Historical Perspectives on Race-Based Medicine in *American Family Physician*

Kenneth W. Lin, MD, MPH; Priscilla Auguste, MD; Christopher W. Bunt, MD; and Michelle Nelson, MD

Published online May 14, 2025.

With notable exceptions, past authors and editors of *American Family Physician* (*AFP*) and its predecessor, *General Practitioner*, mostly treated race and ethnicity as sociopolitical constructs rather than inherent biologic traits.[1] For example, articles from 1967 to 1988 on traditional Navajo medicine,[2] caring for refugees from Southeast Asia,[3] and Mexican folk remedies[4] emphasized the importance of understanding differences between patients' health belief systems and the conventional Western model and avoiding cultural misunderstandings.

However, these articles also demonstrated problems with how research studies identified members of a racial or ethnic group. The Mexican folk remedies article discussed how "patients with Hispanic surnames" were asked to complete the survey.[4] The other articles did not explain how patients were identified. The medical community now understands that self-identification is the most appropriate method for identifying any individual or group as a certain race or ethnicity, rather than other factors that can lead to misclassification and perpetuate stereotypes.[5]

During the early years of the HIV/AIDS epidemic, the risk factors were categorized by the US Centers for Disease Control and Prevention and described in the medical literature, including *AFP*, as the 4 Hs. One of the groups this stigmatizing label referred to was Haitians—a prime example of race-based medicine.[6,7] This underscores the importance of the authors and editors of AFP subsequently pointing out harmful stereotypes and advocating for evidence-based, equitable health care. *AFP* has also published letters to the editor and clinical review articles highlighting the potential harm of stereotypes. The author of a 1996 letter to the editor questioned the relevance of race or ethnicity to the interpretation and management of positive purified protein derivative (PPD) tests: "Clearly, it is poor access to health care services that should better determine the physicians' management decisions for [Black, Hispanic, and Native American] PPD converters, not a generalization that stereotypes ethnic minorities as the best examples of the high-risk medically underserved."[8]

Similarly, a 1997 article on health considerations in older African American patients stated that "socioeconomic factors affect longevity and functional status more than race" and noted that patients who reached adulthood before the Civil Rights Movement of the 1960s "have adapted to a society in which institutions have been authoritarian and discriminatory," potentially making it more difficult to establish a trusting physician-patient relationship.[9] And, in 2011, a letter to the editor cautioned physicians against making "inappropriate and even hurtful race-based assumptions" about Black patients when screening for sexually transmitted infections.[10]

Regrettably, for decades, *AFP* left unchallenged a standard hypertension guideline recommendation to treat Black patients differently from others for biologic reasons. A 1990 article on individualizing hypertension therapy speculated that "low-renin, volume-expanded hypertension may be more common in Black patients, perhaps because of increased salt sensitivity," before quoting the Joint National Committee's recommendation to preferentially prescribe diuretics in Black patients because they were thought to not respond as well to beta blockers or angiotensin-converting enzyme (ACE) inhibitors.[11]

As more recent hypertension guidelines continued to incorporate recommendations based on race, a 2020 *AFP* article indicated that Black patients with hypertension should receive a thiazide-type diuretic or calcium channel blocker rather than an ACE inhibitor or angiotensin receptor blocker.[12] Three readers countered that there was no strong evidentiary rationale for treating Black patients differently than patients of other races and that "this was a missed opportunity for *AFP* to raise awareness about the insidious way in which outdated assumptions about the biological basis of race permeate current medical practice." They also noted that "race-based medicine is not benign; it perpetuates structural racism, thereby leading to inequalities in treatment and outcomes."[13] Other readers disagreed, commenting that race can be as useful a risk factor as

Author disclosure: No relevant financial relationships.

WHAT *AFP* MEANS TO ME AS A STUDENT

AFP is the first resource I turn to when I have questions about clinical cases. It transforms information into power and allows me to make a meaningful difference in the lives of patients. *AFP* is always there, offering multiple ways to acquire the knowledge I need, like with podcasts and through Instagram. I look forward to relying on it for decades to come as I continue my journey in medicine.

Adedayo O. Jobi-Odeneye, third-year medical student and former *AFP* Student Representative

Downloaded from the American Family Physician website at www.aafp.org/afp. Copyright © 2025 American Academy of Family Physicians. For the private, noncommercial use of one individual user of the website. All other rights reserved. Contact copyrights@aafp.org for copyright questions and/or permission requests.

age, body mass index, or the presence of diabetes or cardiovascular disease, and a failure to acknowledge race could hamper efforts to reduce health disparities. In response, an editor's note was added to clarify that the variability in response to ACE inhibitor monotherapy is greater within races than between races, and treatment should prioritize the role of ACE inhibitors for chronic kidney disease, diabetes, and uncontrolled hypertension, irrespective of race.[12] These comments highlight the complexities of race in health care and emphasize the need for continued dialog and research to address disparities.

