Committee on Education & Workforce Full Committee Hearing

"Training Activists, Not Physicians: The Impact of DEI on Medical Schools"

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Introduction

To Chairman Walberg, Ranking Member Scott, and the members of the Committee on Education and Workforce in the 119th Congress of the United States of America. I bid you greetings on behalf of the National Medical Association. It is my great honor and duty to appear before this body as the 126th President of the National Medical Association. The NMA was established in 1895 in a time when majority institutions would not allow African Americans privileges and access to "white-only" hospitals. We are the oldest and largest group of physicians dedicated to ensuring access and parity for the care of patients who are the most disenfranchised and disinherited—regardless of race, creed, religion or gender. We are an organization, today and yesterday, dedicated to addressing the plight of Black physicians and their patients. Our membership includes the likes of Dr Daniel Hale Williams, one of our founders, who performed the first open heart surgery on the pericardium, Dr Charles Drew who established the science and technology of the blood transfusion leading to thousands of lives saved during WWII...and millions of lives saved since including today, Dr W Montague Cobb who led the efforts on Medicare and hospital integration in 1965 signed by LBJ, Dr Patricia Bath who invented the probe that serves as the basis of laser cataract surgery restoring sight for millions...or Dr Vivian Pinn....the founding Director for National Institute of Health, Office of Research on Women's Health and the 88th President of the National Medical Association.

Excellence stands as the legacy of medical diversity, equity, and inclusion for this nation.

There is an incredibly destructive narrative being espoused that somehow programs intended to improve the diversity of the physician workforce are harmful. Some have even insisted that just because a physician is Black or a woman, somehow, we are less than—less capable. In fact, diversity leads to improved patient safety and better health outcomes, especially when the patient and the physician share similar racial and cultural backgrounds.

The United States needs a physician workforce that is both scientifically excellent and prepared to care for an increasingly diverse population. Diversity and inclusion in medicine should be understood as a workforce, educational, and patient-care quality strategy. It is not a claim that race should replace merit, that standards should somehow be lowered, or that patients should receive a different quality of care based upon identity. The medical education framework must begin with rigorous biomedical preparation and then add the competencies needed to understand the patient's lived context, recognize bias, work across differences, and serve communities that have historically had less access to high-quality care.

This testimony supports three linked propositions. First, diversity and inclusion in admissions can expand the pool of qualified future physicians by recognizing excellence across academic achievement, service, leadership, resilience, language capacity, lived experience, and mission fit. Second, diversity in medical education benefits all students by improving preparedness to care for patients whose social, cultural, geographic, and economic contexts shape health. Third, diversity in the physician workforce is associated with improved patient access, equity of care, quality of care for historically marginalized and rural communities.

Importance of Diversity and Inclusion for Medical Admissions

Admissions to medical school are the primary entryway into the physician workforce. The medical school admissions strategy in the US must be framed around selecting qualified applicants who can satisfy rigorous academic and clinical standards as well as contribute to public health need of the nation. Medical schools are not simply selecting high test performers; they are selecting future clinicians, scientists, educators, advocates, and leaders who must care for patients across a myriad of settings. The question is not whether academic metrics matter,

because they absolutely do. The question is whether academic metrics alone capture all the attributes needed to become an excellent physician in this day and time.

Inclusion in medical school admissions does not require the elimination of high standards; it improves them. It requires transparent thresholds for academic readiness, structured rubrics, trained admissions committees, bias mitigation, and continuous review of outcomes, including academic progression, licensing performance, clinical performance, professionalism, specialty choice, and service to underserved communities. It requires an intentionality dedicated to producing a physician workforce that not only represents the nation but also prepares all physicians to serve a diverse one. Evidence from the Black Men in Medicine Action Collaborative underscores the necessity of such structures. The authors note that applicants in the middle third of the MCAT score scale can truly succeed and are more likely to include first-generation college graduates, applicants from rural or medically underserved areas, and applicants from groups underrepresented in medicine (Poll-Hunter et al., 2023; Terregino et al., 2020).

Let's be clear: we do not require abandoning merit; in fact, we suggest that diversity elevates what it means to have merit. A merit-based admissions framework should ask whether applicants can master biomedical science, communicate across differences, work in teams, serve patients with humility and without bias, meet the needs of communities with limited access to care. We want a new physician.

