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Family Medicine

LETTER TO THE EDITOR

Using a Shared Framework for Monitoring EDI in Academic Family Medicine Departments

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TO THE EDITOR:

We applaud Dr Shalina Nair et al's thoughtful article "Departmental Metrics to Guide Equity, Diversity, and Inclusion for Academic Family Medicine Departments,"[1] which presents an innovative shared framework to measure equity, diversity, and inclusion (EDI) in academic family medicine departments. The authors highlight how such a framework could help family medicine departments establish baselines and track progress in fostering inclusive workplaces.

Successful application of Nair et al's well-designed EDI framework depends on multiple factors, including the department's geographical location, hospital or academic affiliations, institutional policies, and resources.[2] While these factors may influence implementation of a framework, three potential benefits of adopting this framework remain substantial: fostering a more diverse workforce, intentionally retaining and recruiting faculty, and enhancing patient health outcomes.

Building a more diverse workforce is a key reason to adopt Nair et al's EDI framework. Doing so would enable the recruitment of individuals who more accurately reflect the US population. Institutions may implement a holistic review process[3] that considers life experiences alongside traditional metrics. Additionally, incorporating interview questions that explore how race has shaped a candidate's experiences can provide valuable insight while remaining permissible.

Retention is equally important, because recruitment alone is insufficient to sustain a diverse workforce. Without intentional efforts to foster inclusion, diverse faculty may experience isolation, burnout, or attrition. Nair et al's EDI framework can support long-term retention by helping institutions implement mentorship programs, affinity groups, and leadership development opportunities that create a sense of belonging. Additionally, departments must assess workload distribution and advancement opportunities to ensure that faculty from underrepresented backgrounds receive equitable access to career growth. Investing in these structural supports allows faculty to better manage stress, feel valued, and remain engaged in their roles.[4]

Beyond workforce diversity, adopting this framework can also ultimately enhance patient health. Studies show that a diverse health care workforce improves patient trust, communication, and adherence to medical recommendations, leading to better health outcomes.[5] Physicians from underrepresented backgrounds are more likely to serve in medically underserved areas, helping to address health disparities.[6] These benefits can be measured through improved quality metrics, patient satisfaction scores, and health equity indicators. Furthermore, training all providers in culturally responsive care fosters a

more inclusive health care environment, ensuring that patients receive respectful and effective treatment regardless of background.[7]

We acknowledge the challenges of implementing EDI efforts in the current political climate; legislative shifts have introduced external barriers. But leveraging Nair et al's cleverly designed shared framework ensures continued progress and enables family medicine departments to track progress and refine their efforts. Contributing to the broader academic discourse—both nationally and globally—can help sustain momentum despite local obstacles.[8] We hope these metrics will be widely adopted, given the well-documented and far-reaching benefits of advancing equity, diversity, and inclusion.

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