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ROUNDTABLE: HOW CAN WE IMPROVE HEALTH WORKFORCE DIVERSITY AND ADDRESS SHORTAGES? A CONVERSATION WITH HISTORICALLY BLACK COLLEGE AND UNIVERSITY LEADERS AND STUDENTS

FIELD HEARING

OF THE

COMMITTEE ON HEALTH, EDUCATION, LABOR, AND PENSIONS

UNITED STATES SENATE

ONE HUNDRED EIGHTEENTH CONGRESS

FIRST SESSION

ON

FIELD HEARING HELD IN MOREHOUSE SCHOOL OF MEDICINE, ATLANTA, GA

MAY 12, 2023

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C O N T E N T S

STATEMENTS

FRIDAY, MAY 12, 2023

ROUNDTABLE: HOW CAN WE IMPROVE HEALTH WORKFORCE DIVERSITY AND ADDRESS SHORTAGES? A CONVERSATION WITH HISTORICALLY BLACK COLLEGE AND UNIVERSITY LEADERS AND STUDENTS

Friday, May 12, 2023

U.S. SENATE,
COMMITTEE ON HEALTH, EDUCATION, LABOR, AND PENSIONS,
Washington, DC.

The Committee met, pursuant to notice, at 10:08 a.m., in Morehouse School of Medicine, 720 Westview Drive, Building A, Atlanta, Georgia, Hon. Bernard Sanders, Chairman of the Committee, presiding.

Present: Senator Sanders [presiding].

OPENING STATEMENT OF SENATOR SANDERS

The CHAIR. The Senate Committee on Health, Education, Labor, and Pensions will come to order. This is what we do in Washington. I don't know what it means but——

[Laughter.]

The CHAIR.

[Technical problems]—and a couple of months ago, Dr. Rice was in my office, and we chatted about these issues. And I said, let's see if we can do something about it. And this is the very first field hearing that the Committee has held, and this is an official hearing. The transcript will be part of the Congressional Record.

Most importantly, I hope that what I and other Committee Members will learn from this hearing will be translated into law and will have an impact on how we provide health care to minority communities all across this country.

I don't have—and I want to give a special thanks to everybody who is here this morning, but especially to the young physicians and those of you who will soon become physicians. You are the heroes and heroines of this moment. You are devoting your lives to taking care of people who are in need, in a very difficult moment for our Country.

I thank you very much for your entering the profession and all of those who are mentoring you as you proceed. I don't have to tell anybody up here, this is not a group of people I have to explain this to, our current health care system is broken, correct? What does that mean? It means that in the richest country in the history of

the world, we should lead the world. People should look to us. In terms of what quality, accessible health care is, we are behind many, many other countries.

In America today, 85 million Americans are uninsured or underinsured. We just went through a pandemic when millions of people lost their jobs and when they lost their jobs, what else did they lose? They lost their health care in the midst of a pandemic.

Meanwhile, we spend, unbelievably $13,000 on health care for every man, woman, and child—$13,000. Family of four, $52,000. Who can afford that? It is unsustainable. It is twice as much per capita as the people of any other country spend.

We pay the highest prices in the world for prescription drugs. And what physicians here know, and younger physicians will learn, you are going to write out a script, and your patient will not be able to afford it.

How insane is that? But what happens to the person who can't afford the medicine? They get sick or they end up in the emergency room at a very expensive cost. Half a million Americans go bankrupt in this country because of medically related issues. You end up in a hospital, you are $50,000 in debt. If you make $30,000 a year, how are you going to pay that? You can't.

Then your credit is destroyed. Your family's life is destroyed. We don't talk about it very much. 60,000 Americans die every single year because they don't get to a doctor on time. I applaud the doctors all across this country.

How many people walk into their offices very, very sick, why didn't you come in when you first felt your symptoms? What is the answer? Well, I couldn't afford my co-payment. I couldn't afford—I was uninsured. I didn't want charity. Some of those people don't make it. So, you are entering a system which is broken, and I know that you will work as hard as you can every day to treat your patients.

But I hope we will work together to transform this system. Health care is a human right, not a privilege. Then on top of all of that, we are just seeing a particular issue today. Unbelievable. We spend $13,000, for every man, woman, and child. We don't have enough doctors. That is a problem that has gone on for years.

COVID exacerbated that problem. We could talk about that, what COVID did to the workforce. We don't have enough nurses. We don't have enough dentists. Dental care is a huge issue. We don't talk enough about, people can't afford to get to a dentist. There is, and the young doctors here will learn this soon enough if you don't know it now, there is a major mental health crisis in this country, again, exacerbated by COVID, and many other things.

Do we have enough counselors, psychologists, psychiatrists? Do we have enough people trained to deal with the terrible problem of addiction? No, we don't. But we have to transform all of it.

The midst of all of that, the problem is much worse in the African American community, in the Latino community, in the Native-American. Unbelievable—unbelievably, today, with a population where African Americans are about 13 percent of our population.

About 5 percent of our doctors are black. And even fewer, I think, percentage wise are dentists. That is why we are here. So what our Committee hopes that I am not making any promise to anybody because we got a tough political climate in Washington, DC, as you know. You know, in the midst of this, some geniuses there want to throw millions of people off the healthcare they have, not expand it.

We are going to do our best to grow the healthcare workforce and put a special focus on the need for more black doctors, nurses, psychologists, dentists, etcetera. So that is why we are here today. And I am just really very thankful to Dr. Rice and to everybody here. You know, I am—I don't have to tell anybody here how an extraordinary job the HBCUs are doing, colleges, the medical school. And it is a story worth telling a million times.

Thank you for what you do. We look forward to working with you in the years to come, in the months to come, in the weeks to come.

Again, thank you all very much for being here today.

Okay, I think we are currently—mic over to Dr. Rice—Dr. Rice, thank you very much.

STATEMENT OF VALERIE MONTGOMERY RICE, M.D., FACOG, PRESIDENT AND CEO, MOREHOUSE SCHOOL OF MEDICINE, ATLANTA, GA

Dr. RICE. Thank you so much, Senator Sanders. Chairman Sanders, we are extremely proud of our accomplishments and track record.

Morehouse School of Medicine and the other HBCU medical schools have consistently been ranked at the top or near the top of all medical schools and social missions. Our institutions have produced the Secretary of Department of Health and Human Services, a Director of the CDC's Centers for Disease Control and Prevention, and two U.S. Surgeon General.

Just as importantly, though, numerous physicians and other health care professionals who disproportionately and proudly serve people of color in medically underserved communities. We are doing what needs to be done for the American people in a way that is incomparable to other schools.

Our mission, though, to train culturally competent providers willing and eager to serve their community comes at a cost. HBCU medical schools do not enjoy the institutional financial resources, academic affiliations, and endowments of other medical schools.

But we accept that as a part of our mission, but it leads to be disproportionately focused on us securing support from Federal programs that are or should be designed to level the playing field, and our ability to train health care professionals and strengthen our institutions.

We continue to need your Committee's help and leadership to continue to position us to make an outsized contribution to improving the health status of minorities and all Americans, which is clearly a national priority.

In recent years, Congress responded to health workforce challenges by increasing the number of federally supported graduate

medical education, GME positions, through Medicare and the Teaching Health Centers Program.

Medical schools in general are grateful for the additional positions because they support training opportunities against the backdrop of a national physician shortage. Unfortunately, though, relative few of these additional GME programs have accrued to teaching hospitals or health centers affiliated with historically black medical schools.

If indeed it is a priority to increase the number of physicians and communities of color in medically underserved communities, there should be specific provisions in each of these programs that direct a meaningful portion of these GME slots to teach in hospitals and health centers affiliated with our HBCU medical—[technical problems].

We are asking for priority consideration of such hospitals and health centers who align with the goals of the GME programs and ensure workforce shortages are being appropriately addressed in medically underserved communities throughout the U.S.

Representative Terri Sewell of Alabama and Brian Fitzpatrick of Pennsylvania have introduced the Resident Physician Shortage Reduction Act of 2023, H.R. 2389, which would dedicate additional GME positions to teach in hospitals affiliated with HBCU medical schools.

We believe this bill is a good model for the Senate's effort on Medicare and teaching health center, GME legislation. However, Mr. Chairman, we have not just been sitting idle waiting for others to work on our behalf. We have been creating partnerships like the More In Common Alliance, focused on addressing diversity and the health care provider shortage.

I would like to take a few moments of my time to describe the Morehouse School of Medicine's partnership with CommonSpirit Health. This 10-year partnership is the first nationwide initiative between two of the country's leading health organizations to address the underlying causes of health inequities, including underrepresentation of black clinicians.

This partnership lays the foundations for patients to have more access to black clinicians, and for black medical students and graduates to gain community-based experience. It will allow Morehouse School of Medicine to expand its enrollment, allow us to expand our pipeline initiatives.

CommonSpirit Health serves some of the most diverse communities in this country, and cares for more Medicaid patients than any other health system in the United States.

Leveraging our combined 100-year experience, we believe that by opening up five regional medical campuses across the country at CommonSpirit sites, and ten graduate medical education programs with no less than two specialties, one being primary care and another being a specialty area, we believe that we can create a pipeline that creates a pathway from students from those diverse communities that go back and serve in their communities.

My colleagues—and I have to add, this was seeded by $115 million gift from CommonSpirit Health to Morehouse School of Medicine.

My colleagues will discuss the importance of other Federal programs at the Health Resources Services Administration, HRSA, and the National Institutes of Health that will support our pipeline programs and research infrastructure at our other schools.

Once again, we are grateful to your Committee for taking the time and making the effort to join us today to examine these critical issues. Thank you very much.

[The prepared statement of Dr. Rice follows:]

PREPARED STATEMENT OF VALERIE MONTGOMERY RICE

Chairman Sanders, we are extremely proud of our accomplishments and track record. Morehouse School of Medicine and the other HBCU medical schools have consistently been ranked at the top or near the top of all medical schools in social mission. Our institutions have produced a Secretary of the Department of Health and Human Services, a Director of the Centers for Disease Control and Prevention, and two U.S. Surgeon Generals—and just as importantly, numerous physicians and other health care providers who disproportionately and proudly serve people of color in medically underserved communities. We are doing what needs to be done for the American people in a way that is incomparable to other schools.

Our mission to train culturally competent providers willing and eager to serve their community comes at a cost. HBCU medical schools do not enjoy the institutional wherewithal, financial resources, academic affiliations, and endowments of other medical schools. We accept that as part of our mission, but it leads us to be disproportionately focused on securing support from Federal programs that are—or should be—designed to level the playing field in our ability to train health care professionals and strengthen our institutions. We need your Committee's help and leadership to continue to position us to make an outsized contribution to improving the health status of minorities and all Americans—which is clearly a national priority.

In recent years, Congress has responded to health workforce challenges by increasing the number of federally supported graduate medical education (GME) positions through Medicare and the Teaching Health Centers program. Medical schools in general are grateful for these additional positions because they support training opportunities against a backdrop of a national physician shortage. Unfortunately, relatively few of these additional GME positions have accrued to teaching hospitals or health centers affiliated with Historically Black Medical Schools.

If indeed it is a priority to increase the number of physicians in communities of color and medically underserved communities, there should be specific provisions in each of these programs that direct a meaningful portion of these GME slots to teaching hospitals and health centers affiliated with our HBCU medical schools. Priority consideration of such hospitals and health centers will align with the goals of the GME programs and ensure health workforce shortages are being appropriately addressed in medically underserved communities throughout the U.S.

Representatives Terri Sewell (AL) and Brian Fitzpatrick (PA) have introduced the Resident Physician Shortage Reduction Act of 2023 (H.R. 2389) which would dedicate additional GME positions to teaching hospitals affiliated with HBCU medical schools, and we believe this bill is a good model for the Senate's efforts on Medicare and Teaching Health Center GME legislation.

Mr. Chairman, I would like to take a few moments to describe Morehouse School of Medicine's partnership with CommonSpirit Health (CSH). This 10-year partnership is the first nationwide initiative between two of the country's leading health organizations to address the underlying causes of health inequity, including underrepresentation of Black clinicians. The partnership will lay the foundation for patients to have more access to Black clinicians and for Black medical students and graduates to gain community-based experience.

Additionally, it will allow MSM to expand its enrollment—increasing the pipeline of students recruited from underserved and rural communities. As one of the largest nonprofit health systems in the Nation, CSH serves some of the most diverse communities in the country and cares for more Medicaid patients than any other health system in the United States. Together, our two organizations will leverage a combined 100 years of experience to address health disparities in underserved communities and continue to elevate care for vulnerable patients.

One of the greatest impacts of this partnership is the transformation of career opportunities for MSM students within the CommonSpirit network of medical facilities. Five remote medical campuses will launch as a part of the Morehouse School of Medicine and CommonSpirit partnership, enabling third-and fourth year medical and second year physician assistant students to complete their respective degrees while working in settings that reflect MSM and CommonSpirit's commitment to educating students from underserved and rural communities.

Critical to the success of this partnership is the availability and targeting of graduate medical education positions to this effort. Through this partnership, we are doing our part in the national effort to improve the health status of minority Americans. We need your help in making this effort an ongoing success.

My colleagues will discuss the importance of other Federal programs at the Health Resources and Services Administration (HRSA) and the National Institutes

of Health (NIH) that provide institutional support, pipeline programs, and research infrastructure at our schools—and are critical to our success.

In my opening remarks, I made reference to our partnership with Bloomberg Philanthropies that has been so meaningful to reduce the debt burden our students take on to become a physician. More detailed information is submitted below for the record.

Once again, we are very grateful that you and the Committee are taking the time and making the effort to join us today to examine these critical issues.

IMPACT of Bloomberg Partnership with Morehouse School of Medicine to be submitted for the hearing record:

- Black doctors save more Black lives. Black patients overall have better health outcomes when they are treated by Black doctors. The data overwhelmingly supports this, and better health leads to fewer medical bills and more economic opportunity.
- Medical school debt is a big factor in future Black doctors not getting their degrees or feeling that it's necessary to work outside of their communities and desired specialties when they graduate.
- Bloomberg Philanthropies' $26.5-million investment in the students of Morehouse School of Medicine helps lift the crushing burden of student debt and empowers graduates to work in underserved areas.
- Morehouse School of Medicine has currently awarded almost $19 million in scholarship support from the Bloomberg award.
- The Bloomberg Scholarship program has worked in lowering M.D. student debt. From the two M.D. classes to graduate with the Bloomberg Scholarship, the average student debt was reduced $59K per student ($250K to $191K) for the class of 2021 and $64K per student($250K to $186K) for the class of 2022.
- The Mobile Vaccination component of the Bloomberg Initiative has been instrumental in 2 aspects. The funds allowed for MSM to better serve and protect the community during the Covid pandemic and enhance the training of all MSM students in providing care to the underserved.
- Since receipt of the funds, there has been an emphasis to vaccinate the following communities, 65 and over, Black and Hispanic, and rural communities. MSM used its funding support to extend the institution's outreach to include influenza vaccinations and health screenings. These efforts were further enhanced with the purchase of two sprinters that have been used to provide care and vaccinations to rural communities and provide services in diverse communities in North, Southeast and Southwest Georgia. As a result, the following was achieved:
- 12000+ vaccinations
- 1000+ health screenings for chronic disease
- 175 influenza vaccination
- 90+ zip codes served, throughout the State of GA
- Regarding the students, all disciplines have been exposed to the needs of both urban and rural underserved communities. This has allowed development of their clinical skills, educating the community regarding the covid virus, the impact on chronic illness, and in understanding the importance of primary care for the underserved. Many of the outcomes highlighted were the results of students committed to advancing health equity through our student-led clinic, the MSM HEAL Clinic (Health Equity for All Lives) and our mobile team. Additional impact:
- 154 students trained to provide POC (point-of-care) health screenings
- 100+ students trained to provide covid and flu vaccinations

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The CHAIR. Thank you. Thank you, Dr. Rice. Our next panelist is Dr. Jeannette South-Paul, Provost, the Meharry Medical College. Dr. South-Paul.

STATEMENT OF JEANNETTE E. SOUTH-PAUL, M.D., DHL(HON), FAAFP, EXECUTIVE VICE PRESIDENT AND PROVOST, MEHARRY MEDICAL COLLEGE, NASHVILLE, TN

Dr. SOUTH-PAUL. Thank you so much, Chairman Sanders, for inviting the Meharry Medical College to be a part of this Committee.

Thank you, Dr. Montgomery Rice and Morehouse School of Medicine for welcoming us here. I am Jeannette South-Paul, the Executive Vice President and Provost at Meharry, and I am honored to be here today to talk about these critical issues.

As an academic family physician who has practiced for more than 22 years in the U.S. Army, and then in corporate health care prior to coming to Meharry, and who has been an active volunteer leader of minority faculty leadership programs sponsored by the Association of American Medical Colleges for more than 30 years, I recognize the value of intertwining our academic mission with service to the most vulnerable communities.

