






## Editorial

# An essential goal within reach: attaining diversity, equity, and inclusion for the *Journal of the National Cancer Institute* journals

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Cancer research has led to remarkable advances in our understanding of cancer biology and strategies for prevention, screening and early detection, treatment, and survivorship care, resulting in declines in cancer mortality rates (1). For more than 80 years, the *Journal of the National Cancer Institute* (JNCI) has chronicled and contributed to these advances by publishing peer-reviewed, multidisciplinary scientific research and commentaries addressing basic science, practice-changing advances in cancer prevention, treatment and care, cancer epidemiology, health economics and health services research, and behavioral and implementation sciences. Starting with its launch in 2017, the *JNCI Cancer Spectrum* also began publishing similar research.

Our journals have published rigorous research documenting and examining factors underlying disparities and inequities in cancer risk and prevention, screening, diagnosis, treatment, survivorship, and health outcomes, including patient-reported outcomes, morbidity, survival, and mortality. Despite progress, disparities in cancer outcomes across population groups persist (2,3) and, in some instances, may have widened (4) with medical advances that are not equally accessible to all (5–9). In early 2022, the leadership of the *JNCI* and *JNCI Cancer Spectrum* developed a diversity, equity, and inclusion initiative to increase representation of diverse groups who lead and participate in cancer research—including study participants, communities, clinicians,

and scientific investigators—and throughout the peer review and publication process (10,11). An aim of our journals and Oxford University Press (OUP) is to create a community that fosters and represents diversity, equity, and inclusion. As part of our commitment to these principles, OUP is a proud partner of the Coalition for Diversity and Inclusion in Scholarly Communications (C4DISC) (12). C4DISC works with organizations and individuals within the scholarly communications landscape to cultivate equity, inclusion, diversity, and accessibility for authors as well as for the content of publications across the publishing industry. The journals are proud to adopt the Joint Statement of Principles of C4DISC.

We define diversity in cancer research based on representation across population groups characterized by race, ethnicity, gender, sexual orientation and gender identity, age, religion, socioeconomic position, national origins, immigration status, ability, and geography, among others. We also consider scientific discipline, training, and career stage of investigators in the conduct of research. The benefits of diversity of lived experiences and expertise gained from training backgrounds and professional experiences within and outside of scientific communities and clinical workforces (such as government or community outreach) are many (13). For example, improving diversity of lived experiences and professional backgrounds broadens the pools of knowledge

available to address challenges hindering our progress in cancer control, and engaging with diverse perspectives creates opportunities for identifying relevant, meaningful, and distinct research ideas. Expanding the pool of knowledge and perspectives is especially needed for better addressing long-standing disparities and inequities (13). For example, researchers from historically marginalized communities are more likely to propose research focused on social and economic determinants of health (14), the main determinants of disparities (15).

In addition to research settings, clinician diversity and clinician–patient concordance on sociodemographic factors are associated with improved quality of patient care (16–19), including preventive care (17), uptake of cancer screening (19), and receipt of recommended care (18,20), as well as health outcomes (21). The need for diversity across all levels of clinical and scientific staff will only grow with the new (as well as persistent and growing existing) challenges faced by the health-care community in demonstrating trustworthiness, among communities experiencing disparities and the general population.

In this editorial, we reaffirm the commitments from our journals to improve diversity, equity, and inclusion; provide a progress update on the diversity, equity, and inclusion initiative begun in 2022; highlight recent journal content featured in the diversity, equity, and inclusion collection; and renew and expand the request for journal submissions of innovative research aimed at addressing and improving cancer health equity. We also provide information about plans for monitoring and evaluating progress in the diversity, equity, and inclusion initiative in the coming years.

## Progress in the diversity, equity, and inclusion initiative

Initial steps taken as part of the JNCI and JNCI Cancer Spectrum diversity, equity, and inclusion initiative included several strategies to broaden diversity in the peer-review process, to encourage submissions from a more diverse group of professionals, and to expand the content we publish relevant to diversity, equity, and inclusion and cancer control efforts across the care continuum. To enhance diversity, equity, and inclusion in the peer-review process, JNCI and JNCI Cancer Spectrum have made efforts to improve the diversity and inclusiveness of the editorial board members and peer reviewers through targeted recruitment and referrals to ensure the journals can support all individuals throughout the manuscript submission and publication processes. In addition, Associate Editors have been asked to consider career stage and geography when recommending peer reviewers, and the journals can now accommodate mentored reviews to provide opportunities for less experienced scientists. To increase diversity of editor seniority and to improve breadth and depth of expertise, especially in emerging fields, the journals have recently adopted term limits, as is increasingly recommended (22,23). The journals now have renewable 3-year term limits with absolute term limits of 9 years for Associate Editors and Editorial Board members. The journals will evaluate these ongoing efforts and continue to identify new approaches for improving the diversity and inclusiveness of the Editorial Board and peer reviewers.

