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Dear Chairman Richard Neal and Members of the House Ways and Means Committee,

Thank you for your request for information on the Misuse of Race Within Clinical Care. Mass General Brigham is honored to participate in this discussion as we have been at the forefront of national discussions on this important topic.

I would like to begin by highlighting what we feel to be the most important points in the national discussion of the use of race.

1) Race is a social, not a biologic or scientific construct

It is imperative that we recognize at the outset that race is a concept rooted in historical oppression of targeted populations and has been used primarily to the advantage of those in power. We simply cannot embed a social construct into clinical decision tools. And we cannot conflate race with genetics, as is often done in discussions of the misuse of race in clinical care.

The use of race as a social marker has been enmeshed with racist assumptions of biological difference nearly from the inception of American society. These racist assumptions still influence clinical decision making today; the idea that Black individuals are more able to tolerate pain arose as a psychological salve for slave owners who subjected Black individuals to painful punishments and now finds its modern expression in the lower odds of Black patients with pain receiving opioid pain medications (Tamayo-Sarver et al. Am J Public Health 2003).

2) The classification of patient race in clinical studies is inherently flawed

Collection of patient race for the purposes of generating clinical decision algorithms has often not been performed in a scientifically acceptable manner. The methods used by investigators have included “examination of skin color”, or even worse, the methods have not been documented. There is no other clinical variable that we would find acceptable for use if its collection was so flawed.

3) The application of patient race in the clinical setting reinforces racism

We do not know how clinicians assign patient race in a clinical encounter, whether they are asking patients, or worst case scenario applying their own judgment based on physical or other characteristics. The use of race in clinical decision making encourages our clinicians to apply the very stereotypes and judgments we implore them to avoid. Equally as important, even if patient race is self-reported, we are

certainly not informing patients that such information will be used to adjust their clinical care – which many (if not most) patients would find entirely unacceptable.

Finally, the population is increasingly multi-racial, and no clinical decision tools are able to account for this concept – and again reinforces racist approaches to classifying individuals based on their familial ancestry. Grouping all Black individuals for the purposes of clinical decision making denies the diversity within the Black community. It has been shown, for example, that there is potentially more genetic difference between West Africans and East Africans than there is between African and European individuals (Tishkoff et al. *Science* 2009). In addition, individuals who are of mixed-race ancestry are not adequately accounted for in the derivation and validation of the equations (Eneanya et al. *JAMA* 2019). Eneanya posits that race should only be used in medical decision making if: 1) its use confers substantial benefit; 2) the benefit cannot be achieved through other feasible approaches; 3) patients who reject race categorization are accommodated fairly; 4) the use of race is transparent.

Mass General Brigham has been actively involved as a thought leader as well as generating the research base to understand the implications of the misuse of race in clinical care. Dr. Vyas (Massachusetts General Hospital) and other colleagues at Harvard have compiled numerous examples of the use of race corrections in clinical medicine, highlighting equity concerns for each of them (Vyas DA et al. *N Engl J Med* 2020). For example, a risk calculator for cardiac surgical procedures concludes that Black patients may have higher risk for operative mortality and major complications, potentially steering clinicians away from even offering these procedures to Black patients. A calculator used to guide decisions about vaginal birth after prior cesarean section delivery (VBAC) suggests a lower success rate for Hispanic and Black women, potentially leading providers to offer trial of labor to women of color less often. The authors warn “Researchers and clinicians must distinguish between the use of race in descriptive statistics, where it plays a vital role in epidemiologic analyses, and in prescriptive clinical guidelines, where it can exacerbate inequities.” In other words, observing vulnerable communities have worse outcomes should not lead, like a straight arrow, to clinical decision tools that further limit or obstruct treatment options for those same vulnerable persons.

Mass General Brigham researchers, population health and quality leaders specifically sought to study the impact of the “race multiplier” term included in estimating equations for kidney function that assign higher kidney function to Black patients. In a recently published study in the *Journal of General Internal Medicine* by Ahmed S et al., performed using data from the Mass General Brigham Chronic Kidney Disease registry, we demonstrate that the continued use of race in estimated kidney function contributes to disparities in advanced chronic kidney disease care delivery. We found that by removing the use of race in estimating kidney function, up to one in every three Black patients would be reclassified as having a more severe stage of CKD — an important distinction that could lead to better access to advanced kidney care including dialysis and renal transplantation. We raise several substantive critiques of the inclusion of Black race for the estimation of kidney function in equations for estimated glomerular filtration rate (eGFR), principally that the inclusion of Black race in eGFR reporting



may delay necessary care for this community already vulnerable to several disparities in kidney care.

Based on the work led by Mass General Brigham researchers and other leaders across the country, we announced in June the elimination of use of race correction for kidney disease function. However, the use of race correction remains common at health systems throughout the country for estimating kidney function and many other clinical calculators as well. We applaud this congressional committee's leadership to re-evaluate the use of race in clinical medicine in a manner that could exacerbate existing racial disparities. We will continue to evaluate our own practices, educate clinicians on this topic, and work collaboratively with health systems, policy makers, and patients across the country to eliminate structural racism within medicine. We believe that federal leadership and guidance on this topic is of paramount importance to ensure that this crucial step to ensuring health equity is advanced systematically, consistently, and universally.

Sincerely,

A handwritten signature in black ink, appearing to read "T. Sequist".

Thomas D. Sequist, MD MPH
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Mass General Brigham