These experiences have informed my comments that I will share with you today. The health care workforce shortage in the United States is a multifaceted problem with significant implications for our Nation's health and well-being.

Our recent and lingering pandemic, declining life expectancy for the first time in our lifetimes, burgeoning mental health crisis and health care workforce, the struggle to stay well and engaged in the middle of these other crises, present a call to action for our leaders in Government, in health care, and education, and in our—and in corporate America to prioritize our most medically vulnerable.

The physician workforce continues to lag behind the U.S. population in terms of race and ethnic diversity, as you have heard from our previous speakers. And so, we have many more than a third of the population defines themselves as underrepresented minorities, but fewer than 7 percent of those are physicians, and fewer than 5 percent are those who make up other academic faculty.

These numbers are most acute amongst primary care, family physicians, pediatricians, general internists, and OB-GYNs, as well as psychiatrists and other mental health providers.

High quality primary care is a critical foundation for preserving the health of our Nation and cannot be achieved without investment in those institutions most likely to train primary care physicians, so we stand at a critical juncture of our Nation's health care landscape.

At Meharry Medical College, we are working diligently to address the health care workforce shortage through a variety of innovative programs and initiatives, but we need the unwavering support of Congress to carry out this mission. To that end, I would like to highlight some of the policy actions that we would like Congress to take to support not only Meharry Medical College, but our sister HBCU medical schools.

As part of our comprehensive approach to addressing this workforce shortage, and to improve health outcomes in our most medically underserved communities, let's consider enhancing the infrastructure of our institutions.

As my colleagues, Dr. James Hildreth, the President of Meharry, testified before your full Committee in February, a dedicated allocation of $5 billion for improving research and development infrastructure for academic health sciences centers at historically black graduate institutions and other minority serving institutions would represent a monumental commitment by bolstering the capabilities of these institutions to conduct cutting edge research, develop innovative solutions to pressing health issues, and train the next generation of health care leaders.

We recommend increasing that funding with a focus on supporting minority serving institutions and their faculty, for translational research which is essential for bridging the gaps between scientific discoveries and their practical applications in health care settings. This investment will enable us to advance our understanding of the causes and consequences of these health care disparities, and then to develop the targeted interventions.

We know pipeline programs play a crucial role in attracting and retaining students from diverse backgrounds who are interested in pursuing careers in health care and increasing funding and support for pipeline programs such as summer education enrichment programs, mentorship initiatives, and scholarship opportunities will expose these young people to health care careers at an early age.

Programs such as Meharry's GOALS Program, Go Out and Love Science, events in collaboration with the Ascension Foundation and the Medical School for Early Acceptance Program, a collaboration between Middle Tennessee State University's College of Basic and Applied Sciences and Meharry Medical College, are examples of innovative initiatives aimed at increasing the number of primary care physicians serving medically underserved populations in rural Tennessee.

Federally qualified health centers, something that is very close to my heart because I helped to form the first one in a major teaching institution in western Pennsylvania, they play a vital role in providing access to quality interdisciplinary health care for underserved populations.

We recommend updating Federal regulations to allow academic institutions, such as HBCU medical schools, to sponsor FQHCs, which can create vulnerable interprofessional health workforce training opportunities for students and trainees in physical, oral, and behavioral health in the same space so that it is one stop shopping for the most vulnerable populations—[technical problems]—continue to keep—trying to keep on time.

Another priority should be building a pipeline for demand—in demand discipline, such as primary care, behavioral health, maternity care, and women's health that our OB-GYN family medicine colleagues are so embedded and involved with. And general practice and pediatric dentistry.

We know the need for maternity care services, which are essential for the health of women and newborns, and it is incredibly urgent, particularly in medically underserved communities. This shortage in urban and rural communities can lead to increased health risks and complications for the people who anchor our families, women and their children.

It is particularly disturbing in this country where black women in the United States are more than three times more likely to die in pregnancy, childbirth, and the postpartum a year than white women, a gap that persists in spite of income or education.

It is also important to highlight the critical need to invest in mental and behavioral health practitioners and research. The current workforce in the field is insufficient to meet the growing demand, particularly in our communities, where the impact of mental health disparities is so profound.

It is not just about numbers of physicians educated in minority serving institutions, but it is about offering sensitivity and culturally competent care that understands and respects the unique experiences of individuals in these communities. GME programs, such as residencies and fellowships, are crucial for preparing our health professionals to serve in urban and rural communities.

This is why Meharry Medical College applauds the bipartisan Resident Physician Shortage Reduction Act of 2023, as you have heard, H.R. 2389 introduced in the House of Representatives by Representative Terri Sewell, which adds 14,000 new GME positions, and amends and expands the policy to give special consideration to hospitals, the trainers who are shared graduates from historically black medical colleges and minority serving institutions.

In addition, the Veterans Affairs Graduate Medical Education Program offers an unparalleled training ground for physicians, behavioral health professionals, and other associated health graduates, providing them with the opportunity to serve our Nation's veterans, which I am one, and of which I have two sons who are serving, while gaining valuable experience and a wide array of specialists.

Finally, we must address rural health disparities in our Nation, a critical aspect of overall public health and unfortunately is often overlooked.

I will include some of my comments to be respectful of time and say that we are facing significant challenges in training and retaining a diverse health workforce, and we are looking for support for those us institutions who have demonstrated our ability to serve and to train the next gen—not only today but the next generation of professionals.

The journey is long, the work is significant, but we can ensure a future where quality health care is accessible and equitable overall, regardless of race, ethnicity, or geographic location. Thank you for your time, Senator Sanders.

[The prepared statement of Dr. South-Paul follows:]

PREPARED STATEMENT OF JEANNETTE E. SOUTH-PAUL

Chairman, Ranking Member, and distinguished Members of the Senate HELP Committee, thank you for inviting Meharry Medical College to be a part of this Committee field hearing to discuss the vital role Historically Black Colleges and Universities (HBCUs) play in addressing the healthcare workforce shortages in the United States. My name is Dr. Jeannette South-Paul, Executive Vice President and Provost of Meharry Medical College, and I am honored to be here today as a representative of our institution along with my fellow HBCU medical school colleagues.

As you may recall my colleague, Dr. James E. K. Hildreth, President of Meharry Medical College, testified before this Committee in February 2023, highlighting the critical role HBCUs play in addressing the healthcare workforce shortage and the need for additional resources and support to enhance our ability to train the next generation of healthcare professionals. Today, I am here to provide an update on our progress and to present specific policy recommendations for your consideration as you develop future legislation aimed at addressing this pressing issue.

The healthcare workforce shortage in the United States is a multifaceted problem with significant implications for our Nation's health and well-being. The shortage is particularly acute in rural and medically underserved communities, where access to quality healthcare is often limited. HBCU medical schools are uniquely positioned to address this shortage, given our long-standing commitment to training healthcare professionals from diverse backgrounds who are dedicated to serving in these underserved areas.

Our recent and lingering pandemic, declining life expectancy for the first time in our lifetimes, burgeoning mental health crisis, and healthcare workforce that has struggled to stay well and engaged in the middle of these crises present a call to action for our leaders in government, policymakers, health care and educational institutions, and industry leaders to prioritize our most medically vulnerable. The physician workforce continues to lag behind the U.S. population in terms of racial and ethnic diversity with only 10.8 percent of active physicians identified as an underrepresented minority (URM) and just 6.8 percent of academic faculty identified as URMs, while URMs make up 33 percent of the U.S. population. These numbers are most acute among primary care (family physicians, pediatricians, general internists, and obstetrician/gynecologists) and psychiatrists and other mental health clinicians. High quality primary care is a critical foundation for preserving the health of our Nation and cannot be achieved without investment in those institutions most likely to train primary care physicians and clinicians (Jetty A, Hyppolite J, et al. Underrepresented Minority Family Physicians More Likely to Care for Vulnerable Populations. J Am Board Fam Med 2022;35:223—224.; Milbank Fund February 2023 Report. *The Health of U.S. Primary Care: A Baseline Scorecard Tracking Support for High-Quality Primary Care. The Health of U.S. Primary Care: A Baseline Scorecard Tracking Support for High-Quality Primary Care (aafp.org)).*

The data are equally disturbing with respect to the representation of dentists with numerous communities having no one serving their oral health needs. Studies have demonstrated that physicians and dentists identifying as URM are more likely to practice in medically underserved communities (both urban and rural) and provide care to people experiencing profound health and healthcare disparities.

At Meharry Medical College, we are working diligently to address the healthcare workforce pipeline shortage through a variety of innovative programs and initiatives. These efforts include:

- Enhancing our medical and dental education programs to ensure that our students are well-prepared to serve in urban and rural medically underserved communities upon graduation.
- Expanding our research enterprise to focus on health disparities and minority health issues, which are critical components of our mission as an HBCU medical school.
- Strengthening our partnerships with local healthcare systems and other academic institutions to provide our students with a wide range of clinical training opportunities and resources.
- Developing and implementing pipeline programs to recruit and support students from underrepresented backgrounds who are interested in pursuing careers in healthcare.

As we continue to refine and expand our programs, we believe that targeted policy interventions can further enhance our ability to address the healthcare workforce

shortage and improve health outcomes in underserved communities. To this end, we propose the following policy recommendations for your consideration:

I. Significant and meaningful investments in infrastructure. As part of our comprehensive approach to addressing the healthcare workforce shortage and improving health outcomes in medically underserved communities, we must consider the significant need for enhanced infrastructure at our institutions. As Dr. Hildreth testified in February, a dedicated allocation of $5 billion for improving research and development infrastructure for academic health science centers at Historically Black Graduate Institutions (HBGIs) and other minority-serving institutions would represent a monumental commitment to bolstering the capabilities of these institutions to conduct cutting-edge research, develop innovative solutions to pressing health issues, and train the next generation of healthcare leaders. These funds would be used to modernize laboratories, improve technology, and enhance other critical facilities. By doing so, we could foster an environment that not only supports current research endeavors but also fuels future innovation. This improved infrastructure would undeniably have a direct impact on the quality of education and training we provide and allow us to expand programs that we know help grow and diversify the healthcare workforce. For example:

Funding for Translational Research Programs. Translational research is essential for bridging the gap between scientific discoveries and their practical application in healthcare settings. Research that targets conditions that disproportionately affect low and middle income and minority communities and can take those discoveries from the bench to the bedside to the community as rapidly as possible is critical. We recommend increasing funding for these translational research programs, with a focus on supporting minority serving institutions and their faculty. This investment will enable us to advance our understanding of the causes and consequences of health disparities and to develop targeted interventions that improve health outcomes for minority populations.

Increase and accelerate investments in HRSA Title VII workforce diversity programs. Pipeline programs play a crucial role in attracting and retaining students from diverse backgrounds who are interested in pursuing careers in healthcare. We recommend increasing funding and support for pipeline programs, such as summer enrichment programs, mentorship initiatives, and scholarship opportunities, which target underrepresented students and expose them to healthcare careers at an early age. Programs such as Meharry's #GOALS (Go Out and Love Science) events, in collaboration with the Ascension Foundation, exemplify our dedication to fostering interest and competency in the medical sciences among young learners. These community-focused initiatives provide hands-on, engaging educational experiences that inspire the next generation of healthcare professionals and underscore the importance of scientific exploration in improving health outcomes. The Medical School Early Acceptance Program (MSEAP), a collaboration between Middle Tennessee State University's College of Basic and Applied Sciences and Meharry Medical College, is another example of an innovative initiative aimed at increasing the number of primary care physicians serving medically underserved populations in rural Tennessee. Students selected for the program receive tuition aid from the State of Tennessee in exchange for a commitment—after completing 3 years of undergraduate premedical curriculum they transition into medical school study with the intent, upon graduation, of serving residencies in rural and underserved areas. Physicians tend to stay in the communities where they spend their residencies, marking a significant milestone in growing access to quality care in rural communities. Only by challenging young minds through such pipeline programs and supporting those who teach and serve in these programs and the institutions and communities that sponsor them can we propel these young people through middle and high school to even dream of and then pursue careers in medicine, dentistry, and other critical health professions.

Allowing and Expanding Funding for Academic Institutions to Sponsor federally Qualified Health Centers (FQHCs): FQHCs play a vital role in providing access to quality, interdisciplinary healthcare for underserved populations. By allowing academic institutions, such as

HBCU medical schools, to sponsor FQHCs, we can create valuable interprofessional health workforces training opportunities for students and trainees in physical, oral, and behavioral health while simultaneously expanding access to care in underserved communities. We recommend updating Federal regulations to enable HBCU medical schools to sponsor and operate FQHCs, thereby facilitating the integration of clinical training, research, and service in these critical healthcare settings.

Enhance Opportunities for Loan Forgiveness Programs as Incentive to Work in Rural and Underrepresented Communities, Specifically Non-Contiguous States: The burden of educational debt is a significant barrier for many students pursuing careers in healthcare, particularly those from low, middle income, and historically underrepresented backgrounds. We recommend expanding opportunities for loan forgiveness programs, such as the National Health Service Corps, for students who commit to serving in rural and underrepresented communities. By providing financial incentives for service in these areas, we can help attract and retain a diverse healthcare workforce that is committed to improving health outcomes in underserved communities.

Prioritize programs that build the pipeline of healthcare workers in demand disciplines such as primary care, behavioral health, maternity care and women's health (Obstetrics and Gynecology (OBGYN) and Family Medicine) and General Practice and Pediatric Dentistry. The need for maternity care services, which are essential for the health of women and newborns, is incredibly urgent, particularly in medically underserved communities where access to comprehensive women's health services is often limited. This shortage in urban and rural underserved areas can lead to increased health risks and complications for women and newborns—evident in the particularly disturbing high rate of maternal morbidity and mortality among women of African descent in the United States. Black women in the U.S. are more than three times more likely to die in pregnancy, childbirth, and the postpartum year than White women—a gap that persists regardless of income or education (Petersen EE, Davis NL, Goodman D, Cox S, et al. Vital signs: pregnancy-related deaths, United States, 2011—2015, and strategies for prevention, 13 states, 2013—2017. MMWR Morb Mortal Wkly Rep. 2019;68(18):423—9).

The importance of specialized programs, such as Pediatric Dentistry, cannot be overstated, especially when we consider the significant oral health disparities that exist in our Nation. Children in underserved communities often lack access to quality dental care, leading to preventable dental conditions that can adversely impact their overall health and well-being. Moreover, it is essential to highlight the critical need to invest in mental and behavioral health practitioners and research. The current workforce in this field is insufficient to meet the growing demand, particularly in underserved communities where the impact of mental health disparities is most profound. By investing in education, training, and research in the mental and behavioral health field, we can cultivate a robust and diverse workforce capable of addressing these disparities. It is not just about numbers, physicians educated in minority-serving institutions can offer sensitivity and culturally competent care that understands and respects the unique experiences of individuals in these communities.

II. Additional Funding for Graduate Medical Education (GME) Programs with an emphasis on minority-serving institutions: GME programs, such as residencies and fellowships, are crucial for preparing healthcare professionals to serve in urban and rural underserved communities. That is why Meharry Medical College applauds the bipartisan Resident Physician Shortage Reduction Act of 2023 (H.R. 2389) introduced in the House of Representatives which adds 14,000 new Medicare-supported GME positions. We support Medicare's GME policy being amended and expanded to give special consideration to hospitals that train a large share of graduates from historically Black medical colleges and minority serving institutions. This additional funding will enable us to expand our GME offerings, providing our students with a wider range of training opportunities and experiences in medically underserved areas.

Expand the number of VA GME slots allocated with an emphasis on minority serving institutions. The expansion of the Veterans Affairs Graduate Medical Education (VA GME) program is another critical piece in our efforts to address health disparities and healthcare workforce shortages. The VA system offers an unparalleled training ground for physicians, behavioral health professionals and other associated health graduates, providing them with the opportunity to serve our Nation's veterans while gaining valuable experience in a wide array of specialties. By expanding this program, we can increase the number of well-trained healthcare professionals, particularly in specialties where shortages are most acute, ultimately reducing health disparities and improving access to quality care for all, including our deserving veterans.

III. Prioritize addressing disparities in oral health. Addressing oral health disparities is a critical aspect of overall public health that unfortunately is often overlooked. These disparities disproportionately affect underserved communities and can lead to significant health complications if not properly addressed. Minority-serving institutions, including HBCU dental schools, are uniquely positioned to tackle these disparities due to their historical and ongoing commitment to serving these populations. It is well established that a person's health care improves and their trust in the medical community grows when they are seen by a provider of their own race. Currently, only 4 percent of our Nation's dental workforce is Black. That means of the 202,000 dentists in the U.S., only 8,000 are Black. That is barely one Black dentist for every major city in the United States. And 27 percent of those dentists were educated at Meharry. Through dedicated oral health programs, including dental residency and pediatric dentistry programs, these institutions can expand and diversify the oral healthcare workforce, equipping it to better serve communities with high oral health needs. By investing in oral health programs at minority-serving institutions, we not only improve access to care but also help to reduce oral health disparities, leading to healthier communities overall.

