Do No Harm

Testimony of Kurt Miceli, MD

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Chairman Owens, Ranking Member Wilson, and members of the Subcommittee on Higher Education and Workforce Development, thank you for the invitation and opportunity to speak with you about the cultural crisis that persists in American medicine due to the harmful effects of DEI.

My name is Kurt Miceli. I am the medical director for Do No Harm, a membership organization that seeks to protect medicine from identity politics. For more than a decade I have also taught at the collegiate level as an adjunct professor. I come before you on behalf of Do No Harm, not my university affiliations.

America is a diverse and exceptional nation, founded on the fundamental values of individual liberty, equality, and opportunity. It has long stood as a beacon of hope and a welcoming home for people from all walks of life. As a first-generation American and native New Yorker, I grew up near the Statue of Liberty, which served as a constant reminder of hope and freedom, instilling in me a deep appreciation for this country's promise and vast opportunities. Each day, we strive, as a people, to fulfill that promise of a more perfect union, embracing the richness of our differences while upholding the principles that unite us through our hard work, dedication, and perseverance.

Unfortunately, the principles that have long made America exceptional are being undermined by the way diversity, equity, and inclusion (DEI) is practiced today. What was meant to foster mutual respect and celebrate differences has instead become a system that divides us by identity and completely disregards both our individuality and commonality as Americans. It values group identity over merit and views the world through the lens of conflict between oppressors and the oppressed. Rather than encouraging open dialogue and recognizing individual achievement, it uses discrimination in the name of equity and fosters exclusion in the name of inclusivity, silencing viewpoints that challenge its prevailing narrative. It is far from American and is wreaking havoc throughout medicine – the last place we need DEI driving us towards mediocrity.

Prior to joining Do No Harm, I spent two decades working as a physician and executive. I am board certified in psychiatry and internal medicine, and have worked in mental health crisis centers, drug and alcohol rehabilitation programs, and adolescent residential treatment facilities. I was most honored to work for a short period of time at West Point as a civilian psychiatrist serving soldiers in the Warrior Transition Unit. Most recently, I spent the past nine plus years in human services, working as a physician executive supporting individuals with intellectual and developmental disabilities as well as those with severe and persistent mental illness.

Within the past few years I witnessed firsthand how DEI, in practice, undermined collaboration and professionalism. A behavioral health treatment team fell into disarray when a clinical disagreement between the psychiatrist and psychologist escalated into accusations of microaggressions. As someone who had hired both professionals and had full confidence in their abilities, mediating the conflict was one of the most disheartening experiences of my career. Identity politics overshadowed the true purpose of their work. Instead of fostering rigorous discussion to ensure the best possible care for the patient – where differing perspectives can lead to stronger treatment decisions – disagreement was met with race-based allegations rather than constructive dialogue. Unfortunately, a Human Resources department beholden to DEI, and overly cautious of discrimination claims, only fueled the situation, prioritizing identity politics over proper resolution.

That was, unfortunately, only the tip of the iceberg when it came to DEI's influence. There were broader implications where quality continued to take a backseat, particularly as it related to payors. I recall, for instance, submitting a program description to a Medicaid managed care payor as they routinely requested. I expected a review focused on the quality of care provided. Instead, the feedback centered solely on our replacing "he" and "she" with "they/them/theirs." Later, I encountered another payor's language guide, where terms like "opposite sex," "heterosexual," and "homosexual" were deemed outdated.[i] These directives were reinforced by performance standards that mandated "all providers engage in affirmative treatment," shifting the focus from medical excellence to ideological compliance.[ii]

It soon became clear that, as an administrator, I had little influence against this growing ideological tide. The pattern was unmistakable: academia promoted an ideology with its vast research resources and educational centers, organized medicine blindly supported the idea as best practice, payors reinforced it through policies and purse strings, and ultimately, providers had no choice but to comply – or risk losing contracts. For a nonprofit committed to serving the most vulnerable of which nearly all had Medicaid as their insurance, there was no real option but to follow the directives of the Medicaid managed

care organizations, regardless of whether or not they prioritized ideology over patient care.

