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BRIEF REPORT

Strategies and Barriers for Diversity, Equity, Inclusion, and Antiracism Work in Family Medicine Departments: A CERA Study

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ABSTRACT

Background and Objectives: Medical schools and family medicine organizations have been working on advancing diversity, equity, inclusion, and antiracism (DEIA). Black, Indigenous, and People of Color (BIPOC) faculty members are disproportionately expected to lead DEIA initiatives, negatively affecting academic promotion and well-being. Our study aimed to describe the existing DEIA initiatives, strategies, and barriers to implementing support for DEIA work, as well as the implications of addressing the minority tax in US and Canadian family medicine departments.

Methods: We used data collected as a part of the 2023 Council of Academic Family Medicine Educational Research Alliance (CERA) study. The survey was delivered to 227 department chairs across the United States and Canada.

Results: The survey response rate was 50.2% (114/227). Sixty-two percent of the respondents strongly agreed that advancing DEIA was important, and 55.4% reported having a DEIA leader, with 75.4% of those positions reportedly held by BIPOC faculty. Lack of funding was identified as the most significant barrier (26.2%), followed by lack of faculty expertise (18.7%). Department chairs who strongly agreed that DEIA work was important were significantly more likely to report having a DEIA committee, mentorship for BIPOC faculty, and a holistic review for faculty recruitment than those who did not strongly agree.

Conclusions: Though most department chairs perceived advancing DEIA work as important, appropriate compensation and institutional support are often lacking. Further study is needed to explore ways in which departments can enhance their institutional support for DEIA initiatives.

INTRODUCTION

A diverse workforce is critically important when serving diverse populations, because greater gender and racial/ethnic concordance between patients and physicians is associated with better patient satisfaction and health care outcomes.[1–6] Medical schools and family medicine organizations have been working on advancing diversity, equity, inclusion, and antiracism (DEIA), and the Council of Academic Family Medicine has been striving to address the lack of diversity in academic family medicine leadership as well.[7–10] Institutions have made various efforts to advance DEIA initiatives, including implementing a holistic applicant review process, introducing mentorship streams, and developing DEIA committees.[11,12]

All faculty should be involved regardless of their gender, race/ethnicity, and academic rank; however, disparity exists, such that Black, Indigenous, and People of Color (BIPOC) faculty take on and/or are expected to initiate more of the DEIA-related tasks, including, but not limited to, task forces/committees or mentorship of minority trainees.[13,14] Those extra responsibilities of BIPOC faculty in academic medicine are referred to as the minority tax.[13] The inequities from the minority tax can disrupt BIPOC faculty from advancing in academic medicine. To sustain DEIA efforts along with addressing the minority tax, experts have suggested adding financial support, staff support, and protected time; involving senior leadership in DEIA activities; and updating institutional promotion metrics.[13,15,16]

A 2020 national survey of family medicine department chairs examined the chairs' assessment of DEIA activities and infrastructures for advancing DEIA.[17] However, few studies have illustrated the existing strategies and barriers to advancing DEIA. Our study aimed to describe the existing DEIA

initiatives, strategies, and barriers to implementing support for DEIA work, as well as the implications of addressing the minority tax in family medicine departments within the United States and Canada.

METHODS

Survey

Our study team developed a cross-sectional survey consisting of nine items that were distributed to family medicine department chairs in the United States and Canada as part of a larger 2023 study conducted by the Council of Academic Family Medicine Educational Research Alliance (CERA). The survey items aimed to understand the existing DEIA initiatives, as well as the supports for and barriers to DEIA efforts in family medicine departments.

Sample and Data Collection

Data for this study were collected from August 8, 2023, to September 15, 2023, as part of the CERA survey. The methodology of the CERA survey has been previously described in detail.[18] Email invitations to participate in the survey were sent to family medicine department chairs as identified by the Association of Departments of Family Medicine. Responses to the survey were collected using the online program SurveyMonkey (SurveyMonkey Inc). Following the initial invitation, reminder emails were sent to nonresponders for 5 consecutive weeks, with a sixth reminder on the morning the survey closed.

Analyses

All analyses for the study were conducted using SPSS Statistics version 29 (IBM). We used descriptive statistics, including frequencies and crosstabs, to summarize all study variables. We conducted bivariate analyses using χ^2 tests to examine relationships among variables of interest. A P value of <.05 was used to determine the statistical significance of studied relationships. The American Academy of Family Physicians Institutional Review Board approved this project in August 2023.

