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Race-Conscious Bioethics: The Call to Reject Contemporary Scientific Racism

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“Hypertension in Blacks is a salt disease,” Dr. Anderson¹ explained. “Too much salt overloads their renin-angiotensin system and their kidneys can’t handle it. It’s just the way their bodies work. We’ll start her on a diuretic and see how she does.”

Our patient, Tonya, a quiet woman in her mid-thirties, sat with her hands folded, her groomed eyebrows in a knot. She shifted in her seat.

“Doc, I’m a bus driver,” Tonya said. “I don’t want to be on something that’s going to make me have to go to the bathroom. I don’t get breaks.”

“Why don’t we start an ACE inhibitor instead?” I suggested.

Dr. Anderson shook his head.

“Nope, she’ll do much better on a thiazide. She just needs to cut out the salt and take her meds. We’ll see her in a month.”

INTRODUCTION

My exchange in the primary care clinic with Dr. Anderson was too familiar. Race-based medicine—or the misuse of race as an inherent biological trait in clinical practice in ways that promote unequal treatment—dehumanizes patients every day, reducing them to a diagnosis and a set of socially freighted physical traits. Rigid power dynamics and time pressures force harmful, biologized notions of race to go unchecked. In this instance, when I—a medical student—and the patient questioned the attending physician, racism shrouded in science silenced us both.

In this commentary, I argue that clinicians have an ethical imperative to reassess clinical guidelines relying on flawed data that treat race as an essential biological trait. Synthesizing clinical experience and anthropological framings of race, I discuss the inherent scientific error in stratifying by race in clinical research

and the ethical risks of designing and implementing treatment guidelines based on such data. I conclude with race-conscious alternatives that more fully support the principle of justice, or respect for equitable treatment.

CONTEMPORARY SCIENTIFIC RACISM: THE ‘SLAVERY HYPOTHESIS’ AND THE JNC-8 CRITERIA

The myth that Black Americans experience higher rates of hypertension due to increased salt sensitivity—known as the “slavery hypothesis”—comes from the erroneous idea that enslaved Africans who survived the Middle Passage had a selective advantage for salt retention (Wilson and Grim 1991). Despite the fact that the theory is widely contested (Kaufman and Hall 2003), based on a misunderstanding of genetic drift, and that one of its primary proponents admitted to developing the idea after reading Alex Haley’s *Roots* (Beasley 1988; Kendi 2019), this notion continues to shape racialized beliefs about the pathophysiology of hypertension in Black Americans. In 2014, the hypothesis became codified in clinical practice through the Eighth Joint National Committee (JNC-8) hypertension guidelines, which prescribe alternate pathways for “Black” and “Nonblack” patients (see Figure 1).

Based on a systematic review of 64 articles, a panel of researchers examined the efficacy of common hypertension pharmacotherapies, including diuretics and angiotensin converting enzyme (ACE) inhibitors. The researchers found that in Black patients, thiazide-type diuretics yielded greater benefits relative to ACE

