

Race-based medicine is wrong. How should physicians oppose it?

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You might have heard of “racial essentialism”—the decades-old belief races are biologically distinct groups determined by genes. It has no scientific basis, yet it lingers, along with many other racist ideas, in U.S. health policies and clinical practices. Along with racism in medicine, the belief has perpetuated generations of harm.

In “Examining Race-Based Medicine,” a recent episode in the [AMA “Prioritizing Equity” video series](#), a panel of experts discussed the core criticisms of race-based medicine and what physicians can do proactively to oppose it in clinical practice, medical education and research.

At the November 2020 AMA Special Meeting, the House of Delegates adopted policy to counteract the notion of racial essentialism, which was identified in a resolution presented at the meeting as “the belief in a genetic or biological essence that defines all members of a racial category.” It was one of the several actions that delegates took to oppose racism and advance equity in medicine and public health.

How we got here

Perhaps the most infamous example of race-based medicine is the use of isosorbide dinitrate/hydralazine (marketed as BiDil) to treat congestive heart failure in African Americans. The Food and Drug Administration at first rejected the drug’s application after a clinical trial failed to show the drug’s efficacy for a multiracial population.

After looking over their data, though, the drugmaker, NitroMed, ran a clinical trial that enrolled only men and women who self-identified as African American. The results showed sufficient decrease in mortality and reduction in risk of first hospitalization against placebo, and the FDA approved it—for

Black patients only—in 2005. It was the first drug approved for a single racial group.

But the study had at least one major flaw: It had no control group. Fifteen years later, BiDil remains, according to the drugmaker’s website, “the only heart failure medicine specifically indicated for self-identified African American patients.”

The story of BiDil demonstrates how durable race-based medicine can be. There are also years-old race adjustments in clinical algorithms, such as the estimated glomerular filtration rate (eGFR) equation and the vaginal birth after Cesarean section (VBAC) calculator. Some have only dubious evidence supporting them; others have been shown to produce negative health outcomes.

“What race-based medicine tells me [is] if I go into a clinic and I need to do spirometry to test my lung function, then what I’m being told is, because I’m of Asian race, that my lung function should be corrected differently than that of a white or a black person,” said Rohan Khazanchi, a medical student at University of Nebraska Medical Center College of Medicine.

“That implies that there’s something different about my lungs than [those] of somebody else, and it implies that there’s a biological trait that is different in me than somebody else—just because I’m Asian,” said Rohan Khazanchi. But race is merely a social and political construct. It is not, he noted, equivalent to ancestry or genetics.

“We just need to think about how nonsensical this is in a biological and scientific sense,” Khazanchi said. “It’s important to know that race as a category has changed throughout time in American society,” he added, noting that U.S. Census definitions of race change every 10 years. “So it’s not even a stable category.”

How to counter it

The panelists noted several ways that physicians can actively stamp out race-based medicine.

Adapt your programs. For example, the Maternal-Fetal Medicine Units Network, created by the National Institute of Child Health and Human Development, is revising its VBAC calculator to omit race/ethnicity. This change came after scholarship and advocacy over several years by medical trainees and physicians challenging this use of race adjustment, led by one of the panelists, Darshali Vyas, MD.

“In medical school the VBAC calculator was one striking example of the potential damage done by correcting for race where racial inequity already exists. But this practice is widespread in medical tools,” said Dr. Vyas, a resident physician at Massachusetts General Hospital who recently co-wrote a *New England Journal of Medicine*

article outlining additional examples of race correction in medicine.

Hammer home research inconsistencies. So much scholarship on race-based medicine doesn't define the major operating variable, said Michelle Morse, MD, MPH, a hospitalist and assistant professor at Harvard Medical School. "Why is the burden of proof on us to prove that it's faulty when there's ... so much going against some of this existing data?"

Partner with quality improvement experts. You should have help at your institution in your effort to advance accountability and outcomes, as well as at state and federal agencies.

Push for nationwide agreement. "Right now, there's huge variability in terms of institutions who have access to certain biomarkers, who are using different eGFR equations," said Nwamaka Eneanya, MD, MPH, attending nephrologist and assistant professor of medicine and epidemiology at the Perelman School of Medicine at the University of Pennsylvania.

"We all need to get on the same page and think about ... what's the most equitable option that will be safe for our patients?" she said.

Dr. Eneanya is part of a race and eGFR task force formed by the National Kidney Foundation and American Society of Nephrology that will help standardize race and eGFR reporting across the country and also advance health equity for patients with kidney disease.

Systemwide bias and institutionalized racism contribute to inequities across the U.S. health care system. Learn how the AMA is fighting for greater health equity by identifying and eliminating inequities through advocacy, community leadership and education.

Check out recent episodes in the "Prioritizing Equity" video series on research and data for health equity and moving forward after the 2020 elections.