RESULTS

Participant Characteristics

The CERA survey was delivered to 227 department chairs across the United States (N=211) and Canada (N=16), of which 114 (50.2%) responded. A majority of participants identified as male (62.5%) and White (71%), and 25.9% of the sample identified as BIPOC (Table 1).

Perceptions, Supports, and Barriers Associated With DEIA Work

With regard to chairs' perceptions, 61.5% strongly agreed that advancing DEIA was important, and 22% strongly agreed that they felt confident in advancing DEIA work. Only 18.4% strongly agreed that their institutional promotional metrics valued DEIA work, and 23.9% strongly agreed that they had faculty with expertise to advance DEIA in their department. Lack of funding was identified as the most significant barrier (26.2%), followed by lack of faculty expertise (18.7%). Fifty-five percent of participants reported having a DEIA leadership position in their department, with 75.4% of those DEIA leadership positions reportedly held by BIPOC faculty. Of the 61 department chairs who reported having a DEIA leadership position, 50.8% reported having both financial and administrative support for DEIA work in their department (Table 2).

The bivariate analyses revealed that participants who strongly agreed that DEIA work is important were significantly more likely to report having a DEIA committee (χ^2=5.23, P=.02), mentorship for BIPOC faculty (χ^2=5.37, P=.02), and a holistic review for faculty recruitment (χ^2=5.70, P=.02) than those who did not strongly agree (Table 3).

DISCUSSION

This study revealed department chairs' perceptions of DEIA efforts, support for DEIA leaders, and barriers to advancing DEIA in family medicine departments. Most department chairs strongly agreed that advancing DEIA is important, but fewer chairs strongly agreed that they felt confident in doing so. A 2020 study of family medicine department chairs indicated that 44.7% of departments had a designated DEIA officer/lead, and our study found that 55.4% now have a DEIA leader, which may reflect an increase over the past 3 years.[17] Additionally, our study found that in departments where chairs are in strong agreement about the importance of DEIA work, a higher likelihood exists of having DEIA initiatives such as committees and mentorship.

Most DEIA leadership positions were held by BIPOC faculty, and many chairs perceived that the departments provided financial and/or administrative support. However, a recent qualitative study showed that early career BIPOC faculty contributing to DEIA committee service experienced a lack of protected time for scholarship, a lack of mentorship, and a lack of acknowledgment.[14] This discrepancy of perception between department chairs and the BIPOC faculty indicates that financial support and resources may not meet the actual needs for their DEIA initiatives. Departments that have a DEIA leader but not enough support for that person and/or their team should consider developing platforms for mentorship and accessing established programs nationally, especially for BIPOC faculty with limited institutional mentorship.[19,20]

Our study had several limitations. First, the CERA survey results were based on the perceptions of department chairs rather than DEIA leaders, so the findings may not accurately represent DEIA work in departments, depending on the depth of department chair involvement/supervision. Second, response bias and social desirability bias remain possible in this survey methodology. Third, given the timing of this survey, responses may have been impacted by the Supreme court's decision on affirmative action and the anti-DEIA climates in some states.[21,22] Lastly, while our survey listed five choices for the most significant barrier to advancing DEIA based on previous research findings, 26.2% (28/107) of respondents

chose "other," without the opportunity to provide additional information in their answers.

CONCLUSIONS

In conclusion, the majority of family medicine department chairs perceived advancing DEIA work as important. However, appropriate financial and administrative support are still lacking in many departments. To promote sustainable progress toward advancement of DEIA and well-being among BIPOC faculty, further study is needed to explore ways in which departments can enhance their institutional support for DEIA initiatives.

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TABLE 1. Department Chair Respondent Characteristics

Description		n (%)
Community size of department location (n=110)	Less than 30,000	2 (1.8)
	30,000 to 75,000	6 (5.5)
	75,001 to 150,000	12 (10.9)
	150,001 to 500,000	30 (27.3)
	500,001 to 1 million	22 (20.0)
	More than 1 million	38 (34.5)
Race or ethnicity (n=114)	American Indian/Alaska Native/Indigenous	0
	Asian	10 (8.8)
	Black or African American	14 (12.3)
	Hispanic/Latino/Of Spanish Origin	6 (5.3)
	Middle Eastern/North African	1 (0.9)
	Native Hawaiian/Other Pacific Islander	0
	White	81 (71.0)
	Choose not to disclose	2 (1.7)
Age (n=111)	30-39	4 (3.6)
	40-49	17 (15.3)
	50-59	42 (37.9)
	60-69	39 (35.1)
	70+	9 (8.1)

