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Diversity, Equity, and Inclusion

Misapplication of Race in Editorial Decisions: Navigating Ethical Dilemmas in Case Reporting

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Abstract

The inclusion of race in medical research has a complicated and troubling history. For centuries, medical institutions and medical research contributed to racist beliefs and have been used to justify a racial caste system. Academic clinicians today must intentionally address the inclusion of race and racism in scholarly work to avoid perpetuating the sins of our profession's past. In this perspective, we recount an experience in which a journal reviewer inappropriately requested the inclusion of race in a case report and share the lessons our team learned in navigating the situation. We also explore the nuanced role of race in research, offer best practices for its inclusion in manuscript submissions, and provide sample language for addressing inappropriate requests for race-related content.

BACKGROUND

We recently submitted a case report involving a Black woman who presented with an unusual complication of a rare disease. The case report was prepared by three fourth-year medical students, an internal medicine resident, a senior infectious disease fellow, and a hospitalist. Recognizing the case's potential to inform clinicians faced with this uncommon diagnosis, we submitted it to a widely read journal. We gave additional consideration to swift publication, hoping this scholarship would maximally impact the career progression of the trainees involved.

In preparing the manuscript, we made the conscious decision to omit the patient's race, acknowledging that race is a social construct with no biological basis or salience for disease. Exploration of the complex relationships between race, racism, and health was beyond the scope of this report. As such, we opted to exclude the patient's race as its inclusion would risk bias.

During the review process, we received constructive feedback from the reviewer and made substantial revisions that strengthened the manuscript. However, one suggestion stood out as misguided: "Could you add her ethnicity?" While this seemed an innocuous request, we believed it would introduce bias. We responded with our rationale against using race as a proxy for biological differences. To our dismay, the reviewer dismissed our concerns, asserting: "I disagree with the authors regarding the myth of biological basis in not mentioning ethnicity...In fact, mentioning ethnicity may improve understanding of the immunogenetics of diseases particularly in this case."

This left us with a difficult choice: acquiesce to the reviewer's requests and risk perpetuating false narratives about race or stand our ground and risk rejection of a valuable case report. This article aims to explore the nuanced role of race in research, offer best practices for its inclusion in manuscript submissions, and provide sample language for addressing inappropriate requests for race-related content.

USE OF RACE IN RESEARCH

The use of race in medical research has a storied and checkered past. At the height of the transatlantic slave trade, physicians sought to legitimize the emerging racial caste system by grounding it in supposed biological differences. To this end, they co-opted pseudoscientific disciplines like phrenology—the debunked belief that skull size and structure predicts intelligence—and fabricated diagnoses such as drapetomania, which defined runaway slaves as mentally disordered, to justify the enslavement and subjugation of Africans. Additionally, physicians corrupted medical technologies, like spirometry, by introducing arbitrary race-based adjustments to reinforce beliefs of Black inferiority. This exploitation extended beyond technology, as Black bodies were subjected to unethical medical experimentation; for instance, the so-called 'Father of Gynecology,' James Marion Sims, performed experimental surgeries on unanesthetized Black

women, and the U.S. Public Health Service conducted the infamous Tuskegee Study of Untreated Syphilis in the Negro Male. These practices not only reinforced the racial hierarchy of the time but also had enduring implications for medical research and practice..

For much of the 20th and early 21st century, racial and ethnic minorities were underrepresented in clinical trials.[1] More recently, there has been a push for greater inclusion of historically marginalized groups, alongside a firm recognition of race as a sociopolitical construct. Despite this progress, race continues to be misused and misapplied as a biological variable, as occurred in the US Food and Drug Administration (FDA) application for BiDil—the first FDA-approved, race-specific medication.[2] After finding no benefit to the general population, NitroMed, the manufacturer of BiDil—despite significant financial conflicts of interest—studied the drug in self-identified Black patients. Following this subanalysis, NitroMed applied for and received FDA approval for BiDil. Notwithstanding inherent statistical shortcomings of the trial, the decision to treat race as a biologic predictor of pharmacologic response raised serious ethical concerns. As a result, Black patients were more often prescribed the more expensive BiDil and were less likely to be prescribed more effective classes of medications, such as angiotensin-converting enzyme inhibitors and angiotensin receptor blockers. This also inappropriately reinforced the idea that there are inherent biological differences between people of different self-identified races. Such practices also hurt non-Black patients, who are much less likely to be prescribed BiDil, even when it may be beneficial.[3]

This does not imply that race cannot be appropriately included in medical research or case reports. When race serves as a proxy for the health impact of generations of systemic racism, community disinvestment, environmental exposures, microaggressions or other lived experiences in a racialized society, its inclusion can be appropriate and necessary, especially if it can lead to interventions to mitigate the untoward effects of racism.[4,5] However, the use of race as a biological or genetic variable is inappropriate, as it may introduce bias, hide true causal pathways, and compromise the scientific integrity of the work.

