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

September 3, 2020

Anupam Agarwal, MD
President
American Society of Nephrology
1401 H Street, NW, Suite 900
Washington, DC 20005

Dear Dr. Agarwal:

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 such as calculating kidney function.[2] This longstanding practice runs counter to the goal of health care and has led to poorer health outcomes for thousands of Americans. As highlighted in the American Society of Nephrology's (ASN) July 2020 issue of *Kidney News*, medical students are leading the charge to end the use of race when calculating kidney function.[3] I write to request an update about any work underway 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."[4] 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.[5] 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.[6] While science has debunked the biological relevance of race, clinical tools continue to use race and ethnicity in ways that exacerbate racial health inequities.

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[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.kidneynews.org/kidney-news/current-issue/medical-students-lead-effort-to-remove-race-from-kidney-function-estimates
[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).

Thus, this issue is not new and the pervasive breadth of these findings is disturbing and warrants prioritization by ASN as well as other professional societies.[7] [8] 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 patients with chronic kidney disease (CKD) and end-stage renal disease (ESRD) have been long known to experience delayed nephrology referral and disproportionately low rates of transplantation compared to other racial groups.[9] 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 the only racial group singled-out in eGFR calculation.

Drs. Vanessa Grubbs, Nwamaka Eneanya, and Peter Reese recently described concerns about race correction in kidney function calculation.[10] [11]. As you know, in the case of kidney function, the "correction" factor for Black race calculates a level of kidney function for "Black" patients that appears healthier than that of White patients for the same measured lab result. Considering the extensively documented racial inequities in outcomes for CKD and ESRD for Black people, 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 and to ultimately fix them. Some nephrologists worry that ending race correction in eGFR calculation may decrease access to first-line diabetes medications and cause over-referral for kidney disease evaluation for Black patients, but these impacts can be studied over time and medications can be tailored with input from nephrologists. While these questions are being studied, the significant harms of race correction can stop now.

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.

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

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[7] https://www.whijournal.com/article/S1049-3867(19)30098-2/fulltext
[8] https://science.sciencemag.org/content/366/6464/447
[9] Purnell TS, Luo X, Cooper LA, Massie AB, Kucirka LM, Henderson ML, Gordon EJ, Crews DC, Boulware LE, Segev DL. Association of Race and Ethnicity With Live Donor Kidney Transplantation in the United States From 1995 to 2014. JAMA. 2018 Jan 2;319(1):49-61.
[10] https://cjasn.asnjournals.org/content/early/2020/05/09/CJN.00690120
[11] https://jamanetwork.com/journals/jama/article-abstract/2735726

1. Please update the Committee on ASN's education efforts that specifically describe the lack of scientific rigor in defining race and differences in "muscle mass" in the research studies that led to the current equation that guides eGFR calculation. How will the ASN inform clinicians of the connection between race correction in eGFR calculation and racial health inequities in CKD, ESRD, and kidney transplantation?

2. What strategies is the ASN undertaking to reevaluate the scientific basis for the use of Black race in eGFR calculation? How will the ASN work to support, encourage, and coordinate with other specialty organizations that are also conducting a reevaluation?

3. While ending the use of Black race in eGFR calculation could take some time to implement, what guidance can the ASN issue quickly to redirect clinicians' practice? What guidance would the ASN offer on how this should be communicated to patients?

4. What remedies could be implemented to ensure appropriate care for patients who have not received it because of race correction in eGFR calculation? What role could the federal government play in this implementation? What role should the ASN play in the implementation?

5. 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 ASN ensuring racial diversity in the discussion 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 Melanie Egorin at Melanie.Egorin@mail.house.gov of the Committee on Ways and Means Democratic Staff.

Sincerely,

Richard E. Neal
Chairman