October 2, 2020

The Honorable Richard Neal
Chairman
House Committee on Ways and Means
Washington, D.C. 20515

Dear Chairman Neal:

On behalf of the American College of Emergency Physicians (ACEP) and our 40,000 members, thank you for your attention to the issue of racial health inequities, as well as the efforts physicians and medical professional societies are undertaking to address these disparities and improve outcomes for communities of color. We also appreciate and share your concerns about the misuse of race and ethnicity in clinical decision support tools and algorithms, especially as the physician community broadens its efforts to identify and eliminate structural racism from the health care system. ACEP is grateful for the opportunity to share the perspective of emergency medicine (EM) and the actions we are taking to address these critical public health issues.

Emergency physicians see any patient, any time, and promoting health equity within the communities we serve is a core part of ACEP's mission. Our policy, "Non-Discrimination and Harassment" advocates "…tolerance and respect for the dignity of each individual and opposes all forms of discrimination against and harassment of patients and emergency medicine staff on the basis of an individual's race, age, religion, creed, color, ancestry, citizenship, national or ethnic origin, language preference, immigration status, disability, medical condition, military or veteran status, social or socioeconomic status or condition, sex, gender identity or expression, sexual orientation, or any other classification protected by local, state or federal law."

Racism has been identified by some as a social determinant of health, and the structural racism experienced by so many nationwide undermines the health of individuals, families, and our communities. Fully addressing the facets of structural racism present in our health care system, and more broadly throughout all aspects of our society, is a substantial and ongoing effort that requires greater awareness, understanding, and direct action in order to achieve our shared goal of a truly equitable society. For ACEP, these efforts are essential to both our professional mission as an organization and our clinical practice as physicians.

ACEP Efforts to Promote Diversity and Inclusion

As you note, a critical part of addressing racial inequities and improving diversity is intentional inclusion, prioritization, and amplification of health equity scholars and community members who are people of color. This should be a key goal for any medical professional organization, especially given historical disparities in representation.

Underrepresentation of communities of color is an issue that affects the physician profession more broadly, as documented in a report issued by the Association of American Medical Colleges (AAMC), "Diversity in Medicine: Facts and Figures 2019." The report notes the continued underrepresentation of minority communities – while the medical student population is increasingly diverse (though still significantly underrepresented by certain populations), diversity in physician workforce and medical school faculty populations continue to lag, underrepresented by Black and Hispanic populations in particular. Emergency medicine admittedly has much work to do in this regard as well, as we still have deficits to erase in order to achieve a workforce, membership, and leadership that better reflects the population we serve. Efforts to promote diversity are clearly needed at institutional levels so that the physician workforce and medical faculty demographics are more reflective of the broader population, which in turn will help dismantle structural biases and exclusionary environments that currently exist throughout the medical education continuum.

As part of ACEP's work to promote diversity within the profession and to amplify the voices of communities of color, the ACEP Diversity, Inclusion, and Health Equity Section (DIHE) was chartered by the ACEP Board of Directors to provide a forum in which members of the College with special interests in these aspects of EM can develop a knowledge base, share information, receive and give counsel, and serve as a resource to others interested in this particular area of EM. The DIHE has also collaborated with the Emergency Medicine Residents' Association (EMRA) Diversity and Inclusion Committee to establish the Diversity Mentoring Initiative, a joint effort to facilitate mentoring relationships to promote and support leadership and career development within our increasingly diverse emergency medicine community.

Additionally, in 2017, ACEP's Academic Affairs Committee issued an information paper, "Fostering Diversity in Emergency Medicine through Mentorship, Sponsorship, and Coaching."[1] This information paper was designed to "…identify best practices for promoting full participation and leadership in emergency medicine by underrepresented minorities (URM)." It also provides recommendations for institutions and organizations on how to improve the pipeline for URMs in emergency medicine, both in terms of medical education and organizational leadership. Ultimately, the paper concludes that a "robust network of national, regional and local mentorship, sponsorship and coaching programs aimed to support, foster and promote URMs throughout their careers" are needed to advance the goal of greater diversity and inclusion in emergency medicine.

The ACEP Social Emergency Medicine Section is also engaged in efforts to incorporate social context into the structure and practice of emergency care. This section's priorities include incorporating an individual patient's social context into routine emergency care, fostering high-quality research and translating this research into best practices for the application of social determinants of health, disseminate emergency department interventions that improve population health through emergency care informed by community needs with a focus on EDs that see underserved patients, and to engage in the policymaking process around issues that affect the social determinants of health. This section provides resources for interested emergency physicians on a wide variety of social medicine concepts, including social determinants of health inequalities, structural violence, narrative competence in medicine, among many others.

