AMERICAN MEDICAL ASSOCIATION MINORITY AFFAIRS SECTION

MAS Resolution: 02
(Nov. 2020)

Introduced by: Luis Seija, MD and Priscilla Mpasi, MD

Subject: Racial Essentialism in Medicine

Referred to: Reference Committee (TBD)

WHEREAS, At the turn of the twentieth century, sociologist and civil rights leader W.E.B. DuBois synthesized sociological and scientific evidence to conclude that race is not a scientific category, and rather that racial health disparities stemmed from social, not biological, inequalities[1]; and

WHEREAS, "Racial essentialism" is defined as the belief in a genetic or biological essence that defines all members of a racial category[2–4]; and

WHEREAS, The modern scientific consensus is that race is a social construct based on prevailing societal perceptions of physical characteristics, and that there are no underlying biological traits that unite people of the same racial category[3–15]; and

WHEREAS, Race as a variable has been inconsistently defined in research literature, clinical practice guidelines, and even U.S. Census categorizations[5,8,12–14,16–22]; and

WHEREAS, Race is often inappropriately conflated with ethnicity, which led to passage of AMA policy recognizing that race and ethnicity are conceptually distinct (H-460.924)[8,15,16,23]; and

WHEREAS, Decades of rigorous genetics research has confirmed that genetic and biological variation exists within and among populations across the planet, and groups of individuals can be differentiated by patterns of similarity and difference, but these patterns do not align with socially-defined racial groups (e.g., white, Black) or continentally-defined geographic ancestral clusters (e.g., Africans, Asians, and Europeans)[4,5,7–11,13,16,23]; and

WHEREAS, Many clinical calculations that "correct for race" were developed under the mistaken belief that race is a useful proxy for intrinsic biological or genetic traits[11,13,14];and

WHEREAS, Spirometric pulmonary function tests (PFTs) guidelines currently recommending a race-based correction factor despite a 2013 literature review demonstrating that 94% of articles comparing PFTs between white and non-white groups do not assess confounders like socioeconomic status[14,17,18,24]; and

WHEREAS, Current literature demonstrates that use of race in clinical score calculators is unnecessary, less precise than biological measures, and leads to results that are not reproducible, as evidenced by the use of race in the calculation of estimated glomerular filtration rate (eGFR) based on a 1999 study of 1,628 patients (only 12% of whom self-identified as "Black")[14,19–21,25,26]; and

WHEREAS, Because the use of race in clinical algorithms reifies racial essentialism and can disproportionately harm Black patients, leading institutions around the country have discarded

race-based reporting of eGFR and key stakeholders in the nephrology field are actively working to eliminate this practice in lieu of non-race-based alternatives[13,19–21,27–31]; and

WHEREAS, Clinical tests and criteria that use race-based factors often do not account for the existence of people from multiracial backgrounds, a population that now makes up 14% of infants born in the US, and other underserved populations including American Indians and Alaskan Natives[13,22,32]; and

WHEREAS, Current AMA policy supports "research into the use of methodologies that allow for multiple racial and ethnic self-designations" and encourages applying research evidence on race, ethnicity, and health to "the planning and evaluation of health services" (H-460.924); and

WHEREAS, Perpetuating the incorrect belief that race by itself can explain biological variation contributes to tangible inequities, such as the undertreatment of pain due to wrongly perceived biological differences in pain tolerance, delays in referral for renal transplantation, under-referral for DEXA scans, industry denial of worker's compensation, and more[11,13,14,21,33–36]; and

WHEREAS, Although racial essentialism is harmful and has no scientific validity, teaching trainees about and researching race as a sociopolitical construct is useful to understand structural racism as a root cause of health inequity, the lived experiences of patients which contribute to their relationship with the healthcare system, and the day-to-day experiences which affect individual health outcomes[3,10–12,37–42]; and

WHEREAS, Since race and racism impact multiple structural and social determinants of health, there is no easy replacement risk factor, which highlights the need for directed research to uncover the true causal pathways mitigating racial differences in disease prevalence and health outcomes[10,11,20,21,23,40–43]; and

WHEREAS, Our AMA denounces practices which exacerbate health disparities, serves as a leading voice for marginalized minority groups, and "encourages investigators to recognize the limitations of current methods for classifying race" (H-65.963, H-460.924), but current policy does not identify or explicitly discourage the inappropriate practice of using race as a proxy for biological risk factors; and

WHEREAS, In June 2020, our AMA Board of Trustees publicly recognized racism as an urgent threat to public health and resolved to "actively work to dismantle racist and discriminatory policies and practices across all of health care"[44;] and

WHEREAS, In September 2020, the U.S. House Ways & Means Committee released a series of letters which called upon medical societies, including the AMA, to "describe how racism has influenced the use of race in medicine, science, and research, and call for a new path forward where medicine considers race as a tool to measure racism, not biological differences" letter[45]; and be it further

WHEREAS, In September 2020, lawmakers requested the Agency for Healthcare Research and Quality to conduct a review of clinical algorithms that correct for race and investigate the impact of structural racism on the health of communities of color to advance data-driven, antiracist health policy[46,47]; therefore be it

RESOLVED, That our AMA recognizes that the false conflation of race with inherent biological or genetic traits leads to inadequate examination of true underlying disease risk factors, which exacerbates existing health inequities; and be it further

RESOLVED, That our AMA encourages characterizing race as a social construct, rather than an inherent biological trait, and recognizes that when race is described as a risk factor, it is more likely to be a proxy for influences including structural racism than a proxy for genetics; and be it further

RESOLVED, That our AMA will collaborate with the AAMC, AACOM, NBME, NBOME, ACGME, other appropriate stakeholder organizations, including minority physician organizations and content experts, to identify and address aspects of medical education and board examinations which may be perpetuating the mistaken belief that race is an inherent biologic risk factor for diseases; and be it further

RESOLVED, That our AMA will collaborate with appropriate stakeholders and content experts to develop recommendations on how to interpret or improve clinical algorithms that currently include race-based correction factors; and be it further

RESOLVED, That our AMA will support research that promotes antiracist strategies to mitigate algorithmic bias in medicine.

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Fiscal Note: TBD

RELEVANT AMA POLICY:

Race and Ethnicity as Variables in Medical Research H-460.924
Our AMA policy is that:
(1) race and ethnicity are valuable research variables when used and interpreted appropriately;
(2) health data be collected on patients, by race and ethnicity, in hospitals, managed care organizations, independent practice associations, and other large insurance organizations;
(3) physicians recognize that race and ethnicity are conceptually distinct;
(4) our AMA supports research into the use of methodologies that allow for multiple racial and ethnic self-designations by research participants;
(5) our AMA encourages investigators to recognize the limitations of all current methods for classifying race and ethnic groups in all medical studies by stating explicitly how race and/or ethnic taxonomies were developed or selected;
(6) our AMA encourages appropriate organizations to apply the results from studies of race-ethnicity and health to the planning and evaluation of health services; and
(7) our AMA continues to monitor developments in the field of racial and ethnic classification so that it can assist physicians in interpreting these findings and their implications for health care for patients.
CSA Rep. 11, A-98; Appended: Res. 509, A-01; Reaffirmed: CSAPH Rep. 1, A-11

Reducing Discrimination in the Practice of Medicine and Health Care Education D-350.984
Our AMA will pursue avenues to collaborate with the American Public Health Association's National Campaign Against Racism in those areas where AMA's current activities align with the campaign.
BOT Action in response to referred for decision Res. 602, I-15