

**MEDICINE AND SOCIETY: PEER-REVIEWED ARTICLE**

**How Abolition of Race-Based Medicine Is Necessary to American Health Justice**

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**Abstract**

Modern medicine has always endorsed White supremacy by maintaining social, political, and economic structures that have exacerbated Black and Brown persons' lived embodiment of racism. Racial essentialism persists in health professions education and practice, especially in kidney disease etiology and intervention. This article considers how glomerular filtration rate estimates are one example of historically, politically, and scientifically situated racialized practice in health care today that illuminates a glaring need to abolish race-based clinical care of any kind.

*The function, the very serious function of racism is distraction...*

**Toni Morrison**<sup>1</sup>

**Racism in Medicine**

In the past 2 years, the medical community has once again witnessed a revival of passionate discourse and engagement centered on race and racism in medicine, a shift primarily incited by the resurgence of the Black Lives Matter movement following the racialized slayings of George Floyd, Ahmaud Arbery, and Breonna Taylor, among many others.<sup>2,3</sup> The scope of these activities has been broad, ranging from position statements on antiracism proffered by national health organizations to renewed commitments by academic programs for enhanced recruitment and retention of individuals identifying as Black, Indigenous, or persons of color.<sup>4,5</sup> Such efforts, together with a renaissance of racial justice-oriented research and publications, have spurred hope for transformative change in medical training, practice, and care delivery that will abrogate race-based disparities in health.

Despite the medical community's current energy to foment change, a cursory glance at the history of biomedical science and medicine demonstrates that neither the presence of racism nor ardent calls for its elimination are novel. That is to say, *we have been here before*. This history speaks to the enduring nature of the problem of racism in medicine and begs the question: Are we truly addressing racism as a root cause of health disparities or merely reengaging with its downstream consequences? The answer to this query depends not only on the metrics used but also on the ideology and biases that

these measures reflect. In this work, we affirm that modern medicine has been from its inception deeply grounded in ideologies of White supremacy and that its continued support for such frameworks sustains the socioeconomic, political, and health inequities that derive from them. Furthermore, we hold that **racial essentialism** (ie, the notion that race is biologically based) is one such deleterious framework that is not scientific but rather is a method for operationalizing views of racial minorities as inferior.<sup>6</sup> With this in mind, the abolition of race-based ideology must be included in our contemporary movement to end racial injustice in medicine.

### **Race as Biological**

Detailed accounts of the unethical and unscientific use of race as a biological concept have been elaborated for decades, as has strong evidence for social determinants of health.<sup>7,8</sup> What has seldom been discussed in the medical literature, however, is why race-based medicine rather than race-conscious medicine—ie, consideration of the ways in which society’s handling of race affects health—continues to prevail as the dominant explanatory model for racial disparities.<sup>9</sup> Conversely, we have seen staunch advocacy for the faulty concept of “biological race” in scholarship purportedly aligned with principles of racial justice.<sup>10</sup> These contradictions demonstrate how deeply embedded and intertwined are race and racism in medical theory and practice and how challenging it is to disentangle racial ideology from science, even when equity is at stake.

In line with best practices on publishing on race and racism, we provide the following definitions.<sup>11</sup> *Racism* is defined as a sociopolitical and economic system that creates and uses race as an organizing principle for the unequal distribution of wealth, power, and resources, including health. *Race* is defined as a social construction created by racism that establishes group-based differences (eg, physical appearance) as the basis for differential treatment and outcomes. To better understand the threat of race-based medicine and the necessity of its abolition, we propose as a case example the racialized assessment of kidney function examined through 3 critical lenses: (1) language and meaning, (2) racism as science, and (3) power and practice.

### **Race-Based Assessment of Kidney Function**

Estimation of the glomerular filtration rate (GFR), or the rate at which the kidneys filter one’s blood, has become the centerpiece of national discourse on the use of race in medicine.<sup>12,13</sup> It is perhaps the quintessential example of race-based medicine purporting race as biologically meaningful in accordance with claims of early researchers who accounted for apparent racial differences in GFR estimates by claiming that the kidney function of African Americans must be racially distinct in response to changes in dietary sodium.<sup>14</sup> These assumptions were not further investigated; rather, they were codified in race coefficients that would presumably confer greater precision to GFR estimations. The MDRD and CKD-EPI equations, which are now widely used to assess kidney function, include “race corrections” that result in 21% and 16% higher estimates, respectively, for African Americans alone.<sup>15,16,17,18</sup> These specious estimates can result in years’ delayed referrals to kidney specialty care and kidney transplant evaluations for Black patients compared to other racial groups.<sup>19</sup>

Debate about abandoning race correction has transpired against a backdrop of some of the most profound racial disparities in medicine. Prevalence of end-stage kidney disease is more than 3 times higher in African Americans than in White Americans.<sup>20</sup> While Black candidates make up a third of the **waitlist for deceased donor** kidney transplants and White candidates make up more than half, African Americans receive a quarter of

transplants, while White Americans receive roughly two-thirds.<sup>21</sup> Some attempt to lay the blame for these disparities on the Black community itself, pointing out that the absolute number of kidneys donated from Black donors is less than the number awaiting a kidney transplant.<sup>21</sup> However, such attempts ignore the facts that race concordance is not a requirement for transplantation and that African Americans only make up 13% of the US population<sup>22</sup> but are disproportionately affected by conditions that make many ineligible to donate. Furthermore, that this discourse ensued even though a GFR-estimating equation that not only performs better than currently ubiquitous methods but also does not include a race correction *already existed* underscores the hold that race-based medicine has on the American health care system.<sup>23</sup>