Another ACEP priority is in addressing the issue of implicit (unconscious) bias of physicians. Implicit bias may affect a physician's clinical decision-making, which may have significant impacts on a patient's outcome. ACEP offers a free online continuing medical education (CME) course to members, "Unconscious Bias in Clinical Practice," to help emergency physicians learn about the negative effects of unconscious or implicit bias in clinical scenarios, as well as learn how to employ strategies to minimize these effects. Among the objectives of this course is analysis of the link between social determinants of health, cultural competence, bias, and patient care. This course provides several examples of existing health disparities and how implicit bias factors into these differences, including how Black patients are systematically undertreated for pain, are diagnosed as schizophrenic at disproportionately higher rates, and how differences in provider communication may contribute to an observed phenomenon that Black patients are more likely to die in the intensive care unit (ICU) relative to white Americans. The course offers strategies to help emergency

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[1] "Fostering Diversity in Emergency Medicine through Mentorship, Sponsorship, and Coaching." ACEP Academic Affairs Committee, November 2017. Available at https://www.acep.org/globalassets/uploads/uploaded-files/acep/clinical-and-practice-management/policy-statements/information-papers/fostering-diversity-in-emergency-medicine-through-mentorship-sponsorship-and-coaching.pdf

physicians take action and implement practices to help recognize and reduce the effect of implicit bias in their clinical decision-making.

In addition to these internal efforts, we also have externally-directed efforts aimed at addressing health equity. One of DIHE Section's recent priorities is a focus on the COVID-19 pandemic and the significant disparities we have witnessed in terms of the disease's impact, with disproportionate rates of infection, severe complications, and death within communities of color. More thorough and rigorous study is still needed to fully understand the effects of COVID-19, including the specific risk factors and physiologic mechanisms resulting in such significant differences in cases and outcomes. However, initial data shows substantially higher rates of infection and mortality especially within Latino/Hispanic and Black populations. For example, the Centers for Disease Control and Prevention (CDC) Morbidity and Mortality Weekly Report (MMWR) issued on September 15 highlights the disproportionate impacts of COVID-19 on younger individuals in communities of color, finding that "[a]mong 121 SARS-CoV-2-associated deaths among persons aged <21 years reported to CDC by July 31, 2020, 12 (10%) were infants and 85 (70%) were aged 10-20 years. Hispanic, non-Hispanic Black and non-Hispanic American Indian/Alaskan Native persons accounted for 94 (78%) of these deaths…"[2]

DIHE's COVID-19 Initiative[3] was developed to reach out to communities of color, leaders within these communities, and community partners to assist with the effort to communicate the risks of COVID-19 and offer recommendations for safety. We recognize that trusted ministers, community leaders, and others have a great impact in terms of communicating with many of the communities most at risk. DIHE developed an individualized, audience-dependent set of letters to circulate to these various leaders to help disseminate information we believe will be beneficial within higher-risk communities.

COVID-19-related disparities are further noted in ACEP's COVID-19 Field Guide in the section "Racial and Ethnic Minority Groups."[4] There also appear to be correlated socioeconomic factors, independent of race, that contribute to the increased level of risk for these groups (e.g., less ability to work remotely, use of public transportation, the need to take risks of health-related complications to maintain economic stability, etc.). Beyond this contextual information, the ACEP field guide also offers strategies for prevention, screening, and mitigation of disparities for communities at risk. This includes increased awareness of how some underserved racial and ethnic groups may have undiagnosed or untreated underlying comorbidities that may increase their risk of severe COVID-19 infection, as well as baseline treatment or screening options in the emergency department that may help put at-risk individuals on a more positive trajectory. (It should also be noted that this field guide is not intended for public dissemination, nor does it indicate an exclusive course of treatment or serve as a standard of medical care – it is a living resource for emergency physicians that is updated on an urgent basis).

Clinical Decision Support Tools and Algorithms

Emergency physicians contribute to a rapidly growing body of medical literature and study that seeks to identify racial disparities in the context of emergency medicine and their broader health impacts on these communities. However, simply identifying disparities in a vacuum is not enough. Research must be paired with action by physicians, other health care providers, and policymakers in order to implement needed improvements that push both clinical practice and public policy forward.

One of the challenges, we believe, is highlighted in a 2017 information paper issued by ACEP's Public Health and Injury Prevention Committee, "Disparities in Emergency Care":

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[2] Morbidity and Mortality Weekly Report. Centers for Disease Control and Prevention, September 15, 2020. https://www.cdc.gov/mmwr/volumes/69/wr/mm6937e4.htm?s_cid=mm6937e4_e

[3] https://www.acep.org/how-we-serve/sections/DIHE/acep-diversity-inclusion-and-health-equity-covid-19-initiative/

[4] ACEP COVID-19 Field Guide, "Racial and Ethnic Minority Groups." Available at https://www.acep.org/corona/covid-19-field-guide/special-populations/racial-and-ethnic-minority-groups/.

