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BROADENING INCLUSION OF PRIMARY CARE: TRAINEE INSIGHTS AND COMMENTARY ON DIVERSITY, EQUITY, AND INCLUSION

Abstract

We, as the current and immediate-past NAPCRG Trainee Committee, share our perspectives as an international and diverse group of primary care research trainees. In this essay, we discuss the challenges and opportunities for achieving a more diverse, equitable, and inclusive primary care workforce by reflecting on 2 main challenges: (1) insufficient support for underrepresented identities in medicine, and (2) inadequate integration within existing primary care teams. Within each of these challenges, we pose potential opportunities for improvement using a trainee lens.

Introduction

It has been more than 45 years since the 1978 Declaration of Alma Ata underscored the importance of team-based primary care and several years since it was further highlighted in the 2018 Declaration of Astana.[1] Despite these declarations, primary care systems continue to struggle with the inclusive integration of interprofessional primary care team members from diverse backgrounds. Meanwhile, the need for diverse primary care team members is rapidly expanding as the interconnected nature of health grows and continues to strain the already stretched workforce globally. Health care systems worldwide are at a crucial moment for critical reflection on the goals of the Quintuple Aim, which includes health equity as an essential component for achieving improved patient care, provider satisfaction, health outcomes, and decreased costs.[2] Of vital importance is an equitable expansion of our global primary care workforce. To grow an effective and equitable primary care system on a global scale, we critically need to expand and diversify our primary care workforce, while valuing each team member as essential to the overall mission of primary care.

This essay underscores key challenges and opportunities for achieving a more diverse, equitable, and inclusive primary care workforce by critically reflecting on 2 main challenges: (1) insufficient support for underrepresented identities in medicine, and (2) inadequate integration within existing primary care teams. Underrepresented identities in medicine include racial and ethnic backgrounds, geographic locations, and other marginalized groups (eg, individuals from low socioeconomic backgrounds, first-generation college graduates, and nontraditional students). We take a broad approach when discussing interprofessional teams and consider teams including medical assistants, nurses, researchers, advanced care practitioners, physicians, Indigenous healers, and more. Diversity is a complex topic that exists on a spectrum of representations. Within the complexity of diversity, we bring a unique position and perspective to this critical reflection as a committee of medical and graduate students, new clinicians, and/or trainee primary care researchers with international representation from Africa (Nigeria), North America (United States and Canada), and Oceania (Australia and New Zealand). As the future of this primary care workforce, this is our call to action for researchers, clinicians, funders, and policy makers alike to truly strengthen the future of primary care and research through an equity-driven lens.

Challenge #1: Insufficient Support and Anti-Diversity, Equity and Inclusion (DEI) Policies for Underrepresented and Marginalized Trainees and Professionals

Capacity development initiatives and intentional funding to support underrepresented and marginalized trainees and professionals is an integral component of ensuring a more diverse, equitable, and inclusive primary care workforce. DEI initiatives vary across international health systems, with some countries offering more support for marginalized and under-represented groups than others. For example, in New Zealand, Indigenous health perspectives and medicines are being recognized and integrated within policy,[3] student recruitment, and research scholarships (Health Research Council of New Zealand).[4]

Alarmingly, in the United States, several new anti-DEI policies and laws have recently been passed and subsequently enacted in many states, specifically targeting university admissions for those of underrepresented communities.[5] These anti-DEI policies aim to eliminate DEI offices at public universities and colleges, restrict diversity training, and curb identity-based preferences in hiring.[6] This not only impacts the primary care workforce, but will also limit the quality of care available for patients from underrepresented backgrounds. In 2025, a US executive order entitled "Ending Radical and Wasteful Government DEI Programs and Preferencing"[7] was signed and outlines a ban on DEI initiatives within the federal government, alongside its implications for private sectors like health care, and exemplifies the United States' growing shift toward anti-DEI policies.[8] This raises significant concerns about the future of NIH grants aimed at fostering diversity, such as the Kirschstein-NRSA Individual Predoctoral Fellowship to Promote Diversity in Health-Related Research (F31-Diversity). These programs, which play a critical role in developing diverse cohorts of trainee scientists and researchers, face potential threats, creating yet another

obstacle for underrepresented individuals pursuing scientific careers in the United States.