Expand General Practice Residency (GPR) Programs. GPR programs provide valuable training for dental graduates, particularly in the areas of comprehensive and emergency dental care. We recommend increasing funding for GPR programs and encouraging the establishment of new GPR programs at HBCU dental schools. This support will enable our institutions to better prepare dental graduates to serve in urban and rural underserved communities, where access to dental care is often limited.

In closing, it is evident that we stand at a crucial juncture in our Nation's healthcare landscape. We face significant challenges in training and retaining a diverse healthcare workforce that has a direct and negative impact on health disparities and inequities if unaddressed. Yet, in the face of these challenges, minority-serving institutions, and particularly Historically Black Colleges and Universities continue to train clinicians dedicated to the most vulnerable but can only effectively forge ahead in this critical work with continued Federal support through transformed policy and increased funding as described.

Our institutions have a rich history and proven track record of cultivating a diverse, culturally competent, and community-responsive healthcare workforce. We are uniquely positioned to address these issues head-on, given our deep understanding of the communities we serve and our commitment to their health and well-being. However, we cannot accomplish this monumental task alone.

We call upon Congress to acknowledge and support our mission and the significant role we play in the nation's healthcare system. Through increased funding for expanding our knowledge of those conditions that most impact the health of minority, urban and rural populations through translational research, expanded training through pipeline programs, undergraduate and graduate medical education, and infrastructure development, along with policy initiatives that promote loan forgiveness and sponsorship opportunities, we can continue to expand and diversify the healthcare workforce.

We are willing and eager to continue this work, but we need the focus, dedication, and support of Congress to continue to address and lead on these issues. The journey is long, and the work is significant, but together, we can ensure a future where quality healthcare is accessible and equitable for all, regardless of race, ethnicity,

or geographic location. Thank you for your time and consideration, and we look forward to your support as we continue this vital work.

The CHAIR. Dr. South-Paul, thank you very much. Our next panelist is Dr. Hugh E. Mighty, Senior Vice President for Health Affairs at Howard University.

STATEMENT OF HUGH E. MIGHTY, M.D., MBA, FACOG, SENIOR VICE PRESIDENT FOR HEALTH AFFAIRS, HOWARD UNIVERSITY, WASHINGTON, DC

Dr. MIGHTY. Good morning and thank you, Chairman Sanders. And thank you to all my colleagues for what is going to prove to be an eloquent discussion on improving the diversity of the Nation's health workforce.

Our HBCU medical schools are the backbone of training black doctors in this country, where black doctors make up only 5 percent of all American physicians. The value of our HBCU medical schools is more important now than ever before. Howard University has a 156-year history of training minority physicians in this country.

More than 50 percent of these graduates return to work in underserved communities nationwide. Howard also has the distinction of having a college of dentistry, a school of pharmacy, a school of nursing and allied health, and a school of social work.

Together, these schools provide a diverse solution to many of the health care challenges faced in the Nation. As the problem of black physician shortages rise within the general context of physician workforce shortage, many communities of need will continue to be underserved.

Our medical school and our HBCU colleagues have witnessed a surge in the number of applicants for medical school with a limited capacity to accept more. Barriers to growing programs often reside in the high cost of medical school education.

These issues faced at the medical school graduation are just as significant because there are fewer funded residency program positions than there are graduates. Highly trained physicians who can provide critical medical help for the most underserved communities struggle to find residency programs.

The GME dollars are only available for some who graduate. Clinical research is yet another area where HBCUs have been underfunded and therefore restricted in their ability to expand the movement of solutions to communities of color, where trusted voices would lead to better participation in clinical trials.

Howard also has a robust undergraduate pipeline via its STEM Scholars Programs, which continues to send more black graduates to medical school each year than any other school in the Nation.

While addressing physician shortages is one path to solving health care disparities in the Nation, we at Howard also believe that leveraging a team-based approach of training and deploying physicians, nurses, and advanced practice nurses, and pharmacists, and working units can do much to extend care within communities, cost effectively and efficiently.

Without continued support for these programs, it is unlikely that any of us will be able to meet the country's physician shortage challenge and needs for inclusive health care. In closing, I would like to certainly echo what my colleagues have said and which, again——

[technical problems]—to say.

One is that we would urge Congress to prioritize and designate graduate medical education physicians for teaching hospitals affiliated with HBCU medical schools through Medicare and the Teaching Health Centers Program. Legislation introduced in the House of Representatives, the Residents Physician Shortage Reduction Act, H.R. 2389, is a good model for this effort.

It designates GME positions by health professionals' shortage areas and prioritizes slots of teaching hospitals affiliated HBCU medical schools. An increase in funding and accelerating funding for HRSA VII health workforce diversity programs, particularly with a focus on Centers of Excellence and the Health Career Opportunity Program.

Both programs are currently funded at less than they were in Fiscal Year 2005. Right sizing these programs will allow more schools to build meaningful diversity training programs and establish and maintain workforce pipeline programs that help professional skills.

We should accelerate investments in the programs of the national institutes of minority health and health disparities, that improve the research capacity and infrastructure of minority serving health professional schools.

Both the NIMHD, research centers at minority institutions, the RCMIs, and the research endowment programs are short funded. The budgets for the RCMIs and the research endowment program should reflect a national commitment to level the research infrastructure playing field at minority health schools compared to those other nationwide. Thank you for your time.

[The prepared statement of Dr. Mighty follows:]

PREPARED STATEMENT OF HUGH E. MIGHTY

Thank you, Chairman Sanders, and thank you to my colleagues for their eloquent discussion on improving the diversity of the nation's healthcare workforce. Our HBCU medical schools are the backbone of training Black doctors in this country, where Black doctors make up only 5 percent to 7 percent of American physicians. The value of our HBCU medical schools' work is more important now than ever before.

Howard University has a 156-year history of training minority physicians in this country. More than 50 percent of these graduates return to work in underserved communities nationwide Howard also has the distinction of having a College of Dentistry, a School of Pharmacy, a School of Nursing and Allied Health, and a School of Social Work. Together these schools provide a diverse solution to many of the healthcare challenges faced in the nation

As the problem of Black physician shortages rises within the general context of the physician workforce shortage, many communities of need will continue to be underserved in the future. Our medical school and our HBCU colleagues have witnessed a surge in the number of applicants to medical school with a limited capacity to accept more. Barriers to growing programs often reside in the high cost of medical school education The issues faced after medical school graduation are just as significant because there are fewer funded residency positions than there are graduates. Highly trained physicians who can provide critical medical help to the most underserved communities struggle to find residency programs. The GME dollars are only available for some who graduate.

Clinical research is yet another area where HBCUs have been underfunded and therefore restricted in their ability to expand the movement of solutions to communities of color, where trusted voices would lead to better participation in clinical trials.

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While addressing physician shortages is one path to solving healthcare disparities in the nation, we at Howard also believe that leveraging a team-based approach of training and deploying physicians, nurses and advanced practice nurses, and pharmacists in working units can do much to extend care within communities cost-effectively and efficiently. Without continued support for these programs, it is unlikely that any of us will be able to meet the country's physician shortage challenges and needs for inclusive healthcare. In closing, I would like to echo the sentiments of my colleagues and:

(1) Urge Congress to prioritize and designate graduate medical education (GME) positions for teaching hospitals affiliated with HBCU medical schools through Medicare and the Teaching Health Centers program. Legislation introduced in the House of Representatives, the Resident Physician Shortage Reduction Act, H.R. 2389, is a good model for this effort It designates GME positions for Health Professions Shortage Areas (HPSAs) and prioritizes slots at teaching hospitals affiliated with HBCU medical schools.

(2) Increase and accelerate funding for HRSA Title VII health workforce diversity programs—with a particular focus on Centers of Excellence and the Health Careers Opportunity Program. Both programs are currently funded at less than they were in fiscal year 2005. Right-sizing these programs would allow more schools to build meaningful diversity training programs and establish and maintain workforce pipeline programs at health professions schools.

(3) Accelerate investments in the programs of the National Institute on Minority Health and Health Disparities (NIMHD) that improve the research capacity and infrastructure at minority-serving health professions schools. Both the NIMHD Research Centers at Minority Institutions (RCMI) and the Research Endowment Program are short-funded. The budget for the RCMI and the Research Endowment programs should reflect a national commitment to level the research infrastructure playing field at minority health schools compared to other health schools nationwide.

The CHAIR. Thank you, Dr. Mighty. Dr. David Carlisle is President and CEO at Charles R. Drew University. Dr. Carlisle, thanks so much for being here.

STATEMENT OF DAVID M. CARLISLE, M.D., PH.D., M.P.H., PRESIDENT AND CEO, CHARLES R. DREW UNIVERSITY, LOS ANGELES, CA

Dr. CARLISLE. Thank you, Chairman Sanders, and thank you for convening this important forum. And thank you to President Montgomery Rice for hosting us here this morning. I bring you greetings from the faculty, the trustees, the students and the alumni of Charles R. Drew University.

We are the only historically black institution of higher education west of Texas and the great Western part of the United States. You know, the main job of the medical school is to train physicians to treat patients in various health care settings.

As my colleagues have stated, our four schools have and continue to serve a unique role in training blacks and other minorities for careers as physicians, and we do it better than any other set of institutions.

A key element in building a diverse and capable health care workforce and to study health conditions that just disproportionately impact our communities is through the research enterprise that is associated with our medical schools.

Collectively, our HBCU medical schools advocated for the establishment of the National Institute on Minority Health and Health Disparities, NIMHD, at the National Institutes of Health to heighten the importance of research and innovation on minority health and status disparities. Initially, NIMHD was established as a center in the year 2000, and then elevated to an institute in 2010, thanks to the work of Senator Sanders' HELP Committee.

My colleagues have stated, the challenges that face HBCU medical schools, in terms of resources, endowment, and financial wherewithal, these challenges extend to our research capabilities as well, and the NIMHD has several programs designed to address improving research infrastructure at minority serving health professionals schools.

NIMHD's research centers at minority institutions, RCMIs, and the Resource Endowment Program, REP, are two critical initiatives designed to build research infrastructure at minority serving institutions. Both programs have been short funded in recent years.

RCMI is not growing at the same rate as NIMHD's overall rate of increase during the last several years. The RCMI program has provided the resources needed for our schools to build a research infrastructure comparable to non-minority institutions, allowing us to attract world class researchers, expand research facilities, and support cutting edge investigation into questions about health disparities and how to improve and eradicate them.

We urge Congress to prioritize support for the RCMI program and resize the RCMI program to a proportionate level of the NIMHD's budget.

In the last Congress, the bipartisan John Lewis NIMHD Resource Endowment Revitalization Act was passed into law. Thanks to our local Congresswoman Nanette Barragan, and to the HELP Committee, and Ranking Member Senator Cassidy of Louisiana for their sponsorship of this legislation.

The Research Endowment Program helps our institutions build a research endowment that is comparable to the average endowment of all medical schools. The new Research Endowment Program is supported by only $12 million annually, when historically it had been supported upwards to $50 million per year.

More funding for this program is needed to accelerate the pace of strengthening our institutions. Thank you again, Chairman Sanders, for your leadership and interest in our views.

[The prepared statement of Dr. Carlisle follows:]

PREPARED STATEMENT OF DAVID M. CARLISLE

Charles R. Drew University of Medicine and Science (CDU) in South Los Angeles was founded in 1966 in the wake of the historic Watts Rebellion to cultivate diverse health professional leaders who are dedicated to social justice and health equity for underserved populations. CDU has an ambitious yet attainable vision of a future with excellent health and wellness for all in a world without health disparities. Having diversity across all health care, including researchers, practitioners, administrators, educators, and policymakers, is an essential component in making this vision a reality. CDU's participation in education, research, clinical service, and community engagement indicates certain strategies will support achieving this goal.

Providing quality health professions education opportunities to students of color will ensure and expand a pipeline of diverse and diverse-minded nurses, doctors, dentists, physician assistants, and technicians, who create a more equitable and culturally competent health care landscape. This can be attained through the continued or increased support for Historically Black Medical Schools. These institutions hold a unique and valuable position within the medical profession by providing opportunities for those who have historically been denied equal access to higher education.

Investing in the health and growth of America's Historically Black Medical Schools is investing in the health and growth of our most underserved communities across the Nation. As non-profit institutions, we rely on the support of the government, philanthropist, corporations, partners, and the community to pursue our mission, build our endowments, support hard scale construction, and provide the best learning experiences for the next generation of the medical workforce.

Addressing the shortage of graduate medical education slots/residency positions must also be a priority. Every year, thousands of aspiring physicians are unable to find a residency opportunity. Most will have to wait an entire year to reapply to practice medicine, preventing them from filling the physician shortage.

Innovative initiatives like the National Health Service Corps, of which I am an alumnus, provide scholarships and loan repayment opportunities for new medical professionals. These programs increase access to quality health care in communities every day and deserve whatever support can be mustered to maintain and grow them.

In undergraduate education, funding summer programs, increasing scholarships, and supporting stipends for work study efforts would go a long way towards decreasing the dropout rate among minority populations that is bottlenecking the supply of medical school candidates. Providing resources and support to expand the scope and number of pre-med and undergraduate medical education programs at colleges and universities in communities of color would also increase the flow of students into 4-year medical programs, and ultimately into the workforce.

It is our hope at CDU that these ideas and initiatives can be provided the support they need from the highest levels of our government in order to move them forward in a timely manner so the issue of the health professional shortages and health workforce diversity can be meaningfully addressed.

The CHAIR. Dr. Carlisle, thank you very much. Our next panelist is Dr. David G. Skorton, President and CEO of the Association of American Medical Colleges. Dr. Skorton.

STATEMENT OF DAVID J. SKORTON, M.D., PRESIDENT AND CEO, ASSOCIATION OF AMERICAN MEDICAL COLLEGES, WASHINGTON, DC

Dr. SKORTON. Thank you, Chairman Sanders, for this and for all you do. Thank you, Dr. Montgomery Rice, for this and for all you do. And to all my colleagues leading these incredibly important institutions that we are proud to have as members of the AAMC.

Thank you for the learner for giving us our future. I am going to try very hard, Chairman Sanders, not to repeat things that you have already heard about, but just to endorse them.

The physician shortage that you mentioned, Chairman Sanders, we estimate by 2034 will be 124,000 physicians. And if your vision

for the future came to pass, that everybody had access to medical care, we would right now be, right now 180,000 positions short. So, this is a real crisis. It is not getting any better.

Since the Flexner Report, the HBCUs have been fighting back valiantly to return from a very low point, to distinguish things that they are doing now. And I am very proud of these four schools. I learn so much from their leaders all the time. I mean that quite sincerely.

We are also looking forward as AAMC to Xavier University of Louisiana and Ochsner Health opening a College of Medicine, and I also want to recognize—[technical problems]—and also want to recognize, Chairman Sanders, that Morgan State University in Baltimore will open a College of Osteopathic Medicine—[technical problems].

All these added up, the HBCUs are less than 3 percent of all M.D. granting institutions, and as Dr. Montgomery Rice said, produce more than 50 percent of all black medical graduates. Make no mistake about it, we have been going nowhere in our work to increase blacks, and especially black men in medicine, except for the HBCUs.

My first faculty appointment in January 1980 and last year, the very same proportion of matriculants were black men across America. That is a record that I am not proud of.

Through our action collaborative for black men in medicine, Chairman, which is a joint effort between the AAMC and the National Medical Association, and through an additional facet of our strategic plan, we are starting to see some improvement in these areas, and a lot of it is due to the leaders you see before you today.

I want to switch gears and mention that in the coming weeks the U.S. Supreme Court is going to decide on two cases about the use of race as one factor among many in higher education admissions, including but not limited to medical schools.

An adverse ruling by the Supreme Court would be very detrimental to addressing physician diversity. In the states in the United States where the use of race conscious admissions has been banned, there has been a 37 percent reduction in diversity of the classes going forward, and we are here today to say publicly that no matter the ruling of the Supreme Court of the United States, we will continue to push forward for diversity in our—[technical problem].

In addition to our endorsement of the bipartisan Resident Physician Shortage Reduction Act, which is H.R. 2389 and S. 1302, I want to talk a little bit more about the HRSA programs that have been brought up by our other colleagues.

As was mentioned, those funds have not gone up. They have gone down actually over the last couple of decades. And we support doubling funding for a broad range of HRSA Title VII and VIII workforce. We are urging Congress, Mr. Chairman, to provide at least $1.51 billion combined across Title VII and Title VIII programs.

