We were grateful for Dr Hayes’s [1] close reading of our recent reports from the ACR Commission for Women and General Diversity [2,3]. One of the principal goals of the commission is to stimulate awareness, thought, and discussion of issues that concern diversity and inclusion in radiology and radiation oncology. We appreciate the opportunity to clarify our analysis, views, and positions.

The motto of our commission is “Excellence through diversity.” We propose to actively encourage gifted and qualified women and minorities underrepresented in medicine to enter radiology and radiation oncology. It should be made clear that nowhere do we suggest any lowering of standards. These talented physicians enter other specialties at much higher rates; we believe the radiologic professions should benefit from this diverse pool of talented doctors as much as any other medical specialty. Similarly, nowhere do we propose any reparations or special treatment. We emphasize that quotas and preferences are primarily of historical and cautionary interest.

For these two initial, evidence-based reports, we deliberately and explicitly focused on race, ethnicity, gender, gender identity, and sexual orientation, as acknowledged in Part 1, the opening summary box: “The current states of diversity and inclusion in [radiology and radiation oncology] are reviewed in regard to gender, race, ethnicity, sexual orientation, and gender identity” [2]. This is where there is the most evidence, and these are the demographic criteria being universally assessed by academic and business enterprises and by the health care industry in particular. In Part 2, Table 2, we acknowledge that a future diversity and inclusion goal should be to “expand initiatives to include diverse, excluded groups such as those who are veterans; disabled; or socio-economically disadvantaged” [3].

Regarding preferential hiring practices, Hayes presents a fundamentally flawed example at the outset. Who are the “we” in this scenario? The assumption that any hiring “preference” based on an individual’s age, race, ethnicity, culture, gender, gender identity, sexual orientation, or disability status is ever acceptable is rejected by any legally responsible hiring body. This is not an example of “natural” personal bias and secondary group bias,” as the author suggests; it is an example of discrimination.

Furthermore, if, as Hayes originally states, biases are natural, then how can the hiring process ever be fully “impersonal” and “objective”? There are conscious and unconscious, explicit and implicit, de jure and de facto biases. Acknowledging bias and its potential mitigations is relevant in every encounter. For example, research has repeatedly shown that a woman’s curriculum vitae with equivalent competence is less favorably received than that of a male counterpart by both men and women [4]. Similar findings have been found for racial and ethnic minorities [5] and with regard to academic publications and institutional biases [6]. Many journals have moved to blinded submission to attempt to mitigate such inequity. Symphony orchestra auditions held behind closed curtains increase diversity by 25% [7]. These are examples of solutions that address “natural” biases.

“Preferential hiring and special treatment” were not listed anywhere in our reports as remedies for environments lacking diversity and inclusion. Furthermore, improving diversity and inclusion extends far beyond new hiring practices; it also means revealing, embracing, and valuing the diverse representatives already existing within one’s group. It means being open to exploring the subtle, yet offensive use of terms such as sexual preference instead of
sexual orientation and nontraditional when referring to gender identity. It is not a singular project for a practice to take on in isolation. Hayes and other readers are referred to the seminal report by Dr Marc Nivet, chief diversity officer of the Association of American Medical Colleges, “Diversity 3.0: A Necessary Systems Upgrade” [8], to understand better how diversity in the modern era is understood as a concept not in isolation or apposition to others [9]. Diversity and representation are relevant in many situations. In fact, all of the “typical challenges for a medical imaging group” Hayes proposes should be examined through the lens of diversity and inclusion to ensure successful resolution. A practice more reflective of its service population may attract more patients. Diverse life stages can offer opportunities such as flexible workload scheduling, such as the 3-to-11 shift, or dictating offsite. A group with a wider variety of members may develop closer relationships with its community or local media.

The most voluminous data and literature come from the business community. An excellent example cited by Dr Hayes is Peter Drucker, who greatly valued diversity [10]. Often called “the man who invented management,” Drucker directly influenced numerous leaders from a wide range of organizations across all sectors of society, as diverse as General Electric, IBM, Intel, Procter & Gamble, Girl Scouts of the USA, The Salvation Army, Red Cross, United Farm Workers, and several presidential administrations. Several of these corporations we identify in our reports as leaders in improving the diversity and inclusion of their workforces. Leaders influenced by Drucker know something about diversity and have embraced it to enhance their own success.

The strategies we proposed have been applied broadly by a wide variety of business entities and are well documented. They are not solely addressed to the “struggling imaging practice” but to all radiology practices, large and small. Are diversity and inclusion “a heavy lift”? They don’t have to be. We’ve compiled a list of practical ways radiology groups large and small can apply a little levity in assessing and achieving best practices [11,12].

Just how seriously our most important business partners take diversity and inclusion is illustrated by their own tracking of this quality measure [13,14]. Hospitals conscientiously work at improving diversity (Fig. 1) and are arguably the most important business partners working with radiology practices. Building diversity is a core project of the academic medical centers at which many radiologists and radiation oncologists teach [15]. Aligning Diversity 3.0 initiatives with those of our host health care institutions is a real Imaging 3.0™ [16] opportunity to help secure our places in our local medical communities.

The commission’s review and position statements are offered for information and educational purposes. Our practice leaders can learn here and elsewhere about why those

![Fig 1. Percentage of hospitals increasingly participating in diversity improvement plans, American Hospital Association surveys, 2012 (red) and 2013 (blue) [13,14].](image-url)
many corporations and academic and health care institutions that embrace diversity are successful and how they make diversity 1 of their core missions. We invite radiologists to become aware of the advantages of inclusive and diverse environments and sensitive and industrious in how they implement improvement. We hope that there will be practices that will share their experiences to empower others.

Our goal is to illuminate and stimulate; we certainly do not have all the solutions. “We” are you; we speak as leaders in your house of radiology and radiation oncology. Doing business as usual will not take us forward to a future in which all members of the radiologic professions are included, welcomed, and valued as contributors. Advancing diversity and inclusion presents critically important opportunities to ensure a modern, progressive, and inclusive and diverse environments to become aware of the advantages of inclusive and diverse environments and sensitive and industrious in how they implement improvement. We hope that there will be practices that will share their experiences to empower others.

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REFERENCES


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