The American Association of Medical Colleges defines underrepresented in medicine (URM) as racial and ethnic minorities that are underrepresented in the medical profession in relation to the general population.[10] American medical students who are URM tend to pursue primary care specialties.[9] First-generation medical students are more likely to report wanting to care for underserved populations during their career.[11] Additional considerations are needed for health professionals, such as nurses, who have unique flexibility and can be recruited into family medicine later in their careers. A 2023 commentary highlights the potential impact of anti-DEI policies on nursing education citing that nurses from diverse backgrounds can be crucial in mitigating the health disparities in marginalized communities.[12,13] It is not enough to simply enroll diverse trainees; we must provide additional support to ensure success.

Moreover, trainees need ongoing support to facilitate their decision to enter primary care fields. Efforts supporting diverse trainees and career choices in primary care must be a part of the ongoing process of expanding primary care.

Furthermore, in the United States, international medical graduates (IMGs), whether born in the United States or abroad, are more likely to pursue primary care specialties and practice in underserved areas.[14,15] This trend extends beyond the US to other countries as well. For instance, in the United Kingdom, IMGs comprise 41% of the physician workforce.[16] More than 52% of Australia's General Practitioners were IMGs in 2021.[17] Thus, as long as they are recruited ethically, IMGs are essential in meeting the demand for primary care in many countries. Ethical recruitment ensures that IMGs do not drain resources from countries with fewer resources, maintaining a balance that benefits both the graduates and the health care systems in need.[18,19] Despite their contributions, however, IMGs face significant challenges, including visa restrictions, social isolation, and professional bias, with little institutional support to ease their transition. Many also encounter unique social, psychological, and geographical obstacles that hinder their integration into new health care systems.[20] Addressing these barriers is essential for sustaining a diverse and resilient primary care workforce, ensuring that IMGs can continue to provide high-quality care to the communities that need it most.

Beyond training, professionals from diverse backgrounds have a powerful impact on patient care, such as impacting social determinants, mental health, cultural, and spiritual needs. By addressing these complex needs, professionals from diverse backgrounds can substantially improve overall health outcomes[20,21] for our most vulnerable populations.[22] It is these professionals, however, who may be most at risk for experiencing burnout.[23] We must continue to both support and build the capacity of our professionals already in practice who come from diverse backgrounds. Doing so elevates patient access, satisfaction, and care quality but also mitigates burnout and disperses workload across providers and administrative staff.[24-26]

Challenge #2: Inadequate Integration and Governance of Diverse Primary Care Professionals

To support a culture of inclusion, we must expand the concept of what it means to be a member of the primary care workforce. This begins with recognizing the crucial roles played by biomedical and allied health professionals such as primary care researchers, behavioral health specialists, community health workers, pharmacists, dieticians, health coaches, and dentists. Further, incorporating cultural practices such as traditional healers in Indigenous communities ensures that health care services can be impactful for a diverse array of cultural contexts.[27,28] These roles are crucial in addressing the complex needs of patients and communities, offering specialized knowledge and skills that complement biomedical care.

While a diverse range of roles are needed in quality holistic care, the voices of other primary care professionals, beyond that of physicians, have been underrepresented in primary care and research. The exclusion of non-physician voices is a missed opportunity that creates disparities in the power structure of primary care and primary care research. Physician-centric governance structures in primary care run the risk of being unable to leverage the diverse perspectives, ideas, and skill sets of the entire health care team. To support a diverse primary care workforce, it is crucial to recognize, integrate, and uplift non-physician roles into more inclusive governance structures, including opportunities for roles in decision-making processes and leadership. These inclusive governance structures can lead to more impactful and comprehensive primary care delivery by leveraging a diversity of expertise.[29]

