

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

September 3, 2020

James L. Madara, MD
Chief Executive Officer & Executive Vice President, Pathology
American Medical Association (AMA)
330 N. Wabash Ave., Suite 39300
Chicago, IL 60611-5885

Dear Dr. Madara:

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 As the American Medical Association (AMA) continues to examine issues of structural racism and inequities,³ I request an update about the work AMA is undertaking to investigate and change such clinical decision support tools that fuel inequities in care, and look to your collaboration and leadership to 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.”⁴ Relying on this foundation, the NEJM article describes how the legacy of racism and discrimination continues to influence clinical medicine algorithms in our country.⁵ Analyses of the human genome continue to show that there are more differences within racial groups than there are among racial groups.⁶ Despite this proven fact, clinical tools continue to use race and ethnicity in ways that exacerbate racial health inequities.

While this issue is not new, the pervasive breadth of these findings is disturbing, and needs to be addressed by the American Medical Association (AMA).^{7 8} Considering your recent

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 <https://www.ama-assn.org/delivering-care/health-equity/covid-19-health-equity-resources>

⁴ Jones CP. Levels of Racism: A Theoretic Framework and a Gardener’s Tale. *American Journal of Public Health*. 2000; 90(8): 1212-1215.

⁵ Vyas DA et al. Hidden in plain sight – reconsidering the use of race correction in clinical algorithms. 2020; DOI: 10.1056/NEJMms2004740.

⁶ 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).

⁷ [https://www.whijournal.com/article/S1049-3867\(19\)30098-2/fulltext](https://www.whijournal.com/article/S1049-3867(19)30098-2/fulltext)

⁸ <https://science.sciencemag.org/content/366/6464/447>

announcement about the AMA's investment in Chicago through West Side United as well as your efforts through the "Prioritizing Equity" video series, we are encouraged by your work and count on you to lead on this issue. 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 unfortunate practice.

According to the World Income Inequality Database, the U.S. has the highest rate of inequality of all Western Countries.⁹ 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. What has become increasingly clear is that race and ethnicity are social constructs, making the root cause of inequities racism, not race. Unfortunately, race has been misinterpreted and misused in clinical care to the harm of communities of color, especially Black Americans who are referenced most frequently in clinical algorithms.

The NEJM article highlights instances across most medical specialties about how clinical medicine algorithms integrate race and ethnicity as variables.¹⁰ From heart failure to kidney function to Vaginal Birth After Cesarean (VBAC) algorithms, race and ethnicity are widely misused. For many of these clinical algorithms, the "correction" factor for race or ethnicity ends up assigning Black or Latinx patients inaccurate risk scores that have the potential to worsen their health outcomes and deepen racial health inequities. It is also important to note that the health status and needs of marginalized Indigenous communities are often so understudied that they are made invisible – a notable omission that is another force driving health inequities. It is past time for this practice to be meaningfully reevaluated and paired with efforts to effectively communicate the history and harms of this practice in clinical medicine to ultimately fix them.

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.¹¹ ¹² Legal scholar Dorothy Roberts has written about the social construct of race and its negative impact on health equity for decades.¹³ To that end, 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. We know that physicians throughout the country will build on changes like this at respected institutions to drive needed change to promote racial equity.

⁹ <https://ourworldindata.org/income-inequality>

¹⁰ Vyas DA et al. Hidden in plain sight – reconsidering the use of race correction in clinical algorithms. 2020; DOI: 10.1056/NEJMms2004740.

¹¹ <https://cjasn.asnjournals.org/content/early/2020/05/09/CJN.00690120>

¹² <https://jamanetwork.com/journals/jama/article-abstract/2735726>

¹³ Roberts D. Killing the Black Body: Race, Reproduction, and the Meaning of Liberty. 1998.

I appreciated your submission for the public record for our recent hearing *The Disproportionate Impact of COVID-19 on Communities of Color* and was encouraged to learn about your newly inaugurated AMA Center for Health Equity. Your leadership to encourage the end of the inappropriate use of race and ethnicity in clinical algorithms is critical. I would like to work with the you and the leadership team of the AMA to ensure that these issues are addressed expeditiously.

In particular, by September 25, 2020, I would like to better understand your perspective at the AMA on the following issues:

1. Please update the Committee on AMA's efforts to educate its members and raise awareness about health inequities affecting Black, Latinx, Indigenous, and other communities of color?
2. What strategies is the AMA undertaking to review and reevaluate the use of race and ethnicity in clinical algorithms? How will the AMA 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 AMA issue quickly to redirect clinicians' use of these algorithms? How will the AMA inform clinicians of the impact of these algorithms on racial health inequities? What guidance would the AMA offer on how this should be communicated to patients?
4. What remedies should be implemented to ensure appropriate care for patients who have not received it because of the clinical algorithms? What role could the federal government play in this implementation? What role should the AMA play in the implementation?
5. Considering the unique experience of Black, Indigenous, and Latinx scholars, have a leading and vital perspective on these issues and the proposed solutions, despite being underrepresented in medicine. How is AMA supporting diversity in the discussions and strategy development relating to health equity?

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.

Sincerely,



Richard E. Neal
Chairman