Around the beginning of the 2000s, articles in *AFP* brought attention to the family physician's role in addressing health disparities in patients identifying as Black, Hispanic, American Indian/Alaska Native, or Asian and Pacific Islander by implementing the objectives of the Healthy People 2010 initiative of the US Department of Health and Human Services.[14,15] Unfortunately, these disparities largely persist today, and effective health system–level interventions remain limited.[16] Recognizing that race-concordant clinicians are associated with better patient outcomes, a 2008 Graham Center One-Pager sounded the alarm that fewer Mexican and Black physicians were choosing primary care careers and proposed policy solutions to support a diverse physician workforce.[17]

In 2021, *AFP* initiated a collaboration with nine other family medicine journals to recognize the responsibility "to actively examine the effects of racism on society and health and to take action to eliminate structural racism in our editorial processes."[18] Our journal's mission statement includes this goal: "To highlight and support scholarship and continuing medical education about social determinants of health, health disparities, antiracism, and social justice." We subsequently published a progress report on our efforts to improve diversity, equity, and inclusion, which featured encouraging mentorship of underrepresented minorities in medicine and making recommendations on how to critically appraise each study's use of race and gender as variables or risk factors.[19]

Most recently, we have solicited antiracist content that challenges readers to be aware of their own implicit biases and avoid disparaging or stereotyping language in clinical documentation.[20,21] As part of *AFP*'s educational journey, we hope to continue to promote unique individuals and actively support appropriate health care for all, regardless of how they identify, and engage readers in thoughtful dialog throughout this process.

Editor's Note: Drs. Lin, Auguste, and Bunt are editors of *AFP*. Dr. Nelson is the *AFP* medical editing fellow.

REFERENCES

1. Reddick B. Fallacies and dangers of practicing race-based medicine. *Am Fam Physician*. 2021;104(2):122-123.
2. Porvaznik J. Traditional Navajo medicine. *GP*. 1967;36(4):179-182.
3. Goldfield N, Lee W. Caring for Indochinese refugees. *Am Fam Physician*. 1982;26(3):157-160.
4. Marsh WW, Hentges K. Mexican folk remedies and conventional medical care. *Am Fam Physician*. 1988;37(3):257-262.
5. Use of race and ethnicity in public health surveillance. Summary of the DC/ATSDR workshop. Atlanta, Georgia, March 1-2, 1993. *MMWR Recomm Rep*. 1993;42(RR-10):1-16.
6. AIDS. *Am Fam Physician*. 1983;28(1):111.
7. Marc LG, Patel-Larson A, Hall HI, et al.; National Haitian-American Health Alliance. HIV among Haitian-born persons in the United States, 1985-2007. *AIDS*. 2010;24(13):2089-2097.
8. Mosby JA. Relevance of race or ethnic group in case reports. *Am Fam Physician*. 1996;53(5):1530.
9. Mouton CP. Special health considerations in African-American elders. *Am Fam Physician*. 1997;55(4):1243-1253.
10. Swain GR. Individualized approach to screening patients for STIs. *Am Fam Physician*. 2011;83(4):350-352, author reply 352.
11. Taylor RB. Patient profiling: individualization of hypertension therapy. *Am Fam Physician* 1990;42(5 Suppl):29S-31S, 34S-36S.
12. Smith DK, Lennon RP, Carlsgaard PB. Managing hypertension using combination therapy. *Am Fam Physician*. 2020;101(6):341-349.
13. Westby A, Okah E, Ricco J. Race-based treatment decisions perpetuate structural racism. *Am Fam Physician*. 2020;102(3):136-137.
14. Hixon AL, Chapman RW. Healthy People 2010: the role of family physicians in addressing health disparities. *Am Fam Physician*. 2000; 62(9):1971-1972, 1975, 1978.
15. Smith JH Jr. Eliminating health disparities: our mission, our vision, our cause. *Am Fam Physician*. 2001;64(8):1333-1334.
16. Lamina T, Abdi HI, Behrens K, et al. Strategies to address racial and ethnic disparities in health and health care for chronic conditions: an evidence map of research from 2017 to 2024. *Ann Intern Med*. 2025; 178(1):88-97.
17. Turner EJ, Bazemore AW, Phillips RL Jr, et al. Will patients find diversity in the medical home? *Am Fam Physician*. 2008;78(2):183.
18. Sexton SM, Richardson CR, Schrager SB, et al. Systemic racism and health disparities: a statement from editors of family medicine journals. *Am Fam Physician*. 2021;103(1):10-11.
19. Sexton SM, Lin KW, Bunt CW, et al. Improving diversity, equity, and inclusion in *AFP*. *Am Fam Physician*. 2023;107(1):11-12.
20. Rodríguez JE, Campbell KM, Washington JC. Dismantling anti-Black racism in medicine. *Am Fam Physician*. 2021;104(6):555-556.
21. Roth AR, Lazris A, Haskell H, et al. Avoiding racist and judgmental clinical documentation: helping to achieve health equity. *Am Fam Physician*. 2024;109(6):575-577. ■