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

September 3, 2020

Thomas J. Nasca, MD, MACP
President and Chief Executive Officer
Accreditation Council for Graduate Medical Education
Suite 2000
401 North Michigan Avenue
Chicago, Illinois 60611

Dear Dr. Nasca:

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] While the Accreditation Council for Graduate Medical Education (ACGME) did not develop these clinical guidelines, your leadership role within medical education and organized medicine can help Congress gain greater insight into these issues and potentially identify areas of collaboration to rectify these ongoing concerns. More specifically, I would greatly appreciate an update on the work ACGME is undertaking to review and update the strategy and standards for training medical residents on clinical decision support tools like those that are known to fuel inequities in care. Collaboration between Congress and the ACGME can help address these important issues.

While this issue is not new, the pervasive breadth of these findings is disturbing and needs to be addressed.[3] [4] I hope the ACGME can help with this effort. Considering your announcement last year of the first ever Chief Diversity and Inclusion Officer, Dr. William McDade, we are encouraged by your work and count on you to lead on this issue. Medical professional bodies and societies should take a clear stand against the misuse of race and ethnicity in clinical algorithms and issue new guidance to correct this practice.

---

[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.whijournal.com/article/S1049-3867(19)30098-2/fulltext[4]
https://science.sciencemag.org/content/366/6464/447
[4] https://science.sciencemag.org/content/366/6464/447

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."[5] Relying on this foundation, the NEJM article describes how the legacy of racism and discrimination continues to influence clinical medicine algorithms in our country.[6] Analyses of the human genome continue to show that there are more differences within racial groups than there are among racial groups.[7] Despite this proven fact, clinical tools continue to use race and ethnicity in ways that exacerbate racial health inequities.

According to the World Income Inequality Database, the U.S. has the highest rate of inequality of all Western Countries.[8] 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. 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 time for this clinical practice to be reevaluated and paired with efforts to communicate the history and harms of the practice and to address them.

The NEJM article highlights instances about how clinical medicine algorithms integrate race and ethnicity as variables across most medical specialties.[9] 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 alter or delay appropriate care, and as a result lead to worse health outcomes while deepening health inequities.

Black, Indigenous, and Latinx scholars of clinical medicine have long studied and critiqued inadequacies of medical education on these subjects and the use of race in the field; however, their scholarship has not received adequate attention. Legal scholar Dorothy Roberts has written about the social construct of race and its negative impact on health equity for decades.[10] Dr. Helena Hansen has led essential work describing structural competency – an approach that empowers medical trainees to understand social and structural causes of poor

---

[5] Jones CP. Levels of Racism: A Theoretic Framework and a Gardener's Tale. American Journal of Public Health. 2000; 90(8): 1212-1215.
[6] Vyas DA et al. Hidden in plain sight – reconsidering the use of race correction in clinical algorithms. 2020; DOI: 10.1056/NEJMms2004740.
[7] 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).
[8] https://ourworldindata.org/income-inequality
[9] Vyas DA et al. Hidden in plain sight – reconsidering the use of race correction in clinical algorithms. 2020; DOI: 10.1056/NEJMms2004740.
[10] Roberts D. Killing the Black Body: Race, Reproduction, and the Meaning of Liberty. 1998.

health rather than rely on oversimplified approaches used in cultural competency curricula.[11] Drs. Vanessa Grubbs and Nwamaka Eneanya recently described concerns about race correction in kidney function.[12] [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.[14] Several other institutions, including Vanderbilt University Medical Center, recently made similar announcements.[15] 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.

Your leadership to encourage the end of the inappropriate use of race and ethnicity in clinical algorithms and its influence on the training and education of residents is critical. The Committee would like to work with the you and the leadership team of the ACGME to ensure that these issues are addressed expeditiously. In particular, by September 25, 2020, I would appreciate receiving ACGME's perspective on the following issues:

1. Please update the Committee on the ACGME's efforts to educate its staff and raise awareness about health inequities affecting Black, Latinx, Indigenous, and other communities of color. How is the ACGME supporting racial and ethnic diversity of leading voices in the discussions and strategy development relating to health equity education as it relates to medical training and accreditation?

2. What efforts are being undertaken to ensure that medical residents understand the challenges with including race and ethnicity in clinical algorithms? How will the ACGME work to support, encourage, and coordinate with other organizations that are also conducting a reevaluation?

3. While development of structural competency curricula, reevaluating, and ending the misuse of race/ethnicity in these algorithms and resident training could take some time, what is ACGME doing to work with its accredited institutions on the understanding of these algorithms' use of race and ethnicity? How will the ACGME inform accredited programs of the impact of these algorithms on racial health inequities? What guidance would the ACGME offer on how residents in accredited programs and their supervisors should communicate this to patients?

---

[11] Metzl JM and Hansen H. Structural Competency: Theorizing a new medical engagement with stigma and inequality. Social Science and Medicine. 2014. 103: 126-133.
[12] https://cjasn.asnjournals.org/content/early/2020/05/09/CJN.00690120
[13] https://jamanetwork.com/journals/jama/article-abstract/2735726
[14] https://www.kidneynews.org/kidney-news/current-issue/medical-students-lead-effort-to-remove-race-from-kidney-function-estimates
[15] https://news.vumc.org/2020/07/13/groups-efforts-lead-to-removal-of-race-as-a-variable-in-common-test-of-kidney-function/

4. What are some of the various options for remedies that could be implemented prospectively to ensure appropriate training for residents? What role could the federal government play in this implementation? What role should the ACGME 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