Do No Harm

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I'd like to thank Chairman Owens and Ranking Member Wilson for the invitation and the opportunity to speak with you about the crisis that's unfolding in American medicine and, in fact, in American life in general.

My interest in the impact of the so-called Diversity, Equity, and Inclusion regimens, or DEI, began about eight years ago when I realized that my medical school, the Perelman School of Medicine at the University of Pennsylvania, had embarked on a new direction driven by its new senior leadership. I was serving as the Associate Dean for Curriculum at that time. The new plan was aimed at drastically altering the medical education program at Penn.

What had been a traditional approach focused on clinical science and aimed at developing medical leaders was being readied for transformation into a far greater emphasis on community involvement and concern for social issues. The rationale for this was the hypothesis that the root cause of disparate health care outcomes between minority, particularly black, and majority communities was the result of bias on the part of physicians and health care institutions. Only through a dramatic reimagining of the practice of medicine, the hypothesis continued, could these disparities be eliminated.

In many professional fields, academics is divorced from the world of practice and has little influence on the community of practitioners. Medicine is quite different. The goings-on in law schools have traditionally had little to do with the actual practice of law and have had minimal influence on it. The same is true in many fields of endeavor. But the academic health center is the driving force in local health care and has great influence across the nation. American academic medical centers have been the engines of advances in the treatment and cure of diseases. What happens in academic medical centers doesn't stay there but diffuses out into the larger community.

As it turns out, the expanded focus on social issues in medical care was well established in other medical schools and our school was rather late to the game. We did have courses that discussed some aspects of West Philadelphia, a very

heterogeneous community with large and varied immigrant populations, but this was felt to be insufficient. The new vice dean of the med school told me that there was "too much science in the curriculum."

My concerns about the new initiative to modify Penn's curriculum led me to speak out on this issue. So did my growing awareness of the fact that medical schools around the country were much further along in adopting an approach that seemed to echo the curricula of schools of social work. I felt that medical school curricula should maintain a strong focus on medical science, should increase its rigor, and should concern itself with turning out the highest quality physicians who would care for those suffering from illness. I also felt that while social factors are important in defining the quality of life in communities, physicians had no agency to influence such issues as poor housing or community violence. It seemed that the purpose of raising these issues was to create advocates for political solutions to these problems rather than educating physicians to improve health care outcomes.

In 2019, I wrote an op-ed in the Wall Street Journal about my sense that medical education was heading down a path that would weaken American health care. The Wall Street Journal decided to entitle that article, *Take Two Aspirin and Call Me by My Pronouns*.[i] This elicited a rather strong reaction on Med Twitter and really began my new career as an activist.

This background explains why I am here today speaking with you about this issue. Four years have now passed and increasingly, the impact of DEI programs that focus on identity politics in the recruitment of medical practitioners and on the manner patients are to be treated has become increasingly evident. Recently, Wesley Yang, one of the editors of Esquire magazine posted my article from 2019 on Twitter and commented, "Shouldn't we have listened to him then?" It is tough being Cassandra, the mythic Greek figure who could predict the future but no one would listen.

So what is happening to American health care in the DEI era? We've begun to see the impact of identity politics, a phrase that I feel describes the underlying principles of DEI. Yascha Mounk has written a new book entitled *The Identity Trap*.[ii] He, a self-described Liberal and a professor of political science at Johns Hopkins, decries the impact of identity politics on American life. I quote from his book: "The identity trap poses serious dangers. It undermines important values like free

speech. Its misguided applications have proven deeply counterproductive in areas from education to medicine. If implemented at scale, it won't provide the foundation for a fair and tolerant society; it will inspire a zero-sum competition between mutually hostile identity groups."

His concern, which I share, is that this political and philosophical theory, known as Critical Race Theory, paints a hostile and irredeemable society based on oppressors and oppressed, and will lead to division and conflict. It will poison the American experience.

I think we can discuss this issue from two perspectives: the impact of identity politics on the practice of medicine and the impact of identity politics on who can practice medicine.

Health care disparities between minority and majority populations are real and of legitimate concern. But attributing them in large part to the black community's oppression by white males and the health care system in general is without real proof and without merit. As Mounk points out in his book, once group identity Is viewed in the formulation of either being oppressed or an oppressor, a fixed set of responses ensues. Oppression is unending and can only be overcome through conscious and illiberal actions. Accepting this formulation requires, in the words of Ibram Kendi, a discriminatory regimen. To quote him, "past discrimination can only be remedied by present discrimination. Present discrimination can only be remedied by future discrimination."

During the COVID pandemic we received a taste of how this all could play out. When monoclonal antibodies were a potential lifesaving treatment for severe cases, two states, California and New York, created guideline algorithms that gave points toward justification for the use of the drugs in particular cases based on race. The use of the scarce drugs would be determined in part based on skin color rather than purely on medical need[iii]. This violates the Hippocratic oath but is in concordance with Critical Race Theory.