It is clear that this ideology has been and continues to be imposed onto the medical field top-down through its ostensibly prestigious institutions. These are (1) the medical schools themselves, as the academic purveyors of DEI ideology, (2) the accrediting bodies for medical education, who impose DEI requirements onto medical schools, and (3) the medical associations, specialty societies, and medical boards that license and certify physicians. Collectively, these institutions are most responsible for driving the spread of DEI in medicine and medical education. These bodies have either been outright champions of DEI ideology, actively working to inject it into various facets of healthcare, or have at the very least been remiss in their duty to uphold the integrity of this great and noble profession – one which aims to serve humanity with compassion, dedication, and excellence.

I want to stress that, while progress has been made to curb the influence of DEI in medicine and protect physicians and patients alike from racial discrimination, activism, and division, there is still much to do. DEI is ultimately a *political* ideology that has worked its way into the cogs and gears of healthcare, and ameliorating its harms is not an easy task. In some cases, it lives quite visibly, and in other cases it has been cloaked with new words such as belonging, accessibility, and inclusive excellence. Do No Harm has found that nearly half of medical schools in the United States, for example, still noticeably maintain a DEI office on their website, thereby perpetuating the bureaucracy supporting this ideology.[iii]

Medical schools along with teaching hospitals serve as the foundry of medical knowledge and the means by which future generations of physicians learn how to practice their profession. Unfortunately, many schools have invested significant sums in promoting DEI ideology, as well as building an expensive and expansive infrastructure to support it. With limited resources of time and talent, these choices come at the opportunity cost of medical education. Furthermore, these DEI efforts range from attempts to inculcate medical students and residents with radical political ideology to instances of racial discrimination by the schools themselves, such as racially discriminatory scholarships and discrimination in the admissions process.

This embrace of DEI ideology on the part of medical schools and teaching hospitals has regrettably allowed identity politics to encroach upon the profession in a way that compromises both its quality and integrity. Our medical schools have been the envy of the world because of their educational excellence and embodiment of merit – all for the

benefit of the patient. However, in recent years, we have strayed from our foundational Hippocratic pledge as physicians, allowing contemporary causes to overshadow our core principles and unwavering dedication to the patient in our care. Issues of social justice have become a rallying cry, and yet physicians have no agency in this domain; they are not meant to be social workers or political actors, but rather professionals trained in the art of healing.

As a high-level illustration of how politics and ideology have pervaded medical school curricula, in September 2024 Do No Harm published an analysis of the course catalogs of 20 leading medical schools to identify the relative emphasis given to radical political goals compared to traditional medical knowledge. Our analysis identified eight terms associated with DEI political ideology, and eight terms associated with the traditional practice of medicine. We then searched the course catalogs of these schools for the respective terms.[iv] We found that words like "diverse/diversity" appeared nearly as often as "anatomy." "Race/racism," "equity," and "inclusive/inclusion" appeared ten times more than words typically associated with medicine like "randomized," "placebo," or "Hippocratic."

To put it simply, the actual course offerings at medical schools are, at least outwardly, overly concerned with social and political issues compared to medical excellence. For example, in addition to teaching about the "kidney, endocrine, and reproductive endocrine system" in Integrated Human Pathophysiology III at Harvard, this course also integrates content exploring health equity and climate change.[v] Similarly, the Department of Medicine at Stanford University offers a course entitled, "Global Leaders and Innovators in Human and Planetary Health: Sustainable Societies Lab," which includes topics such as "social and environmental justice and equality."[vi] My alma mater, Drexel University College of Medicine, has an entire curriculum dedicated to "Antiracism in Healthcare" which, as a learning goal, has students "commit to being antiracist in [their] attitudes and behaviors."[vii] As we state in our report, this curricular trend towards social justice "is not an isolated development in a handful of atypical medical schools, but a broad change that is affecting the future of medical practice across the country." The emphasis on science has waned much to the detriment of the profession and the clinicians it trains.

