Racism, Not Race is the Risk Factor: The (mis)Use of Race in Medicine

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Disclosure Slide

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This talk is an introduction of this content

Recognition of past trauma and abuse

It is important that we personally and professionally recognize the trauma, medical abuse, and discrimination that have happened to our Black, Indigenous, people of color, disability, and LGBTQ+ communities, leading to distrust in medicine.

The work of equity and antiracism requires that we acknowledge the many legacies of violence, displacement, migration, and settlement that bring us together here today and we remain actively committed to rebuilding trust with those who have had it violated.
Our Road Map

❖ Look at race-based medicine and provide examples of the misuse of race in medicine’s history
❖ Discuss how to approach race-based medicine within clinical and systems practice
❖ Review recent updates and how to shift towards racism-conscious medicine

Levels of Racism

**Racism:** “system of structuring opportunity and assigning value based on the social interpretation of how one looks (which we call ‘race’) that unfairly disadvantages some individuals and communities, unfairly advantages other individuals and communities, and saps the strength of the whole society through the waste of human resources.” (Jones)

**Antiracism:** A personal and collective identity which embraces the intentional dismantling of our racialized society and proactively builds racial peace (McKinney and Essenburg)

**Antiracist policy:** Any measure that produces or sustains racial equity between racial groups [Kendi]

“There has never been any period in American history where the health of blacks was equal to that of whites...Disparity is built into the system.”

- Evelyn Hammonds, historian of science at Harvard University
**Race and Institutional Racism: Medicine’s Roots**

Illustration of Dr. J. Marion Sims with Anarcha by Robert Thom. Pearson Museum, Southern Illinois University School of Medicine

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**Race and Institutional Racism: the Hidden Curriculum**

Diagram illustrating the distribution of social and structural causes and explicit biological differences.

n = 4, 4%

n = 59, 58%

a = 30, 38%

**Race-based tools in Medicine - Spirometry**

Spirometry image and description.
Race-based tools in Medicine - Spirometry


- 226 articles from 1922–2008
- Researchers only defined how they assigned individuals to racial categories in 17.3% of the articles
- 94% of the articles failed to include any measures of social class, environmental exposure or geographical context

Race and Institutional Racism: the Hidden Medical School Curriculum

Race and Institutional Racism: the Hidden Curriculum

| Table 1. Percentage of white participants endorsing belief about biological differences between blacks and whites |
|---|---|---|---|---|---|
| Study | 1st year | 2nd year | 3rd year | 4th year | Resolved |
| Study | Sample | sample | sample | sample | sample |
| Study 1 | Study 2 | Study 2 | Study 2 | Study 2 | Study 2 |
| Study 1 | Study 2 | Study 2 | Study 2 | Study 2 | Study 2 |
| Study 1 | Study 2 | Study 2 | Study 2 | Study 2 | Study 2 |
| Study 1 | Study 2 | Study 2 | Study 2 | Study 2 | Study 2 |

What “Race” am I??

□ White

Enter, for example, German, Irish, English, Italian, Lebanese, Egyptian, etc.

At some points in American history the Germans, Greeks, Hispanics, Irish, Italians, Slave, or Ashkenazi Jews were not considered white people.

"The Census Bureau complies with the Office of Management and Budget’s standards for maintaining, collecting, and presenting data on race, which were revised in October 1997. They generally reflect a social definition of race recognized in this country. They do not conform to any biological, anthropological or genetic criteria."

What “Race” am I??

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What “Race” am I??
What “Race” am I??

Race and Institutional Racism: Race-based tools in Medicine - GFR


The hypothesis that black individuals release more creatinine into the blood, perhaps because of more muscle mass, was not definitively explored or supported by data.

50 yo woman with:
- An elevated Cr of 2.0
- No proteinuria

KDIGO guidelines:
eGFR < 30 = Referral
- “White” eGFR = 28
- “Black” eGFR = 33

5 years later patient's Cr has worsened, now 2.8 mg/dL

KDIGO guidelines:
eGFR <20 = transplant wait-list
- “White” eGFR = 18
- “Black” eGFR = 21

Race and Institutional Racism: Race-based tools in Medicine - GFR

Race and Institutional Racism: Other Race-based tools in Medicine

▪ The American Heart Association’s Get with the Guidelines–Heart Failure Risk Score
▪ The Society of Thoracic Surgeons Short Term Risk Calculator
▪ Kidney Donor Risk Index
▪ Vaginal Birth after Cesarean (VBAC) Risk
▪ STONE Score
▪ Pediatric UTI calculator**
▪ Rectal Cancer Survival Calculator
▪ National Cancer Institute Breast Cancer Risk Assessment Tool & Breast Cancer Surveillance Consortium Risk Calculator
▪ Fracture Risk Assessment (FRAX) tool & Osteoporosis Risk SCORE
▪ JNC Hypertension guidelines
▪ Neonatal Hyperbilirubinemia

Institutional Racism, Race-based medicine and mental health
Institutional Racism, Race-based medicine and mental health

“The eugenicists advocated the rational control of reproduction in order to improve society’s mental, moral and physical health through selective breeding. In reality, eugenics endorsed social judgments about race, class and gender cloaked in scientific terms.”

