American Thoracic Society

American Journal of Respiratory and Critical Care Medicine ®
American Journal of Respiratory Cell and Molecular Biology ®
Annals of the American Thoracic Society ®
ATS Scholar ™ Open Access

September 28, 2020

The Honorable Richard Neal
Chairman
Committee on Ways and Means
U.S. House of Representatives
Washington, DC 20515

Dear Chairman Neal:

The American Thoracic Society (ATS) was originally founded in 1905 as a consortium to prevent, control, and treat tuberculosis, a disease known for its predilection for those living in impoverished settings. Since its founding, the ATS has progressively focused its efforts towards addressing respiratory health disparities (1).

A diverse workforce is key to efforts targeting the elimination of health disparities. Since 1994, the ATS has sponsored an annual Diversity Forum luncheon for under-represented minority fellows and faculty during its International Conference, which includes keynote speakers focused on health disparities and fosters networking. At that event, the ATS has formally awarded Minority Trainee Travel Scholarships since 2002 to recognize promising and talented early-career minority scientists; 40 of these scholarships were awarded by the ATS in 2020. In parallel with efforts to increase diversity, inclusion, and representation, the ATS has sponsored or facilitated scholarly work on health disparities. For example, a group of ATS members published a "State of the Art" review on respiratory diseases in U.S. minorities in its flagship journal, the American Journal of Respiratory and Critical Care Medicine, in 1994.

In 2013, the ATS renewed, strengthened, and formalized its commitment to health equity, diversity, and inclusion through the creation of a Health Equality and Diversity Committee (HEDC). Since its creation, the HEDC has convened an annual fellowship to honor and support an early-career investigator focused on respiratory health disparities, developed a dedicated focus on health disparities at the ATS annual conference through the Clinical Year in Review series, and has commissioned a series of official documents and publications on issues related to health disparities (published between 2013 and 2020). For example, the ATS published a special issue of the Annals of the American Thoracic Society focused on respiratory health disparities in May 2014, which included the society's Position Statement on Respiratory Health Equality. Moreover, a brochure summarizing this position statement was distributed to all members at the annual

JUAN C. CELEDÓN, MD, DrPH, ATSF
President

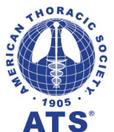
LYNN M. SCHNAPP, MD, ATSF
President-Elect

JAMES M. BECK, MD, ATSF
Immediate Past President

GREGORY P. DOWNEY, MD, ATSF
Vice President

M. PATRICIA RIVERA, MD, ATSF
Secretary-Treasurer

KAREN J. COLLISHAW, MPP, CAE
Executive Director



conference. In 2019, the HEDC and the ATS Executive Committee formalized and disseminated the society's Diversity and Inclusion Policy.

The recent deaths of George Floyd, Ahmaud Arbery, and Breonna Taylor, all lives shortened for being Black in the U.S., highlight the important role of structural racism in creating and perpetuating racial or ethnic disparities in respiratory health. Moreover, the ongoing COVID-19 pandemic has further exposed such longstanding and unacceptable disparities, thus motivating us to redouble our efforts to address such disparities and pursue respiratory health equity. Herein, we respond to the four questions put forth to us by the Ways and Means Committee to communicate current actions and futures plans.

1. **Describe ATS's efforts to educate its members and raise awareness about health inequities affecting Black, Latinx, Indigenous, and other communities of color. How is the ATS supporting racial and ethnic diversity of leading voices in the discussions and strategy development relating to health equity?**

   To respond more immediately to and address racism in the field of pulmonary, critical care, and sleep medicine, and identify focus areas to address root causes of ongoing racial and ethnic respiratory health disparities, the Health Equality and Diversity Committee convened a Town Hall meeting of ATS committee chairs and vice-chairs on July 14, 2020. This Town Hall was intended to facilitate first step discussions, to explore new or ongoing ATS initiatives, and to re-evaluate current benchmarks with an equity lens. The Town Hall also incorporated discussions of short- and long-term efforts that the Society and individual committees may undertake to address systemic racism and the long-standing inequities in respiratory health and academia, as well as reaffirm our stance in support of public policies to promote health equity. In addition, our executive committee (EC), composed of six members, is actively pursuing avenues to swiftly provide diversity, equity, and inclusion training geared towards all members who hold a leadership position within ATS, including the EC.