### Language and Meaning

Perhaps the most obvious threat to the abolition of race-based medicine concerns the ways in which we in the medical science community speak of and understand the race construct. A lack of common language and understanding has led to misrepresentations of its place, purpose, and value in medicine.<sup>24</sup> Such misrepresentations have not occurred in isolation but are heavily informed by our nation's history of racializing individual differences. Yet, it is crucial to realize not only what meanings we have made for race, but also how race itself makes meaning. Race possesses an almost magical quality of obviating the need for sound scientific explanation. As it obscures the mechanisms of racism, race makes meaning where there was none, providing the substrate for **implicit bias** and stereotypes alike.

Consider how numerical coefficients like those found in race-based estimated GFR (eGFR) equations demonstrate the symbolic power of racialized language, how scientific meaning is made through belief, and how that belief is thereafter reinforced by science. These coefficients situate race correction as a mathematical rule, a universal truth, as unchanging as *pi* or the speed of light. In doing so, they ignore the sociopolitical and semantic complexity inherent in racial identification and fail to quantify how much "Blackness" is necessary to qualify for said correction. Thus, we hold that contemporary mechanisms, such as race-based calculators and clinical decision rules that claim a biological basis for race, are simply racism by another name.

### Racism as Science

Abolition of race-based medicine is further threatened by its continued validation as a component of sound science. Likewise, sound science is jeopardized by the continued inclusion and reproduction of race as biologically meaningful. This convention derives in part from a poor understanding of what race is and how it functions. Race-based medicine violates basic principles of scientific integrity, including the need for variables to be discrete, unique, and measurable.<sup>25</sup> As a social construct, race defies these criteria and is instead arbitrary, fluid, and unquantifiable, as immigration, intermarriage, and the mixed-race populations have eroded some racial boundaries and social science research has repeatedly shown that racial identity fluctuates at the individual level.<sup>26</sup> Moreover, any variable serving as a proxy must have close correlation with the variable of interest.<sup>27</sup> Such correlations with respect to race are not demonstrated in sound biomedical research but are routinely assumed or omitted with a normative understanding that race itself (rather than racism) is the associated or causal factor.

Regarding our eGFR case example, the MDRD and CKD-EPI studies are emblematic of how race operates as a unique exception in medicine, thereby precluding the need for high-level scientific rigor as is demanded elsewhere in biomedical research. Despite

these alarming compromises to validity, researchers continue to sew bias into the fabric of study design, priming their results to suggest statistically significant biological differences between races. For example, the biracial stratification (ie, African American or other) used to develop the MDRD equation was not only put forward as the only relevant intergroup difference without supporting evidence but also carried forward to the subsequent development of the CKD-EPI equation within a multiracial study population.<sup>15,16</sup> Subsequent findings are declared evidence, and interpretations are widely accepted as valid because ideological constructs like racial essentialism predominate in biomedical sciences.<sup>28</sup> Thus, the overwhelming normativity of race-based medicine and its associated biases allow racial ideology to be translated into medical research, education, and clinical practice with relative ease. Dismantling these connections is the formidable work of abolition.

### **Power and Practice**

Just as racism cannot be separated from race, neither can it be divorced from power. The role of race in medicine depends not only on the complexities of racial language or its validity in biomedical science, but also on who has decisional power to make change and the ideology espoused by such persons.<sup>29</sup> White supremacy in medicine has historically concentrated predominantly White-favoring biases and ideologies in roles of power and provided robust socioprofessional structures and practices to support them. Therefore, the problem that race-based eGFR represents is not simply one of race-based medicine—it is one of all of medicine. While we know elimination of racial coefficients from GFR estimations alone will not resolve disparities in kidney disease, it is an integral step to dismantling racism in power and practice.

The eGFR discourse has thus far resulted in a recommendation to omit a race correction, but it was mired in deliberations on the potential repercussions of removing race coefficients and paid little attention to the potential harm already done by race correction and by maintaining the status quo throughout the 10-month deliberation process.<sup>30</sup> What the eGFR discourse has done is to demonstrate the validity of the late Nobel laureate Toni Morrison's oft-quoted words that, indeed, "the very serious function of racism is distraction."<sup>1</sup> Race-based medicine has provided the easy-to-digest explanation that race itself underlies disparate outcomes. It has decentered our focus from known determinants like structural racism and obscured them behind flawed ideology masquerading as science. Moreover, analysis of important determinants of health, including sociopolitical, economic, and environmental factors, has been largely ignored in favor of racial essentialism. Thus, we as a medical community remain distracted, lost in the ever-present hunt for evidence that Black people are biologically other and yet unwilling to accept racism as a root cause of this belief.

Race-based coefficients, calculators, and decision rules should have been the low-hanging fruits of dismantling racism, but the resistance to abolishing race-based medicine demonstrates that our true problem lies in the orchard. Because systemic racism persists as a function of how power is organized and distributed, abolition of systemic frameworks like race-based medicine must necessarily involve the erosion of White supremacy. Moreover, it will not be the presentation of new and compelling evidence that ends race-based medicine but rather a shift in our thinking away from the ideology that needs it to exist.

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