CrossMark

Diversity, Inclusion, and Representation: It Is Time to Act

Johnson B. Lightfoote, MD, MBA[a], Curtiland Deville, MD[b], Loralie D. Ma, MD, PhD[c], Karen M. Winkfield, MD, PhD[d], Katarzyna J. Macura, MD, PhD[e]

Abstract

Although the available pool of qualified underrepresented minority and women medical school graduates has expanded in recent decades, their representation in the radiological professions has improved only marginally. Recognizing this deficit in diversity, many professional medical societies, including the ACR, have incorporated these values as core elements of their missions and instituted programs that address previously identified barriers to a more diverse workforce. These barriers include insufficient exposure of underrepresented minorities and women to radiology and radiation oncology; misperception of these specialties as non–patient care and not community service; unconscious bias; and delayed preparation of candidates to compete successfully for residency positions. Critical success factors in expanding diversity and inclusion are well identified both outside and within the radiological professions; these are reviewed in the current communication. Radiology leaders are positioned to lead the profession in expanding the diversity and improving the inclusiveness of our professional workforce in service to an increasingly diverse society and patient population.

Key Words: Diversity, underrepresented minorities, health disparities, health policy, radiology, radiation oncology, leadership, women in medicine, health equity

J Am Coll Radiol 2016;13:1421-1425. *Copyright © 2016 American College of Radiology*

Since its inception in 2013, the ACR Commission for Women and General Diversity (the "Commission") has taken the lead in changing the face of radiology [1]. The Commission formulated a strategic plan consonant with the ACR Strategic Plan of 2014, in response to its goal of increasing diversity and inclusion in the radiological professions [2]. In 2015, the ACR Council adopted Resolution 14, affirming that diversity is central to our mission, strengthens our organization, and should be measured [3]; ACR members now voluntarily report their ethnicity at membership renewal. The Commission and members have published many peer-reviewed and informal communications, in these pages and elsewhere, to expand the awareness of challenges and opportunities in diversity and inclusion, and has sponsored presentations, forums, and discussions in venues ranging from ACR 2015 and ACR 2016 to university training programs and state radiology societies. Projects pending implementation include pipeline enhancement; focused research on the barriers to improving diversity and inclusion in radiology; and diversity, inclusion, and cultural proficiency training for top leadership.

[a]Department of Radiology, Pomona Valley Hospital Medical Center, Pomona, California.

[b]Department of Radiation Oncology and Molecular Radiation Sciences, Johns Hopkins University School of Medicine, Washington, DC.

[c]Advanced Radiology, LLC, Baltimore, Maryland.

[d]Department of Radiation Oncology Office of Cancer Health Equity, Wake Forest Baptist Comprehensive Cancer Center, Wake Forest, North Carolina.

[e]Russell Morgan Department of Radiology and Radiological Science, Johns Hopkins University School of Medicine, Baltimore, Maryland.

Corresponding author and reprints: Johnson B. Lightfoote, MD, MBA, Department of Radiology, Pomona Valley Hospital Medical Center, 1798 North Garey Ave, Pomona, CA 91767; e-mail: Lightfoote@msn.com.

The authors have no conflicts of interest related to the material discussed in this article.

CURRENT STATE AND TRENDS IN DIVERSITY OF THE RADIOLOGICAL PROFESSIONS

Women and individuals from backgrounds underrepresented in medicine (URM)—historically, Blacks, American Indians, Alaska Natives, Native Hawaiians, Pacific Islanders, and Hispanics—are underrepresented in the diagnostic radiology [4,5] and radiation oncology [6] (RRO) physician workforce at all levels, including practicing physicians, academic faculty, and trainees. Both specialties rank near the bottom in female and URM representation

© 2016 American College of Radiology
1546-1440/16/$36.00 ■ http://dx.doi.org/10.1016/j.jacr.2016.08.008

compared with the 20 largest residency specialties, including several surgical and non–primary care specialties [7], with similar trends in radiologic subspecialties, such as vascular and interventional radiology [8,9]. For women (see Figure 1), representation among trainees (27% and 29% in radiology and radiation oncology, respectively) is improved relative to practicing physicians (24%, 26%) [10], suggesting historical gains; however, the numbers of women trainees in radiology have remained stagnant over the past 8 years [4] and show only a subtle 0.3% increase per year in radiation oncology over the past 20 years [11]. At this rate, it would take 50 years for women to reach parity with the graduate medical education trainee pool and medical school graduates (46%-48%). For URMs in RRO (see Figure 2), there have been minimal trends toward improvement, with URMs representing 8% and 9% of radiology and radiation oncology trainees, respectively, compared with 15% of both medical school graduates and graduate medical education trainees [7]. In fact, although the number of radiation oncology residents has increased approximately 30% over the past 16 years, from 493 to 644, the absolute number of Black residents, for example, remains relatively unchanged over the same time period, with only 24 residents in both 1997 and 2012 [11,12] These findings suggest that the underrepresentation of women and URM in RRO is more than just a pipeline issue.