To welcome and encourage submissions from a more diverse group of scientists, we enhanced the clarity of our author guidelines and implemented format-free initial submissions, and we further expanded availability of discounted editing and English translation services. To further support individuals in the manuscript submission and publication processes, JNCI is launching a new Early Career Investigator special section devoted to

manuscripts from early career investigators, defined as individuals within 10 years of the award of final degree or final training experience (whichever is later), including postdoctoral fellowships, internships, or medical and professional residencies. Manuscripts submitted for consideration in this section will receive expedited review and detailed summary comments from the handling editor synthesizing reviews to aid in revisions. The early career investigators will be featured on the JNCI website, and OUP will waive color figure charges when publishing under the standard license (24). The journals will continue to identify new approaches for welcoming and encouraging diverse manuscript authors.

## Monitoring and evaluating progress

As part of the commitment to increasing diversity of authors, peer reviewers, and Editorial Board members, the journals will begin to collect demographic information for use in evaluating our progress. Our submission system, Editorial Manager, is developing the ability to anonymously collect demographic data from users. Our publisher, OUP, is a member of the Joint Commitment for Action on Inclusion and Diversity in Publishing and committed to sharing anonymized author data publicly, as have other major publishers, to create subject-specific benchmarks. The Joint Commitment working groups developed 3 standardized questions to collect self-reported gender identity, race, and ethnicity data (Box 1). The process for developing these questions was thoughtfully undertaken, under the guidance of a subject matter expert (25). It's important to note that all data will be collected anonymously and separately from the normal submission workflow—individual responses will not be linkable to an author's submission. JNCI, JNCI Cancer Spectrum, and OUP will only ever receive aggregated data that cannot be reverse engineered to identify individuals. Submission site users will be able to opt out of answering any or all of the questions as they prefer. This information will be used for benchmarking purposes and will allow us to evaluate the effectiveness of journal projects focused on improving diversity and inclusion of our author, reviewer, and editorial board pools by comparing data over time.

## Enhancing health equity content in the journals

As part of the diversity, equity, and inclusion initiative related to enhancing health equity content, in the fall of 2022, JNCI published a series of commentaries and editorials to highlight the root causes of many inequities in cancer care and patient outcomes, stemming from webinars sponsored by the National Cancer Policy Forum of the National Academies of Sciences, Engineering, and Medicine (26–28). These commentary papers addressed key social determinants of health—the social, economic, and environmental conditions within which people are born, live, and work and age that affect health—and their relationship with cancer care and patient outcomes. Social determinants of health are the conditions that underlie individual health-related social needs associated with the long-standing inequities that vary by geography, socioeconomic factors, and other social constructs, such as race and ethnicity. The commentary papers featured housing insecurity, food insecurity, and transportation barriers to cancer care and described the current state of the science and identified challenges and opportunities for addressing health-related social needs and improving equity at the provider; practice; health systems; and local, regional, and national policy levels (26–28). Access to health insurance coverage

**Box 1. The standardized questions for collecting self-reported data on gender identity and race and ethnicity, endorsed by the Joint Commitment**

1. With which gender do you most identify? Please select one option:
  - Woman
  - Man
  - Non-binary or gender diverse
  - Prefer not to disclose
2. What are your ethnic origins or ancestry?
  - Western Europe (eg, Greece, Sweden, United Kingdom)
  - Eastern Europe (eg, Hungary, Poland, Russia)
  - North Africa (eg, Egypt, Morocco, Sudan)
  - Sub-Saharan Africa (eg, Kenya, Nigeria, South Africa)
  - West Asia/Middle East (eg, Iran, Israel, Saudi Arabia,)
  - South and Southeast Asia (eg, India, Indonesia, Singapore)
  - East and Central Asia (eg, China, Japan, Uzbekistan)
  - Pacific/Oceania (eg, Australia, Papua New Guinea, Fiji)
  - North America (Canada, United States)
  - Central America and Caribbean (eg, Jamaica, Mexico, Panama)
  - South America (eg, Brazil, Chile, Colombia)
  - Self describe\* [open text box]
  - Prefer not to disclose
3. How would you identify yourself in terms of race? Please select ALL the groups that apply to you:
  - Asian or Pacific Islander
  - Black
  - Hispanic or Latino/a/x
  - Indigenous (eg, North American Indian Navajo, South American Indian Quechua, Aboriginal or Torres Strait Islander)
  - Middle Eastern or North African
  - White
  - Self describe\* [open text box]
  - Prefer not to disclose

and affordable care were central themes underlying inequities, underscoring a key difference in the United States compared with other countries—the lack of a universal health system. To increase dissemination of this content, *JNCI* published these papers and the accompanying editorial as open-access papers.