We also encourage publicly today increasing Federal investment in minority serving institutions, including HBCUs, including pre-

dominantly black institutions, including Hispanic serving institutions, and very importantly, tribal colleges and universities. Of all the many underrepresented in our Country in medicine, the Native Americans and Alaska Natives were the only group, Chairman, in the last 2 years where the applicants went up and the matriculants went down, so we need to work on that issue as well.

We also support the Expanding Medical Education Act, which would authorize HRSA grants to establish or expand medical schools, including regional branch campuses, and would prioritize HBCU's, NSIs, or those institutions that propose to establish or expand schools in medically underserved communities.

Also, the Pathway to Practice proposal and National Medical Corps Act scholarship programs introduced in 117th Congress H.R. 9105 would help address the high financial debt for students represented—underrepresented in medicine. This is a daunting thing to look at, especially from early in the education cycle.

I want to talk very briefly, Chairman, about learner and physician burnout. We know that burnout and stress on our learners and physicians is real. We have to create a more supportive environment for current and future physicians.

I would like to highlight the Dr. Lorna Breen Health Care Provider Protection Act, LBA, P.L. 117–105, which passed in 2022 but has not been funded. We urge support for this. We also urge support for immigration programs that continue to bring physicians and other health professionals to underserved areas.

We need those excellent physicians and health care workers in this country. There is a backlog of green card applications and also J–1 waivers that can be used to bring more physicians not only to the United States in general, but also to underserved areas.

In closing, I want to thank you, Chairman Sanders. I want to thank Dr. Montgomery, President Montgomery Rice, and all here. We have a lot of work to do. Let's get on with it. Thank you.

[The prepared statement of Dr. Skorton follows:]

PREPARED STATEMENT OF DAVID J. SKORTON

The AAMC appreciates the opportunity to participate in the Roundtable on Historically Black Colleges and Universities (HBCU) medical schools and health care workforce diversity, held at Morehouse School of Medicine, one of our member institutions.

The AAMC is a nonprofit association dedicated to improving the health of people everywhere through medical education, health care, medical research, and community collaborations. Its members are all 157 U.S. medical schools accredited by the Liaison Committee on Medical Education; 13 accredited Canadian medical schools; approximately 400 teaching hospitals and health systems, including Department of Veterans Affairs medical centers; and more than 70 academic societies. Through these institutions and organizations, the AAMC leads and serves America's medical schools and teaching hospitals and the millions of individuals across academic medicine, including more than 193,000 full-time faculty members, 96,000 medical students, 153,000 resident physicians, and 60,000 graduate students and postdoctoral researchers in the biomedical sciences. Following a 2022 merger, the Alliance of Academic Health Centers and the Alliance of Academic Health Centers International broadened the AAMC's U.S. membership and expanded its reach to international academic health centers.

The need for a more diverse health workforce is clear, and the need for Black physicians cannot be underestimated. A recent study found that Black people live longer in places with more Black doctors.[1] Looking at primary care physician supply and population health at the county level, greater Black representation among physicians was associated with higher life expectancy for Black individuals, and inversely associated with all-cause Black mortality and mortality rate disparities between Black and White individuals. We know physician workforce diversity is in the best interest of the health of people everywhere. We all should work on policies and partnerships that move toward this goal.

The Flexner Report

In 1910, Abraham Flexner published what would be known as the Flexner Report,2 which held as its thesis "that the country needs fewer and better doctors." While the stated intention was to normalize medical education for the majority of physicians and there were significant problems in medical education, the actual result was that the Flexner Report was weaponized to severely limit opportunities for Black Americans pursuing medical education and as a result, deepened health inequities for Black Americans for decades. When Flexner traversed the country in 1909 and visited 155 medical schools, he advocated for the closing of almost 80 percent of all the contemporary programs in what he labeled as, "medical sects" including chiropractic, osteopathy, homeopathy, and physical therapy programs. Flexner included professional requirements that brought about the closure of many medical schools, and the report was particularly harmful to the existence of Black medical schools. Unfortunately, institutions in the Midwest and the South bore the brunt of these closures, and the largely underserved and rural communities in those locations were left with even fewer local medical resources.

Flexner pushed to close for-profit medical schools, which had filled the need to educate Black people for medical training. During the time of the report, white institutions would not admit Black students to train as physicians or treat Black patients. In 1910, there were seven medical schools that filled this unmet need and admitted Black students who then became physicians. I list them in this testimony to honor their contributions to society, which were truncated or scaled back following the Flexner Report:

1. Howard University Medical School (est. 1868, remains in existence today)
2. Meharry Medical College (est. 1876, remains in existence today)
3. Leonard Medical School / Shaw University (est. 1882, closed in 1915)
4. New Orleans University Medical College (est. 1887, closed 1911)
5. Knoxville Medical College (est. 1895, closed 1910)
6. Chattanooga National Medical College (est. 1902, closed 1908)

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[1] Snyder, John E.; Upton, Rachel D.; Hassett, Thomas C.; Lee, Hyunjung; Nouri, Zakia; & Michael Dill. 2023. Black representation in the primary care physician workforce and its association with population life expectancy and mortality rates in the U.S.. JAMA Network Open. 2023; 6(4):e236687. DOI:10.1001/jamanetworkopen.2023.6687.

7. University of West Tennessee College of Physicians and Surgeons (est. 1904, closed 1923)

Key Statistics and Factors Demonstrating the Need for Change

The lack of sufficient physicians and insufficient diversity in the physician population continues to affect the health of the population today amid a complex and multifactorial landscape of challenges.

1. The U.S. will face a projected physician shortage of up to 124,000 physicians by 2034. The AAMC continues to project that physician demand will grow faster than supply (primarily driven by a growing, aging U.S. population) leading to a projected total physician shortage of up to 124,000 physicians by 2034. Within this total, we project a shortage of up to 48,000 primary care physicians and a shortage of up to 77,100 non-primary care specialty physicians (e.g., psychiatry, infectious disease, and general surgery) by 2034. These shortages build on existing measured shortages of behavioral health and primary care providers. Moreover, the AAMC's "Health Care Utilization Equity" scenario finds that if underserved populations were to experience the same health care use patterns as populations with fewer barriers to access, the U.S. would need up to an additional 180,400 physicians just to meet current demand.[2] Make no mistake—these shortages in the physician supply have real impact on patients, particularly those living in rural and other underserved communities.

2. The number of HBCU medical schools has not rebounded since the Flexner Report. Today, there are four HBCU medical schools: Howard University College of Medicine, Meharry Medical College, Morehouse School of Medicine, and most recently, the Charles S. Drew College of Medicine. These institutions comprise less than 3 percent of all M.D.-degree granting institutions, but are responsible for producing more than 50 percent of all Black medical graduates. They also train other racial and ethnic groups who become physicians. We are looking forward to Xavier University of Louisiana and Ochsner Health opening a College of Medicine. We also acknowledge that Morgan State University in Baltimore will open a college of osteopathic medicine in 2023. Collectively, the HBCU medical schools have the potential to train more physicians, including underrepresented physicians, but those institutions must be supported to execute their important mission.

3. Black male physician totals have remained relatively stagnant over 40 years. In 1978, there were 1,140 Black male applicants to medical schools across the country, with 542 Black male matriculants in that same year. In 2014, the number of Black male applicants stayed relatively the same—1,137—but resulted in 515 Black male matriculants for 2014. In essence, for more than 30 years, the number of Black male applicants and matriculants at institutions across the country were stable or on the decline. This was the sounding of an important alarm, and groups like the AAMC have leaned into this problem to come up with solutions. Through the Action Collaborative for Black Men in Medicine, a joint effort between the AAMC and the National Medical Association, and through one core facet of the AAMC's recently adopted strategic plan, Action Plan 4: Increase Significantly the Number of Diverse Medical School Applicants and Matriculants,[3] we are starting to see improvement in these areas. 1A[4] Programs that have demonstrated impact on exposing historically excluded racial and ethnic groups to careers in medicine and that support the pathway to becoming a physician must be funded and replicated.

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[2] The Complexities of Physician Supply and Demand: Projections From 2019 to 2034, Prepared for the AAMC by IHS Markit Ltd., June 2021.

[3] For more information on the Action Collaborative, please visit Action Collaborative for Black Men in Medicine—AAMC. The AAMC Action Plan 4 updates can be accessed at Action Plan 4: Increase Significantly the Number of Diverse Medical School Applicants and Matriculants—AAMC.

[4] In 2020, there were 1,457 Black male applicants to medical school and 2020 Black male matriculants. In 2021, there were 1,895 Black male applicants to medical school and 813 Black men matriculants. These represent some of the highest totals since the data has been collected. For additional data, please visit https://*www.aamc.org/data-reports/students-residents/interactive-data/2021-facts-applicants-and-matriculants-data*

4. A United States Supreme Court decision not allowing race as one factor to consider in medical school admissions would be detrimental to addressing physician diversity. Longitudinal studies in states that have bans on race-conscious admissions demonstrate significant decreases in the number of underrepresented minority medical school matriculants. Should the Supreme Court's opinion result in greater restriction or prohibition of race-conscious admissions, it is foreseeable that similar decreases in diversity will be experienced nationwide, ultimately reducing the overall diversity of the physician workforce. **In that scenario, it will be even more important for Congress to support programs, noted below, that are designed to increase the diversity of our Nation's healthcare workforce.**

Legislative Priorities and Policies to Increase Health Care Workforce Diversity. There are programs that will have a positive impact on health care workforce diversity and the training of more diverse physicians. We urge the enactment of legislation and the funding of programs to ensure the success of these efforts that will deliver meaningful results.

1. Expanding the Workforce and Graduate Medical Education. The AAMC strongly supports the bipartisan Resident Physician Shortage Reduction Act of 2023 (S. 1302 / H.R. 2389) which would gradually add 14,000 new Medicare-supported GME positions over 7 years. These positions would be strategically targeted at a wide variety of teaching hospitals, including those affiliated with HBCU medical schools, helping to strengthen and diversify the health care workforce and improve access to care for patients, families, and communities across the country. AAMC strongly supports the expansion of Medicare support for GME and urges the inclusion of additional GME positions in any health care legislation.

GME programs administered by the Health Resources and Services Administration (HRSA), including Children's Hospitals GME and Teaching Health Centers, are important complements to Medicare GME that help to increase the number of residents training in children's hospitals and community health centers, respectively. Funding for HRSA programs specifically targeting GME at children's hospitals and teaching health centers will help alleviate physician workforce shortages in those settings.

2. Investing in HRSA Title VII and Title VIII Workforce Programs and the National Health Service Corps. The AAMC supports doubling funding for a broad range of HRSA's Title VII & VIII workforce development and diversity pathway programs to help shape the workforce to meet patient needs, including:

- Centers of Excellence (COE), student support and minority health training programs at health professions institutions;
- Health Careers Opportunity Program (HCOP), K–16 diversity pathway programs;
- Scholarships for Disadvantaged Students (SDS), scholarships for minority and/or disadvantaged health professions students; and
- Faculty Loan Repayment (FLRP), loan repayment program for minority health professions faculty to serve as mentors.

The HRSA Title VII diversity programs are smaller today than they were two decades ago ($115 million in 2002, compared to $106 million for 2023). The AAMC calls on Congress to adequately fund these programs in order to address the imperative to improve our commitment to diversity.

Many medical schools aim to identify potential candidates from rural and underresourced communities and encourage them to pursue a career in medicine. 1A[5], 1A[6] Additional Title VII programs support these and other efforts to help address gaps in the workforce. For example:

- HRSA Title VII Area Health Education Centers (AHECs) specifically focus on recruiting and training future physicians in rural areas, as well as providing interdisciplinary health care delivery sites; and

[5] Attracting the next generation of physicians to rural medicine, Peter Jaret, Special to AAMCNews, Feb. 2020.

[6] To facilitate new rural residency programs, the HRSA Office of Rural Health Policy provides technical assistance and startup funding to rural hospitals under the Rural Residency Planning and Development programs.

- HRSA Title VII Primary Care Training and Enhancement (PCTE) and Medical Student Education (MSE) programs support education and training programs for future primary care physicians.

The AAMC urges Congress to provide at least $1.51 billion combined for all Title VII and Title VIII programs in the fiscal year 2024 spending bill. Additionally, the AAMC looks forward to working with the HELP Committee and the full Congress to reauthorize these programs before they expire at the end of fiscal year 2025.

Additionally, the National Health Service Corps (NHSC) in particular has played a significant role in recruiting primary care physicians to federally designated Health Professions Shortage Areas (HPSAs) through scholarships and loan repayment options. Despite the NHSC's success, it still falls far short of fulfilling the wide-ranging health care needs of all HPSAs due to growing demand for health professionals across the country.

Supporting Title VII, Title VIII, and the NHSC not only would help address pervasive gaps in the health workforce, it also would encourage a whole health care, team-based approach to health care so the entire system can be fortified.

3. Expanding Medical Schools at Minority Servicing Institutions, Historically Black Colleges and Universities, and in Underserved Communities. The AAMC encourages increasing Federal investment in minority serving institutions (MSIs), including Historically Black Colleges and Universities (HBCUs), Predominantly Black Institutions (PBIs), Hispanic Serving Institutions, and Tribal Colleges and Universities. The AAMC supports the Expanding Medical Education Act, which would authorize HRSA grants to establish or expand medical schools, including regional branch campuses, and would prioritize HBCUs, MSIs or those institutions that propose to establish or expand schools in medically underserved communities or areas with shortages of health professionals where no such schools exist.

4. Reducing or eliminating financial obstacles to medical education. Medical education costs can be a significant deterrent for individuals interested in medicine and can impact the physician pathway.[7] The "Pathway to Practice" proposal and National Medical Corps Act scholarship programs introduced in the 117th Congress (H.R. 9105) would help address the high financial debt for students who are underrepresented in medicine. Importantly, the Pathway to Practice program would prioritize applicants who attended HBCUs or MSIs, as well as those who participated in certain HRSA pathway programs.

Public service loan repayment programs offered by HRSA, the National Institutes of Health, Department of Veterans Affairs, the Department of Defense, and the Indian Health Service are effective, targeted incentives for recruiting physicians and other health professionals to serve specific marginalized populations. Increasing Federal investment in these programs is a proven way to increase the supply of health professionals serving HPSAs, nonprofit facilities, and other underserved communities.

In addition, continued access to income-driven student loan repayment plans and the Public Service Loan Forgiveness (PSLF) Program ensure payments commensurate with salary and foster engagement in critical public service careers. The PSLF program is an essential tool for nonprofit and government facilities to recruit and retain first-generation and underrepresented students to medical schools, encouraging physicians to practice at nonprofit facilities, and incentivizing physicians to become our next generation of medical researchers.

5. Addressing learner and physician burnout. The AAMC is grateful to Congress for enacting the Dr. Lorna Breen Health Care Provider Protection Act (LBA, P.L. 117–105) in 2022, to support initiatives to address the mental health and well-being of aspiring and practicing health professionals. Demand for such funding far outpaces the limited resources that HRSA has been able to provide for such programming, and the AAMC urges lawmakers to fully fund the LBA in fiscal year 2024.

6. Supporting immigration programs that continue to bring physicians and other health professionals to underserved areas. Immigration must be mentioned as we consider health workforce shortages. The U.S. health workforce has been bolstered by individuals who have come

[7] Physician Education Debt and the Cost to Attend Medical School: 2020 Update.

from other countries to our Nation. Over the last 15 years, the State Conrad 30 J–1 visa waiver program has brought more than 15,000 physicians to underserved areas—comparable to (if not more than) the NHSC, at no cost to the Federal Government. Bipartisan legislation that would allow Conrad 30 to expand beyond 30 waivers per state would be useful, as well as recognizing immigrating physicians as a critical element of our Nation's health care infrastructure. In addition, the U.S. should address the backlog of green card applications by lifting per country caps that are impeding physicians and other healthcare professionals entering the U.S. from certain countries. To break these backlogs, the bipartisan Healthcare Workforce Resilience Act would authorize the recapture of unused immigrant visas and redirect them to 25,000 immigrant visas for professional nurses and 15,000 immigrant visas for physicians. These visas would be issued in order of priority date, not subject to the per country caps, and premium processing would be applied to qualifying petitions and applications.

Next Steps for Action and Change

The responsibility of increasing diversity in health care, especially among physicians, does not rest solely on the government. We offer here a few suggestions for many stakeholders interested in increasing physician diversity.

1. Support innovative approaches and public-private partnerships for medical education and residency training. Addressing the nation's physician workforce shortages in both primary care and among needed specialists requires a multipronged, innovative, public-private approach beyond just increasing the overall number of physicians, such as implementing team-based care and better use of technology. While we believe that increasing Federal support for GME is an important component to any comprehensive workforce strategy, we are open to, and in fact ask for, these and other innovative solutions to address health workforce shortages.

