this applies to. When I started medical school, I didn't have a lot in common with my colleagues, but over time that changed and now I'm comfortable in any space. Another major challenge occurred in my first faculty position after fellowship. I knew I wanted to focus on education; however, that institution did not value medical education as a pathway to promotion. After realizing that this institution was not conducive to my career growth, I transitioned to my current position at NYULH. At NYULH, my career has blossomed institutionally and nationally through mentorship and sponsorship. I have now had multiple opportunities for leadership within NYULH, the American College of Gastroenterology, ABGH and the Association of American Medical Colleges (AAMC). However, I am grateful for my first faculty position as that is where I learned how to ignore minutiae and focus on the big picture, which has been instrumental in my leadership journey.

How can academic medicine promote inclusivity and equity within gastroenterology and hepatology?

J.A.C.-M. Seek out and involve those who show interest in science, technology and mathematics in gastroenterology. Partner with local high schools and colleges to create shadow and enrichment programmes. Those summer programmes should provide a reasonable stipend that allow students that have to work to be able to benefit as well. Share your love of gastroenterology and hepatology. Speak with pride of the great healing that we do for so many. Teach skills that might be lacking. You have those skills. Identify them and teach them systematically. The language of science and technology, grant and paper writing, poster and oral presentation are all acquired skills. The earlier one is taught, the greater facility one will have. Mentorship at the programmatic or individual level is vital.

A.G. Within gastroenterology fellowship programmes, leadership can promote inclusivity on multiple levels. Ensuring a diverse cohort of fellows enables organic learning of varying cultures and perspectives. To move the needle forward in health equity, I support the movement towards improving gastroenterology fellowship curricula with formal structured health equity training tools, such as speakers, presentations and training modules on topics of cultural competency within gastrointestinal illnesses and implicit bias[16]. Creating mandatory benchmarks for community engagement within the curriculum of gastroenterology fellowships should also be implemented. Division chiefs have a responsibility to ensure that a diverse faculty is distributed within all ranks and that opportunities to enhance promotion portfolios are equally allocated. These actions should be tracked by governing bodies, such as national gastroenterology organizations and/or the Accreditation Council for Graduate Medical Education, and can be bolstered by incentivization. I believe the incentivization can be used as a scorecard to measure the success of hospital and organizational gastroenterology leaders for use in future promotions and financial endowments. More importantly, this would strengthen the accountability needed to ensure and document progress.

J.L. Academic institutions have a duty to their medical students, trainees, faculty and patients to actively promote diversity, equity and inclusion (DEI). First, institutions must be aware of the pervasiveness of implicit biases, particularly in the selection of students and trainees. An acknowledgement of how implicit biases contribute to inequities can then be followed by education and training on methods to reduce these biases[17]. Second, institutions should methodically create mentorship structures that work to bridge known disparities in mentorship opportunities[18]. Specifically, efforts to pair mentees under-represented in medicine with senior mentors can immediately allow access to a wide network of potential mentors, sponsors and coaches[19]. Finally, initiatives to promote diversity and inclusion should receive the funding and credit towards career promotion worthy of such an important endeavour[19]. When these contributions are undervalued, it diminishes the effectiveness of these efforts and simultaneously impedes career advancement via the minority tax[20]. Promoting equity and inclusion must move beyond statements if institutions truly aspire to create environments that recruit, retain and promote those under-represented in medicine.

R.W. Based on data from the AAMC, <10% of practising gastroenterologists identify as under-represented in medicine[21]. Academic medicine is now witnessing an increase in journal articles discussing DEI. What is striking in some of these otherwise well-written articles is the use of the words 'diversity', 'equity' and 'inclusion' in an interchangeable fashion without explicit definitions. Additionally, we are now seeing articles discussing the need to be explicit in these definitions and not to conflate the terms[22,23]. To adequately promote inclusivity and equity within our field, we have to understand the inherent differences between these terms. Equity and inclusivity each require distinct strategies for success. Equity refers to 'justice'. In essence, it's addressing and mitigating barriers that disadvantage a subset of your workforce[24]. Inclusion is 'involvement', promoting a culture of respect, value and equal opportunity[22,24]. I have a recent publication with Dr Sophie Balzora and Dr Pascale White on this very topic, which discusses proactive strategies to promote DEI within gastroenterology and hepatology[22]. Specifically, these strategies include targeting DEI metrics, establishing DEI as a priority, acquiring resources to sustain and support these efforts, and measuring the progress over time[22]. Other strategies include having a shared institutional definition, spotlighting this work as essential to the institutional mission, appointing leaders with expertise, providing resources, using evidence-based approaches, and establishing accountability[23].

What advice would you pass to Black students interested in a career in medicine or scientific research?

