

COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES
WASHINGTON, DC 20515

September 3, 2020

Nancy Brown
Chief Executive Officer
American Heart Association
7272 Greenville Ave.
Dallas, TX 75231

Athena Poppas, MD, FACC
President, Board of Trustees
American College of Cardiology
2400 N Street NW
Washington, DC 20037

Dear Ms. Brown and Dr. Poppas:

The United States (U.S.) has some of the most dramatic racial health inequities in the world despite its overall wealth and modern health care and research systems.¹ I am deeply concerned about the research findings published in *The New England Journal of Medicine* (NEJM) on June 17, 2020 that demonstrated racial bias in tools used by physicians and other providers to make clinical decisions for conditions that span from childbirth to cancer care.² The American Heart Association (AHA) developed “Get with the Guidelines – Heart Failure” which are referenced in the NEJM article, and the American College of Cardiology (ACC) has supported the AHA guidelines. Considering your leadership roles at AHA and ACC and within organized medicine, I know that you can help the Ways and Means Committee gain greater insight into these issues and potentially identify areas where collaboration can rectify these ongoing concerns. More specifically, I would greatly appreciate an update on the work AHA and ACC are undertaking to investigate and change clinical decision support tools that may fuel racial inequities in care. Collaboration with Congress and leadership from the AHA and ACC can help address these important issues.

Dr. Camara Jones defines race as “a socially constructed way of grouping people, based on skin color and other apparent physical differences, which has no genetic or scientific basis.”³ Analyses of the human genome continue to show that there are more differences within racial groups than there are among racial groups.⁴ Despite this proven fact, clinical tools continue to use race and ethnicity in ways that can exacerbate racial health inequities.

¹ <https://www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=22533&LangID=E>

² Vyas DA et al. Hidden in plain sight – reconsidering the use of race correction in clinical algorithms. 2020; DOI: 10.1056/NEJMms2004740.

³ Jones CP. Levels of Racism: A Theoretic Framework and a Gardener’s Tale. American Journal of Public Health. 2000; 90(8): 1212-1215.

⁴ American Association of Physical Anthropologists. AAPA statement on race & racism. March 27, 2019 (<https://physanth.org/about/position-statements/aapa-statement-race-and-racism-2019/>. opens in new tab).

Societal issues with race and poverty have influenced our health system in such a way that avoidable risk and exposure to harm are embedded for communities of color and low-income individuals who suffer both from higher disease burden and less access to lifesaving treatment. These health inequities are most stark in Black, Indigenous, and Latinx communities. As race and ethnicity are social constructs, the root cause of health and economic inequities is racism, not race. Unfortunately, in clinical care, race has been misinterpreted and misused to the harm of communities of color, especially Black Americans who are referenced most frequently in clinical algorithms.

As you know, the “Get with the Guidelines–Heart Failure” tool predicts in-hospital death in patients with heart failure.⁵ Clinicians use it to guide decisions on what treatments to start in order to preserve aggressive treatments for the sickest patients and offer less aggressive treatments for lower-risk patients. The effect of the tool is that Black patients are systematically scored as lower risk for death and thus lower need for aggressive treatments. Though this tool may be based on empirical data, it is very unclear what researchers were measuring by including race in the tool. The researchers themselves note that race had a very modest effect on death risk while other parameters like age and blood pressure had a much more significant effect. Lastly, significant racial inequities exist in heart failure and cardiovascular outcomes with Black patients often having worse outcomes. Considering these concerns, inclusion of race in this tool must be reevaluated. Medical professional societies should take a clear stand against the misuse of race and ethnicity in clinical algorithms and issue new guidance to correct this practice.

Black, Indigenous, and Latinx scholars of clinical medicine have long studied and critiqued the use of race in the field; however, their scholarship has not received adequate attention. Drs. Vanessa Grubbs and Nwamaka Eneanya recently described concerns about race correction in kidney function.^{6 7} Legal scholar Dorothy Roberts has written about the social construct of race and its negative impact on health equity for decades.⁸ Considering the recent controversy about the Journal of the American Heart Association (JAHA) opinion piece authored by Dr. Norman Wang, I recognize that you are working to address misconceptions about diversity and inclusion in medicine.⁹ Thus, another critical part of the solution must be intentional inclusion, prioritization, and amplification of the work of health equity scholars and community members who are people of color.

Minimizing the harm clinical algorithms present to care and outcomes for communities of color is an important starting point. Recently in my home state of Massachusetts, Massachusetts General Brigham announced that it would no longer use the “race correction” for kidney function. Several other institutions, including Vanderbilt University Medical Center, have since

⁵ Peterson PN, Rumsfeld JS, Liang L, et al. A validated risk score for in-hospital mortality in patients with heart failure from the American Heart Association Get with the Guidelines program. *Circ Cardiovasc Qual Outcomes* 2010;3:25-32.

⁶ Grubbs V. Precision in GFR Reporting: Let’s Stop Playing the Race Card. *CJASN*. May 2020. DOI: <https://doi.org/10.2215/CJN.00690120>

⁷ Eneanya ND, Yang W, Reese PP. Reconsidering the Consequences of Using Race to Estimate Kidney Function. *JAMA*. 2019;322(2):113–114. doi:10.1001/jama.2019.5774

⁸ Roberts D. *Killing the Black Body: Race, Reproduction, and the Meaning of Liberty*. 1998.

⁹ <https://www.tctmd.com/news/aha-editors-and-cardiologists-ask-how-did-racist-paper-make-it-print>

made similar announcements. We know that physicians throughout the country will build on changes like this at respected institutions to drive needed change to promote racial equity.

Your leadership is critical to efforts to discourage and eliminate the misuse of race and ethnicity in clinical algorithms. I would like to work with you and the leadership team of the AHA and the ACC to ensure that these issues are addressed expeditiously. In particular, by September 25, 2020, I would appreciate receiving the ACC and AHA's perspective on the following issues:

1. Please update me the AHA and ACC's efforts to educate its members and raise awareness about health inequities affecting Black, Latinx, Indigenous, and other communities of color. How are the AHA and ACC supporting racial and ethnic diversity of leading voices in the discussions and strategy development relating to health equity?
2. What efforts are being undertaking to review and reevaluate the use of race and ethnicity in clinical algorithms like "Get with the Guidelines-Heart Failure"? How will the AHA and ACC work to support, encourage, and coordinate with other specialty organizations that are also conducting a reevaluation?
3. While reevaluating and ending the misuse of race/ethnicity in these algorithms could take some time, what guidance can the AHA and ACC issue quickly to redirect clinicians' use of these algorithms? How will the AHA and ACC inform clinicians of the impact of these algorithms on racial health inequities? What guidance would the AHA and ACC offer on how this should be communicated to patients?
4. What are some of the various options for remedies that could be implemented prospectively to ensure appropriate care for patients who have not received it because of the misuse of race and ethnicity? What role could the federal government play in this implementation? What role should the AHA and ACC play in the implementation?

Thank you for your attention to this critical matter. If you have any questions about this request, please contact Sarah Levin at Sarah.Levin@mail.house.gov or Orriel Richardson at Orriel.Richardson@mail.house.gov of the Committee on Ways and Means Democratic Staff at (202) 225-3625.

Sincerely,



Richard E. Neal
Chairman