The available literature on disparities in health care outcomes focuses on three broad categories: race, gender, and socioeconomic status (SES). While these disparities are plausible and in some studies significant, this research is often confounded by variables that are difficult to address methodologically. For example, while some researchers clearly find race an independent predictor of clinical outcomes, other investigators find that such racial disparities disappear when other factors, such as the facility where care is received, are carefully controlled for. Isolating disparities in outcomes attributable solely to emergency medicine-related factors adds additional complexity, and good literature on the subject is sparse.[5]

We also appreciate your concern regarding the potential for clinical decision support (CDS) tools and clinical algorithms to exacerbate racial health inequities through misuse of race and ethnicity and how this can negatively affect patient outcomes. As you noted in letters to stakeholders, there is growing attention to issue of how "race correction" in CDS tools and algorithms can perpetuate and further embed racism in health care, as recently discussed by Darshali Vyas, MD, et al, in *The New England Journal of Medicine*.[6] Despite the potential for CDS tools to improve care, the challenge as framed by Vyas et al. (2020) remains that the use of race correction perpetuates the notion of race-based medicine in ways that may outweigh any potential benefits of a CDS tool. How best to address these inequities without further amplifying harmful racially-based clinical decision-making requires further study and, candidly, a better understanding of race by the medical profession and medical research community as a whole.

In some cases, standardized CDS tools have shown promise in terms of actually *countering* bias and eliminating potential disparities. For example, a [study] of quality improvement interventions for venous thromboembolism (VTE) found that after implementation of the clinical decision support tool, significant treatment disparities in best-practice prophylaxis prescription between Black and white patients were eliminated.[7] As noted by the authors in that report, "…[t]he tool requires completion of checklists to evaluate VTE risk factors and contraindications to pharmacologic prophylaxis, and then recommends the risk-appropriate VTE prophylaxis regimen." Additionally, others have suggested that the creation of health-disparity-related quality measures may also help reduce or eliminate disparities – for example, the creation of "…quality measures between gender and racial groups in the amount and time to analgesia administration and the treatment of acute coronary syndromes would identify potentially correctable disparities within emergency care."[8]

We are not currently aware of CDS tools used in emergency medicine that may raise equity concerns or result in negative outcomes for communities of color, but we recognize that the medical profession must take a more critical eye to the tools we use every day to help improve the care we provide to our patients. An additional challenge is that the CDS tools available to emergency physicians may be determined at a system or facility level, not by the emergency physicians themselves. However well-intentioned, tools that use race-based factors may unintentionally exacerbate existing treatment and outcome disparities and we must be mindful to ensure that we are not accidentally perpetuating the very issues we are actively trying to fix.

It is also worth reiterating that these tools are by definition support tools designed to assist physicians in their assessments, not to supersede or obviate a physician's clinical judgment, knowledge, or experience. Our primary goal, first and foremost, is always the most appropriate individualized treatment needed to stabilize any patient in need of lifesaving care. This should always be based on the most up-to-date evidence-based medical training and knowledge. The federal government could assist medical specialties in their efforts to address health inequities through grants or other support mechanisms help fill in existing gaps in research and knowledge.

[5] "Disparities in Emergency Care: An Information Paper." ACEP Public Health and Injury Prevention Committee, October 2017. Available at https://www.acep.org/globalassets/uploads/uploaded-files/acep/clinical-and-practice-management/policy-statements/information-papers/disparities-in-emergency-care.pdf

[6] "Hidden in Plain Sight – Reconsidering the Use of Race Correction in Clinical Algorithms." *The New England Journal of Medicine*, Aug. 27, 2020. https://www.nejm.org/doi/full/10.1056/NEJMms2004740

[7] "Eliminating Healthcare Disparities Via Mandatory Clinical Decision Support: The Venous Thromboembolism (VTE) Example." Med Care, Jan. 15, 2015. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4262632/

[8] "Why Diversity and Inclusion Are Critical to the American College of Emergency Physicians' Future Success." *Annals of Emergency Medicine*, Jan. 27, 2017

Once again, thank you for your attention to this critical matter and for the opportunity to share the important work currently underway within emergency medicine. We assure you and your staff that we are mindful of these concerns and that eliminating health disparities has always been, and continues to be, a top priority for our profession and for ACEP as an organization. We always welcome the opportunity to work with you and the Committee, and we look forward to engaging with you on your continued efforts in this space.

Sincerely,

William P. Jaquis, MD, MSHQS, FACEP
ACEP President