J.A.C.-M. Support each other. Avoid isolation. I was often alone in the room, having to maintain my humanity all the while tired of being hailed as an exception to some stereotype. Join organizations such as ABGH and use them as safe spaces to ask difficult or naive questions[25]. Use them to find mentors and peer support. Read constantly. Those who can effectively manage the current deluge of information will have half the battle won. Take courses in college that force you to write: the humanities, history, literature. Writing is a critical skill that many doctors lack and is becoming a forgotten art. Spend your summer vacations in a science, technology and mathematics environment. Search for that paid lab experience. Learning and survival do not have to be mutually exclusive.

A.G. One piece of advice I share with Black students interested in a career in medicine or scientific research is to cultivate interests outside of the sciences that allow you to briefly step away, rest and reset to sustain the rigours of a career in science.

A 2007 study that aimed to elucidate the barriers that prevent African American students from pursuing careers as physicians identified time commitment as a large barrier[26]. I believe this to be more complex than stated. A larger proportion of Black students than white students come from a lower socioeconomic status or have family financial responsibilities; the time commitment needed for careers in medicine and science competes with careers that provide a shorter road to financial profit. Careers in medicine and science are indeed arduous and require lengthy preparation, which can be discouraging to some, but the payoff in job satisfaction and security is high. Black students need to learn this as a fact. Learning about opportunities for scholarship, financial guidance and work–life balance tips, among many other important topics, from individuals who mirror their home environment or culture helps students of colour to perceive these goals as attainable.

It is also very important to me that Black students are assured of the need and worthiness of their presence in these scientific fields. In the past few years, there has been an acknowledgement in the literature regarding the US physician shortage projected over the next 15 years[27]. The lack of Black physicians and scientists will contribute to the reluctance of some in the Black community to seek and trust health care. Thus, it is crucial that we strengthen the pipeline for students of colour. This underscores the importance of continuous early exposure to and substantial communication with Black physicians and scientists from various levels of training in both formal and informal ways. This will instil personal attributes such as confidence and tenacity, which are needed to endure long years of training during which, for many Black students, racist barriers to successful completion are often encountered.

Structural racism in education is set in place to invalidate the agency of Black men and women. This can adversely affect the wellbeing of a student and diminishes the learning environment. There might be experiences with superiors, colleagues or patients during which the message communicated, consciously or subconsciously, is that the student does not belong. Irrespective of what others might project onto you, when you are confident that your skills and abilities are valuable and will make a difference in your own life foremost, it will be hard for others to shake you off your path.

Last, a great piece of advice I incorporate into practice is never resent or shy away from feedback in a learning environment. This is not to suggest that everyone's opinion will be favourable but, even when faced with an individual or setting that seems to be against you, remain receptive to feedback and learn to extract grains of truth that will improve you and discard what doesn't fit. Your job during training is to simply leave every experience a better physician or scientist than when you entered.

J.L. My advice for Black students interested in a career in academic gastroenterology and hepatology would be the following. First, mentorship is paramount. A strong mentorship team challenges you to grow as a clinician-researcher while also supporting and helping you to find clarity in times of uncertainty. Second, keep an open mind when presented with opportunities. The rewards of saying 'yes' (and following through) to mentored opportunities during training are invaluable in terms of new experiences and lessons learned from both failures and successes. Third, trust your gut when something does not feel right or appropriate; lean on your friends, family and mentorship team to process these situations and determine a plan to advance and excel beyond each barrier. Fourth, seek out professional societies, such as the ABGH, that have opportunities for networking, service, career advancement and a community of uplifting support[28]. Fifth, it is never too early to reach back into the academic pipeline to serve as a role model and mentor to someone else. Be visible to the next generation so they can see first-hand what is possible. Last, reject with confidence any and all notions that you do not deserve to thrive in, receive recognition from, or be a leader in academic medicine. We provide innumerable contributions. We advance the field. We belong.

R.W. First and foremost, choose medicine because it's what you want to do, and choose an area in medicine because it's your passion. Do not choose a specialty for lifestyle or income reasons as you will run the risk of dissatisfaction with your career. Once you've made your choices, establish mentorship and, further down in your career, establish sponsorship. We discuss the importance of mentorship often, but we rarely discuss

sponsorship, and both are equally important for any successful career. In regard to mentorship, remain open to mentors who are not from your same racial or ethnic background, and it is extremely important to be proactive in asking for mentors and building your networks[29]. While mentorship is critical earlier in your career and necessary for career development, sponsorship is critical later in your career and necessary for career advancement[30]. Sponsorship is focused on specific career-advancing opportunities and is a key professional relationship[30]. Your mentor can also be your sponsor so the two are not mutually exclusive. Imposter syndrome, which disproportionally affects women and those under-represented in medicine, refers to doubting one's abilities and a persistent fear of being exposed as a fraud[13]. Imposter syndrome is common, especially early in our careers, but utilize your network of support. Understand that you will face challenges along the way, that those challenges will include discrimination and bias, but do not let these challenges hinder your path as your presence in this space is needed and necessary.

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