A portfolio analysis of National Cancer Institute–funded research grants also published in 2022 found that few grants focused on health-related social needs; authors highlighted the importance of community- and health system–level approaches for addressing social needs (29). Accompanying editorials of the commentaries and the portfolio analysis highlighted the need for action to improve care for patients in communities historically targeted for marginalization (30,31). Another recent paper underscored the importance of National Cancer Institute research funding in reducing cancer disparities and inequities (32). As mentioned above, researchers from underrepresented backgrounds are more likely to propose research focused on social determinants of health (14). Because funding agencies rely heavily on citation metrics as a proxy for scientific expertise, facilitating publication of rigorous research and diverse perspectives in *JNCI* will contribute to many components of scientific advancement.

The *JNCI Monographs* also publish related content, and a thematic collection, “Reducing Disparities to Achieve Health Equity,” is currently in progress. Beyond these special thematic collections, our journals are making a focused effort to increase content on cancer health disparities and inequities. Other recent research papers and commentaries published in *JNCI* and *JNCI Cancer Spectrum* addressed the need for diversity, equity, and inclusion in cancer clinical trial leadership (33), within panels at scientific meetings (34) and within oncology leadership more broadly (35–37). Implementation of modernized cancer clinical trial eligibility criteria (38) and enrollment of diverse populations in trials have also been highlighted (39). Critical aspects of social determinants of health and equity in cancer care and patient outcomes include published research and commentaries about ability status (40), sexual orientation and gender identity (41), country of origin (42,43), housing instability (44), transportation barriers to care (45), medical financial hardship (46,47), mass incarceration (48,49), and structural racism measured through historical redlining housing policies in the United States (50–52). Several publications addressed methodologic and analytical issues, such as ecological and individualistic fallacy in research examining disparities (53,54), definitions and categorization of rurality (55–57), and the limited validity of cancer risk prediction models that treat the social construct of race as a biological factor and/or exclude critical socioeconomic and contextual factors from the models (58).

Recent papers published in *JNCI* and *JNCI Cancer Spectrum* have highlighted how health policies that improve access to care through health insurance coverage reduce disparities in cancer screening, diagnosis stage, receipt of treatment, treatment delay, survival and/or mortality for populations defined by race and ethnicity, socioeconomic status, and geography and/or rurality of residence (59–63). Research papers and commentaries describing approaches for speeding implementation of effective interventions (64); addressing the differential impacts of the COVID-19 pandemic on communities targeted for marginalization (65,66); improving health equity in value-based payment models, such as the Center for Medicare and Medicaid Services’ Enhancing Oncology Care model (67); and consideration of political determinants of health (68) add to the discourse about the central role of politics, health-care policies, health insurance benefit design, systems, institutions, practices, and community partnerships in addressing inequities. These papers are part of the diversity, equity, and inclusion collection that is proudly featured on the diversity, equity, and inclusion landing page shared by both journals (69). *JNCI* and *JNCI Cancer Spectrum* will continue to welcome and prioritize research with rigorous methods addressing modifiable factors associated with cancer control inequities, research led by scientists from underrepresented backgrounds, and research that includes underrepresented populations and perspectives.

Because inequities in cancer control and health outcomes are a universal problem, the journals welcome rigorously conducted research with a global health lens. Topics include, but are not limited to, novel approaches for addressing cancer inequities across the cancer control continuum, as well as cross-country comparative studies that can inform evaluation, development, or modification of programs; identify best practices; or be used as contemporaneous “usual care” comparisons to evaluate the introduction of cancer control interventions. Emphasis on a global health lens is critical considering that the World Health Organization projected that by 2030 more than two-thirds of cancers would occur in low- and middle-income countries (70).