In a second instance, The Centers for Disease Control, the CDC, recommended to states to give essential workers access to the mRNA vaccine even ahead of the elderly on the grounds that older Americans are disproportionately white.[iv]

Amazingly, some of the most prominent medical institutions such as the American Public Health Association, the American College of Physicians, and the American Medical Association supported this approach with amicus briefs when it was challenged in the courts.[v]

These two examples show how simply enacting the principles of Critical Race Theory can have a profound impact on the lives of individual Americans. But at least in these cases, there was no attempt to hide the rationale behind the actions. There was complete acceptance of racialism. What's more concerning has been the misuse of medical studies to justify unequal treatment on the grounds that it will improve health care for minority groups.

Let me describe two examples. Physicians at a major Harvard teaching hospital published a study[vi] claiming that there had been discriminatory practices in the emergency room in the treatment of patients who entered with a diagnosis of congestive heart failure. Approximately 57% of white patients who entered with that diagnosis were referred to a cardiology specialty service in the hospital for cardiac care. Approximately 45% of black patients with the same diagnosis were referred to the specialty unit. The alternative unit for admission was a General Medical unit. This discrepancy was presented as proof of racism and led them to propose a new paradigm for care. Black patients would be asked which unit in the hospital they wished to be admitted to.

As it turns out, and as is often the case when comparing two populations of patients, the individual characteristics of the patients govern treatment protocols rather than their skin color. In this instance, the black patients suffered disproportionately from chronic kidney disease and were being treated with renal replacement therapy using hemodialysis. Such patients are better treated on the General Medical unit where hemodialysis treatments are effective in controlling heart failure and are more easily arranged. White patients disproportionately had their heart failure on the basis of intrinsic cardiac disease which required special procedures only available in the cardiac unit.

The researchers ignored the role of these patient characteristics in the admission decision and instead blamed it on physician bias. They accepted the oppressor/oppressed binary of Critical Race Theory that critical thinking was out of the question.

Rather than focusing on the individual patient characteristics, their new paradigm was to focus on skin color, even though this could possibly lead to worse care because of admission to the wrong unit in the hospital. Ultimately, this approach was not enacted but currently the electronic medical record prompts any admitting physician to consider the past discriminatory practices which were, in fact, not discriminatory.

A second example comes in the recent enthusiasm for the concept of patient/physician racial concordance. Organizations such as the Association of American Medical Colleges have written that disparities black patients experience in health outcomes can only be remedied by having a black physician. They typically cite one or two studies that they claim show such a benefit, again misinforming other practitioners and the public.[vii]

Careful study of the medical literature of this issue reveals a very different picture. Our organization, Do No Harm, about which I will speak shortly, has examined this issue in a comprehensive study by our director of research Ian Kingsbury and Jay Greene of the Heritage Foundation.[viii] They have found that the sum of the medical literature does not support the claim that health outcomes improve if black patients have black physicians. Organizations that claim this to be true are simply ignoring facts in favor of an unproven theory.

Critical Race Theory will do that to you; it will demand ignoring facts to support the oppressor/oppressed dyad. For example, there are 42 studies of whether black patients and black doctors communicate better than when the dyad consists of a white physician and a black patient. Six studies show more satisfaction with communication by black patients. However, eight studies show worse communication when black patients had a black doctor. Twenty-six studies showed no difference when the physician was white or black and the patient was black.[ix] Yet, DEI bureaucrats claim that more black physicians are required in order to improve health outcomes. The divisiveness that Yasha Mounk described in his book *The Identity Trap* is on display here. Do we want white patients entering health care institutions and demanding that they only see white physicians? I witnessed bigoted patients making such demands during my days as a clinician. When patients made such demands at our hospital, we told them to seek another hospital.

Another consequence of this model is the conclusion that black patients don't seek the best medical care and are more interested in the race of their health care providers. How demeaning to black patients!

This concept of racial essentialism as a guiding force in American life will only lead to more conflict because individual characteristics become sacrificed for group identity. Mounk calls this idea an identity trap – a trap because it seems attractive on the surface – but once entered, becomes difficult, if not impossible, to escape.

There are many other examples of how the medical literature is being distorted in the service of Critical Race Theory and its demands that so-called anti-racism be practiced to improve health care outcomes. In reality, the solution to health care disparities is not ineffective or counterproductive implicit bias training for physicians, but rather it is better health access for patients. Minority communities do not need different health care, they need more health care.

