Removing Race from Kidney Disease Diagnosis

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The disproportionate effect of kidney diseases on under-represented communities, particularly individuals who identify as Black or African American, is readily apparent on walking through many dialysis units, including those where we work. Patients who are Black are markedly over-represented among patients on dialysis but are less likely to be referred for or receive a kidney transplant. Although the reasons are complex, they demand an examination of the effects of racism in medicine and the use of race in clinical algorithms. Fundamental to this re-examination is the recognition that race is a social construct and not a biologic determinant. In nephrology, led in large part by medical students and trainees, there have been loud calls to remove race from the calculation of eGFR. The inclusion of race in the calculation of eGFR has been linked to disparities in care, including delays in both the diagnosis of kidney disease and the eligibility for listing for kidney transplantation. A more fundamental concern is that the inclusion of a social construct such as race normalizes and perpetuates nonscientific and harmful beliefs regarding race and biology in our training of the next generation of health care professionals.

In July 2020, ASN and NKF formed a joint task force to reassess the inclusion of race in diagnosing kidney diseases. We charged the task force with examining the inclusion of race in the estimation of GFR and its implication for the diagnosis and management of kidney disease; considering the broad implications of any change; basing their recommendations on rigorous science while incorporating the concerns of patients and the public, especially in marginalized and disadvantaged communities; and ensuring that GFR estimation provides an unbiased assessment of kidney function. Task force members included both patients and health care professionals with a wide range of expertise. In April 2021, the task force issued an interim report detailing its processes, initial assessment of evidence, values, options, and desired attributes that it would use in making a final recommendation.

The task force has now released its final report, providing three recommendations. First, current eGFR reporting should be immediately replaced by the new 2021 Chronic Kidney Disease Epidemiology Collaboration (CKD-EPI) creatinine eGFR equation that was developed without consideration of race as a variable.

This article is being published concurrently in the Journal of the American Society of Nephrology and American Journal of Kidney Diseases, the National Kidney Foundation (NKF)–American Society of Nephrology (ASN) Task Force on Reassessing the Inclusion of Race in Diagnosing Kidney Diseases provides its final report and recommendations, providing an important first step in this process.

During the past two decades, automated reporting of eGFR to accompany serum creatinine has increased awareness, diagnosis, and staging of CKD. However, equations using patient age, sex, race, and serum creatinine report higher eGFRs for individuals who are identified as Black as compared with non-Black individuals with the same characteristics. Over the past half decade, there has been an increasing re-examination of the effects of racism in medicine and the use of race in clinical algorithms. Fundamental to this re-examination is the recognition that race is a social construct and not a biologic determinant. In nephrology, led in large part by medical students and trainees, there have been loud calls to remove race from the calculation of eGFR. The inclusion of race in the calculation of eGFR has been linked to disparities in care, including delays in both the diagnosis of kidney disease and the eligibility for listing for kidney transplantation. A more fundamental concern is that the inclusion of a social construct such as race normalizes and perpetuates nonscientific and harmful beliefs regarding race and biology in our training of the next generation of health care professionals.

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Second, cystatin C testing should be more available and more widely utilized for assessment of kidney function. Evidence demonstrates that cystatin C, especially when combined with creatinine, provides a more accurate assessment of kidney function. However, as the task force delineates, there are significant barriers that must be addressed prior to wide-scale implementation of cystatin C testing, including lack of availability across all clinical laboratories, high cost, and inappropriately restrictive coverage by insurance, including Medicare. Laboratory equipment manufacturers, clinical laboratories, and other stakeholders must rapidly increase the availability and decrease the cost of cystatin C testing, and payors must expand coverage for testing. Once these barriers are removed, the benefit of adding cystatin C to routine laboratory profiles should be determined.

Finally, the task force recommended additional research to develop better methods for estimation of GFR. Kidney disease research is markedly underfunded. Despite the Medicare program spending $130 billion annually treating people with kidney diseases, including $50 billion for people with kidney failure, the National Institutes of Health (NIH) spends $700 million annually on kidney research. This is $20 per patient with kidney disease as compared with $300 per patient spent on cancer research and $2,500 per patient spent on HIV/AIDS research. That NIH spends so little on diseases that disproportionately affect minority populations and even less on achieving health equity in diagnosis and treatment of kidney disease is evidence of systemic racism in United States health care.