## Recommendations for research examining race and ethnicity in cancer risk, detection, care, and patient outcomes

As noted above, decades of research have documented disparities in cancer risks, incidence, care, and outcomes among populations racialized as Black, Latinx, or Indigenous. Although genetic ancestry is associated with the presence of some gene variants linked to differences in cancer risk and response to treatment, race and ethnicity are social constructs with no biological meaning and modest proxies for genetic ancestry (71,72). Root causes of inequities in cancer care and outcomes are mainly driven by structural racism; systemic and institutional racism within health care; and differences in access to health care and resources related to social determinants of health (73). With the consensus that race is a social construct and not a biologic construct, we join with other scientific journals and recommend use of language, statement of hypotheses, and interpretation of findings that center the conditions imposed on individuals from different racialized groups and support efforts to improve health equity. More specifically, we at *JNCI* and *JNCI Cancer Spectrum* recommend the following:

- Reporting of the racial and ethnic composition of the study sample, with regard to race and ethnicity, detailed breakdown of distinct population groups.
- Disaggregation of population groups that are historically combined based on statistical properties, but which have distinct history, culture, and lived experiences that impact health outcomes.
- Use of language (such as the term *racialized* instead of *racial* to clarify that race is a social construct, not an innate characteristic) and analytic frameworks (such as evaluating modifiable social and structural factors and conditions imposed on individuals, instead of individual behaviors or innate biological characteristics, as determinants of disparities) that uphold our commitment to dismantling structural racism and advancing health equity.
- In studies that assess inequities by racialized groups, a statement of the hypothesized mechanism(s) through which exposure to different forms of racism are associated with study outcomes beyond stating the statistical significance of associations.
- Strongly discourage hypothesized explanations for inequities by race that include only biologic differences, and instead, encourage inclusion of hypotheses of exposure to different social and structural factors that drive access to care and health-related social needs.
- Research that addresses the root causes of inequities and identifies potentially modifiable factors, such as access to health care and other resources.

To ensure these recommendations are implemented in the papers published in our journals, they will be made available in the guidelines for authors, and a new subject term will be introduced for authors to identify related content on submission. Training and training materials will be made available for Associate Editors and Editorial Boards of both journals. Associate Editors will also be asked to confirm that revised manuscripts describing research that examines race and ethnicity in cancer risk, detection, care, and patient outcomes adhere to these recommendations. The journals will evaluate these efforts and continue to identify new ways of ensuring that published research reflects the goals of the diversity, equity, and inclusion initiative.

In summary, we reaffirm the *JNCI* and *JNCI Cancer Spectrum* and OUP commitments to the diversity, equity, and inclusion initiative began in 2022. We strive to advance the diversity and inclusion of study participants, clinicians and research investigators, community engagement, and investigator leadership in cancer research, including clinical trial participation and epidemiologic observational studies. We also encourage journal submissions of innovative research aimed at addressing and improving cancer health equity to ensure that the advances in cancer biology and strategies for cancer prevention, screening and early detection, and treatment are accessible and affordable to all.

## Data availability

No new data were generated or analyzed for this editorial.

## Author contributions

K. Robin Yabroff, PhD (Conceptualization; Writing—original draft; Writing—review & editing), Amanda Boehm, PhD (Conceptualization; Writing—original draft; Writing—review & editing), Leticia Nogueira, PhD (Writing—original draft; Writing—review & editing), Mark Sherman, MD (Writing—review & editing), Cathy Bradley, PhD (Writing—review & editing), Ya-Chen Tina Shih, PhD (Writing—review & editing), Nancy Keating, MD (Writing—review & editing), Scarlett Gomez, PhD (Writing—review & editing), Matthew Banegas, PhD (Writing—review & editing), Stefan Ambs, PhD (Writing—review & editing), Dawn Hershman, MD (Writing—review & editing), James Yu, MD (Writing—review & editing), Nadeem Riaz, MD (Writing—review & editing), Martin Stockler, MBBS (Writing—review & editing), Ronald Chen, MD (Writing—review & editing), and Eduardo Franco, PhD (Writing—review & editing).

## Funding

No funding was used for this editorial.

## Conflicts of interest

ELF is the *JNCI* Editor-in-Chief; KRY and NR are *JNCI* Deputy Editors; RCC is the *JNCI Cancer Spectrum* Editor-in-Chief; MRS is a *JNCI Cancer Spectrum* Deputy Editor; the Editors-in-Chief and Deputy Editors disclose receiving funding from Oxford University Press for their roles that are directly related to this work. ALB is the *JNCI* and *JNCI Cancer Spectrum* Managing Editor and a paid employee of Oxford University Press. SA, CJB, SLG, DLH, NLK, LMN, MS, and Y-CTS are *JNCI* Associate Editors; MPB and JBY are *JNCI* Editorial Board members. Associate Editors and Editorial Board members serve in voluntary capacities.

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