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

September 3, 2020

Maureen G. Phipps, MD, MPH, FACOG
Chief Executive Officer
American College of Obstetricians and Gynecologists
409 12th Street SW
Washington, DC 20024-2188

Dear Dr. Phipps:

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 about treatment options like who should be offered vaginal birth after cesarean section (VBAC).[2] The American College of Obstetricians and Gynecologists (ACOG) has a very important role to play in addressing longstanding racial inequities. I write to request an update about any work underway at ACOG 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 of the human genome 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. Thus, this issue is not new and the pervasive breadth of these findings is disturbing and warrants

[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).

prioritization by ACOG as well 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.

Black, American Indian, and Latinx women have two to three times higher rates of maternal mortality than white women,[8] and the Centers for Disease Control and Prevention (CDC) deemed two-thirds of pregnancy-related deaths to be preventable in its recent data brief on maternal mortality.[9] Women from these same racial and ethnic groups also have higher rates of cesarean section despite the know health benefits of vaginal delivery. Though the VBAC risk evaluation tool developers note that insurance status and other variables were also predictive of outcomes, race and ethnicity were included in the calculator when it was published in 2007.[10] As race and ethnicity are social constructs, the root cause of racial health and economic inequities is racism, not race. Unfortunately, race has been misinterpreted and misused in clinical care to the harm of communities of color. Black and Latinx Americans, the racial groups singled-out in the VBAC risk calculation tool, deserve an explanation and a new approach.

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. Several other institutions, including Vanderbilt University Medical Center, recently made similar announcements. 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.

ACOG'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 VBAC risk. The Committee would like to work with the you and the leadership team of ACOG to ensure that these issues are addressed expeditiously. In particular, by September 25, 2020, I would appreciate receiving ACOG's perspective on the following issues:

1. Please update me on ACOG's efforts to educate its members and raise awareness about health inequities affecting Black, Latinx, Indigenous, and other communities of color. How is ACOG 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 the VBAC risk calculator? How will ACOG work to support, encourage, and coordinate with other specialty organizations that are also conducting a reevaluation?

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[6] https://www.whijournal.com/article/S1049-3867(19)30098-2/fulltext
[7] https://science.sciencemag.org/content/366/6464/447
[8] H. Cole, et al. Building a Movement to Birth a More Just and Loving World. *The National Perinatal Task Force*, (2018). Available at: https://perinataltaskforce.com/heads-up-maternal-justice-npt-2018-report-out-now/
[9] "Data Brief From 14 U.S. Maternal Mortality Review Committees, 2008 – 2017." *CDC*, (2019). Available at: https://www.cdc.gov/reproductivehealth/maternal-mortality/erase-mm/mmr-data-brief.html
[10] Grobman WA, Lai Y, Landon MB, et al. Development of a nomogram for prediction of vaginal birth after cesarean delivery. Obstet Gynecol 2007;109:806-812.

3. While reevaluating and ending the misuse of race/ethnicity in these algorithms could take some time, what guidance can ACOG issue quickly to redirect clinicians' use of these algorithms? How will ACOG inform clinicians of the impact of these algorithms on racial health inequities? What guidance would ACOG 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 ACOG 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