The influence of DEI in medical education is even more acutely present in medical schools' mission, vision, and values – the very heart and soul of an organization. To demonstrate medical schools' institutional commitments to DEI, Do No Harm analyzed the mission statements of medical schools and looked for language that demonstrated an ideological commitment to the principles of diversity, equity, inclusion, and social justice, which we classified as "woke." We found that in 2024, 77 percent of medical school mission statements could be characterized as "woke," up significantly from just a few years ago.[viii]

This fundamental commitment to DEI at the core of a school's mission comes to serve as its North Star, leading the path for significant DEI activity. At the University of Washington's Psychiatry Residency Program, for example, DEI topics are "deliberately embedded throughout the four-year curriculum."[ix] Similarly, the Department of Obstetrics and Gynecology at The Ohio State University College of Medicine highlights its anti-racism strategies with implicit bias training, anti-racism grand rounds, and anti-racism journal club.[x] The HEAL competency at Indiana University School of Medicine references "systems of inequity" and enables students to become "agents for change who recognize societal problems impacting local communities and health care systems including health disparities, systemic racism, bias and microaggressions."[xi]

Well-meaning as some of these programs may superficially sound, the philosophy underlying them is anything but innocent. With its roots in neo-Marxist thought, Critical Social Justice is the guiding framework and theoretical foundation for DEI. It contends that inequality is woven into the fabric of society, necessitating deliberate actions to dismantle entrenched systems of power and privilege. It creates an oppressor-oppressed dyad, where the designation of each category is often based on an identity group's level of representation. Simply, if overrepresented, then such a group is likely the oppressor.

The result of this zero-sum game between opposing identity groups is anything but fair or just. Oppression must be overcome through illiberal actions, which necessitate oppression itself. It should be no surprise that under this construct, as Ibram Kendi has written, "The only remedy to racist discrimination is antiracist discrimination. The only remedy to past discrimination is present discrimination. The only remedy to present discrimination is future discrimination."[xii]

When such a solution is implemented in the admissions process, racial characteristics of the applicant get priority over merit. With over 50,000 medical school applicants competing for approximately 22,000 first-year spots in U.S. medical schools, the process is highly competitive. If a qualified candidate is not admitted in favor of an unqualified or lesser qualified one, that qualified applicant may lose his or her chance of becoming a physician. Fortunately, the Supreme Court ruled these race-conscious admissions practices to be unconstitutional. Yet, the evidence strongly suggests that many medical schools are continuing to weigh applicants' race when considering their admission.

Do No Harm's "Skirting SCOTUS" investigation reported on admissions to medical school relative to the average score on the MCAT, the achievement test for medical school entry. Based on 2024 data, one year after the Supreme Court's ruling in *Students for Fair*

Admissions v. Harvard (SFFA), matriculating Asian students had MCAT scores around the 89th percentile compared to the 84th percentile for white students, 68th percentile for black students, and 67th percentile for Hispanic students. With the exception of black students being in the 65th percentile in 2023, the data otherwise did not change from the year of *SFFA* to the year thereafter.[xiii] Should merit be the guiding factor, one would expect the percentiles of varying racial and ethnic groups to be much less disparate. Thus, if an 89th percentile score was the average for Asian matriculants one would expect matriculants of other races and ethnicities to be within a similar percentile. This data certainly points to admissions officials continuing to levy a racial penalty on certain groups, or a bonus to others, despite the Supreme Court's ruling.

Merit, however, does matter to patients as well as the quality of healthcare they receive. In medicine especially, the standards must remain high. Whether in a matter of life and death, or in the treatment of a chronic condition, we, as patients, are right to demand the very best. We know from the Association of American Medical Colleges (AAMC) that scores on the MCAT predict medical student performance.[xiv] We also know that performance in medical school is correlated to performance as a practicing physician.[xv] And we know certification exam scores on the internal medicine boards, for example, are associated with improved outcomes among hospitalized Medicare beneficiaries.[xvi] Excellence matters when it comes to results.

Yet, over time medical schools have moved further and further away from clearly measuring performance. We find ourselves with more and more schools that utilize pass/fail grades. Furthermore, Step 1 of the United States Medical Licensing Exam (USMLE), which is the first of three exams assessing competency in prospective doctors, has been pass/fail since January 2022. From my own medical school experience more than two decades ago, preclinical grades and the USMLE Step 1 exam were critical factors in helping residency programs assess the quality of students, and thus determine the future residents they were going to recruit to their teaching hospitals. Now, merit has become harder and harder to distinguish as metrics have become rather binary, leaving little room for distinction and little drive to excel. With less emphasis placed on merit, and the qualifications of medical students blurred by a lack of distinction, mediocrity triumphs for students of all races.