Importance of Diversity in Medical Education

Teaching the impact of cultural diversity on health outcomes in medical education is important for all students, regardless of race. The goal is not to replace anatomy, physiology, pathology, pharmacology, diagnostic reasoning, or procedural skill. The goal is to ensure that biomedical expertise is applied accurately and humanely to patients whose presentations and outcomes are shaped by their culture, language, geography, disability, income, trauma, insurance status, neighborhood context, discrimination, and prior experiences with the health system.

Empirical medical education literature supports this position. The racial and ethnic diversity of a student body in U.S. medical schools is consistent with preparing students to serve a diverse society (Saha et al., 2008). A systematic review found that culturally competent educational interventions improved provider knowledge, attitudes, and skills (Beach et al. 2005). Creating an integrated curriculum of cultural determinants and advanced clinical skills makes certain that diversity education supports improved clinical outcomes rather than symbolic or purely ideological programming (Kelly et al., 2024).

Diversity also improves the learning environment when it is tied to interactional learning. Students who train with peers from different backgrounds encounter different patient stories, clinical questions, ethical issues, and community experiences. This matters for white students as well as for students from underrepresented groups. A diverse classroom and clinical learning environment can reduce overgeneralization, help students identify false assumptions, and strengthen the ability to elicit patient values.

Importance of Workforce Diversity in the Equity of Patient Outcomes

There is a misconception about diversity in the medical workforce. It is not that patients must be racially matched with physicians, or that ONLY same-race physicians can provide high-quality care and equity of outcomes. The evidence shows that a medical workforce that is representative and culturally prepared leads to equity, expands access to care, improves communication, increases trust, broadens patient choice, and can improve outcomes in specific clinical contexts. Workforce diversity is therefore a population-health strategy, not a segregation strategy. It is a construct of patient safety and quality of care, not a radical political indoctrination that harms society.

The literature is consistent on this point and found that Black and Hispanic physicians cared for more underserved patients (Komaromy et al., 1996). In fact, nonwhite physicians provide a disproportionate share of care to minority and non-English-speaking patients (Marrast et al. 2014). This is important because physician workforce shortages and maldistribution do not affect all communities equally. If students from underrepresented backgrounds are more likely to practice in disadvantaged communities, then admissions and pathway strategies that increase physician diversity can improve access to care.

In a randomized experiment in Oakland, researchers assigned Black men to Black or non-Black male physicians. Before consultation, preventive service selection was similar; after meeting their assigned physician, Black men assigned to Black physicians were significantly more likely to select preventive services, particularly invasive services such as diabetes screening. The authors estimated that these effects could reduce the Black-White male gap in cardiovascular mortality by 19 percent (Alsan et al. 2019). This is not evidence that racially matched care should be mandated; it is evidence that a culturally prepared and diverse medical workforce positively affects trust and the uptake of preventive care by willing patients.

Diversity Supports Financial Improvement

The quality improvements that accompany diversity in medical education also have financial implications. The benefits continue when diversity is reflected across healthcare teams, faculty, institutional leadership, and governance. More diverse healthcare teams were generally associated with more accurate clinical decision-making, greater patient satisfaction and adherence, reduced diagnostic and treatment uncertainty, improved communication, and stronger risk assessment (Gomez 2019). Better prevention, adherence, diagnostic accuracy, and patient engagement can reduce avoidable complications, inefficient utilization, and long-term costs, while protecting revenue in value-based and pay-for-performance systems that financially penalize poor quality, preventable readmissions, and persistent disparities. Diversity should be understood as a means of strengthening operational and financial performance.

The financial case summarized by Gomez and Bernet (2019) is particularly compelling. Their umbrella review of 16 large studies and meta-analyses found that most reported positive associations between diversity, quality, and financial performance. The reviewed evidence included companies with above-average management diversity earning 38% more revenue from new products and services; racial and gender diversity being associated with higher sales revenue, larger customer bases, greater market share, and higher profits; board diversity being associated in some studies with improved return on assets and return on investment; and age diversity being associated with greater productivity, employee retention, profits, and projected growth. These benefits are maximized when diversity is meaningful rather than tokenistic and is supported by inclusive leadership and an environment that values differing perspectives. Investment in diversity across medical education, recruitment, retention, and leadership is therefore a practical strategy for improving innovation, workforce stability, quality patient outcomes, and the long-term financial sustainability of healthcare institutions.