“The Mental Tests”
- Turn of the 20th century: Psychologists used “mental” or “intelligence” tests to claim that Black Americans and recent immigrants from southern and eastern Europe were intellectually inferior to Americans of Anglo-Saxon or Scandinavian descent.
- This in turn led to laws that authorized state-sanctioned forced sterilization for people determined to be “feebleminded.”


Schizophrenia & the Civil Rights era: “Drapetomania” 2.0?

The “Protest” Psychosis
A Special Type of Reactive Psychosis
Walter Bromberg, M.D. and French Simon, Ph.D., Brooklyn, NY

“The purpose of this paper is to identify a specific type of reactive psychosis related in part to recent social-political events.”

“Besides depression, mutism, mannerisms, hallucinations and delusions, disturbed behavior and apparent intellectual disorganization, there is a bizarre religious and racial aspect to the productions of these patients, not encountered in schizophrenia.”

“The emotional inappropriateness rather represents a repression of interpersonal relatedness to white officials in court or hospital.”


Institutional Racism, Race-based medicine and mental health: Schizophrenia & the Civil Rights era

"As a race, we are a thinking race!" | "We are the authors of our own destiny!"

Hallucinations | Delusions | Racism | Prejudice

"This is the new science of primitive psychiatry. Thorazine!"

"This is the new science of modern psychiatry. Thorazine!"

References:
1. "As a race, we are a thinking race!" | "We are the authors of our own destiny!"
2. "This is the new science of primitive psychiatry. Thorazine!"
3. "This is the new science of modern psychiatry. Thorazine!"
Institutional Racism, Race-based medicine and Mental Health

- “Excited Delirium”
  - First used in 1985 by forensic pathologist Charles Wetli
  - Police departments across the country have trained their officers to identify excited delirium as a potentially deadly medical condition
  - Despite similar rates of cocaine use across race and ethnicity in the U.S, studies show that younger Black men who use cocaine and who are in police custody are at highest risk for death from “excited delirium.”
  - “I am worried about excited delirium or whatever.” – former Minneapolis Police Officer Thomas Lane, May 25th, 2020

  - “At the present time, the data described in the present review are the most comprehensive data available, and the results of this study indicate that ExDS is a diagnostic construct without meaningful clinical or predictive characteristics that distinguish it from AgDS, with the exception of aggressive restraint and associated high risk of death.”
  - ExDS = excited delirium, AgDs = agitated delirium

Addressing Structural Racism: Denouncing Race-based Medicine

- Medical decisions that disadvantage Black patients
  - Hidden in Plain Sight — Examining the Use of Race Correlation in Clinical Algorithms
Addressing Structural Racism: Denouncing Race-based Medicine

Minneapolis health system eliminates race-based kidney health determinant

Communications: Advocacy No

Moving from Race-Based to Racism-Conscious medicine


1. Clarify the problem and examine evidence
2. Evaluate different approaches to address use of race in GFR estimation
3. Make recommendations

Moving from Race-Based to Racism-Conscious medicine

A Unifying Approach for GFR Estimation: Recommendations of the NKF-ASN Task Force on Reassessing the Inclusion of Race in Diagnosing Kidney Disease

Recommendation # 1
The Task Force recommends for U.S. adults (>85% of whom have normal kidney function) that the CRD-EPIJ equation that was developed without the use of the race variable be implemented immediately, including all laboratories.
A Unifying Approach for GFR Estimation: Recommendations of the NKF-ASN Task Force on Reassessing the Inclusion of Race in Diagnosing Kidney Disease

Recommendation # 2

▪ The Task Force recommends national efforts to facilitate increased, routine, and timely use of cystatin C, especially to confirm eGFR in adults who are at risk for or have chronic kidney disease.

Recommendation # 3

▪ The Task Force recommends that research on GFR estimation with new endogenous filtration markers and on interventions to eliminate race and ethnic disparities in kidney disease be encouraged and funded.

New eGFR equations that incorporate creatinine and cystatin C but omit race are more accurate and led to smaller differences between Black participants and non-Black participants than new equations without race with either creatinine or cystatin C alone.
Can We Use Race?

- Using race to guide clinical care is justified only if:
  1. The use confers substantial benefit
  2. The benefit cannot be achieved through other feasible approaches
  3. Patients who reject race categorization are accommodated fairly
  4. The use of race is transparent

Eneanya ND, Yang W, Reese PP. Reconsidering the Consequences of Using Race to Estimate Kidney Function. JAMA. Published online June 06, 2019. 322(2):113-114.

