

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

September 3, 2020

Juan C. Celedón, MD, DrPH, ATSF
President
American Thoracic Society
25 Broadway
New York, NY 10004

Karen J. Collishaw, MPP, CAE
Executive Director
American Thoracic Society
25 Broadway
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Dear Ms. Collishaw and Dr. Celedon:

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 to make clinical assessments and decisions in various lung disease treatments like the use of pulmonary function tests (PFTs).² The American Thoracic Society (ATS) has a very important role to play in addressing longstanding racial inequities. I write to request an update about any work underway at the ATS to investigate and change such clinical decision support tools that fuel racial inequities in care.

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 Relying on this foundation, the NEJM article describes how the legacy of racism and discrimination grounded in historical texts continues to influence clinical medicine algorithms in our country.⁴ Since the completion of the human genome project in 2003, subsequent analyses continue to show that there are more differences within racial groups than there are among racial groups.⁵ While science has debunked the biological relevance of race, clinical tools continue to use race and ethnicity in ways that exacerbate racial health inequities. This issue is not new and the pervasive breadth of these findings is disturbing and warrants prioritization by ATS as well

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

⁵ 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).

as other professional societies.^{6 7} 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.

Unfortunately, “racial” differences in measured lung function (spirometry) have been used to justify racism in the recent past in our nation.⁸ Current research does not fully investigate the role of social and environmental factors on measurement and interpretation of PFTs. The machines that measure lung function in the U.S. use correction factors for Black and Asian patients. Once “corrected,” PFT results and their interpretation can mean the difference between being offered surgery or not and whether the patient qualifies for certain treatments. On a national scale the clinical impact of these “correctors” should not be underestimated, especially in an arena where there are known racial inequities in outcomes for asthma and other chronic lung diseases among people of color.

Minimizing the harm clinical algorithms present to care and outcomes for communities of color is an important action. Recently in my home state, Massachusetts General Brigham announced that it would no longer use “race correction” for kidney function calculation.⁹ Several other institutions, including Vanderbilt University Medical Center, recently made similar announcements.¹⁰ Physicians throughout the country will continue build on the changes made at respected institutions like these in order to drive needed change to promote racial equity throughout the country.

ATS’s leadership is a critical part of the effort to encourage the end of the inappropriate use of race and ethnicity in the calculation of lung function. The Committee would like to work with the you and the leadership team of the ATS to ensure that these issues are addressed expeditiously. In particular, by September 25, 2020, I would appreciate receiving ATS’s perspective on the following issues:

1. Please update me on ATS’s efforts to educate its members and raise awareness about health inequities affecting Black, Latinx, Indigenous, and other communities of color. How is ATS 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 diagnostic tests like PFTs? How will ATS 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 clinical tools could take some time, what guidance can ATS issue quickly to redirect clinicians’ use of them?

⁶ [https://www.whijournal.com/article/S1049-3867\(19\)30098-2/fulltext](https://www.whijournal.com/article/S1049-3867(19)30098-2/fulltext)

⁷ <https://science.sciencemag.org/content/366/6464/447>

⁸ Washington HA. Medical Apartheid: The Dark History of Medical Experimentation on Black Americans From Colonial Times to the Present. Harlem Moon: New York. 2008.

⁹ <https://www.kidneynews.org/kidney-news/current-issue/medical-students-lead-effort-to-remove-race-from-kidney-function-estimates>

¹⁰ <https://news.vumc.org/2020/07/13/groups-efforts-lead-to-removal-of-race-as-a-variable-in-common-test-of-kidney-function/>

How will ATS inform clinicians of the impact of these tools on racial health inequities?
What guidance would ATS 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 ATS 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,

A handwritten signature in blue ink, appearing to read "Richard E. Neal". The signature is fluid and cursive, with a large initial "R" and "E".

Richard E. Neal
Chairman