As some have recently noted, like Alexander Iyer and colleagues in the *New England Journal of Medicine*, "good enough" is simply not "good enough." While "P" for pass may ultimately equal "MD," we cannot have this minimum standard as our threshold. We must "[dispel] the notion that performance above the passing threshold signifies wasted effort."[xvii] It clearly does not. We must strive for excellence and motivate students to that

end. We must promote meritocracy rather than suffocating it. The future care of patients and innovations that come are at stake.

Outside the admissions suite, there are countless examples of medical schools operating discriminatory scholarships restricted to individuals of a certain racial or ethnic group. Johns Hopkins, for instance, hosts a "Plastic and Reconstructive Surgery Underrepresented in Medicine Visiting Elective."[xviii] Likewise, Duke University Health System offers a "Visiting Clinical Scholars Program" open to fourth year medical students who are "underrepresented minorities" or "socioeconomically disadvantaged."[xix] These scholarships are invariably justified on the grounds that diversity improves medical care, a statement for which evidence is sorely lacking, yet is stated over and over again.

However, medical schools and teaching hospitals are not alone in how they have embraced DEI, particularly through admissions, recruitment, and promotion. Accreditation agencies bear a significant responsibility. These bodies are powerful organizations that set educational guidelines and ultimately decide which schools can grant degrees. Students also need to go to an accredited school to take out student loans, and teaching hospitals need to be accredited so that they can receive graduate medical education funds.

Do No Harm's report, "Unethical Expectations: How Accreditors Inject Identity Politics into Medical and Healthcare Education," identifies a litany of standards and requirements imposed upon medical education programs by accreditors that force the programs to advance DEI initiatives.[xx] These include requirements to increase the racial diversity of the student body and faculty, which, in effect, is a requirement to racially discriminate. For the Liaison Committee on Medical Education (LCME), the accreditation agency for allopathic medical schools in the United States, Standard 3.3 requires schools to "[engage] in ongoing, systematic, and focused recruitment and retention activities, to achieve mission-appropriate diversity outcomes among its students." And the LCME is not alone. Our report shows DEI being imposed by other accreditors such as the Commission on Osteopathic College Accreditation, the Commission on Dental Accreditation, and the Commission on Accreditation in Physical Therapy Education.

These accreditors, whose DEI practices were recently the subject of an executive order by President Trump, obviously wield tremendous power.[xxi] But, there is also another wrinkle: DEI mandates from accreditors enable medical schools to "pass the buck" and absolve themselves of any responsibility for implementing racially discriminatory policies and practices. The accreditors nod to DEI and the schools accept it as a requirement to justify their own DEI programs, all coming at the expense of rigorous education and training for healthcare professionals.

There are some positive signs, however, that accreditors are ditching their DEI ways. Following President Trump's executive order, the Accreditation Council for Graduate Medical Education (ACGME), which is the accrediting body for medical residency programs, announced that it would be suspending enforcement of two key "diversity" recruiting and retention requirements.[xxii] Other accreditors should follow the ACGME's lead, and drop their discriminatory requirements. We must prioritize expertise over politics and restore a culture of meritocracy starting with accreditors who set the standards for education in the healthcare professions.

Still, considerable damage has already been done; medical schools are prime conduits for DEI ideology. The DEI problem thus starts in academia. Once rooted in rigorous scientific inquiry and clinical excellence, medical education has increasingly prioritized DEI initiatives, shaping the current landscape as well as the next generation of providers to embrace ideology as unquestionable doctrine rather than fostering open debate and critical thinking. The ripple effect is enormous, as I saw in my past work experiences.

What then drives DEI in medicine is its attribution of racism as the driving cause of health disparities. While disparities do exist, and we must improve healthcare for all people, to attribute those disparities to racism or a system that is allegedly "structurally racist" is without proof and terribly divisive. Instead of looking to the true causes of such disparities, the prevailing narrative holds that the healthcare system is "systemically racist" and that "structural racism" is deeply embedded in medical practice. Physicians are told that their implicit biases contribute to this inequity, with particular emphasis on the privilege and responsibility of certain groups, such as white males, within this framework of oppression. The proposed solution is not merely reform but a deliberate, ideological correction – one that demands conscious, reactionary actions. In effect, only a new state of oppression can remedy the situation.