   Below we highlight past and current efforts to raise awareness about racial and ethnic respiratory health disparities and promote inclusion and diversity across the ATS membership and leadership.

Supporting Universal Health Care

The ATS recognizes that there is no single cause of health disparities and no single solution to achieving healthy equity, but the ATS strongly believes that universal health coverage is a

necessary step to move toward health equity. As such, the ATS is a strong supporter of the Affordable Care Act (ACA). As a society, we have played an active role in supporting the development and enactment of the ACA, including the support of adoption of a public option.   ATS recognizes and appreciates the leadership chairperson Neal and the Ways and Means committee played in crafting and securing enactment of the ACA. Since its enactment in 2010, ATS has supported state efforts to adopt Medicaid expansion and has opposed subsequent congressional efforts to repeal or retrench the ACA. On multiple occasions, the ATS has submitted amicus briefs before the US Supreme Court to support the constitutionality and severability of the ACA. While imperfect in its construction and incomplete in its implementation, the ACA remains a powerful policy vehicle to help address the persistent gaps in healthy equity that we continue to experience in the US. We will continue to support, and push Congress to improve upon and fully implement the universal health coverage as envisioned by ACA.

Examining and Addressing Racial and Ethnic Respiratory Health Disparities
The ATS raises awareness of respiratory health disparities for its members and the general public through several mechanisms, including public and policy statements, web and social media platforms, conference activities, funding of research on health disparities and under-represented minority investigators, and official documents and publications.

Recent public and policy statements include our stance against the use of tear gas at public protests, death of George Floyd, racism, and Diversity and Inclusion in the ATS. In response to the need to quickly inform the public about the risks for transmission and disease through the ongoing COVID-19 pandemic, the ATS and the American College of Chest Physicians launched the For My Lung Health website and campaign (formylunghealth.com), which is available in English and Spanish and focuses on empowering people from high-risk underserved communities, particularly those living with chronic lung disease. After 7 weeks, the video contained in this website had ~2.6 million views and the website had over 40,000 visits.

We also recently launched a podcast series on systemic racism in academia and the impact on early-career faculty development. The objective of the podcast series is to amplify the voices of underrepresented minority physicians in academia in discussions around challenges and opportunities for early-career faculty development and supporting careers that address health disparities. We hope to expand this series to recount the historical experiences of more senior Black, Latinx, Indigenous, and other minority members of the ATS. In addition,

our newest journal, ATS Scholar, recently issued a call for papers for a Special Collection on Combatting Racism in Health Professions Education.
The ATS Conference offers an opportunity to raise awareness across a large, convening group of members and non-members representing the pulmonary and critical care medicine and research community. Since 2013, we include Health Disparities as part of our Clinical Year in Review Series, one of the best-attended lectures at the annual conference. We also program several Scientific and Abstract Symposia dedicated to Health Disparities at the conference. To raise awareness of these important sessions to our attendees, we recently started to publish a companion document, ATS Roadmap to Health Disparities. The ATS has also commissioned several ATS documents and publications to highlight and address disparities (see table below).

Official Documents • 2013 ATS/ERS Policy Statement on Health Disparities (published in the AJRCCM) • 2014 ATS Position Statement: Respiratory Health Equality in the United States (published in the Annals of the ATS) • 2016 - American Thoracic Society Action Plan Proposal to Increase Health Equality in Pulmonary, Critical Care and Sleep Medicine through Advocacy, Research, Clinical Care and Education (ATS Action Plan Proposal) • 2017 - ATS/NHLBI Workshop Report: Addressing Respiratory Health Equality in the United States (published in the Annals of the ATS) • 2018 - ATS/ERS Workshop Report: Research Needs on Respiratory Health in Migrant and Refugee Populations (published in the Annals of the ATS) • 2020 - ATS Official Statement: Addressing disparities in Lung Cancer Screening Eligibility and Access to Healthcare (will be published in the AJRCCM 10/1/2020)
Publications • 2014 - The Lung Corps' Approach to Reducing Health Disparities in Respiratory Disease (published in Annals of the ATS) • 2016 - Looking to the Future Equality in Health and Marriage (published in the Annals of the ATS) • 2016 - Respiratory Health in Migrant Populations: A Crisis Overlooked (published in Annals of the ATS) • 2016 - Where do we go from here? Improving disparities in respiratory health. In: Health Disparities in Respiratory Medicine (Springer International Publishing) • 2017 Achieving Respiratory Health Equality. A United States Perspective.