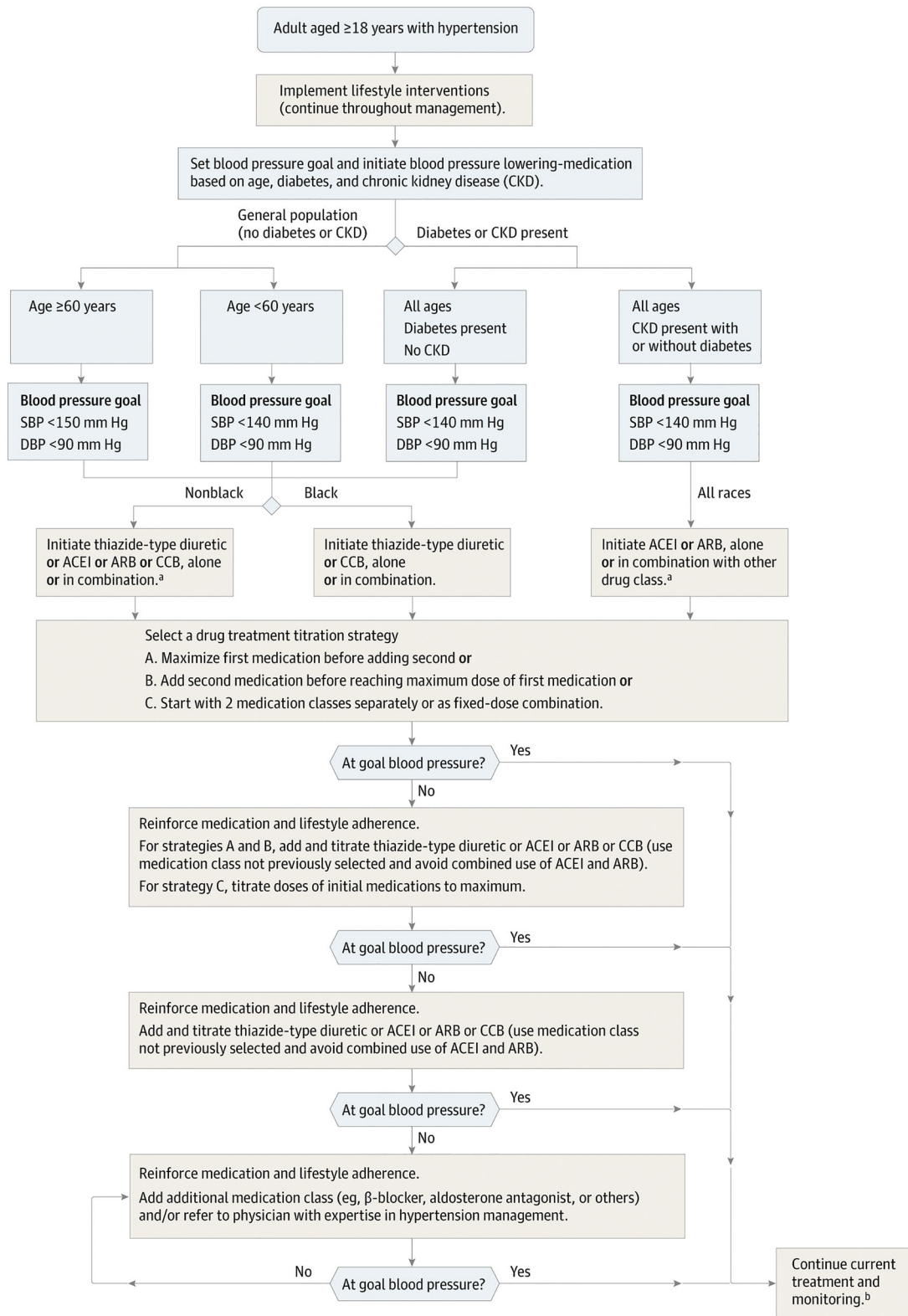


Figure 1. 2014 Hypertension Guideline Management Algorithm (reproduced with permission from James et al. [2014]). Hypertension management algorithm recommending alternate pathways for “Nonblack” and “Black” patients without chronic kidney disease (CKD). Angiotensin-converting enzyme (ACE) inhibitors or angiotensin receptor blockers (ARBs) are not recommended as initial therapy for Black patients.

inhibitors for cerebrovascular, heart failure, and composite outcomes, but demonstrated similar overall mortality and comparable coronary heart disease and kidney outcomes. In addition, they identified improved outcomes for non-Black patients taking thiazide-type diuretics relative to ACE inhibitors for heart failure outcomes but noted that other outcomes were similar between the two drugs. The panel concluded that, “In the general [B]lack population 55 years of age or older with hypertension, initial antihypertensive drug therapy with a diuretic improves cerebrovascular... and combined cardiovascular... outcomes compared to initial antihypertensive drug therapy with an ACE inhibitor,” according to “moderate” and “low” quality evidence (James et al. 2014, Appendix 105, 112).

Most practicing clinicians, like Dr. Anderson, do not have the time to consult a nearly 300-page article appendix to scrutinize the evidence underpinning clinical guidelines. Instead, they consult the resulting algorithm—which may confirm existing racial biases—and tailor their practice accordingly.