The second area where Critical Race Theory and its implementation through DEI and identity politics will have a profound influence on health care is through the admission process into medical school and the promotion process for faculty. We have been told the rationale for seeking a medical school class whose components perfectly reflect the racial distribution of America is better health care outcomes. We have been told by the AMA,[x] by the American College of Physicians,[xi] and by the Association of American Medical Colleges[xii] that diversity improves health care outcomes. They say this but they have no data to support this idea. Is diversity the most important factor in recruitment and hiring for pilots? What about in neurosurgeons? There are certain societal roles where merit and only merit should be the only basis for entry.

In most debates about school admissions, the discussion centers about the interests of the school and the interests of the student. In certain critical professions, however, a third entity must be part of the discussion. In health care it is the patient. When considering entry into medical school, the individual patient's interest must be a primary concern. Unfortunately, identity politics declares that the students' race must be an important determinant. While it is true that the recent Supreme Court decision in the case of *Students for Fair Admissions v. Harvard* seems to have eliminated so-called affirmative action as a basis for admission to university, many medical schools have announced their intention to

ignore this principle and to produce workarounds to allow continued efforts to increase racial diversity.

Part of the justification for this brand of affirmative action is that if students can pass minimal competency exams, like licensure exams, then they are qualified to be physicians. Therefore, seeking out the best and the brightest who have been particularly successful in their academic pursuits is really not necessary to produce adequate health care. But this is not what patients expect. No matter what their racial background is, patients expect and should receive the highest possible quality of care.

Academic achievement by physicians is an ingredient in creating a highly effective physician workforce. I have maintained that medicine is a highly academic pursuit. I point out to students that the way we test their knowledge is through multiple choice questions on exams. In this model, there is a stem, a short statement about a particular patient or a particular medical condition, and then a series of five distractors or possible explanations as to the origin of the clinical problem. Their job is to pick out the right answer. And I tell them that when they enter the clinics and begin to see patients, they will be constructing the multiple-choice question. They will gather the information required for the stem or description of the problem. They will then produce four or five alternative possibilities to explain the problem and pick the right one to properly care for the patient.

This is an academic process. This requires maintaining much information about illness and about the variability of human response to it and it requires judgment that is abetted by a strong understanding of the basic principles underlying the clinical problems that they encounter. This activity requires a nimble mind and the commitment to learn a vast amount of information to deal with patient problems in real time while in the presence of the patient. There is no time to retire to the library to learn about the patient's problem.

How has the health care system and academic medicine responded to this challenge? They have decided that it is more important to pick students based on racial characteristics and it is more important to have a racially diverse corps caring for patients in various medical specialties than it is for identifying the most capable individuals to take on those roles. To achieve this diverse system, there has been a growing movement to eliminate traditional academic qualifications for entry

into medical school and for selection to the most competitive postgraduate training programs. The MCAT, the achievement test for medical school entry, now includes more social science and less hard science. The Council of Deans of Medical Schools has now decreed that grades will no longer be reported for the licensure exam that has been used as an achievement test to determine merit and likelihood for success in some of the most challenging medical specialties. This minimal competency exam is now "pass/fail." They expressly state that the reason for this rule is to increase the numbers of minority applicants who succeed in gaining places in the most competitive education programs.

This down-grading of academic performance and reliance on so-called holistic measures to determine admission to medical school is already leading to evidence of decreased performance in the clinical arena. There are now two large studies that show that minority residents perform less well. In a survey of three institutions' internal medicine residency programs and in a nationwide study of emergency medicine trainees, minority trainees as a group perform less well in multiple assessment domains including professionalism, medical knowledge, and preparation for practice.[xiii] [xiv] This is not to say that there aren't very high performing, high quality minority individuals who were entering these fields. But rather it says that the education programs and medical schools, in some instances, have sacrificed merit in the name of identity politics. There are 22,000 medical students entering medical school each year. There are almost 44,000 applicants for positions in medical school each year. This is a zero-sum game. If a qualified applicant is not admitted in favor of an unqualified or lesser qualified one, that qualified individual may never have the opportunity to become a physician. It is not like undergraduate years where individuals have a multitude of options for their education.

In 2022, the Association of American Medical Colleges compiled a report on its Diversity, Inclusion, Culture, and Equity Inventory, a list of 89 DEI policies it wants to see implemented at medical schools.[xv] Through freedom of information requests, my organization found that most have implemented at least 81% of these demands, and many are close to 100%. For example, some schools engage in the practice of having faculty and staff sign "diversity statements" with the goal of identifying anyone who opposes DEI. To see where that leads, look at Washington University's medical school, where a lecturer threatened students not to debate her on Critical Race Theory.[xvi] This is the essence of compelled speech.

The drive for diversity in medical school classes has led to a concomitant decline in the rigor of medical education. I believe these two issues are linked and mutually supporting. Fifty years ago, the attrition rate of medical students averaged 9% nationally, although it was as high as 14% in some schools.[xvii] Today, the attrition rate in medical education is 3%[xviii]. This reflects an unwillingness to remove all but the most egregious examples of academic failure from medical school classes.