(Springer International Publishing).

- 2020 – The Structural and Social Determinants of the Racial and Ethnic Disparities in the United States COVID-19 Pandemic: What Is Our Role? (published in the AJRCCM)
- 2020 - Disparities in Lung Cancer Screening: A Review (published in the Annals of the ATS)

To further promote research that examines racial and ethnic respiratory disparities, the ATS and CHEST have co-sponsored the ATS/CHEST Foundation Research Grant in Diversity for junior investigators. More recently and in response to the COVID-19 pandemic, the ATS has received over $1 million in philanthropic donations. From this, the ATS is dedicating a significant portion to support junior investigators researching COVD-19 inequities and mechanisms to decrease the disparity gap, as well as to developing low health literacy resources targeted to communities that have been most severely affected by the outbreak. Moreover, the ATS will launch a grant to fund under-represented investigators in 2021.

Despite all our ongoing efforts, we recognize that more active action is needed to address the impact of longstanding racial or ethnic inequities on pulmonary, sleep, and critical care medicine in the U.S.

Promoting Inclusion and Diversity Across the ATS and its Leadership

The ATS sponsors a variety of networking and mentoring opportunities for early-career investigators and trainees, some of which are targeted at traditionally under-represented groups in science. Since 1994, the ATS has sponsored the Diversity Forum, an annual event at the annual ATS Conference, where junior and senior under-represented minority pulmonary physicians and members can meet, network, and mentor each other. As part of the Diversity Forum, the ATS presents Minority Travel Scholarships to promising minority investigators (see above).

Since 2013, the ATS has required diversity missions across all ATS committees, formed the Health Equality Fellowship to promote early-career investigators in this area, and has made an explicit effort to ensure racial, ethnic, and gender diversity across all committees and leadership positions in the ATS. In addition, we now require all formal proposals for official ATS Document Statements to include a diverse membership. Applications that do not include adequate representation are returned or not funded. The ATS is also working towards

broadening the diversity of the voices represented in our annual international conference, which is attended by an average of 15,000 people/year.
While a formalized rubric similar to that employed for our Document Statement proposals is still needed, we have started asking potential speakers to report their race and ethnicity when submitting proposals for programming at the conference. Moreover, we encourage reviewers to acknowledge and promote session proposals that have diverse representation on their panels and incorporate discussions regarding racial and ethnic health equity.

As a result of all ongoing efforts, the ATS Leadership now includes more minority representation. For example, the ATS membership has elected two Latinx to their current Executive Committee, including the current ATS President (Dr. Juan C. Celedón). Moreover, four under-represented minority members currently serve as Chair or Vice-Chair of our Committees. This said the ATS recognizes that more can be done to increase the representation of Black, Latinx, and Indigenous pulmonary physicians within and outside of ATS. To this end, we will explore the development of a Black, Latinx, and Indigenous pulmonary physician pipeline program that will include pre-medical students, medical students, residents, and pulmonary fellows. Our goal is to increase the percentage of Black, Latinx, and Indigenous pulmonary physicians to approach and ultimately equate their percentage of the overall U.S. population.

2. **What efforts are being undertaken 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?**

The ATS is convening an official workshop to address the use of race and ethnicity in pulmonary function testing. This workshop will include participation of a diverse group of more than thirty people, representing various disciplines and including pulmonologists,
physiologists, sociologists, epidemiologists, and geneticists. The broad representation of varied disciplines will allow for thoughtful consideration of all determinants of pulmonary function. The leadership and participant membership of this Workshop includes members from under-represented groups in medicine: a quarter of participants are from underrepresented groups in medicine, and a third are women. The participants include ATS members and non-members, such as Dr. Lundy Braun, who has authored the book, "Breathing Race into the Machine: the surprising career of the spirometer from plantation to genetics"(2). In planning the workshop, the ATS members have sought information from peers in other disciplines that are also reviewing and re-evaluating the misuse of race and ethnicity in medicine to perpetuate rather than eliminate disparities.