And why should clinicians question an algorithm based on a systematic review published in an esteemed journal like *JAMA*? I argue that very inclusion of race as a predictor variable in the analyses of pharmacotherapy response presumes that race is biologically salient, a notion that descends from European colonization (Cerdeña, Plaisime, and Tsai 2020). As Yearby discusses in this issue, race is a fluid, sociopolitical construct that has been inferred as biological to reinforce hierarchies among groups (American Association of Physical Anthropologists 2019; Yearby 2021). The hypothesis—whether implicit or explicit—that members of different racial groups respond differently to antihypertensive treatment falsely implies that racial groups are genetically distinct. This research thereby recapitulates harmful racist and colonial power systems, promoting unequal treatment by race.

Yearby notes, as others have elsewhere, that race alone cannot be treated as a proxy for experience of racialization and racism (Jones 2001; LaVeist, Sellers, and Neighbors 2001; Yearby 2021). The effects of structural racism—or the way racism pervades every system that organizes social life (Hardeman and Karbeah 2020)—must be carefully examined in research on health disparities; simply inventorying disparities risks confirming existing biases of innate predisposition toward disease by race. To elaborate on the importance of analyzing racism, I consider

the recent example of racial disparities in COVID-19.

RACIAL ESSENTIALISM AND COVID-19: CONSIDERING THE EFFECTS OF RACIST POLICIES

In an interview discussing disparities in COVID-19 among Black, Asian, and Minority Ethnic (BAME) communities in the United Kingdom, a health reporter shared:

“Here in the UK, data suggest that, even after arriving at the hospital, South Asians with COVID-19 fare worse than people of other ethnicities. Shouldn’t South Asians then be treated more aggressively?”

I shook my head. “In order to have those data, someone must have asked the question ‘Do South Asians have worse outcomes relative to White people,’ which implies that race is biologically meaningful.”

The reporter nodded, her eyes searching. “But once we have these data, do we just... ignore them?”

This interview prompted me to answer the following: What *do* we do with data obtained through racist methods? Rather than ignoring them, we must consider confounders by which racism can be more effectively analyzed vis-à-vis race. For instance, racial capitalism—or the way racism further organizes structures, like food systems, positioned through capitalism—may contribute to higher rates of diabetes and obesity among South Asians living in the United Kingdom (Laster Pirtle 2020; McKeigue, Shah, and Marmot 1991; Robinson 1983); these comorbidities in turn constitute risk factors for worse prognosis in COVID-19 patients (Dietz and Santos-Burgoa 2020; Zhou et al. 2020). In addition, chronic stress due to lifelong experiences of racism may exacerbate cardiovascular disease, increasing risk for COVID-19 complications (Gravlee 2009; Krieger 2010).

Racism also explains disparities in COVID-19 prevalence (Gravlee 2020). Amid the pandemic, Black and Brown communities are less likely to have the option to work from home and may have fewer protections at work, increasing their potential for exposure to the virus (Cowan 2020). Barriers to accessing quality housing increase the likelihood that structurally oppressed populations—such as migrant farmworkers—will live in crowded homes with inadequate ventilation (Accorsi et al. 2020). In addition, for cultural and cost-saving reasons, Black and Brown families are more likely to live in multi-generational households, which place older adults in particular at

increased risk of infection as younger household members work, attend school, and socialize outside of the home (Anthony 2020; Keene and Batson 2010). In the United States, undocumented community members, who are ineligible for government assistance, may engage in precarious and informal work arrangements that increase their risk of falling ill (Page et al. 2020). Furthermore, speakers of foreign languages may have difficulty accessing information from public health campaigns and may unwittingly engage in unsafe behaviors (Liem et al. 2020). Despite these structural barriers, several studies in high-impact journals attribute racial differences in COVID-19 prevalence or outcomes at least in part to genetic or physiological variation (Anyane-Yeboah, Sato, and Sakuraba 2020; Azar et al. 2020; Chen, Shan, and Qian 2020; Doumas et al. 2020; Katzmarzyk, Salbaum, and Heymsfield 2020; Otu et al. 2020; Pareek et al. 2020).