One example of this is the claim that black patients need black doctors. The logic is clear: if black patients have better health outcomes when treated by black physicians, then creating policies that may be facially discriminatory to recruit more black doctors could be morally justifiable and, in fact, saves lives. Yet, this claim is far from true. Patients need exceptional doctors regardless of demographics.

Nevertheless, the notion that racial concordance – in which patients are treated by physicians of the same racial group – improves health outcomes for racial minorities is omnipresent in medicine today, as both an often-unspoken premise justifying DEI initiatives and as an explicit rallying cry for racially discriminatory hiring practices. We

have seen this notion repeated by professors at prominent medical schools, by medical associations, and even by Supreme Court Justice Ketanji Brown Jackson.[xxiii]

One study often cited in support of racial concordance comes from the *Proceedings of the National Academy of Sciences* in August 2020 and is entitled, "Physician–patient racial concordance and disparities in birthing mortality for newborns." This study examined the effects of racial concordance on infant mortality and found that "newborn-physician racial concordance is associated with a significant improvement in mortality for Black infants."[xxiv] What has since followed has been over 790 scholarly citations, according to Google Scholar, including several prestigious journals, and numerous media reports.[xxv]

However, this study had a major flaw: it did not control for the effect of very low birth weight infants (<1,500 grams) on mortality. The racial concordance effect disappeared once this adjustment was made.[xxvi] Yet, the study debunking the original paper has only received three citations according to Google Scholar. Furthermore, earlier this year, Do No Harm obtained documents related to the original study showing that an early analysis found "racial concordance significantly reduces the fatality rate of white babies." In other words, white babies did better with white doctors. Writing in the study's margin, lead author Brad Greenwood stated, "I'd rather not focus on this. If we're telling the story from the perspective of saving black infants this undermines the narrative."[xxvii]

Whether this effect of racial concordance related to white babies would have been borne out by a final analysis of the data is immaterial. The idea of racial concordance is just wrong at face value. It echoes a call to segregation where black patients have black doctors and white patients have white doctors. This is not a chapter in our history we seek to revisit. It is quite clear that all patients want exceptional physicians, no matter their race.

Beyond this one pivotal study, which has since been discredited, the preponderance of the evidence does not favor racial concordance. Do No Harm's analysis of the evidence on racial concordance found that four out of five systematic reviews of racial concordance in medicine showed no improvement in outcomes.[xxviii] These large-scale reviews provide a rigorous, structured synthesis of existing research, aggregating many relevant studies to offer an assessment of the evidence. They are superior to looking at one study alone. And although one systematic review reported evidence of "better patient-physician communication," further analysis revealed it as an outlier due to the unexplained exclusion of contradictory studies and a skewed depiction of the studies it assessed. Additionally, a sixth systematic review published in late 2024, which examined addiction treatment, found that racial concordance did not improve health outcomes.[xxix]

The discourse surrounding racial concordance is just one example of how narratives that seek to explain health disparities as resulting from some unseen "racism" are marshaled to, in turn, argue for inherently discriminatory policies and practices. DEI, by its nature, demands a new regime of oppression to correct the purported effects of "systemic racism" that is painted as the villain behind all health disparities.

It is in this light that medical associations, for example, have largely accepted the tenets of DEI without question, and propagated cherry-picked studies without truly examining the totality of the evidence. It is near-impossible to peruse the websites of any major American medical association without finding examples of initiatives, policies, or public statements that do not in some way seek to advance DEI ideology. Many medical associations have likewise adopted the DEI framing of health disparities wholesale and seek to remedy these supposed injustices through racial discrimination.

The AAMC, for instance, has argued in favor of race-based college admissions, requesting the Supreme Court uphold affirmative action on the grounds that "racial and ethnic diversity" is critical to the practice of medicine. The association also encourages medical schools to use "holistic" admissions that devalue GPA and MCAT scores.[xxx] More so, the AAMC has recently launched the PREview Exam, which stresses factors other than academics and is aimed to "reflect examinees' understanding of effective and ineffective professional behavior."[xxxi] Less and less weight is being given to the hard sciences and clinical acumen necessary to be an exceptional physician or physician-scientist.