2. Support the role of HBCUs, minority serving institutions (MSIs), and all other institutions to train a diverse workforce. We must support the important role of HBCUs—undergraduate schools, medical schools, and other allied health schools—in producing the future generation of Black scholars with the funding and infrastructure to have innovative and expanded physical facilities, excellent faculty to teach the latest medical techniques and to conduct groundbreaking, NIH-funded research, and to remain a trusted resource situated in their local communities. We should not overlook the importance of other minority serving institutions, which have been noted as an underutilized resource that is available to help create a diverse STEM workforce.[8] Tribal colleges and universities should receive additional Federal support and be brought into conversations about training future physicians and others in the health care workforce. Hispanic-serving institutions are yet another group of institutions that are able to help meet the diverse physician goals we describe above. When thinking about diversifying the workforce, an inclusive approach must be pursued.

While recognizing the strong influence of HBCUs and MSIs in producing a diverse workforce, there is an important role for all other institutions in contributing to the diversification of the health care workforce as well. Instead, all institutions should be supported in their efforts to develop and to execute a plan to help increase workforce diversity, understanding that diversity will take on many different forms.

Conclusion

We at the AAMC are committed to working with the entire Senate HELP Committee to move the Nation forward in efforts to diversify the physician and health care workforce and to ultimately to achieve better outcomes for our Nation. If you have any further questions, please contact AAMC Chief Public Policy Officer Danielle Turnipseed, at *dturnipseed@aamc.org*.

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[8] National Academies of Sciences, Engineering, and Medicine 2019. Minority Serving Institutions: America's Underutilized Resource for Strengthening the STEM Workforce. Washington, DC: The National Academies Press. *https://doi.org/10.17226/25257*.

The CHAIR. Thank you, Dr. Skorton. The next panelist is Dr. Samuel Cook, Internal Medicine Resident Physician here at Morehouse.

STATEMENT OF SAMUEL COOK, M.D., RESIDENT, MOREHOUSE SCHOOL OF MEDICINE, ATLANTA, GA

Dr. COOK. Good morning, everyone. To the Morehouse students, faculty, and staff, for all those from the historically black medical schools to the President of the AAMC, and all the community members who came out today, thank you so much for coming out for this vitally important conversation.

I am Dr. Samuel Cook, PGY2 internal medicine resident here at the Morehouse School of Medicine, and I was asked to share some of my story so you all can get a better idea of what it is like to come up as a resident through the current system. Senator and Chairman Sanders, I come to you today as a fellow American, born and raised in New York City. I grew up in the Bronx.

New York, born to loving parents who instilled in me a passion and need to serve my surrounding community at all costs. On my father's side of the family, I was the first Cook to graduate from college.

While attending the Johns Hopkins University, I quickly began volunteering at a sliding scale medical clinic in a low-income area of Baltimore aimed solely at providing low cost the free medical care for families who had limited access to it.

However, I struggled to get my foot in the door of more established medical institutions, even with my academic pedigree, because I lacked the familial connections to medicine that so many of my white counterparts had in spades.

Nevertheless, I moved forward. I served as a community resource coordinator in East Baltimore, specifically addressing the social determinants of health we so readily take for granted, access to food, shelter, water, electricity, and employment, all necessary components of health, recognizing that true health is not the mere absence of disease, but a total state of physical, mental, and spiritual well-being.

After being told by my undergraduate advisor that my 3.4 GPA at one of the top ten universities in the Nation was not strong enough to support a medical school application, I listened and took a delayed route to my medical education, eventually matriculating to the Drexel University College of Medicine in Philadelphia, Pennsylvania, where I won academic awards and published my medical research.

I dove even deeper into medically centered service work and mentorship of young black STEM students across the Nation, ensuring that they would never have to face a lack of supportive guidance or feet in the doors of credible medical institutions.

We are here today for such a great purpose. We ultimately want more black Americans in white coats, but how do we do this? I believe the right approach is what barriers to entry do we have to dismantle?

How is it right that I am tasked with providing our community high quality health care while struggling to provide for my own family? Why am I struggling financially as a resident physician when I could make a greater hourly wage as a line cook, and I know because I have? And why am I hundreds of thousands of dollars in student loan debt, $320,000, to be exact, when my parents scratched and saved to fully cover my undergraduate tuition?

It is because our system is broken, and we as resident physicians are not fairly compensated for our time spent saving lives by sacrificing our own well-being. For far too long, we have fallen through the cracks of a health care system that blatantly and openly abuses our binding investments into this field, and it is high time that our side is heard, appreciated, and acted upon.

Today I submit to you that the greatest barrier to entry for burgeoning black positions is the immense and seemingly insurmountable financial risk waiting to shackle all those who pass through the gates of medical education. These costs are equally shared for everybody, but the burden they pose is not.

It is an equitably distributed as one of many sequelae of generational and institutional wealth inequity. So, when the COVID pandemic hit, we physicians of color were asked to run headfirst into a largely unknown crisis, putting our lives, our livelihoods, and the health of our families in the path of imminent danger.

As always, we delivered upon our Hippocratic Oath. I am here today to advocate for my fellow physicians of color, those with less than half the general racial wealth of our white counterparts. We, the resident physicians of color who have no financial safety net should a career in medicine not pan out for any reason.

We, the resident physicians of color who have been historically underrepresented, underestimated, and underpaid. It is time for change, and it is time for change today. It is time, Chairman Sanders, for us to get our due so the aspiring physicians in our Country may see that they will be fairly treated and protected should they ever choose a career in medicine.

It should not be such a financially perilous journey to want to save the lives of others. It should be a decision that is celebrated with words, with actions, and with support, from the community level all the way up to our U.S. Government. We are not asking for a silver spoon, and we are certainly not seeking handouts.

We are simply asking for medical school loan cancellation, free medical tuition for the next generation, and the fair compensation that we are due. Thank you very much.

[The prepared statement of Dr. Cook follows:]

PREPARED STATEMENT OF SAMUEL D. COOK

Senator and Chairman Sanders, I come to you today as a fellow American born and raised in New York City. I grew up in the Bronx, NY, born to two loving parents who instilled in me a passion and need to serve my surrounding community at all costs. On my father's side of the family, I was the first Cook to graduate from college. While attending the Johns Hopkins University, I quickly began volunteering at a sliding-scale medical clinic in a low-income area of Baltimore, aimed solely at providing low-cost to free medical care for families who had limited access to it. However, I struggled to get my foot in the door of more established medical institutions, even with my academic pedigree, because I lacked the familial connections to medicine that so many of my white counterparts had in spades. Nevertheless, I moved forward. I served as a Community Resource Coordinator in East Baltimore, specifically addressing the social determinants of health we so readily take for granted: access to food, shelter, water, electricity, and employment—all necessary components of health; recognizing that true health is not the mere absence of disease, but a total state of physical, mental, and spiritual well-being.

After being told by my undergraduate advisor that my 3.42 GPA at one of the top–10 universities in the Nation was not strong enough to support a medical school application, I listened and took a delayed route to my medical education, eventually matriculating to the Drexel University College of Medicine in Philadelphia, PA, where I won academic awards and published my medical research. I dove even deeper into medically centered service work and mentorship of young, Black STEM students across the country. Ensuring that they would never have to face a lack of supportive guidance or feet in the doors of credible medical institutions.

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It is because our system is broken, and we, as resident physicians, are not fairly compensated for our time spent saving lives while sacrificing our own well-being. For far too long, we have fallen through the cracks of a healthcare system that blatantly, and openly, abuses our binding investments into this field, and it is high time that our plight is heard, appreciated, and acted upon. Today, I submit to you that the greatest barrier to entry for burgeoning Black physicians is the immense, and seemingly insurmountable, financial risk waiting to shackle all those who pass through the gate of medical education. These costs are equally present for all, but the burden they pose is not. It is inequitably distributed as one, of many, sequelae of generational and institutional wealth inequity.

When the Covid pandemic hit, we physicians of color were asked to run head-first into a largely unknown crisis, putting our lives, our livelihoods, and the health of our families in the path of imminent dangers. As always, we delivered upon our Hippocratic oath. I am here today to advocate for my fellow physicians of color, those with less than half the generational wealth of our white counterparts. We, the resident physicians of color, who have no financial safety nets should a career in medicine not pan out for any reason. We, the physicians of color, who have been historically underrepresented, underestimated, and underpaid. It is time, Chairman Sanders, for us to get our due so the aspiring physicians in our Country may see that they will be fairly treated and protected should they choose a career in medicine.

It should not be such a financially perilous journey to want to save the lives of others. It should be a decision that is celebrated; not with words, but with actions and support: from the community level all the way up to our U.S. government. We are not asking for a silver spoon. We are certainly not seeking handouts. We are simply demanding medical school loan cancellation, free medical tuition for the next generation, and the fair wages that we are due.

The CHAIR. Thank you, Dr. Cook. Next panelist is—hey, you put a big burden on this young lady. Be nice to her too, all right? Sonya

Randolph is a Medical Student, year 3 here at Morehouse School of Medicine.

STATEMENT OF SONYA RANDOLPH, STUDENT, MOREHOUSE SCHOOL OF MEDICINE, ATLANTA, GA

Ms. RANDOLPH. Definitely a tough act to follow.

[Laughter.]

Ms. RANDOLPH. Good morning, Chairman Sanders. Thank you for having us here today to listen to us. I just want to tell a little bit about my story.

For some, the topic of black representation in the medical field may seem like a trivial matter, but for others it may mean the difference between the life of a loved one. For a young black couple who presented to the hospital to an all-white health care team with concerns that their 5-year-old son was ill, this topic is of particular importance.

This couple trusted their son to be cared for by a capable group of physicians that they believed would render quality medical care for him. How could they have known it would be—he would be misdiagnosed with a 24-hour virus instead of his actual diagnosis of bacterial meningitis, which proved to be fatal the next day?

Why weren't their concerns taken seriously? Why did he not receive the appropriate standard of care? Could this outcome have been any different if he were attended to by a black physician? The couple in this story are my parents and the young child was my brother Bryce, and the reason I aspire to be a physician today.

Senator Sanders, it is imperative that we as a country understand the significance of black physicians providing care for black patients and other patients as well.

Studies show that when black patients are treated by black doctors, they are more satisfied with their health care, more likely to have received the preventive care they needed in the past year, and more likely to agree to recommended preventive care.

Though the AAMC reports an increase in black or African American medical matriculants in 2022 and 2023, we have even greater work to do. With key factors such as student loan forgiveness, increased exposure and visibility, and mentorship for students aspiring to be in health care, we can increase the number of Black Americans in the medical field and subsequently improve health outcomes for Black Americans.

According to an article written in the New England Journal of Medicine, children from underrepresented or disadvantaged backgrounds who aspire to be physicians are more likely than their peers to drop their aspirations before the 12th grade, in part due to lack of exposure, and cultural, structural, and racial biases in society.

Efforts to inspire students from underrepresented backgrounds to pursue a career in medicine should begin at the grade school level. Through pipeline programs, college readiness initiatives, and mentoring opportunities that provide guidance and proctored hands-on activities for students, we can inspire these future leaders to attain their aspirations, despite any obstacles encountered along the way.

With persistent exposure to careers in health care, we will see a significant increase in the number of Black Americans in the medical field. The cost of American medical education has increased substantially over the past decade. Attending medical school without a scholarship can result in hundreds of thousands of dollars of debt.

Despite this, students continue to aspire to be—to have a career in medicine. These aspirations are thwarted when students are not able to afford housing, food, and other necessities while at school. The burden of accumulating debt while attending school works to deter potential students from this rewarding career.

Learners need student loan debt forgiveness, increased funding for scholarships, and more financial support for our HBCU Medical School to be able to afford to continue their education.

We can achieve this goal with a substantial increase—of a substantial increase in Black American representation in the medical field, but it will take more individuals like you, Senator Sanders, and the HELP Committee, to achieve—thank you.

[The prepared statement of Ms. Randolph follows:]

PREPARED STATEMENT OF SONYA RANDOLPH

It is imperative that we as a country understand the significance of Black physicians providing care for Black patients. Studies show that when Black patients are treated by Black doctors, they are more satisfied with their healthcare, more likely to have received the preventive care they needed in the past year, and are more likely to agree to recommended preventive care. Though the AAMC reports an increase in Black or African American medical school matriculants in 2022–23, now making up 10 percent, we have even greater work to do. With key factors such as student loan forgiveness, increased exposure and visibility, and mentorship for students aspiring to be in healthcare we can increase the number of Black Americans in the medical field and subsequently improve health outcomes for Black Americans.

According to an article written in the New England Journal of Medicine, children from underrepresented or disadvantaged backgrounds who aspire to be physicians are more likely than their peers to drop those aspirations before 12th grade in part due to a lack of exposure and structural and racial biases in society. Efforts to inspire students from underrepresented backgrounds to pursue a career in medicine should begin at the grade school level. Through pipeline programs, college readiness initiatives, and mentoring opportunities that provide guidance and proctored hands-on activities for students, we can inspire these future leaders to attain their aspirations despite any obstacles encountered along the way. With persistent exposure to careers in healthcare we will see a significant increase in the number of Black Americans in the medical field.

The cost of American medical education has increased substantially over the past decade. Attending medical school without a scholarship can result in hundreds of thousands of dollars of debt. Despite this, students continue to aspire a career in medicine. These aspirations are thwarted when students are not able to afford housing, food, and other necessities while in school. The burden of accumulating debt while attending school works to deter potential students from this rewarding career. Learners need student loan debt forgiveness, increased funding for scholarships, and more financial support for HBCU medical schools to be able to afford to continue their education.

For some, the topic of Black representation in the medical field may seem like a trivial matter, but for others it may mean the difference in the life of a loved one. For a young Black couple who presented to the hospital to an all-white healthcare team with concerns that their 5-year-old son was ill, this topic is of particular importance. This couple trusted their son to be cared for by a capable group of physicians that they believed would render quality medical care for him. How could they have known he would be misdiagnosed with a 24-hour, instead of his actual diagnosis of bacterial meningitis which proved to be fatal the next day. Why weren't their concerns taken seriously? Why did he not receive the appropriate standard of care? Could this outcome have been any different if they were attended to by a Black physician? The couple in this story are my parents and the young child was my brother, Bryce, and the reason I aspire to become a physician. I want my patients who look like me and those who don't look like me to both receive the same excellent care in an equitable manner.

We can achieve the goal of a substantial increase in the Black American representation in the medical field, but it will take more individuals like you, Senator Sanders, and the HELP Committee to achieve this goal.

The CHAIR. Last but not least—and thank you, Sonya. Dr. Jamil Joyner, who is a medical student here at Morehouse.

STATEMENT OF JAMIL JOYNER, STUDENT, MOREHOUSE SCHOOL OF MEDICINE, ATLANTA, GA

Mr. JOYNER. Good morning, everyone. Thank you, Senator Sanders. Thank you all of my co-panelists. All of your words beautiful and you give me a great chance to close this out tonight. I don't know if I will be as eloquent, but I will try to be as pointed.

I mean, as directly to what I believe the solution is for how we increase diversity and ultimately health outcomes for our black, Latino, and underrepresented communities.

Myself, I am the third generation HBCU graduate, soon to be a HBCU graduate in a week or so, so I don't know if there is anyone that could tell you all anymore how vital HBCUs are as a cultural and economic pillar, not only within the communities that reside in the West end, but in the black community at large.

Studies continue to show that HBCUs are disproportionately responsible for producing black educated graduates, as well as black professionals, disproportionate to the size of their position within the larger college party, as well as their proportion of black students that they education.

That shows that these institutions are not only vital to the number of black students that they produce, but they are better at it—we are better at it. And we are better at it for obvious reasons. While answering the question of how to improve black health outcomes is multifaceted, and we know that one answer is increasing the number of black providers, and we know that the place that produces the most black providers are HBCUs.

Not only do black providers or black patients do better with black providers. We know that black providers are more likely to go into primary care specialties, as well as practice in underserved areas of need.

I believe that black schools, HBCUs are the key to increasing the number of black providers, as has been mentioned, due to their unique capability, commitment to educating these providers, as well as the relative feasibility of increasing their capacity to do so.

In 2018, 2019, the AAMC published that roughly about 1,250 black or African American identifying students graduated from U.S. Memphis schools. Out of roughly 150 of those U.S. medical schools, three, and now four or five, or hoping more as we go, are HBCUs.

We are talking to about 2 percent of the total schools. But that year, they produced roughly 250 to 300 of those black educated students out of that 125. We are talking about 2 percent of the schools producing roughly 20 percent of the physicians, not just historically 50 percent total, but to this day, these institutions right here, as was mentioned, without them, there would be no progress. There would be no retaining of our status quo, which—[technical problems].

These facts aren't just the law of how great these institutions are. It is to show the potency of what resources, finite resources that we all are very familiar with that we have, can do at these institutions. We are talking about potentially increasing these institutions' incoming classes by 50 percent, having a total 10 percent increase in the yearly production of black physicians, let alone other providers.

Dollars here go further than dollars everywhere else, because what we do here is better than what they do everywhere. Every year, thousands of capable applicants to medical school are denied, hundreds of which are black.

