Letters to the Editor

Race-Based Treatment Decisions Perpetuate Structural Racism

Original Article: Managing Hypertension Using Combination Therapy

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To the Editor: *American Family Physician* (*AFP*) is an excellent source of evidence-based updates and review articles, so we were surprised and extremely disappointed with the article on hypertension by Drs. Smith, Lennon, and Carlsgaard. The authors advocated for the use of race in guiding the selection of antihypertensive medications without acknowledging that race is socially constructed. This perpetuates the myth that people of different races are inherently biologically different and warrant different treatment regimens.

Race is a sociopolitical construct that does not represent shared genetic ancestry. It is a way of categorizing people based on physical characteristics and assumed geographic ancestry, but racial categories are defined differently across societies and have changed over time.[1] Politics and power guided the formation of race as a concept, not scientific certainty; as such, using race as a biological category to determine medical treatment is bad science. We recognize that the Eighth Joint National Committee (JNC-8) guidelines differentiate treatments by race, but we assert that the primary literature for these recommendations does not support this practice. In this case, race was not well defined in the study itself, and the reported difference in outcomes was not statistically significant.[2] The study authors did not discuss how they determined which participants were Black: Was race self-reported or researcher observed? How Black must a patient be to not be a candidate for angiotensin-converting enzyme inhibitor therapy, and who decides?

We feel that this was a missed opportunity for *AFP* to raise awareness about the insidious way in which outdated assumptions about the biological basis of race permeate current medical practice. Race-based medicine is not benign; it perpetuates structural racism, thereby leading to inequalities in treatment and outcomes. Research has shown that the mere mention of the racial prevalence of genetic diseases in scientific textbooks is associated with the belief that race influences intelligence,[3,4] which raises concerns about the implications of race-based medicine. A 2016 study showed that medical students and residents who believed that Black and White people are biologically different rated the pain experienced by Black patients as lower than that experienced by White patients, and they recommended inappropriate treatments.[5] The premise of basing treatment decisions on presumed biological differences in race, an ill-defined fluid concept, is flawed at best and directly harmful at worst. With *AFP*'s commitment to evidence-based medicine, we expect better.

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In Reply: We agree with Drs. Westby, Okah, and Ricco that race is a sociopolitical construct rather than a true biological category. Unfortunately, the literature contains many examples of the uncritical use of Black race in clinical decision-making, including first-line antihypertensive medication in JNC-8, calculating 10-year cardiovascular risk using the American College of Cardiology/American Heart Association pooled cohort risk equations,[1] equations for estimating glomerular filtration rate,[2] and a U.S. Food and Drug Administration–approved medication for heart failure,[3] among others. Indeed, another reader pointed out that an article on office spirometry that also appeared in the March 15, 2020, issue mentioned differences in lung volumes based on age, sex, and ethnicity,[4] which refers to the longstanding practice of "race correction" in commercially available spirometers.[5]

Although many medical schools—including our own, Georgetown University—now teach students about the historical, social, and structural determinants of health disparities that affect persons of color,[6] this essential context is stripped away in clinical practice guidelines that require clinicians to base decisions on a patient's self-identified race or to assume race based on physical appearance. Given that journal editors cannot simply rewrite guidelines, what is the way forward? We can strongly encourage guideline authors to justify differential treatment of patients by race, perhaps with reference to one proposed standard: "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; and (4) the use of race is transparent."[2] We will also ask *AFP* editors and authors to critically assess the quality of evidence and unwritten assumptions underlying recommendations regarding the use of race in decision-making. Ultimately, we need research that explores the complexities of health disparities and their effects on clinical outcomes so that we can encourage our authors to include these types of studies in their qualitative reviews of the literature.

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Editor's Note: This letter was sent to the authors of "Managing Hypertension Using Combination Therapy," who declined to reply. ■