TABLE 2. **Department Chairs' Perceptions, Supports, and Barriers Associated With DEIA Work**

Variable		n (%)
I believe it is important to advance DEIA in the department. (n=109)	Strongly disagree	3 (2.8)
	Disagree	0
	Neutral	7 (6.4)
	Agree	32 (29.3)
	Strongly agree	67 (61.5)
I am confident in advancing DEIA in the department. (n=109)	Strongly disagree	1 (0.9)
	Disagree	5 (4.6)
	Neutral	22 (20.2)
	Agree	57 (52.3)
	Strongly agree	24 (22.0)
I believe our institutional promotional metrics value DEIA work. (n=109)	Strongly disagree	1 (0.9)
	Disagree	17 (15.6)
	Neutral	23 (21.1)
	Agree	48 (44.0)
	Strongly agree	20 (18.4)
We have faculty with expertise to advance DEIA in the department. (n=109)	Strongly disagree	2 (1.8)
	Disagree	8 (7.3)
	Neutral	19 (17.4)
	Agree	54 (49.6)
	Strongly agree	26 (23.9)
What is the most significant barrier to advancing DEIA in your department? (n=107)	Other areas are more important	12 (11.2)
	Lack of interest among faculty members	7 (6.5)
	Lack of available faculty with expertise	20 (18.7)
	Lack of funding	28 (26.2)
	Lack of institutional support	12 (11.2)
	Other	28 (26.2)
Does your department have a DEIA leadership position? (n=110)	Yes, led by BIPOC faculty	46 (41.8)
	Yes, led by non-BIPOC faculty	15 (13.6)
	No	49 (44.6)
Do you offer administrative support (staff support) or financial incentives/support for this position? (n=61)	Administrative support (staff support)	12 (19.7)
	Financial incentives/support	6 (9.8)
	Both	31 (50.8)
	Neither	12 (19.7)
Do you currently have any of the following initiatives in your department to advance DEIA? (Select all that apply.) (n=109)	DEIA committee	54 (49.5)
	Mentorship program for BIPOC faculty	26 (23.9)
	Holistic review of faculty applicants	72 (66.1)
	None of the above	20 (18.3)

Abbreviations: DEIA, diversity, equity, inclusion, and antiracism; BIPOC, Black, Indigenous, and People of Color

TABLE 3. **Bivariable Comparisons of the Perceived Importance of DEIA and Confidence in Addressing DEIA With DEIA Strategies and Barriers**

Perceived importance of DEIA			
	Not strongly agree, n (%)	**Strongly agree, n (%)**	χ^2
DEIA support			1.22 (.75)
Administrative support	3 (25.0)	9 (75.0)	
Financial support	2 (33.3)	4 (66.7)	
Both	8 (25.8)	23 (74.2)	
Neither	5 (41.7)	7 (58.3)	
Have DEIA committee			5.23 (.02*)
Yes	15 (27.8)	39 (72.2)	
No	27 (49.1)	28 (50.9)	
Have BIPOC mentorship			5.38 (.02*)
Yes	5 (19.2)	21 (80.8)	
No	37 (44.6)	46 (55.4)	
Holistic review of faculty			5.70 (.02*)
Yes	22 (30.1)	50 (69.9)	
No	20 (54.1)	17 (46.0)	
Perceived value of DEIA in promotion metrics			3.56 (.06)
Not strongly agree	38 (42.7)	51 (57.3)	
Strongly agree	4 (20.0)	16 (80.0)	
Perceived confidence in addressing DEIA			
	Not strongly agree (N=83), n (%)	**Strongly agree (N=24), n (%)**	χ^2
DEIA barriers			8.05 (.15)
Other areas more important	12 (100)	0	
Faculty lack of interest	6 (85.7)	1 (14.3)	
Lack of faculty expertise	17 (85.0)	3 (15.0)	
Lack of funding	18 (64.3)	10 (35.7)	
Lack of institutional support	8 (66.7)	4 (33.33)	
Other	22 (78.6)	6 (21.4)	

*Statistically significant ($P<.05$)
Abbreviations: DEIA, diversity, equity, inclusion, and antiracism; BIPOC, Black, Indigenous, and People of Color