While a universal increase in the number of medical schools matriculants is needed, we know that HBCUs—increases at HBCUs would one, translate most directly to an increase in black

physicians and black providers, as well as again two, require a relatively small amount of capital and infrastructure support.

Improving black health outcomes begins with increasing black representation within health care, and most effective way to do that is to support the growth of HBCU medical schools through direct capital funding for physical infrastructure expansion and increased operating expenses.

Thank you.

[The prepared statement of Mr. Joyner follows:]

PREPARED STATEMENT OF JAMIL JOYNER

HBCUs serve as vital cultural and economic pillars of not only the communities they reside in but the African American community at large. Studies continue to show the prowess of HBCUs in educating a significant percentage of Black professionals, disproportionate to their representation among the total # of colleges and universities and to their proportion of Black students enrolled. As a proud double HBCU alum, I can attest to the impact and importance these institutions have on the development of leaders equipped to go out into the Black community and work toward positive change and equity.

While the answer to improving Black health outcomes is multifaceted, we know that one answer is to increase the number of black healthcare providers educated. Not only do Black patients have better health outcomes when cared for by Black providers, Black providers are more likely to go into primary care specialties and to practice in underserved areas of need. I believe that HBCUs are the key to increasing the number of Black healthcare providers do their unique capability and commitment to educating these providers as well as the relative feasibility of increasing their capacity to educate more providers. In 2018–2019 the AAMC published that roughly 1,250 Black or African American identifying students graduated with a U.S. M.D. from roughly 150 accredited Medical Schools. That same year Morehouse School of Medicine, Meharry Medical College, and Howard University College of Medicine graduated roughly 250 Black M.D.s. 3 Schools, accounting for ?2 percent of all medical schools, producing ?20 percent of all Black graduates. These facts clearly show the potency of resources directed toward HBCU Medical Schools and their production of Black physicians.

Every year thousands of capable applicants to Medical, hundreds of which are Black, are denied admission because of limited capacity. While a universal increase in the number of Medical School matriculants is needed, we know that at HBCUs these increases would (1) translate most directly into an increase in Black physician produced and (2) require a relatively small allocation of funds compared to the resulting increase. A 50 percent increase in the graduating classes of the 3 aforementioned institutions represents a potential 10 percent increase in the yearly production of Black Physicians, while only carrying a price tag in the lows 8 figures.

Improving Black health outcomes begins with increasing the Black representation within healthcare, and the most effective way to do that is to support the growth of HBCU Medical Schools through direct capital funding for physical infrastructure expansion and increased operating expenditures.

The CHAIR. Thank you, Jamil. What I want to do now is kind of open it up. And if it is okay with you, what I would like to do is ask you guys some questions and then you can ask me questions as well. But let me say this, and I might get in trouble for saying this, but—I often get in trouble, but this has been really one of the more extraordinary panels that I have been involved with.

Now, I will tell you why, frankly. You know, Harvard and Yale are great medical schools, and we appreciate all that they do. But at the end of the day, speaking just for myself, what we need in this country are medical schools and doctors who are prepared to go out and serve people who are in need. I am sure that they need more plastic surgeons on Park Avenue in New York City.

But I can think of many other parts of this country where there are zero doctors, where people are dying, women are traveling 100 miles to see a doctor when she is giving birth. And we need doctors who are prepared and medical schools who are prepared to train those who are going out serving the underserved.

Now, this panel has raised just a whole lot of questions, and just one point I want to touch on, why we must significantly increase the number of doctors. We didn't talk about nurses—nurses, dentists, got to do all that.

Medical health councils, mental heatlh counselors, got to do that, all right, with a special focus on Black, and Latino, Native Americans, American, and medical health personnel. We have got to answer questions like you raise, Dr. Cook, the issue of the determinants that results in life expectancy, lower life expectancy.

It is not just health care. So, if you are going to be treating somebody who does not eat or at least have a decent diet, somebody who is working 60 or 70 hours a week with minimum wage what the likelihood is that that person is going to have a significant lower life expectancy than somebody who has money.

Here is a statistic that goes beyond race. This is a statistic that is absolutely shocking. While life expectancy is declining in America, the difference between the people on top and working class Americans is 10 years. Poverty in itself is a death sentence.

I mean we have an enormous amount of work to do. This is the wealthiest country in the history of the world. People, we should not have half a million people who are homeless, etcetera, etcetera, all right.

I want to thank this panel. It has been a great panel. And we are going to take your testimony and do our best, I am not making any promises, but we are going to do our best to incorporate your ideas into legislation. Okay, let me start off my question, and you ask me a question.

We have heard the issue of student debt. Does anybody think it is vaguely sane that at a time when we desperately need more physicians, especially black and Latino physicians, that we are asking people to leave school, medical school, $300,000, $400,000 in debt?

All right, who wants to talk in the audience about student debt, what it means to whether or not young people are going to become physicians, where they are going to practice as physicians, and the stresses on your family?

Who wants to talk about that for a moment? Don't be shy, guys. I see a hand right here.

Ms. SHASANMI ELLIS. My name is Rebecca——

The CHAIR. Rebecca, speak closely into the mic, please.

Ms. SHASANMI ELLIS. My name is Rebecca Shasanmi Ellis. I am a graduate of Morehouse Medicine, M.P.H., 2009. Student debt. Having been someone who came into the health field knowing that I was committed to underserved communities, I went out and I served in North Philadelphia.

I have served globally. Student debt still follows me today. I am a nurse, and I am even faculty at one of the top nursing schools in the country, but student debt still follows me. What needs to be done about student debt?

Some of what is facing us right now, like the legislation to forgive debt for those who have been serving in nonprofit and even public service positions, that needs to be pushed, that needs to be pushed back, that it is time—it is time to recognize that those who have been historically disenfranchised, those who come from minority and even low income backgrounds, they need relief from the debt so that we can keep doing the good work that we have begun.

I think another thing that was raised by the panel is that supporting pipeline programs. Pipeline programs are so key. It prepares young people to understand what is the road ahead. It helps them to understand the varied field of health care. So medical education is one part, nursing education is one part, going to dental education, etcetera, etcetera, etcetera.

Even mental health is another part. And then the other part of it is financial literacy. I think a lot of the programs need to build in—and even updating the capacity of minority serving institutions and HBCUs to talk about financial literacy with their students.

How do I make it—how can I remain in underserved communities working and still have the wherewithal to pay down my student loan debt?

The CHAIR. Rebecca, thank you very much. Okay, somebody have a question for me, which I will try my best to answer or push on to somebody else who might have a better answer? Yes.

Dr. MCCOY. Thank you very much, Senator Sanders, for being here, and the panel who are here. So, your question has to do with what is it like to finish medical school free of debt?

Well, I stand as one of those individuals who, as my cap shows, is from University of Texas Medical Branch in Galveston. And when I finished medical school and did my residency there, and graduated, I had $5,000 back in now 50 years ago, in the bank. I had no debt.

What it did for me at that point was to allow me to go to Mombasa and serve at the Southern Baptist Mission without thinking about paying debt.

I spent a year and a half with the University of Nairobi, teaching in the surgery department free of debt, to come to Morehouse School of Medicine, Atlanta, Georgia as a person without debt to give lovingly, and kindly, and empathically to the patients that I saw and to the students that I taught, to the learners that I taught.

What it means? It means that I had no debt, therefore, I could give freely what had been given to me. Thank you.

The CHAIR. Another question—somebody raised the issue of salaries for residents. I spoke to residents at the University of Vermont Medical School. They were telling me they were working 70, 80 hours a week.

I hadn't realized how residents were really almost maintaining the local hospital. Didn't know that. So, when you get elected to the Senate, you actually began learning things.

They were making, as I recall, something like $62,000 a year. So, if you worked, was that roughly what you got?

Dr. COOK. Spot on.

The CHAIR. Pardon me?

Dr. COOK. Yes.

The CHAIR. Okay. All right. So, what does it mean if you have a family, and you are working very long hours and you are making $62,000 bucks? What impact does that have on your life and your ability to go forward? Who wants to address that one? Yes.

Dr. IVONYE. Thank you for your visit, Senator Sanders. I am Dr. Ivonye and a—[technical problem]—of GME, over the—[technical problems]. Thank you. Over all our—training programs. I would say I live with this precedent.

I know what they feel. PGY1 make about $50,000. PGY2s about $63,000. And it goes up by about $2,000. Some of the residents have families. They have relatives. They have student loan. They have other obligations. Inflation—and inflation, every day is affecting our residents. They walk long hours taking care of our patients, the more vulnerable.

Talking to them, they are not earning livable wages to sustain what they do. I appear to you to please take the message back to the Senate that our residents deserve better compensation to live well.

You said poverty is a disease, and a threat to long life and prosperity. Thank you.

The CHAIR. Okay. Anybody wants to ask about myself or anybody up here on the panel a question? Okay.

Public Speaker. Thank you. Thank you for being here, Chairman Sanders, and hosting it, Dr. Montgomery and the panelists. It is a question in regards to the residents, but not so much about the payment. Anyone in the panel can answer it.

It is—I have been hearing and we have all been hearing a good amount about how you guys? plan to pretty much increase the number of students in medical institutions and having regional places as well in different states.

But I was hoping you guys can reiterate what are we going to do, or what do you guys? plan to do about these available spots in the residency programs? What point is it to increase the amount of students in medical institutions if the spots are still limited in their residency programs?

The CHAIR. Thank you. The answer is, as you have heard, every year there are thousands of students, and somebody up here correct me, who graduate medical school who cannot find a residency spot, which is—at a time where we are in desperate need of doctors, that gets slightly insane.

Welcome at the U.S. Congress.

In Build Back Better, which was a major piece of legislation which would have dealt with many of the issues we are talking about here today, which lost by two votes, we substantially increased the number of GME slots, I think by about 14—what was it, 1,400? 2,000, which would have gone a long way to address this issue.

The other thing that we are trying to do with graduate medical education slots is to put an emphasis on primary care. We want to encourage medical schools to graduate students who are prepared to serve in underserved areas. There is a major crisis in doctors in general, especially in primary care, so we wanted to address that as well.

I hope that within the midst of the GME issue, we can deal with the issue of salaries for residents as well. The other thing we are doing, there is a program called the Teaching Health Center Pro-

gram, which will allow right now residents usually attached to large medical facilities, hospitals, what we want to do is give residents the opportunity to get their education and get early qualified health centers as well.

That is in community health centers and primary care. So that is a program that is expanding. We want to substantially expand it. One program we did not talk about, in the American Rescue Plan, we tripled funding for the National Health Service Corps.

Is that something you guys are familiar with? All right. And that is a model that says if you are prepared to serve, I think it is 5 years or so, in an underserved area, we will forgive your student debt.

We want to substantially increase funding for that again. But the bottom line here is I think everybody has said, at a time when we desperately need physicians, we especially need African American and Latino physicians, we need to have physicians in underserved areas, the idea that people are graduating medical school hundreds of thousand dollars in debt, which prevents them from doing the work—you heard the previous gentleman talking about his ability to go to places he wanted to go. He couldn't do that if he was—$500,000 in debt.

There is a lot of work to be done, and that is some of the issues that we will be addressing. Okay. Other questions? Comments? Yes. I am sorry——

Mr. CHAMBERS. Hey, how is it going, Senator Sanders.

The CHAIR. Good.

Mr. CHAMBERS. My name is Ty Chambers. I am an artist and an entrepreneur. I am currently in the M.P.H. program here at Morehouse School of Medicine. And I just wanted to ask a question about universal health care. Gavin Newsom over in California has been doing some great work——

The CHAIR. Pull the mic a little bit closer to you.

Mr. CHAMBERS. Gavin Newsom in California is doing some great work as far as getting health care to Americans in that state and also undocumented immigrants.

I just wanted to know, as a sitting U.S. Senator, how soon do you see something like that in the single player health care system come into to fruition federally?

The CHAIR. Oh, boy. On Wednesday, this coming Wednesday in D.C., I will be meeting with, I think, several hundred doctors and nurses to announce that we will be introducing legislation for a Medicare for all single payer program.

But I want to, and I think it is important—look, I have enormous respect, unbinding respect for the people up here and you who are devoting your lives to serving the underserved, and that is what you are going to have to do. But I am even asking more of you than that.

You can knock your brains out 24 hours a day, doing fantastic work, saving lives, and yet if you have a system that is totally broken, the situation overall is not going to—we have got to change the system. But what are the basic tenets? And this—what I am

telling you now and what you all know is not a radical idea, all right.

We spend twice as much per person on health care as any other country. With the amount of money we spend, every American, child, elderly person should have quality health care. That is what we should do. You asked me that question, all right. It is a very political question.

That is all right, we are allowed to be involved in politics here, too. I do that occasionally. What does it mean? The system today, the health care system today is working really good, for the insurance companies and for the drug companies.

They are making tens of billions of dollars a year. It ain't working so well for working people, for low-income people, people of color, young doctors. But what we need to do, and I am not going to give you a 3-hour speech on this—could because I believe in this passionately—what we need to do is very simply.

Create a health care system designed to provide quality, affordable health care to all as a human right, not a system designed to make huge amounts of money for insurance companies and drug companies. This is not a radical idea, all right. You will all understand—I want you to understand. You practice in Canada, all right.

Do you know how much people have to take out of their wallet to walk into your practice? Zero. They go to a hospital, they got a serious illness, are in a hospital for a month. They walk out, no bill at all, all right. And yet they spend half as much per capita as we spend on health care, all right.

As we go forward and as you do the enormously important work you do taking care of your patients, we also need to understand that we have to change the system. But the opposition there is enormous. The people who are making the money want to maintain the status quo. It is working for them.

If I could, as a politician, talk about this 24 hours a day, you as physicians will have more impact on this debate than I will have. You will say that you want to treat all the patients who walk at your door, not just those who have the money, right.

You don't want to see people walking in the door who should have walked in the door 6 months before because they didn't have insurance. We need your help on that. Yes, ma'am.

Dr. DAY. Good morning. My name is Shaila Day. I am an internal medicine physician. I am one of the faculty members for the GME program.

But my question is to Dr. Skorton and also the leaders of the HBCUs here on the panel. I think one of the things that we need to address in terms of making physicians more culturally competent is getting rid of the racist medical education that exists.

What is being done about change in the curriculum? Because I feel like even as someone who is black, what I learned in medical school was inherently racist, if we are going to be honest. And even growing up as a black person, I can't change that. But what I was taught sort of changed my thinking sometimes.

I will tell you, there has been times when I have had bias that I really couldn't believe because I am like, well, it is in conflict with

who I really am, but that is the education that I was given. So, what is being done about that curriculum or how can we address that? Because I think that is also important.

Dr. SKORTON. Thank you very much for raising this. And before I answer real quick, I just want to say, Senator, everything can't be on you. We have to work with you in the private sector to make this work. You can't do everything yourself in Washington.

This is unbelievably important, and this is what we are trying to do about it. Obviously, we are not getting the job done yet. Out of our strategic plan, we have a specific plan based on this. If you grab me right afterwards, I will tell you how to find out more about that. Get involved, criticize it, write to me, and so on.

That is one thing. Second, periodically, very periodically, the AAMC will send out a suggestion to all 157 medical schools. We don't tell them what to teach. Those curriculums are developed appropriately by the faculty locally.

But we will say here are some competencies that we think are so important, that we would like you to consider putting them into practice. And just a few months ago, we sent out diversity, equity and inclusion, anti-racism competencies. If you haven't had a chance to see them yet, I will also tell you how to find them if you want to have some fun.

I introduced those competencies in an Op-Ed with the Dean of the University of Miami School of Medicine, Ari Ford, and the editorial board of the Wall Street Journal, who came after us saying that this was all baloney. There is no such thing as embedded racism and so on.

If you want to have some fun at my expense, read that exchange that we had. But we are beginning to work on it. It is unbelievably important to do that. Since I have gone to the floor, two more quick things, Chairman. One is about the residents? situation. Are the residents employees? Are the residents trainees? And the answer is yes.

We have—always have a resident on the board of the AAMC. At our last board meeting, we had a long 74 slide presentation by the residents, three of them from the organization of resident reps that gave us basically what Dr. Cook gave us but wasn't limited by that little clock going off in red. And we are just starting to tackle and figure out what that is.

The last thing, about the debt is, I was a college President twice, and somehow every curriculum, whether it is English literature or physics, takes 4 years. It can't just be a coincidence. This is just sort of the way things have always been. And there are experiments going on, Chairman, with different ways of medical training.

Tuesday of next week I will be on Long Island giving a commencement to the second graduating class of a 3-year medical school where everybody does primary care.

I am not saying everybody can do that, but that kind of experimentation—we can't leave the whole thing on the back of the U.S. Congress. Thank you for the question.