1. Race, Genetics and Ancestry are “inextricably linked”
2. Their case in Genetics is correlated with physiology and disease: Ancestry is closely linked to Genetics ➔ Race is an acceptable proxy for Ancestry
3. Race is also an acceptable proxy for the confluence of, “the relative importance of bias, racial discrimination, culture, socioeconomic status, access to care, environmental factors, and genetics to racial/ethnic differences in disease”
4. While they advocate for further study of the impact of these individual factors, they state, “ignoring it [race] would be counterproductive.”

What “Race” am I??

- Even Ancestry has its limits
- I’m Cameroonian, but more specifically my family is from the Northwest part of Cameroon
- And my family more specifically is Bamileke
Take Home Point: Race is a Risk Marker, NOT a risk Factor

“Rather than a risk factor that predicts disease or disability because of genetic susceptibility, race is better conceptualized as a risk marker—of vulnerability, bias or systemic disadvantage.”
- Dr. Jennifer Tsai

Moving from Race-Based to Racism-Conscious medicine


Moving from Race-Based to Racism-Conscious medicine

Moving from Race-Based to Racism-Conscious medicine


1. Racist, racially tailored practices that propagate inequity should be avoided.
2. It should be taught that racial health disparities are a consequence of structural racism.
3. Resolutions denouncing race-based medicine across clinical leadership should be adopted.
4. Clinical research should be used to examine structural barriers, rather than using race as a proxy for biology.

Applying Racism-Conscious Behavioral Health Care: Mitigating bias in care of agitated patients


Exploring bias in restraint use: Four strategies to mitigate bias in care of the agitated patient in the emergency department

At the public health systems level: support focused research

At the health system policy level: address ED overcrowding and staffing ratios

At the institutional level: invest in bias assessment and restraint education

At the individual level: employ a “restraint checklist”
Applying Racism-Conscious Behavioral Health Care: Mitigating bias in care of agitated patients

Five restraint checklist questions

1. Have I tried to listen to the patient’s desires, employ verbal deescalation, and other alternatives to chemical/physical restraints (such as offering food/drink)?

2. Is a different staff member, outside of myself or the patient’s primary care team, better at deescalating this patient based on demographic similarities (or differences, such as an agitated male patient who responds better to female staff)?

3. Is my fear of this patient exaggerated by their appearance?

4. Are there cultural differences in the patient’s expression of frustration and control?

5. Am I using racial, gender, socioeconomic, or other potentially harmful bias in determining my agitation care plan for this patient?


Addressing Structural Racism: Denouncing Race-based Medicine

"voted unanimously to immediately retire the guidance "Urinary Tract Infection: Clinical Practice Guideline for the Diagnosis and Management of the Initial UTI in Febrile Infants and Children 2 to 24 Months" because of improper use of race as a factor in disease risk"

All AAP authors are now asked to do the following:

- ensure race is acknowledged as a social construct rather than a genetic or biological descriptor;
- consider whether use of racial and/or ethnic categories in models, analyses, and selection of comparison groups is explicitly justified when reviewing literature;
- and write all policies in accordance with the Academy’s "Words Matter" guidance, which encourages use of inclusive, anti-biased language to mitigate and combat bias, remove stigma, and avoid stereotypes.
Addressing Structural Racism: Denouncing Race-based Medicine

Changes you may wish to make in practice:

1. Reassess the use of race as a risk factor or correction in your clinical tools
2. Understand how structural racism and inequity is contributing to health disparities you see in practice and read about in the literature
3. If using race in clinical decision making ensure you have allowed your patient to self-identify their race and inform them about how and why their race is being factored into their care

Recommended Reading

“Race-based Medicine 101”

“Medical Apartheid: The Dark History of Medical Experimentation on Black Americans from Colonial Times to the Present” by Harriet Washington

“Fatal Invention: How Science, Politics, and Big Business Re-Create Race in the Twenty-First Century” by Dorothy Roberts

“American Academy of Pediatrics”

“AAP Perspective: Race-Based Medicine”

“Race/Ethnicity”

• Race should be acknowledged as a social construct and should not be used as a biological genetic description or should not be used as a biological group for disparities.

• Language that is not benign to the community to disparities in different cultural groups. Instead, describe how structural racism and other structural factors cause the disparities. Be descriptive to explain how from one group to another.

“Recommended Reading”


• Eneanya ND, Yang W, Reese PP. Reconsidering the Consequences of Using Race to Estimate Kidney Function. JAMA. Published online June 06, 2019. 322(2):113–114.


• Fatal Invention: How Science, Politics, and Big Business Re-Create Race in the Twenty-First Century – by Dorothy Roberts
Questions?

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