We expand on the importance of this topic in the following response.

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 clinician's use of them? 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?**

The ATS is committed to leading action to address racism in medicine and eliminate the misuse of race and ethnicity in clinical decision making as it relates to pulmonary and critical care medicine.

Differences in lung function among healthy, non-smokers have been consistently observed between African American and Non-Hispanic White individuals. Differences were noted in the National Health and Nutrition Examination Survey (3, 4), which focused on the U.S. population, and in the Global Lung Initiative (GLI), an international effort to define population normal values for lung function among populations in regions throughout the world (5).

The longstanding assumption has been that these differences are biologically based, and race was capturing these differences. However, as race is a social construct, we know this assumption to be false (6). Rather, these differences likely represent the coalescing effect of social and environmental determinants that disproportionately impact communities of color (7, 8). The ATS acknowledges that by recommending race-specific reference equations for pulmonary function estimates, it has had a role in the continuation of the use of race in a manner that ignores the effects of structural racism. In recognizing and addressing multifactorial causes of differences in lung function, the ATS is actively supportive of collaborative work, the most concrete example of which is the planned Workshop described above.

In moving forward, it will be important for the ATS to thoughtfully evaluate instances in which actions to revise consideration of race and ethnicity in clinical tools may have unintended adverse consequences. The current practice does not rely on arbitrary corrections but uses race-specific equations based on population-specific data derived from healthy non-smokers to estimate lung function. This practice of using race-specific equations results in predicted lung function estimates that are greater than what would be expected if using pulmonary reference equations derived from summative populations. This change may impact those decisions or practices that are dependent on achieving a certain lung function threshold before proceeding. The most poignant examples of these unintended adverse consequences

are those where positions of employment are dependent on lung function thresholds, such as firefighting, and those where lung function is used as a threshold to offer or withhold, life-saving or life-extending therapies, including but not limited to, chemotherapy and cardiac and thoracic surgeries. These last examples are significant, as there are already documented racial and ethnic disparities in these areas. However, these unintended consequences must be balanced against the consideration of how the elimination of race/ethnic-specific reference equations would lead to benefit for historically disadvantaged populations. Examples include increasing the availability of disability benefits and potentially identifying previously undiagnosed pathology.

Importantly, the GLI has published approaches that represents an average of all data in defining normal values in addition to ascribing to methods that incorporate race and ethnicity in defining normal lung function (9). This provides an available avenue to examine whether the inclusion of race and ethnicity contributes to worsening health disparities and a way to examine for potential unintended consequences.

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?**

We recognize that the use of race-specific reference equations for pulmonary function testing requires a critical re-evaluation of its ongoing use (and the subsequent negative consequences to Black, Latinx, and Indigenous populations), and outline the steps above we are taking to actively address this issue. The ATS recognizes that the potential for bias in clinical decision-making is not limited to PFT interpretation. As healthcare professionals, we make biased decisions all the time, examples include denying services or treatments because the treatment plan is “too complex” or “too much” for an already socially-burdened patient, or that a patient is not “fit” enough for the treatment, as demonstrated by disparities in referrals for surgery for lung cancer patients (10). As members of ATS, we need to fill these gaps. There is an opportunity to reduce racial and ethnic respiratory health care disparities by developing, testing, and implementing care algorithms shown to be effective in improving care for these patient populations. As members of ATS, we are actively evaluating our research funding priorities and have already begun to dedicate research money to health disparities. In addition to research, the ATS is re-examining how patient-facing materials and guideline documents, including those for PFT interpretation, are designed to support equitable health outcomes across all population groups. In areas where there are evidence-

based interventions to reduce racial and ethnic disparities, such as for lung cancer and asthma care (11, 12), the federal government must provide funding and authority that support programming and reimbursements of such programs, which heavily rely on soft money. To this end, partnerships between the ATS with the Centers for Medicare and Medicaid Services, Agency for Healthcare Research and Quality, and the Veteran's Health Administration would further facilitate the development and implementation of racially equitable care pathways for the diagnosis, assessment, treatment, and overall management of pulmonary diseases.