Dr. RICE. I want to comment also on this. And so, Dr. Skorton said something very important early in his talk. Regardless of what

happens with SCOTUS, we are going to continue to work to diversify the health care workforce.

Regardless of what the Wall Street Journal and others say, we are going to ensure that we have a curriculum that helps us to move through our conscious and unconscious biases, which really do begin early on. And so many times we happen to unravel once we get into medical school.

We are trying to make sure that we expose our learners to all of the opportunities to ask that question based on who sitting in front of me, what is possible. And it does mean that you have to deal with diversity, equity, inclusion, and racism because that is what this country has been founded on. And so, we have to begin to unravel.

On match of this, and then I will just ask you all to believe that there is hope. You all remember the NAA—what is it, the basketball. They all love the sports, right.

These college athletes have made a lot of money for colleges and universities. And they finally are starting to recognize, right, that that was in there. And so, we are recognizing that we are paying our residents for a service that doesn't align with their efforts.

I know that Congress is going to work with us to be creative in how we can increase the wages. And that is what we need to do, because you should make a living wage that is reflective of you being able to live and care for your family and not incur all of the debt.

We also have to recognize we have to create more programs to forgive debt, offer debt to be relieved based on the service that you have——

The CHAIR. Okay. Two points. No. 1, I—my staff mentioned to me that we would have increased our GME slots by 14,000 over 7 years. That was the number that I wanted.

No. 2, I have got a plane to catch. Maybe two more questions, and I apologize for that, but we are not going to be able to take all the questions. So just the first two people. Yes, ma'am.

Dr. MALLETT. Good morning, Senator Sanders and panel. I am Veronica Mallett. I am the Chief Administrative Officer for this historic partnership between the Morehouse School of Medicine and CommonSpirit Health to increase the diversity in the health care workforce.

My question is a follow-up to our previous questioners in the panel about what we can do as citizens in light of the pending decision and in this current political climate where there is a denial and an attack on fact.

Given that, what can we do as citizens, and what would be your recommendation? Because, again, you can't do this alone. So, how can we help? How can we advocate?

The CHAIR. Well, I think you know the answer. And by the way, let me thank the people of Georgia for giving us two excellent United States Senators. I would not be here as Chairman of the Committee if the people of Georgia had not done what they did. And that is what we have to do all over the country.

Georgia actually is doing better maybe than any other states in this country in bringing people who often do not get involved in the political process. Lower income people, people of color standing up and fighting back. We have got to do that in Texas. We have got to do that in many, many states in this country.

The ideas that we are talking about, which are being livestreamed. I suspect 200,000 people may watch it. People say nothing radical about this. This is what we should be doing. But so many people have given up on the political process. You know them, you see them every day. They don't vote.

They don't—you know, they say, nobody cares about me, why would I want to vote? And we have got to bring those people into the process. You got to elect people who are going to stand up and fight for them, make a difference in their lives to show people that actually democracy can deliver for ordinary Americans.

That is the challenge that we face. But thanks to the question. As to individuals who lie all of the time, I will not name any names, will not mention Presidents who have been pathological liars. I wouldn't do that.

Oh, but, I mean, this is this whole thing, and artificial intelligence is going to make it worse. It really is. It is one thing to debate facts, right, difference of good knowing somebody is lying all the time pops up. But I am not mentioning any names. Yes, ma'am.

Public Speaker. Good morning, Senator Sanders. Dr. Montgomery Rice and the panel, and every white coat in this building, I want to say thank you for your service.

I am the product of the Morehouse pipeline and to the Health Informatics Master's Program. So, I want to say thank you for that opportunity. My question is for the panel.

In light of what Senator Sanders just said with AI and the increase of technology in the medical profession, how do health programs that train health informatics, master's degree students, and health administrators and policy thought leaders figure into the funding that you all have mentioned here?

Dr. RICE. I think my colleague who spoke to research infrastructure—I mean, I want to give you the opportunity to speak to that. I think that is where the key is. So, it is not just about getting you in the door. It is the, what is going to be the experience when you get there.

Dr. SOUTH-PAUL. I would love to comment that informatics, as we know, anchors everything we do in health care because it is the beginning of how we gather data, and data provides us the facts that allow us to appropriately look forward toward how we can make a difference.

At Meharry Medical College, we have a new school, the School of Applied Computational Sciences. And that is a school that is now prioritizing how we manage data and integrating with their Enterprise Data Analytics Center, how we then gather the data, especially for populations that are most underserved.

I think that inextricably linking those two things together is important. I was fortunate to just recently co-chair the National Academy of Medicine VA Whole Health Committee, and what we are

trying to do is get whole health, comprehensive, not just physical, behavioral, spiritual, integrative health in—and implemented not only for veterans but for all of our populations.

One of the anchoring things was having an electronic data system that will allow us to have the data we need. So, there are many efforts going on to show how important what you do is to allow us to—if we don't measure it, we can't change it. If we don't measure it, we don't know what is going on. So, all of those are so important for our vulnerable populations.

The CHAIR. All right. Let me just thank Dr. Montgomery Rice for hosting this event. Let me thank the representatives of the great HBCU medical schools who are here, the students, the faculty, let me thank all of you.

I think what we—this has been a great panel that at least I have enjoyed. It has been a great discussion. And the American people want us to succeed on this, all right. They perceive the crises that we are talking about today. So let us go forward.

Let's work together. Let's bring the kind of change in this issue and so many others that the American people want to see. Thank you all very much for being here. Thank you. Any Senators listening in who wish to ask additional questions, our questions of the record will be doing ten business days on May 26 at 5.00 p.m.

Finally, I ask unanimous consent—I am the only person, I think I will get it—to enter into the record four statements from stakeholder groups related to the conversation today.

[The following information can be found on pages 46 through 52 in Additional Material.]

The CHAIR. The Committee stands adjourned. Thank you all very much.

Dr. RICE. And if I can just say on behalf of the Morehouse School of Medicine, the four historically black medical schools, the AAMC, and to all of you all, thank you, Senator Sanders, for showing us continuously what leadership looks like, for being our voice when others are not listening, always speaking louder than others.

We appreciate that. And more importantly, though, we appreciate what you have to say because it leads to action, and it needs to change.

Doctor, I can tell you that when I look at the doctors here and the to be doctors, and the to be M.P.H. students, and all of the students, they are relying on us to institute change that is going to be a better future for them, but more importantly, a better future for the American public.

Thank you for your leadership, and we look forward to creating more partnerships.

We are adjourned.

ADDITIONAL MATERIAL

OPENING REMARKS OF VALERIE MONTGOMERY RICE

Please allow me to welcome all of you to this very important roundtable meeting of the Senate Health, Education, Labor, and Pensions Committee to examine topics related to diversity in the healthcare workforce and addressing workforce shortages, hosted by Morehouse School of Medicine and the nation's three other Historically Black Medical Schools—Meharry Medical College, Charles R. Drew University of Medicine and Science, and the Medical School at Howard University. Historically and collectively our four schools have trained approximately half of the Black physicians in the country—so we know our stuff in this space!

We are very grateful to HELP Committee Chairman Sanders, Ranking Member Cassidy, and all Members of the Committee for your interest in and focus on national health workforce challenges and your willingness to hear from the leaders of our institutions, view our campus—and most importantly—see the students that are the future of health care in the United States. We are proud of everything we do, but our students, graduates, and faculty are the crown jewel of each of our institutions.

Notwithstanding the big contributions to the healthcare workforce by our four schools and others, we are facing broader social challenges that are expressed in our enrollment. Black males now represent less than 40 percent of medical school matriculants, and together, Black males and females represent only about 8 percent of all medical school matriculants—only about half of where we should be given that Blacks are approximately 13–15 percent of the U.S. population. Significant financial barriers exist for the very students from economically challenged backgrounds that we are trying to recruit. Consequently, Federal support for programs, and that of philanthropic organizations such as our scholarship partnership with Bloomberg Philanthropies are exponentially meaningful to our students and schools.

Our institutions are poised to be at the vanguard of the national effort to improve diversity in the healthcare workforce and increase the sheer numbers of minority physicians. We stand ready to lead the way and set an example for all the medical schools in the country, because we four institutions can't do it alone. We need all the nation's medical schools to redouble their efforts to increase the enrollment of people of color, provide support programs, and renew their commitment to this purpose. Consequently, we are very pleased to be joined today by Dr. David Skorton, President and CEO of the Association of American Medical Colleges, which represents all U.S. medical schools and teaching hospitals.

To all of today's participants, I can't stress enough that now is the time to act! The nation is emerging from a devastating pandemic that shone a harsh light on how people of color and medically underserved communities are disproportionately impacted by a lack of access to qualified and culturally sensitive health care providers. At best, we can learn from this experience and do something meaningful to reverse this sobering national tragedy. The worst thing we can do is take no action and wish it were better.

Legislators like Senator Sanders and his colleagues, our four schools, every other U.S. medical school, and health care systems throughout the Nation, have the power to make change happen. Collectively, we must also have the will to do so.

Today, we will have the opportunity to share with Senator Sanders and his Committee our successes, plans, and challenges—and make specific recommendations for improving diversity in the healthcare workforce and strengthening our institutions.

We are very grateful for this opportunity.

AMERICAN ASSOCIATION OF COLLEGES OF OSTEOPATHIC MEDICINE,
BETHESDA, MD 20814,
May 10, 2023.

Senator BERNIE SANDERS, Chairman,
Senator BILL CASSIDY, Ranking Member,
U.S. Senate Committee on Health, Education, Labor, and Pensions,
Washington, DC 20510.

Chairman Sanders, Ranking Member Cassidy and esteemed Committee Members, as you examine our Nation's healthcare workforce shortages, especially in Black and other minority communities, the American Association of Colleges of Osteopathic Medicine (AACOM) believes that the physicians trained at our Nation's colleges of

osteopathic medicine (COMs) are an important part of the solution. We commend you for holding today's field roundtable and appreciate you permitting AACOM to offer this written testimony for the record. AACOM stands ready to work with you and your Senate colleagues to advance policies and programs that will help ensure our Nation has the healthcare workforce we need for the patients of today and tomorrow.

About AACOM and Osteopathic Medicine

AACOM is the leading advocate for osteopathic medical education (OME) and its commitment to improving public health. Founded in 1898 to support and assist the nation's osteopathic medical schools, AACOM represents 40 accredited COMs—educating more than 35,000 future physicians, 25 percent of all U.S. medical students—at 64 medical school campuses in 35 states, as well as osteopathic graduate medical education professionals and trainees at U.S. medical centers, hospitals, clinics and health systems.

Osteopathic medicine encompasses all aspects of modern medicine, including prescription drugs, surgery and the use of technology to diagnose and treat disease and injury. Osteopathic medicine also confers the added benefit of hands-on diagnosis and treatment of conditions through a system known as osteopathic manipulative medicine. Doctors of Osteopathic Medicine (DOs) are trained in medical school to take a holistic approach when treating patients, focusing on the integrated nature of the various organ systems and the body's incredible capacity for self-healing. DOs are licensed in all 50 states to practice medicine, perform surgery and prescribe medications. The osteopathic medical tradition holds that a strong foundation as a generalist makes one a better physician, regardless of one's ultimate practice specialty—which is the reason why more than half of DOs currently practice in primary care.[1] In excess of 7,300 DOs were added to the U.S. physician workforce in 2022, adding to the 141,000 DOs already in practice.[2]

AACOM and its member institutions have made a concerted effort to promote training in diverse healthcare settings, such as community hospitals and healthcare facilities located in underserved parts of the country. Sixty percent (60 percent) of osteopathic medical schools are located in a federally designated Health Professional Shortage Area (HPSA), and 64 percent require clinical rotations in rural and underserved communities. Our research shows that the location of medical education and residency training directly impacts practice location, so the osteopathic community training model leads to more physicians in underserved areas.

AACOM and our Colleges of Osteopathic Medicine Are Committed to Increasing Medical Student Diversity and Ensuring Medical Education Is Accessible to All

It is AACOM's goal to enhance the diversity of osteopathic medical students to contribute to the development of a culturally competent healthcare workforce. Underrepresented minority students currently account for 12.1 percent of matriculants across the nation's COMs. AACOM is committed to positively impacting these rates while increasing the number of qualified applicants pursuing osteopathic medicine.

In 2021, AACOM member institutions unanimously released a *Consensus Statement on Diversity, Equity and Inclusion* acknowledging that the American education system is affected by systemic inequities that impact the diversity of the applicant pool to osteopathic medical schools.[3] The statement also outlines model strategies to improve and support diversity, equity and inclusion across osteopathic medical education, as well as opportunities to reframe and expand diversity, equity and inclusion efforts.

AACOM created a new program for its member colleges to advance diversity by supplementing instruction around health equity and health disparities—AACOM's Academic Recognition Program.[4] Launched in 2022, this program is available to

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[1] National Resident Matching Program, 2021 Main Residency Match, available at *https://www.nrmp.org/wp-content/uploads/2021/08/Advance-Data-Tables–2021—Final.pdf*

[2] American Osteopathic Association, 2022 report tracks increased growth in the osteopathic profession, available at *https://osteopathic.org/about/aoa-statistics/*

[3] AACOM, Consensus Statement on Diversity, Equity and Inclusion, available at *https://www.aacom.org/docs/default-source/old-documents/old-to-sort/consensus-statement-final.pdf*

[4] AACOM, Academic Recognition Program, available at *https://www.aacom.org/programs-events/programs-initiatives/academic-recognition-program*

second-and third-year medical students at every COM in the United States. The program's initial course is focused on inequities and disparities, while subsequent courses enhance the student's ability to recognize and understand circumstances that may contribute to inequities.

Moreover, AACOM's Council on Diversity and Equity (CDE) promotes evidence-based practices and programs to foster a culture of diversity and inclusion at our COMs.[5] CDE initiatives have included the creation of a free online course focused on unconscious bias for healthcare and medical research professionals, medical students and medical educators and a collaboration with the Council of Osteopathic Medical Admissions Officers to increase DEI outcomes in recruitment by creating a more inclusive environment for applicants and matriculants.

Last month, AACOM joined the Federation of Associations of Schools of the Health Professions in a statement encouraging academic freedom around diversity, equity and inclusion in schools of health professions.[6] Creating a diverse, equitable, and inclusive academic health community is essential to patient care and a core competency of health professions education.

COMs are leading the effort to increase diversity in the physician workforce:

- In 2020, the Oklahoma State University Center for Health Sciences College of Medicine (OSU-COM) at the Cherokee Nation became the nation's only tribally affiliated medical school. Currently, 11 federally recognized tribes are represented in OSU-COM's student body and the school's Tribal Medical Track prepares students to serve as primary care physicians in tribal, rural, and underserved areas throughout Oklahoma.
- The Maryland College of Osteopathic Medicine at Morgan State University (MDCOM) is on track to become the first new medical school at a Historically Black College and University (HBCU) in 40 years. As one of only five medical schools at an HBCU, MDCOM will strengthen and diversify the physician workforce and improve healthcare access for the underserved populations served by its students and graduates.
- The Cleveland Clinic Physician Diversity Scholars Program is a partnership with the Ohio University Heritage College of Osteopathic Medicine (OUHCOM). The program takes a proactive approach to building diversity by giving first-year URM students a unique opportunity for growth and engagement. Those selected to participate in the 4-year program are matched with a Cleveland Clinic health system physician with whom they will have an opportunity to develop a mentor/scholar relationship. The program is designed to complement each scholar's curriculum at OUHCOM while offering purposeful and meaningful interaction with underrepresented minority community populations in a healthcare context. The Physician Diversity Scholars program is open to all underrepresented minority medical students at OUHCOM, Cleveland.
- The University of the Incarnate Word School of Osteopathic Medicine's Anti-Racist Transformation in Medical Education (ART in Med Ed) project is a 3-year project funded by the Josiah Macy, Jr. Foundation to replicate the Icahn School of Medicine and Mount Sinai's change-management strategy at 11 partner medical schools in the United States and Canada. The project aims to develop the capacity of medical schools to dismantle systemic racism and bias in their work and learning environments and promote shared learning on how to dismantle racism within and across medical schools.