Physician Shortage in the United States

Lastly, the United States is facing a serious physician workforce shortage. Instead of investing in efforts to discourage young people of diverse backgrounds from seeking medicine as a career, we should be developing national programming to develop and train the best and brightest to serve the health of our nation. Our ability to produce physicians directly affects the capacity of our nation to respond to disaster, our military readiness, care of our aging population, and our global competitiveness. The Association of American Medical Colleges (AAMC) projects a national shortfall of 13,500 to 86,000 physicians by 2036, including an estimated primary care shortage of 20,200 to 40,400 and a specialty shortage of 10,100 to 35,700. The current annual medical school output - roughly

28,000 to 29,000 MD and DO graduates - is only modestly above the estimated annual physician losses from retirement, burnout, and career attrition. This creates a narrow net gain that is insufficient to meet the health needs of a growing, aging, and increasingly diverse nation.

What is clear is that the nation should increase medical school seats, expand the development of new medical schools, and expand graduate medical education (GME) positions. However, the expansion must center diversity, equity, and inclusion. A larger physician pipeline that fails to reach rural communities and historically marginalized populations will reproduce the same access gaps that define the current crisis. The pathway must include a culturally inclusive student population, first-generation students, lower-income students, and students committed to underserved practice if it is going to be effective. A physician workforce expansion strategy that incorporates diversity is central to the physician workforce policy. Building the strongest physician workforce requires identifying talent wherever it exists and preparing physicians to care for every American community.

The National Medical Association recommends the development of a National Medical Education Capacity Plan that adds seats and schools while intentionally broadening the applicant pool through legally compliant inclusive admissions, pathway programs, mission-driven recruitment, affordable tuition models, community-based training, and new residency positions—aligned with primary care, psychiatry, general surgery, obstetrics and gynecology, geriatrics, and other high-need specialties.

Many communities, especially in rural America, have fewer physicians per capita, longer travel times, fewer specialists, less access to cultural and linguistically concordant care, and lower trust in health systems. A medical education system that expands seats but does not diversify the physician workforce may increase the total number of physicians while leaving the most vulnerable rural communities behind.

The National Academies' Institute of Medicine concluded that increasing racial and ethnic diversity among health professionals is associated with improved access to care for racial and ethnic minority patients, greater patient choice and satisfaction, better patient-provider communication, and better educational experiences for all students (Institute of Medicine, 2004). This is directly relevant to seat expansion. Diversity is not a separate objective competing with excellence; it is one of the mechanisms through which a larger physician workforce becomes more effective, better distributed, and more trusted.

Conclusion

The United States cannot meet the health needs of its citizens with a narrow, uneven, or culturally disconnected physician workforce. Diversity, Equity, and Inclusion are essential not only to the stability of the physician workforce but also to meeting the future needs of medicine. What is clear is that excellence in medicine begins with rigorous biomedical preparation, but it does not end there. Medical schools must prepare physicians who can master science, develop innovative treatment, communicate across differences, recognize the social realities that shape health, and serve communities where access to care has been historically limited. A stable medical education system is one that protects standards while broadening opportunity, expands the physician pathway while addressing maldistribution, and trains every student to care for the full diversity of the American people.

We are in a generation where the physician's ability to understand and incorporate Artificial Intelligence and scientific innovation into patient care will be paramount. Understanding and incorporating the lived social experience and the cultural expression of the patient is no less important for that physician. Medicine advances when teams ask better questions, challenge assumptions, examine evidence from multiple perspectives, and understand how biology, environment, lived experience, structural conditions, and health systems interact. Diversity does not dilute merit; it strengthens merit by insisting that the physician of the future be judged not only by scores

but by competence, judgment, service, leadership, integrity, and the ability to translate knowledge into the healing of people. All people.