Race is a sociopolitical—not a biological—category, the meaning of which shifts to suit the objectives of those in power; yet the effects of racist policies like immigration enforcement contribute to health inequities. The mischaracterization of race as biological is unique: as COVID-19 surged in North and South Dakota, increasing by more than 14 and 20% in 1 week, respectively, no one spoke of genetic differences between “high-risk” Dakotans and “low-risk” Vermonters, the latter of whom had the lowest per capita case rate during the same period (CDC 2020; Lopez 2020). Both racial categories and state borders are political; however, we more readily recognize health disparities between states as the result of policy interventions—such as stay-at-home orders, mask mandates, and testing procedures—and quickly assume that racial health disparities may be due to genetic causes. We must thereby turn our attention away from race-as-biology and toward antiracism-as-policy.

CONCLUSION AND RECOMMENDATIONS

Research and practice that reify race as an immutable, biological trait rely on racist and unscientific falsehoods that lead to injustice in medicine. As Braddock so carefully notes, we must not be “colorblind,” because to do so promotes White supremacy (Braddock 2021). Rather, we must be race-conscious, considering the effects of racism, rather than race, on illness and health (Cerdeña, Plaisime, and Tsai 2020).

First, when faced with “evidence-based” guidelines for racially tailored care, clinicians should use the

option that makes the most sense for the patient given the patient’s medical history and social circumstances. In the case of Tonya, from the start of this essay, an ACE inhibitor likely would have been a more effective option as she would be more likely to consistently take a medication that did not interfere with her work. Better yet, we should advocate for more amenable working conditions that would facilitate all treatment options. Second, scholars and clinicians alike must conduct and promote research that more carefully accounts for effects of racism rather than race (Boyd et al. 2020; Hardeman and Karbeah 2020). Amid the current pandemic, we must analyze how current and historically racist policies such as redlining and housing discrimination, healthcare exclusion for undocumented Americans, and workplace discrimination contribute to racial disparities in COVID-19 morbidity and mortality. Third, we must pursue structural solutions to racial health disparities rather than recommending racially tailored care. Instead of prescribing Black patients alternative antihypertensives, we should dismantle the ways interpersonal and institutional racism contribute to elevated blood pressure among Black Americans, through discrimination, socioeconomic disadvantage, differential healthcare access, over-policing, and poor neighborhood quality (Calvin et al. 2003; Krieger and Sidney 1996).

Mithani, Cooper, and Boyd reimagine bioethics as proactive, calling for expansion of the principle of justice (Mithani, Cooper, and Boyd 2021). Race-based medicine is inherently unjust. Clinicians and scientists must therefore dispute evidence that biologizes race and advocate for race-conscious medicine that advances health equity.

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OPEN PEER COMMENTARIES



Beyond the Medical Model: Retooling Bioethics for the Work Ahead

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The three important target articles (Braddock 2021; Mithani, Cooper, and Boyd 2021; Yearby 2021) make a strong case for regarding racism as a public health crisis. Each calls for advocacy by the bioethics community. Such calls are not new, though they have gained an urgency over the past year. Yet the advocacy for which they call must be matched, we argue, by a critical examination of the conceptual tools that bioethicists typically employ to do their work. If we are to promote understanding of the medical policies and practices that sustain racism, we must first examine how the usual ways of doing bioethics contribute to the problem. Moreover, we must look beyond medicine to examine the social determinants, especially structural racism, that create

and sustain health disparities with profound medical effects.

It is all too clear, as Jonathan Moreno (2005, W18) put it, that “bioethics has followed popular trends rather than led them.” We concur, and suggest that in large part this is because we have not set our own agenda for meaningful work. Rather, we have followed medicine’s paradigm of individual patient care as the proper locus for ethics, as the place where our abilities matter the most, and as identifying problems worthy of our attention. This is how bioethics began 50 years ago; it is reinforced by the current pattern of bioethicists as largely affiliated with, and paid by, medical institutions, and as conducting research directed by National Institutes of Health (NIH) funding priorities.

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