Grading in the preclinical years of medical school is now almost universally pass/fail. At Harvard, in a recent graduating class, 92% of the students received an honors grade for their clinical work. When this occurs, there is essentially no such a thing as "honors" and no real grades. The fault for this set of circumstances lies with both the faculty and the students. Faculty feel compelled to guarantee that students can pass the curriculum and graduate. Faculty performance is graded by students who tend to downgrade faculty members who demand extreme rigor in classwork.

So too has the recruitment and promotion of faculty been diminished by DEI. Many medical schools now actively declare that they specifically seek to hire black faculty. If they can identify highly qualified faculty that happen to be black, that is one thing. But if they choose faculty on the basis of race, that is no different than denying an opportunity on the basis of race.

The DEI regimen also demands that faculty seeking promotion be able to demonstrate not only that they support Diversity, Equity, and Inclusion but that they have actively worked to promote this divisive idea. This is an example of compelled speech at institutions that purportedly honor Freedom of Speech principles.

The idea that research faculty should also adhere to DEI principles and that the recruitment of such faculty should be closely overseen by representatives of the DEI offices of medical schools is particularly absurd. The privilege of performing research, particularly laboratory research, is reserved for those with both the drive and the intellectual capacity to be creative and to make important contributions to the health of the American people. There is no rationale for injecting a diversity requirement in recruiting individuals or promoting individuals who are scientists. The NIH has recently downgraded the role of faculty expertise or institutional resources in determining who will receive the highly competitive individual

research grants.[xix] Sacrificing merit on the altar of diversity can only lead to a less meritorious scientific enterprise.

Lastly, I would like to slightly divert this discussion to confront the most recent manifestations of DEI in the outpouring of antisemitic vitriol in America. The health care system, unfortunately, is well represented in those tearing down posters of kidnapped children and those equating the slaughter and rape of women, children, and the elderly by Hamas terrorists with Israel's legitimate efforts at eliminating a barbarous enemy.

Medical organizations like White Coats for Black Lives have expressed support[xx] for the atrocities that Hamas is so eager to publicize.[xxi]

There is a clear nexus between identity politics, Diversity, Equity, and Inclusion programs, and anti-Semitism. In each case, traditional Judeo-Christian ideas about morality have been replaced by the tenets of Critical Race Theory.

Simply judging Israel as the oppressor eliminates all responsibility for even the most barbarous actions by the "oppressed" Palestinians. In this way, the vile declarations by physicians on social media who praise Hamas terrorism are substituting Critical Race Theory for traditional morality and reliance on facts to make moral judgments. Thus, the actual independence of Gaza after Israeli withdrawal in 2005 is called "occupation." The movement of over 17,000 Gaza residents each day into Israel for employment on Oct 6 is called an "open air prison." The killing of young women, children, and the elderly is justified as they are part of the oppressor class. The values passed down to western civilization through the Decalogue are now replaced by Critical Race Theory as our moral compass.

I would like to conclude this rather morose view of the effect of DEI on the world of medicine by highlighting some hopeful signs. In April 2022 we founded Do No Harm,[xxii] a non-profit organization devoted to combatting Critical Race Theory corruption of health care. It is a membership organization and now numbers over 7000 health care workers and concerned citizens as its members and has members in 14 countries.

We have worked to inform the public about this danger through more than 4,900 mentions in print and online media, 25 op eds and editorials in the Wall Street Journal, the Washington Post, and other top outlets, and over 50 appearances on

television. We have strived to contain the DEI regimen through legal and legislative efforts around the nation. We have initiated seven lawsuits against defendants like the Medicare system, Pfizer, the journal *Health Affairs*, the State of Arkansas Medical Board, and the State of California. In conjunction with our senior fellow Mark Perry, we have initiated hundreds of letters with the Office for Civil Rights in the Department of Education protesting discriminatory fellowships and scholarships in a variety of public and private institutions, many of which bar white and Asian applicants. We recently blew the whistle on UCLA's medical school for holding "racial caucuses" in a mandatory course.[xxiii] And finally, we have worked with leading national law firms to generate model legislation to combat DEI activities in a variety of public institutions that depend on state support.

Over and over again, we have found support in physicians and students in many medical schools and academic medical centers. They understand the danger that DEI poses to the American health care system. They object to the divisiveness and the discriminatory practices that the DEI regime promotes.

Some important commentators have begun to express hope that the "woke mind virus," in the terminology of Elon Musk, is beginning to face serious questioning. The recent American descent into anti-Semitism has been directly tied to the identity politics at the heart of DEI. When we stop seeing people as individuals and relegate them to group identity, bigotry and hate are the next stage of social evolution. The public is starting to notice this consequence – and that spells hope for the re-emergence of the American idea of individual value and individual responsibility.

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