Most importantly, diversity, equity, and inclusion in medicine is about building a patient safety and quality healthcare system that works for all Americans; especially among those who have been the most disinherited and disenfranchised in our society. The evidence summarized in this testimony shows that a representative and culturally prepared physician workforce can improve access, communication, trust, preventive-service uptake, and patient outcomes. Diversity in medical school admissions, as content in medical education, and as a component of patient care improves patient-safety, care quality, enhances the physician workforce, and improves financial outcomes. If the goal of American medicine is to deliver excellent care to every patient, every family, and every community, then diversity must remain a foundation of medical education and a driver of the nation's healthcare future.

Thank you.

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At-A-Glance Summary Tool

Section	Core Argument	Key Evidence / Rationale	Merit & Excellence Frame	Bottom-Line Message
Diversity in Medical Admissions	Admissions are the gateway to the physician workforce. Medical schools should select qualified applicants who meet rigorous standards and bring experiences, commitments, and competencies aligned with public health needs.	Metrics matter, but they do not capture every physician competency. Structured holistic review can assess academic readiness, clinical potential, service orientation, teamwork, communication, and likelihood of serving underserved communities. Applicants in the middle MCAT range can succeed and often include first-generation, rural, underserved, and underrepresented applicants (Poll-Hunter et al., 2023; Terregino et al., 2020).	Diversity does not replace merit; it expands merit to include the competencies needed to practice medicine in a diverse nation: biomedical mastery, professionalism, humility, communication, bias awareness, and service.	Maintain rigorous standards while using transparent, mission-aligned review. Evaluate who is ready to succeed, prepared to serve, and able to help build the workforce the nation needs.
Diversity in Medical Education	Diversity benefits all learners by preparing students to apply biomedical science accurately and humanely to patients shaped by language, geography, disability, income, trauma, trust, insurance, and prior health-system experiences.	Student-body diversity is associated with diversity-related educational outcomes (Saha et al., 2008). Cultural competence interventions improve provider knowledge, attitudes, and skills (Beach et al., 2005). Curricula on cultural determinants of health and disparities support clinical preparation (Kelly et al., 2024).	Excellent medical education produces physicians who can diagnose, communicate, and lead across differences. Diverse learning environments strengthen clinical reasoning by exposing students to varied patient stories, assumptions, ethical questions, and community realities.	Diversity education should be skills-based, clinically grounded, and tied to excellence, not symbolic programming. It helps every student become a better physician.
Diversity in Patient Outcomes	Workforce diversity is a population-health, quality, access, and trust strategy. It does not require racial matching; it means a representative and culturally prepared workforce can improve communication, trust, care uptake, and patient choice.	Black, Hispanic, and nonwhite physicians provide a disproportionate share of care for underserved, minority, and non-English-speaking patients (Komaromy et al., 1996; Marrast et al., 2014). In Oakland, Black men assigned to Black physicians selected more preventive services after consultation, with an estimated potential to reduce the Black-White male cardiovascular mortality gap by 19 percent (Alsan et al., 2019).	Excellence is measured not only by knowledge but by whether patients receive, trust, and act on high-quality care. A diverse, culturally prepared workforce helps convert biomedical expertise into prevention, diagnosis, treatment, and survival.	Admissions, pathway, and workforce policies that increase physician diversity can improve access and outcomes, especially where shortages and medical mistrust are greatest.

Evidence cited in table: Alsan et al. (2019); Beach et al. (2005); Kelly et al. (2024); Komaromy et al. (1996); Marrast et al. (2014); Poll-Hunter et al. (2023); Saha et al. (2008); Terregino et al. (2020).

Physician Shortage Cross Walk

Shortage Finding	Workforce Meaning	Policy Implication
13,500 to 86,000 projected physician shortfall by 2036	The current training pipeline is not sufficient to meet future demand.	Increase medical school capacity and GME capacity together.
20,200 to 40,400 projected primary care shortage	The front door of the health system is at risk, especially in underserved areas.	Prioritize primary care training, community-based education, and loan/debt relief.
10,100 to 35,700 projected specialty shortage	Patients will face delays in surgical, psychiatric, obstetric, and specialty care.	Align new seats and residencies with high-need specialties.
Roughly 28,000 to 29,000 annual MD/DO graduates in the attached analysis	The annual replacement pipeline is narrow relative to retirement and attrition.	Expand seats while protecting quality and clinical training capacity.
Balanced Budget Act-era GME caps remain a bottleneck	Medical graduates cannot practice independently without residency training.	Increase Medicare-supported and state-supported residency slots.

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