Lessons From Outside the House of Radiology

In organizations and endeavors outside radiology, we see increasingly pervasive appreciation of and permanent commitments to diversity and inclusion.

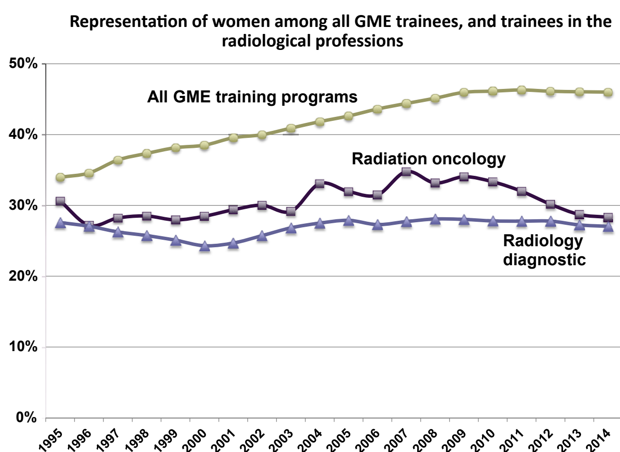

Fig 1. Representation of women as percentages of all graduate medical education (GME) trainee physicians, and in radiation oncology and radiology.

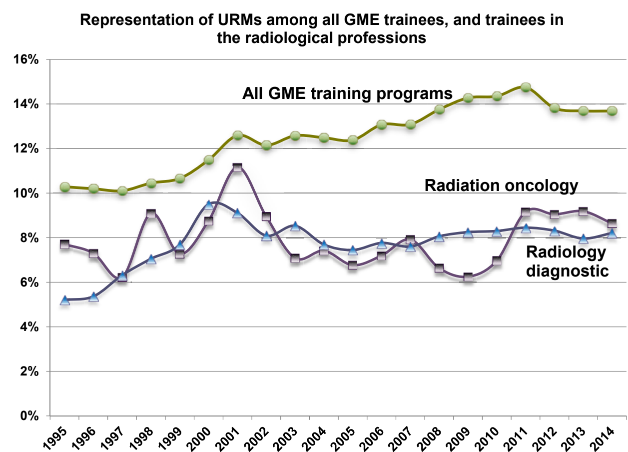

Fig 2. Representation of underrepresented minorities (URMs) as percentages of all graduate medical education (GME) trainee physicians, and in radiation oncology and radiology.

Diversity and Performance

That more diverse organizations have better economic performance than their less representative peers has been part of the business research and educational canon for decades [13]. For example, a study of 454 large global organizations demonstrated that those with diversity strategies had a cash flow 2.3 times greater per employee; smaller, mature organizations had a cash flow 13 times higher [14]. McKinsey similarly demonstrated above-median financial performance, innovation, decision making, and customer orientation among more diverse enterprises [15].

A dramatic illustration of high-functioning organizations committing to a diverse and inclusive future is that of the Academy of Motion Picture Arts and Sciences (AMPAS). Following two consecutive years of Oscar nominations with no artists of color, in January 2016 the Board of Governors unanimously voted sweeping changes to increase diversity, including limiting voting status to active filmmakers; launching global recruitment; immediately expanding the Oscars' Board with three nontraditional board members; and committing to doubling the numbers of women and URM members by 2020 [16]. In June 2016, the Academy added 683 distinguished filmmakers to its membership, of which 46% were women (increasing female representation from 25% to 27%) and of which 41% were people of color (increasing ethnic diversity from 8% to 11%) [17,18]. AMPAS's initiatives were clearly controversial, but the commitment to excellence through diversity was widely applauded [19,20]. AMPAS's diversity and inclusion initiatives illustrate four critical success factors: (1) external considerations, not

Download English Version:

https://daneshyari.com/en/article/5726581

Download Persian Version:

https://daneshyari.com/article/5726581

Daneshyari.com