To ensure pathways that successfully address racial and ethnic respiratory health disparities, equity metrics are needed and should be developed by the federal government in partnership with the ATS and other professional organizations. These can be used to track performance across important quality measures, including but not limited to transplant allocation, lung cancer screening, vaccination rates, and surgical intervention for lung cancer.

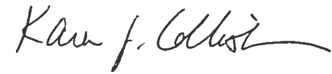
Further, the ATS recommends that the federal government promote more research on the root causes and solutions to racial/ethnic differences in lung function. As racial differences in lung function (particularly Black-White differences) are well-described, the underlying causes of these differences are not as well characterized. The impact of "masking" these lung function differences likely contribute to racial disparities in treatment decisions, including thoracic surgery, lung transplant, and disability allocation. Specifically, we recommend the provision of dedicated funding opportunities through NIH, including the National Institute on Minority Health and Health Disparities, the National Heart, Lung, and Blood Institute and other institutes, Centers for Disease Control and Prevention, Agency for Healthcare Research and Quality and Department of Veterans Affairs Research program directed RFAs to study these areas.

Lastly, there is ample evidence that increasing diversity of the medical workforce improves medical care for minority patients. The federal government has an important role in increasing the availability of loan repayment programs or other policies that directly or indirectly remove the financial burden of pursuing medical education for Black, Latinx, and Indigenous students.

In summary, the ATS remains firmly committed to helping address respiratory health disparities by ensuring an engaged, comprehensive review of the concerns regarding race and ethnicity in clinical decision-making, as well as the clinical and public health implications at the individual and population level. The communication of the recommendations that ensue will be critical to overcome barriers to the adoption of best practices.

This is an iterative process, and we will continue to ask ourselves, as leaders of the ATS, and our membership, how to thoughtfully and vigorously move forward.

Respectfully yours,



Juan C. Celedón, MD, DrPH, ATSF
President
American Thoracic Society

Karen J. Collishaw, MPP, CAE
Executive Director
American Thoracic Society

REFERENCES

1 Coultas D, Gong H Jr., et al. State of the Art: Respiratory diseases in minorities of the United States. *Am J Respir Crit Care Med* 1994; 149(3 Pt 2):S93-131.

2 Braun, Lundy. *Breathing race into the machine: The surprising career of the spirometer from plantation to genetics*. U of Minnesota Press, 2014.

3 NHANES: Stanojevic, Sanja, et al. "Reference ranges for spirometry across all ages: a new approach." *Am J Respir Crit Care Med* 2008; 177.3: 253-260.

4 Hankinson, John L., John R. Odencrantz, and Kathleen B. Fedan. "Spirometric reference values from a sample of the general US population." *Am J Respir Crit Care Med* 1999; 159.1: 179-187.

5 GLI: Quanjer, Philip H., et al. "Multi-ethnic reference values for spirometry for the 3–95-yr age range: the global lung function 2012 equations." *Eur Respir J* (2012): 1324-1343.

6 Smedley, Audrey, and Brian D. Smedley. "Race as biology is fiction, racism as a social problem is real: Anthropological and historical perspectives on the social construction of race." *American psychologist* 60.1 (2005): 16.

7 Braun, L., M. Wolfgang and K. Dickers in "Defining race/ethnicity and explaining difference in research studies on lung function." Eur Respir J 2013; 41(6): 1362-1370.

8 Chadha, N., B. Lim, M. Kane and B. Rowland (2020). Toward the Abolition of Biological Race in Medicine, University of California, Berkeley.

9 GLI: Quanjer, Philip H., et al. "Multi-ethnic reference values for spirometry for the 3–95-yr age range: the global lung function 2012 equations." *Eur Respir J* (2012): 1324-1343.

10 Cykert, Samuel, et al. "Factors associated with decisions to undergo surgery among patients with newly diagnosed early-stage lung cancer." *JAMA* 2010; 303.23: 2368-2376.

11 Lung cancer: Cykert S, Eng E, Walker P, Manning MA, Roberston LB, Arya R, Jones NS, Heron DE. A system-based intervention to reduce Black-White disparities in the treatment of early stage lung cancer: A pragmatic trial at five cancer centers. Feb 2019. DOI: 10.1002/cam4.2005

12 https://www.cdc.gov/asthma/pdfs/EXHALE_technical_package-508.pdf