2026, Volume 58, Issue 8, 607-608, e-ISSN 1938-3800

Family Medicine

LETTER TO THE EDITOR

From Pipeline to System Design: Reframing Diversity in Academic Family Medicine Leadership

Jesus Ruiz, MD

AUTHOR AFFILIATION:

Department of Family Medicine, University of North Carolina at Chapel Hill, Chapel Hill NC

CORRESPONDING AUTHOR:

Jesus Ruiz, Department of Family Medicine, University of North Carolina at Chapel Hill, Chapel Hill NC,
Jesus_ruiz@med.unc.edu

HOW TO CITE: Ruiz J. From Pipeline to System Design: Reframing Diversity in Academic Family Medicine Leadership. *Fam Med.* 2026;58(8):607-608.
doi: 10.22454/FamMed.2026.519817

FIRST PUBLISHED: September 4, 2026

TO THE EDITOR

The analysis by Ringwald et al clarifies diversity trends in academic family medicine leadership. Using longitudinal Council of Academic Family Medicine Educational Research Alliance data, the authors show that recent gains in representation among Black, Indigenous, and People of Color (BIPOC) leaders are driven by retention rather than recruitment, with no meaningful increase in newly appointed leaders.[1]

If the pipeline were the primary constraint, growth would occur at entry. Instead, representation among new leaders remains unchanged, while gains occur only among those who remain, indicating a problem of system design, not access.

At its core, this pattern reflects not only a problem of structure but of institutional trust. Recruitment reflects institutional trust and whether individuals believe they can enter, advance, and be valued.[2-4] For many BIPOC faculty, academic medicine carries a risk of isolation, disproportionate burden, and inequitable evaluation, rooted in both historical exclusion and current structures.[5-7] Systems that misalign incentives, undervalue contributions, and obscure advancement signal that participation comes at a cost.[8,9] Recruitment and retention therefore reflect the same underlying condition: trust.

Work central to institutional missions, including diversity, equity, and inclusion (DEI) efforts, mentorship, and community engagement, is often undervalued.[6,7,10] BIPOC faculty disproportionately shoulder this minority tax, yet advancement continues to rely on informal sponsorship and traditional metrics that perpetuate inequities.[8,9] This burden may include disproportionate mentorship, diversity-related and institutional service work, and expectations to lead DEI efforts, often without protected time, compensation, or recognition within promotion structures.[10]

Representation alone does not redistribute power or resources. Recruitment without structural change requires adaptation to existing systems rather than transformation.[2,3,8]

The findings by Ringwald *et al.* show that gains driven by retention may reflect persistence despite structural misalignment rather than system effectiveness. Many BIPOC faculty may persist because of a commitment to community, mentorship, representation, and the desire to create pathways for future generations despite structural barriers. However, systems should not rely on individual resilience to sustain diversity efforts. Retention dependent on individual endurance is fragile and difficult to scale.[7,10] It risks obscuring the core issue: Individuals are entering systems that remain unchanged.[2]

Reframing diversity as a problem of system design changes both the question and the solution. The question is no longer how to recruit more underrepresented faculty, but how to redesign academic environments so that diverse faculty can enter, advance, and lead without disproportionate burden.

For family medicine, this shift requires aligning values with operations through deliberate system redesign. Leadership must embed mentorship, community-engaged scholarship, and DEI leadership into promotion and compensation structures; fund protected time for this work; and replace informal sponsorship with transparent, accountable pathways to advancement. Foundational elements of structural accountability include transparent promotion criteria, equitable workload distribution, protected time, and formal sponsorship structures. Departments should evaluate these efforts

through measurable outcomes, including retention, promotion, leadership representation, and compensation equity across demographic groups.[6,8] Without structural accountability and resource alignment, recruitment efforts will continue to outpace the systems needed to sustain a diverse and thriving workforce.[2,6,8] Diversity will not be sustained by who we recruit, but by the systems we choose to build.

If recruitment has not produced equity, the solution is not more recruitment but system change. Until academic family medicine aligns its values, incentives, and structures, diversity will depend on individual resilience rather than institutional effectiveness—and resilience is not a strategy.

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