When discussing strategies for promoting workforce inclusion, we recommend considering the values and principles of participatory health research (PHR), which at its core, comes from a rich tapestry of social movements striving for inclusivity.[30] Participatory health research can build initiatives to amplify underrepresented voices in primary care and capacity-building initiatives to encourage interprofessional collaboration. In primary care, those with a vested stake would and often should include a wide range of professionals and also patients at its core. A large pan-Canadian study[31] underscored the need to further develop and scale team-based primary care. As with any PHR partnership, however, we must consider power sharing and trust if we are to ensure effective team collaboration. As such, while promoting interprofessional teams in primary care should be a priority, capacity development especially in regard to power sharing and trust is instrumental for inclusion and ultimately, successful team-based care.

Expanding the definition of "primary care team" to include interprofessional professionals is best practice across international borders, especially in the ever-evolving needs of

patients and the changing health climate. In Africa, physicians are rarely found in primary care outside the private sector.[32] Furthermore, in Malawi, a predominantly rural country in Africa, there are only 284 doctors in the public sector serving a population of 17 million.[32] To meet the demand for family physicians, countries such as Ghana, Botswana, Uganda, Kenya, and Nigeria have established training programs, while Ethiopia and Malawi have recently implemented theirs.[32,33] This further highlights that primary care training programs need to be accessible while also embodying a global health care commitment to DEI principles.

Conclusion

As trainees entering careers in the primary care sector, we underscore the strong need for educators, policy makers, researchers, and health care organizations to support strategies for promoting workforce inclusion and to advocate against anti-DEI initiatives. The path to inclusivity begins with small, measurable steps, but together, these efforts have the power to transform the face of primary care and primary care research. We must intensify our commitment to DEI practices to address and mitigate the impending shortage of the primary care workforce. By doing so, we can strive to reduce clinician burnout, enhance retention among our already limited staff, and ultimately deliver the highest quality of care for our patients. It is time to take a stand against the abandonment of DEI initiatives and advocate for the protection of our diverse trainees, researchers, and ultimately our patients.

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Note: We define trainees as individuals who are actively engaged in the learning process and have not yet completed the entirety of their formal education or training. This includes students and learners at various stages of their academic and professional development, such as students, residents, fellows, postdocs, and more.

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FURTHERING VISION, VOICE, AND LEADERSHIP IN ACADEMIC FAMILY MEDICINE THROUGH THE LEADS AND BRC FELLOWSHIPS

Apply Today!

The mission of Association of Departments of Family Medicine (ADFM) is to support academic departments of family medicine to lead and achieve their full potential in care, education, scholarship, and advocacy to promote health and health equity. One critical element of this is supporting current leaders and growing future ones, particularly as we recognize "academic family medicine faces an impending leadership crisis, embodied by a deficit of available applicants for vacant chair positions nationwide."[1]

ADFM continues to look for ways to embolden future leaders in family medicine,[2] and to that end we take this opportunity to remind the community about the 2 fellowships we offer that are focused on cultivating skills for emerging leaders in academic family medicine and across health systems. Below, we also share details and outcomes of these programs.

We invite those who hear the call to leadership to consider these and other opportunities appropriate for their own career stage; STFM maintains **a running list** on behalf of the community of academic family medicine.

LEADS (Leadership Education for Academic Development and Success) Fellowship

The LEADS Fellowship grew out of the need for a robust and diverse leadership pipeline to meet the growing needs of academic departments of family medicine for both senior leaders and department chairs.[3-5] The program is designed for mid- to late-career family medicine leaders interested in pathways to leadership in academic or other health systems, including department chair, or who want to further explore if these roles would be a good career fit.

The 1-year fellowship curriculum is cohort responsive and structured around the **Leadership Competencies for Family Medicine Department Chairs and Senior Leaders**, developed by ADFM's Leader Development Committee.[3] Fellows participate in weekly virtual sessions focused on strategic career planning and a range of leadership topics, along with the opportunity to learn from their peers and faculty mentors through the program. The connections fellows make with their peers remains an important component of the fellowship. Each fellow selects a project to focus on throughout their fellowship year, culminating in an "Ignite Talk"-style