As the presidents of ASN and NKF and on behalf of both organizations, we congratulate the task force on their outstanding efforts. However, there is still much more that must be accomplished to realize the ultimate goals of ensuring accurate and unbiased diagnosis of kidney disease. ASN and NKF have already begun collaboration with the laboratory medicine community to implement the 2021 CKD-EPI creatinine equation as the standard for eGFR reporting, and NKF’s online eGFR calculator (https://www.kidney.org/professionals/kdqi/eGFR_calculator) has already been updated. In addition to implementation of the new equation, we need to educate both our patients and our colleagues in primary care, endocrinology, cardiology, and other specialties so that they understand the implications of this change. It is worthwhile to note that the kidney community is the first to remove race from a widely used clinical algorithm and has provided a path for other specialties to follow. We must harness the current attention on this issue to demand additional change.

In parallel with implementation, ASN and NKF are working on a policy and regulatory agenda that is critical to eliminating disparities. This agenda includes a focus on identification and removal of criteria that lead to racial and ethnic inequity in kidney transplantation, including the use of race in the kidney donor profile index (KDPI) algorithm. Additionally, work is underway to mandate the inclusion of appropriate screening for kidney diseases to enable earlier diagnosis and intervention, particularly in underserved communities; to expand the kidney disease education benefit; to remove the dual-insurance requirement for kidney transplantation; and to increase access to nutritional resources and medical nutrition therapy, especially kidney-specific diets.

The implementation of the new equation affords us an additional opportunity to remind ourselves and our colleagues of what eGFR is and is not. Although eGFR is far superior to serum creatinine alone in assessing kidney function and is integral to both diagnosis and staging of CKD, we must never forget that the “e” in eGFR is for estimate. Similar to the prior eGFR equations, in using this new equation approximately one in six patients will have a reported eGFR that differs by >30% from the corresponding measured value. For the majority of patients, this will not affect clinical care; however, cystatin C or other assessment of kidney function should be used when a more accurate determination of kidney function is required. In addition, eGFR is only one dimension in the assessment of kidney function, and we must ensure more widespread testing of urine albumin excretion in high-risk patients. The development of panels of kidney function tests that include both blood and urine assays will facilitate this goal.

The elimination of race from the calculation of eGFR is an important step in our efforts to eliminate disparities in the care of patients with kidney disease. We must recognize, however, that there are multiple factors contributing to these disparities. Many are societal and may not be readily addressed at the bedside. However, those factors do not account for why a Black person with an eGFR of <20 ml/min is still less likely to be referred, listed, and ultimately, transplanted than a White patient with the same eGFR. We must look inward at how our own actions and biases contribute to disparities in care and outcomes, and we must each be accountable.

The work of the task force in eliminating race from the calculation of eGFR is an important step demonstrating our commitment to providing more equitable care. ASN and NKF are committed to redoubling our efforts to identify, address, and eliminate the more fundamental causes for the unacceptable disparities that negatively affect the kidney health and care of Black and other under-represented populations.

**DISCLOSURES**

P.M. Palevsky reports serving as president of the National Kidney Foundation, as a member of the Renal Physicians Association’s Quality, Safety and Accountability Committee, and as chair of the Quality Insights Renal Network 4 Medical Review Board; consultancy agreements with Janssen Research & Development, LLC; and serving as section editor for acute kidney injury for UpToDate and as a member of the editorial board of the Journal of Intensive Care Medicine. S.E. Quaggin reports serving as the president of the American Society of Nephrology and as chief scientific officer and founder of Mannin Research; having consultancy agreements with AstraZeneca, Genentech, Goldfinch, Janssen, Johnson & Johnson, the Lowy Medical Research Foundation, Novartis, Pfizer, and Roche; serving as a scientific advisor or member of AstraZeneca, Genentech/ Roche, JCI, Karolinska Cardiovascular, Renal and...
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REFERENCES