This embrace of DEI throughout organized medicine has coincided with a shift toward the increasing politicization of medical associations and societies, similar to the political shift in medical schools and teaching hospitals. Medical specialty societies, for instance, are increasingly issuing statements about political topics ranging from immigration to the Russia-Ukraine war to the Hamas attacks on Israel.[xxxii] They proudly go out of their lane, entering the realm of activism where they have little agency or expertise. This, unfortunately, wears on the trust the public gives physicians. In the summer of 2021 Gallup noted only 44% of respondents had confidence in the nation's medical system. These numbers, unfortunately, have been declining for decades.[xxxiii]

The consequences of medical associations, the supposed standard-bearers for how medicine should be practiced, adopting an ideology that is so divisive and counter to our American values is quite concerning. Organized medicine has looked more and more like a political actor rather than the profession it represents. If trust is to be restored to the House of Medicine, then it must move past identity politics and act with the integrity our

oath demands.

When caring for patients, doctors cannot be activists first, physicians second. DEI places primacy on advocacy over the individual. It teaches physicians to view their actions through the lens of racial equity, so that individual healthcare decisions are made according to larger "health equity" concerns. The individuality of the patient is completely lost in this framework.

This ideology is so embedded in medicine today that even medical boards are requiring adherence to it. Two of Do No Harm's Senior Fellows, Drs. Jared L. Ross and Aida Cerundolo, recently voiced their concerns with the American Board of Emergency Medicine's requirement that they pledge to confront "implicit bias" as a condition of certification.[xxxiv] This idea, popularized by the Implicit Association Test, claims to reveal unconscious bias by assessing reaction times to paired concepts, with quicker responses in one direction suggesting a more favorable perception. However, it is unclear what these reaction times are actually measuring, as the Implicit Association Test demonstrates both poor reliability and validity.[xxxv]

Despite the lack of validity, implicit bias training has nonetheless been mandated in a variety of states. In Michigan, for instance, it is a condition of licensure for over 400,000 healthcare professionals. Its aim is to eliminate health disparities under the assumption that these disparities are a result of unconscious bias. However, this is unproven. Regardless, the notion of implicit bias suggests physicians are otherwise acting in a racist manner, not even consciously known to themselves. Such an implication is more likely to engender enmity than resolve tension.

Ankita Jagdeep and colleagues in their report, "Instructing Animosity: How DEI Pedagogy Produces the Hostile Attribution Bias" noted the lack of rigorous research on the impact of DEI initiatives. They found that instead of reducing bias, reading "anti-oppressive DEI educational materials" prompted a "hostile attribution bias, amplifying perceptions of prejudicial hostility where none was present."[xxxvi]

Additionally, we have anecdotally heard from members who have chosen either not to renew their license or board certification because of these implicit bias training requirements. Five years ago, by the Executive Order of the Governor, Michigan mandated implicit bias training. In 2023, just a few years after the Executive Order, there were 2,000 fewer physicians in Michigan than in 2016.[xxxvii, xxxviii] While correlation does not imply causation, one needs to consider how various DEI mandates may unintentionally cause the departure of experienced healthcare professionals and exacerbate the shortage of

providers, nurses, and other professionals.

While DEI remains within the medical profession, and is very much entrenched in academia, DEI is not what it once was. Progress has been made to restoring merit. Brave individuals – physicians, educators, patients, and parents – are beginning to speak out against the harms of DEI ideology in medicine. Whistleblowers are coming forward, legal challenges are gaining ground, and policy shifts are starting to reflect a renewed commitment to fairness, merit, and excellence. At Do No Harm, for example, we have seen entities like Pfizer and the American Chemical Society end discriminatory actions.[xxxix, xl, xli, xlii]

We have also seen the impact of a new Administration, which has rolled back various equity and diversity-related policies that directly encourage harmful and discriminatory behavior, following the executive orders aimed at restricting DEI.[xliii] I am likewise encouraged by this subcommittee and its focus on restoring excellence to the practice of medicine. I look forward to future Congressional action that will further uphold merit-based standards, ensure medicine remains rooted in scientific rigor, and prioritize patient care over ideological agendas.

Reform is not a matter of politics; it is a moral imperative. The health of our nation depends on restoring integrity to medicine, beginning with education that values skill over ideological zeal, and care that prioritizes science over radical political agendas. Thank you, again, for reading my testimony. I look forward to further discussing this important matter with the subcommittee.

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