CHALLENGES IN PEER REVIEW AND RACIAL BIAS

A peer-review process fraught with delays and low acceptance rates may dissuade some authors from challenging feedback that they suspect to be rooted in bias. Many of the premier journals accept as few as 5% of submissions, meaning that authors often must go through a rejection and resubmission process multiple times before publication. Also, given the volume of submissions, journals may be hard-pressed to find reviewers with adequate expertise on subject matter, particularly when that subject matter intersects with race and racism.

Once conditionally accepted, a manuscript must undergo a series of reviews and revisions, often with highly specific requests from editors and reviewers. While great strides have been made in the handling of race in medical research, no standards for racial bias training exists for reviewers or editors.[6,7] This risks the introduction of bias at the editorial level; as Strauss et al. explained, this occurs through "bias in reviewer selection, devaluing racialized expertise, censorship of critical perspectives, minimal consideration of harm to racialized people, and the publication of unscientific and racist studies."[8] Given the power that reviewers and editors possess to control what information is disseminated in medical literature, this can further perpetuate racialized myths. Many leading journals have recently published clear guidance to authors and reviewers,[9,10] but others have not.

As medical journals grapple to balance inclusion while minimizing bias, it is imperative for authors to be intentional with their use of race.

RECOMMENDATIONS FOR AUTHORS OF CASE REPORTS

To uphold scientific integrity and avoid perpetuating racial bias, we recommend the following:

1. **Omit race and/or ethnicity** unless it has clear sociopolitical relevance to the case.
2. **Discuss race and/or ethnicity as sociopolitical constructs** when included, emphasizing their role as proxies for lived experiences and systemic factors.
3. **Address the sociopolitical context explicitly**, highlighting how racism, rather than race, modulates disease risk and outcomes.
4. **Provide constructive feedback to reviewers** who misapply race, including resources such as the Indiana University Peer Review Equity Toolkit.[11]
5. **Be prepared to withdraw a manuscript** if reviewers insist on the inappropriate inclusion of race.

RESPONDING TO REVIEWER BIAS

Ultimately, we responded using the following template:

> We thank the reviewer for this perspective, but we respectfully disagree. We acknowledge there may be biological or genetic predispositions for [the specific disease] in certain individuals. However, we recognize that racial and ethnic group identities are not based on biologic or genetic characteristics and therefore should not be used as a proxy for biologic or genetic risk.

> We believe that we are adhering to the greatest scientific rigor by not including or ascribing biological and genetic relevance to the patient's race. Furthermore, we feel that this is in keeping with the standards set forth by premier medical journals, such as *The Journal of American Medical Association*, which states "race and ethnicity are social constructs, without scientific or biological meaning," and recommends including race or ethnicity as they pertain to socio-politically generated health inequities but avoiding their use as a proxy for biological characteristics.
> We acknowledge that there remain racial inequities in the diagnosis and outcomes of [specific disease]. However, these inequities result from the adverse impacts of systemic racism rather than biological differences between racial or ethnic groups. As we are unable to adequately address the innumerable socio-political influences that may have contributed to our patient's presentation within the scope of this case report, we stand by our decision to omit [her] racial identity.
> We appreciate the reviewer's time and consideration and look forward to your decision.

After submitting our response, the manuscript was accepted without further edits and the race of the patient was not included in the final, published version.

CONCLUSION

For centuries, medicine has been used to justify and perpetuate racist beliefs. If we are to commit as a profession to renouncing this complicity and adopting a fully anti-racist culture, we must discuss race in our workplace and scholarship with intentionality and rigor. By being mindful of the history of race in research, recognizing that race is a sociopolitical construct with no biological basis, and identifying racism rather than race as a determinant of health, we uphold our commitment to using race appropriately and maintain the highest degree of scientific integrity.

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- Substantial contributions to the conception or design of the work; or the acquisition, analysis, or interpretation of data for the work; AND
- Drafting the work or revising it critically for important intellectual content; AND
- Final approval of the version to be published; AND
- Agreement to be accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved.

Disclosures/Conflicts of Interest

The authors declare they have no conflicts of interest

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