AACOM Policy Recommendations

Osteopathic medicine has a blueprint for success to address the crisis in our Nation's health care workforce, raise the number of Black Americans in the medical field, increase access to primary care and improve health outcomes for underrepresented Americans. We respectfully offer several recommendations for the 118th Congress to ensure a well trained and culturally diverse healthcare workforce for the Nation:

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[5] AACOM, Council on Diversity and Equity, available at *https://www.aacom.org/medical-education/councils-committees/council-on-diversity-and-equity*

[6] FASHP, Statement on Ensuring Academic Freedom and Diversity, Equity, and Inclusion in Associations and Schools of Health Professions, available at *https://www.aacom.org/docs/default-source/advocacy/public-statements/fashp-academic-freedom-and-inclusion-statement.pdf—sfvrsn=f2fc996f—3*

- **Implement policies that leverage all available physicians by ensuring that DOs and MDs have equal access to federally funded GME programs.** At least 32 percent of residency program directors never or seldom interview DO candidates, and of those that do, at least 56 percent require them to take the USMLE (the MD licensing exam), in addition to the osteopathic medical exam, COMLEX-USA.[7] The demands of medical school are arduous, and osteopathic students should not be subjected to the additional 33 hours and $2,235 (as well as prep costs and time) that is required to take the USMLE. Increased financial and academic demands disproportionately impact underfinanced and underrepresented populations and frustrates efforts to diversify the healthcare workforce. Congress should pass legislation that ensures all federally funded GME programs accepts DOs and the COMLEX-USA.
- **Provide permanent funding for the Teaching Health Center Graduate Medical Education (THCGME) Program.** This vital program trains students in outpatient settings, such as Rural Health Clinics, federally Qualified Health Centers and tribal health centers. THCGME Program training sites prioritize care for high-need communities and vulnerable populations, with more than half located in medically underserved communities. Permanent robust funding is needed to strengthen the THCGME Program and establish a healthy, stable infrastructure for physician training in outpatient settings.
- **Increase funding for the Title VII and Title VIII programs.** These programs support the training and education of health practitioners to enhance the supply, diversity, and distribution of the health care workforce. Title VII and VIII programs offer a lifeline to medical students facing financial barriers and underserved communities afflicted by physician shortages. Specifically, the Health Careers Opportunity Program (HCOP) helps develop a diverse health workforce by investing in K–16 health outreach, pipeline, and education programs through partnerships between health professions schools and community-based organizations. Studies show that pipeline programs, such as HCOP, increase the number of underrepresented students enrolling in health professions schools, lead to heightened awareness of factors contributing to health disparities, and attract health professionals more likely to treat underrepresented patients.
- **Provide sustained funding for loan repayment and forgiveness programs, such as the Public Service Loan Forgiveness (PSLF) Program and National Health Service Corps (NHSC), which incentivize physicians to practice in rural and medically underserved areas and help alleviate student debt obligations.** Medical students take on significant
- **Expand funding and support for community-based training models, including clinical rotations in underserved communities.** According to the Health Resources and Services Administration's (HRSA) Advisory Committee on Interdisciplinary, Community-Based Linkages, there is a growing trend toward providing care in smaller community-based clinics instead of academic hospitals. As the provision of care has shifted to community-based settings, so has the training of medical students. Clinical training in these community-based settings expose medical students to the unique healthcare needs of rural and underserved populations and prepare them to serve those communities after graduation. However, over three-quarters of all medical schools report concerns with the number of clinical training sites and the quality and supply of preceptors, especially in primary care. To support this trend toward less expensive and less centralized care, Congress must modify existing funding streams and establish new programs to support community-based training. With underserved communities suffering the most from physician shortages, Congress should fund a new program within HRSA that creates a consortium of osteopathic medical schools, rural health clinics and

[7] National Residency Matching Program, 2022 Program Director Survey, available at *https://www.nrmp.org/match-data-analytics/residency-data-reports/*education debt, which can be a financial burden after graduation, during training, or in medical residency. Robust loan repayment and forgiveness programs decreases financial barriers for URM students and increases health equity.

federally qualified health centers to increase medical school clinical rotations in underserved community-based facilities.

Conclusion

On behalf of the 64 osteopathic medical school campuses and the 35,000 medical students they serve, thank you for your consideration of our views and recommendations. Again, we are eager to be a resource as you examine and consider solutions to the nation's healthcare challenges. For questions or further information, please contact David Bergman, JD, Vice President of Government Relations, at *dbergman@aacom.org*.

AMERICAN FEDERATION OF TEACHERS,
WASHINGTON, DC 20515,
May 10, 2023.

Senator BERNIE SANDERS, Chairman,
Senator BILL CASSIDY, Ranking Member,
U.S. Senate Committee on Health, Education, Labor, and Pensions,
Washington, DC 20510.

Dear Chairman Sanders and Ranking Member Cassidy:

Thank you for your continued focus on healthcare staffing issues. The American Federation of Teachers is the nation's fastest-growing union of nurses, representing more the 200,000 nurses, technicians, therapists and physicians in hospitals nationwide. The AFT has had a standing committee on healthcare equity for many years, so the topic of this field hearing—"How Can We Improve Health Workforce Diversity and Address Shortages?—is of particular interest to our members.

As our Nation's hospitals remain understaffed and the demand for healthcare professionals rises, there is an opportunity to make considerable progress toward greater workforce equity, which is a key component of truly focusing on health equity as the nation's population continues to diversify. When healthcare professionals reflect the populations they serve and operate with a deeper cultural sensitivity to their patients' life situations, patient outcomes improve. This, in turn, increases the comfort level of patients seeking care, who want to trust that their health needs will be acknowledged and addressed.

For numerous reasons, minority healthcare workers are underrepresented; and as the complexity of the positions and the salaries increase, the diversity of the workforce decreases. For instance, people identifying as Black or African American make up 13 percent of the U.S. population, but they make up only 7 percent of nurse practitioners, a higher-paying role requiring more formal education than other nursing positions. This clearly demonstrates a lack of racial equity in the nursing profession, but it also demonstrates an opportunity to "right the ship."

The AFT encourages the Committee to deploy new strategies to increase diversity in the healthcare workforce, such as addressing racism in healthcare workplaces; developing program models that expand career outreach programs in communities of color that are underrepresented in healthcare jobs; developing a workplace equity score that tracks healthcare facilities' workforce diversity numbers, and how many workers from underrepresented communities successfully advance along the career pathway to higher-paying positions; and regularly reviewing equity in compensation differences based on gender, race, sexual orientation, disability and all other protected classes.

In addition to these strategies, we must address staffing challenges through improved working conditions, by addressing workplace violence and instituting safe patient-to-nurse staffing standards. Instead of doing so, hospitals have turned to staffing agencies—domestic and international. Both types of agencies reduce capacity in home states and nations and ignore the underlying issues that have produced shortages. Passing the Nurse Staffing Standards for Hospital Patient Safety and Quality Care Act (S. 1113) and the Workplace Violence Prevention for Health Care and Social Service Workers Act (S. 1176), as well as taking the actions described in this letter, Congress can alleviate staffing shortages, diversify the workforce and improve healthcare outcomes, instead of watching hospitals attempt to apply piecemeal temporary solutions.

Another impediment to workforce equity is the student debt crisis. A 2019 analysis of data from the U.S. Department of Education found the average graduate of an associate degree in nursing program held $19,928 in student debt. For graduates with a Bachelor of Science degree in nursing, the average debt was $23,711, and

for graduates with a Master of Science degree in nursing, the average was $47,321. Nurses of color are more likely to have student loans and more likely to have higher loan balances, according to national debt statistics. Compared with their white peers, Black borrowers, for example, have higher total debt burdens and higher monthly payments. Four years after graduation, 48 percent of Black borrowers owe 12.5 percent more than their original balance, while 83 percent of white borrowers owe 12 percent less than their original balance.

No effort to recruit diverse talent into the healthcare workforce can be complete until the cost barriers for accessing and completing higher education and training programs are addressed. Targeted financial aid and loan repayment programs should be expanded, including the National Health Service Corps and the Nurse Faculty Loan Program.

Thank you for considering our views on this important subject. The AFT stands ready to help you pass legislation to address healthcare staffing shortages.

Sincerely,

RANDI WEINGARTEN,
President,
American Federation of Teachers.

FEDERATION OF ASSOCIATION OF SCHOOLS OF THE HEALTH PROFESSIONS

Lack of Men of Color Graduating From the Health Professions Declared a Crisis by Association CEOs

Washington, DC-The Federation of Associations of Schools of the Health Professions (FASHP) has declared the low number of historically underrepresented men of color (HU MOC) graduating and entering the health care professions a national crisis. Representing CEOs of national academic health professions associations, FASHP has released a addressing this critical issue, and is calling on local and national educational, health care, governmental and community leaders to raise awareness regarding this critical issue and to identify barriers and provide resources to dramatically increase the number of men of color graduating from the health professions.

"We must urgently join forces with P–16 education, government, health care, corporations and other leaders to remove pathway barriers and adopt robust strategies that facilitate a significant increase in the number of historically underrepresented men of color entering and graduating from dental, pharmacy, veterinary medicine, social work and other health professions schools." said Dr. Karen P. West, Secretary of FASHP and President and CEO of the American Dental Education Association (ADEA).

Similar disparities exist across the academic health professions. For example:

- Of 6,665 2021 U.S. dental school graduates, 3,223 (48.4 percent) were men (American Dental Association}. Of those, 431 {6.46 percent) were HUMOC (263 Hispanic/Latino men, 147 Black/African American men, 18 American Indian/Alaska Native men and 3 Native Hawaiian/Other Pacific Islander men).
- Of 21,051 2021–2022 U.S. medical school graduates, 10,268 (48.8 percent) were men (Association of American Medical Colleges [AAMC]}. Of those, 1,251 were HU MOC (664 Hispanic/Latino men, 565 Black/African American men, 13 American Indian/Alaska Native men, and 9 Native Hawaiian/Other Pacific Islander men).
- The 2021 graduating class of veterinary medical students included only 0.6 percent Black/African American men, 1.4 percent Hispanic/Latino men, and 0.2 percent American Indian/Alaska Native men.

In pursuit of greater collective action, FASHP is establishing a coalition with associations across the academic health professions, health care institutions and health professional organizations to tackle the longstanding problem of the low numbers of HUMOC at health professions schools. FASHP plans to expand its work to galvanize P-16, governmental, health care, corporate, foundation, health care research, community and other leaders to develop short-and long-term strategies with focused action plans.

FASHP Member Organizations

American Association of Colleges of Nursing
American Association of Colleges of Osteopathic Medicine
American Association of Colleges of Pharmacy
American Association of Colleges of Podiatric Medicine
American Association of Veterinary Medical Colleges
American Dental Education Association
Association of American Medical Colleges
Associat;on of Chiropractic Colleges
Association of Schools Advancing Health Professions
Association of Schools and Colleges of Optometry
Association of Schools and Programs of Public Health
Association of University Programs in Health Administration
Council on Social Work Education
PA Education Association

Liaison Members

Association of Accredited Naturopathic Medical Colleges
American Council of Academic Physical Therapy
American Occupational Therapy Association
American Physical Therapy
Association American Psychological Association

FASHP Men of Color in the Health Professions

Systematic racism and the oppression of people of color have resulted in significant underrepresentation of men of color (MOC) in the health professions Men of color refer to any individual who identifies as a man and is a underrepresented racially/ethnically in the health professions. MOC area disproportionately underrepresented in the health professions at all levels compared to other racial/ethnic and/or gender counterparts. A continued lack of awareness, marginalization and unconscious bias has led this issue to reach crisis proportions. This crisis is reflected in absolute numbers in academic institutions, in the representation of health professionals, in the elevation to leadership positions, and in health outcomes across the health professions.

The underrepresentation of MOC in the health professions extends well beyond the specifics of low numbers and has significant consequences for public health, education, social justice and historically underserved communities. MOC area disproportionately under-recruited and retained throughout the K–16 and graduate education pathway, creating a national workforce shortage of a diverse health professions sector. Failure to adequately address the underrepresentation of MOC in the health professions will perpetuate and worsen education and health disparities, particular1y for underserved communities.

Entities of health professional practice, research, education and policy have the individual and collective ethical and moral responsibility to prioritize increasing the presence of MOC in the health professions as an essential part of effecting positive structural and systemic change to improve educational and health outcomes for all.

The historic and ongoing crisis of underrepresentation of MOC in the health professions has urgent ramifications, and it calls for intentional collaborative efforts to address it by the healthcare professions. their partners and stakeholders, in partnership with the communities they serve.

MORGAN STATE UNIVERSITY,

MARYLAND COLLEGE OF OSTEOPATHIC MEDICINE AT MORGAN STATE UNIVERSITY,

David K. Wilson, Ed.D., is the 10th inaugurated president of Morgan State University—Maryland'sPreeminent Public Urban Research University.

Barbara Ross-Lee, DO, President, proposed Maryland School of Osteopathic Medicine at Morgan State University (MDCOM.) Three-time Medical School Dean,

Legislative Assistant to Sen. Bill Bradley, NIH Advisory Committee on Women's Health, and U.S. HHS National Advisory Committee on Rural Health.

John Sealey, DO, Founding Dean, proposed Maryland School of Osteopathic Medicine at Morgan State University (MDCOM.) Cardiothoracic surgeon, Former Chief of Surgery and Medical Director, Associate Dean of Clinical Education ARCOM, Regional Dean KCOM, DIO of Authority Health's Residency Program, and Graduate Medical Education (GME) Expert.

Subject: Chairman, Sen Sanders Discussion Roundtable addressing the crisis regarding health care workforce, raising the number of Black Americans in the medical field, increasing access to primary care, and ideas on improving health outcomes for Black Americans.

Favorable—Written Testimony

Morgan State University is the preeminent public urban research university in Maryland, known for its excellence in teaching, intensive research, effective public service and community engagement. Morgan prepares its students for diverse opportunities to succeed in the fast-changing, competitive world they enter upon graduation.

We are delighted to announce the establishment of the proposed Osteopathic Medicine School at Morgan State University, a pioneering institution dedicated to training the next generation of osteopathic physicians. This significant initiative is our response to the growing health care workforce shortage in our region and nationwide.

The shortage of health care workers, especially in underserved rural and urban communities, is a significant challenge we face. Our proposed Osteopathic Medicine School addresses this pressing issue by providing the opportunity for quality education and training to students who aspire to have a career in osteopathic medicine.

Osteopathic medicine is a distinct branch of medical practice in the United States that emphasizes a holistic approach to patient care. With the training provided by our institution at Morgan State University, we will equip students with the necessary skills to approach healthcare from a disease-centered perspective and a human health-centered one, focusing on preventive care.

We are proud and excited to announce the opening of the Maryland College of Osteopathic Medicine at Morgan State University in the Fall of 2024, marking a significant moment in history. This will be the first time in 50 years that a Historically Black College or University (HBCU) has opened a medical school.

Establishing our medical school is a critical step in our ongoing commitment to address our communities' historical shortage of health care professionals. Furthermore, this visionary undertaking is a much-needed step toward increasing diversity in the medical field, as HBCUs have a long-standing tradition of training Black professionals and leaders.

Our graduates will join the health workforce with a unique perspective that places emphasis on viewing the patient in their entirety rather than just their symptoms. This approach is crucial in addressing health disparities and providing well-rounded care in communities of color impacted by health disparities.

We understand that the road to resolving the health care workforce shortage is long, and our institution is just one piece of a much larger puzzle committed to drilling down on the following issues that we deem crucial in determining the mission of the proposed Maryland School of Osteopathic Medicine at Morgan State University:

1. The U. S. is projected shortage of between 37,800 and 124,000 physicians within the next 12 years, according to The Complexities of Supply and Demand; Projections from 2019 to 2034 (PDF), a report released by the Association of American Medical Colleges. This shortage accounts for primary and specialty care physicians. The AAMC reports that physician shortages hamper efforts to remove barriers to care.

2. In 2010, the Sullivan's Commission report classified this as a crisis in Care due to the lack of representation for underrepresented minorities. This crisis was declared not only Physicians but all health professions if this crisis persists.

3. The more recent IOM report states an increasing the number of minority health professionals is a key strategy to eliminate health disparities. The data in the IOM report states that cultural differences, a lack of access to health care, combined with high rates of poverty and unemploy-

ment, contribute to racial disparities in health status and health outcomes.

4. As the U.S. Population grows more diverse, half of all Americans are projected to belong to a minority group by 2044. In the absence of workforce strategy, the problem is going to get worse. Of the 200+ medical schools, only four are considered Historically Black Colleges and Universities (HBCUs) and contribute substantially to the number of minority physicians practicing in the field. Creating a diverse physician workforce can improve health outcomes and reduce health disparities.

5. Approximately 25 percent of medical student are currently enrolled in medical schools. The profession's strong base in primary care contributes to addressing physician shortage in medical underserved regions. The proposed Maryland College of Osteopathic Medicine at Morgan Stage University is planned to continue the tradition of Osteopathic Medicine as the first Osteopathic Medical School at an HBCU and as the first Medical School at an HBCU in 50 years. MDCOM is educating high-quality diverse physicians for specialties to practice in racially and culturally diverse communities.

The Maryland College of Osteopathic Medicine, and its affiliation with Morgan, represents yet another example of Morgan's enduring commitment to Baltimore and the region as an anchor institution producing leaders in a variety of industries.

We believe that by investing in the education and training of future osteopathic physicians, we are investing in the health and well-being of all communities.

Respectfully Submitted,

DR. DAVID K. WILSON,
President,
Morgan State University.

[Whereupon, at 11:27 a.m., the hearing was adjourned.]

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