Diversity 3.0: Are We There Yet?

AS OUR NEW COMMISSION RAMPS UP ITS EFFORTS, THERE IS PLENTY OF WORK AHEAD.

CHANCELLOR'S REPORT

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In an ever changing world, diversity and inclusion became critical components of success in a global economic context. Diversity has long been viewed as an important tool to enhance education, and research has shown that thoughtful, strategic diversity efforts can lead to improved cognitive and social outcomes.[1] Basically, diversity better enables institutions and organizations to excel. For instance, teams comprised of varying viewpoints, perspectives, ideas, and backgrounds tend to outperform homogeneous groups on problem-solving tasks. Pro-diversity climates as perceived by both employees and managers have significant positive effects on key business indicators, such as growth, attendance, and retention. Truly inclusive environments are tied to collaboration, innovation, and ultimately excellence.

IBM, a corporate leader in diversity and inclusion, has built a structure for its workforce that incorporates three distinct phases in the evolution of diversity. These phases have been recently translated into the framework of academic medicine.[2] The goal for the Diversity 1.0 phase is to alleviate discrimination and institutionalized racism in pursuit of fairness, access, and equality with respect to gender, racial, and ethnic differences through isolated efforts and implementation of programs aimed at removing social and legal barriers to access and equality. The Diversity 2.0 phase focuses on expansion of diversity programs, mainly centered on access and fostering the success of racial and ethnic minorities. These diversity efforts focus largely on ancillary and parallel initiatives rather than on becoming part of the core mission of institutions. Fueled by understanding that diversity and excellence are not only complementary but also intricately linked, the emerging diversity movement shifts toward the next paradigm, Diversity 3.0, in which diversity and inclusion become the keys to the institutional mission and integral for achieving excellence. So where does radiology fall on the spectrum of the diversity movement?

A recent study published in *Radiology* and led by Christina Chapman, MD, and Curtiland Deville Jr., MD, from the Department of Radiation Oncology at the University of Pennsylvania's Perelman School of Medicine in Philadelphia revealed that over the past eight years, there has been no significant increase in the percentage of females or traditionally underrepresented minorities in medicine (URMs) among radiologists and radiology residents. These groups include African-Americans, Hispanics, American Indians, Alaskan Natives, Native Hawaiians, and Pacific Islanders. The findings suggest that it is unlikely that in the near future radiologists will become more diverse.[3] Authors studied publicly available records of the American Medical Association, American Association of Medical Colleges, and U.S. Census Bureau registries to assess differences among diagnostic radiology practicing physicians, academic faculty, residents, subspecialty trainees, residency applicants, medical school graduates, and the wider U.S. population for academic years 2003–2004 to 2010–2011. Additionally, for 2010, they compared results among the 20 largest residency training programs.

The results were not encouraging. For practicing radiologists, female and URM representation is 23.5 percent and 6.5 percent, respectively. For academic faculty, representation of the two groups stands at 26.1 percent and 5.9 percent, respectively. And for residents, it is 27.8 percent and 8.3, respectively. This is compared with the U.S. population, which is made up of 50.8 percent women and 30 percent URMs. When we look at incoming medical students — although the percentage of women and URMs in radiology residency has increased compared with practicing physicians — these groups remain underrepresented at the resident level, compared with their proportions as medical school graduates (48.3 percent for women and 15.3 percent for URMs).

Another interesting finding from the study was that despite ranking ninth in size among the 20 largest residency training programs (including primary care and surgical and non-surgical specialties), diagnostic radiology ranked 17th in women and 20th in URM representation. The same group reported similar results in an earlier study referring to radiation oncology.[4] The authors found that women and URMs were underrepresented as radiation oncology residents (33.3 percent and 6.9 percent, respectively), faculty (23.8 and 8.1 percent), and practicing physicians (25.5 and 7.2 percent). Both studies suggest there is no trend toward increased diversification for female or URM radiology trainees over the recent years, and underrepresentation is not diminishing for diagnostic radiology and radiation oncology practicing physicians.

Given an increasingly diverse U.S. society and a growing focus on policies for the inclusion of minorities in the workforce, will radiology be at a disadvantage among other medical specialties in providing care for our patients? This may be the case unless we implement effective programs for diversifying our teams, such as shifting to the Diversity 3.0 paradigm.

Training, recruitment, retention, promotion, and leadership development of radiologists from underrepresented groups are important to the well-being of our profession and the health of our patients. The ACR Commission for Women and General Diversity is committed to identifying barriers to a diverse physician

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