Opinion: Medicine’s Move Toward Race-Neutral Risk Assessments

New guidelines for predicting a patient’s risk for heart disease are rooted in science and health equity.

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As an internal medicine doctor, I strive to center my patients’ needs and concerns during our visits together. But one day after spending half an hour wrapping up an intentional, patient-centered visit, a query appeared on my computer screen, threatening to unravel it all: “Black, White, or other?” The time had arrived for me to calculate my patient’s risk for developing heart disease, and I needed their race to complete my assessment.

Since I started my medical training, this dreaded question has haunted my days in the clinic. Like many doctors across the country, I was awkwardly tasked with guessing or asking my patient’s race in order to use a decade-old risk calculator backed by medicine’s most respected medical societies. (Race can be difficult to find in patient profiles, and appointments are often too short to discuss the context of this question.) I pride myself on providing equitable, evidence-based care, and using this calculator often left a pit in my stomach. “Why is this relevant?” I would ask myself, reflecting on the widely published fact that race is a sociopolitical construct with no scientific basis.

Thankfully, at the start of residency I caught wind of a new evidence-based method to avoid this trap of antiquated, race-based medicine. I learned to use the PREVENT, or Predicting Risk of Cardiovascular Disease EVENTs, equations — which assess a patient’s risk for heart disease in a way that is rooted in equity and up-to-date science. Before March 2026, this practice was the exception; now it is the rule, marking another win for race-neutral medicine, health equity, and patients everywhere.

Today, cardiovascular disease remains the number one cause of death in the United States. It’s a largely preventable illness, and much of it can be mitigated by addressing high cholesterol and other risk factors that impact the health of the heart and its blood supply. As an internist, it’s my job to assess my patients’ risk for the disease and use this data to help them optimize their health.

Since 2013, medical guidelines have instructed physicians to use the pooled cohort equation, or PCE, to assign levels of risk to patients and guide preventive treatment. This equation was derived using data from several landmark longitudinal studies on cardiovascular disease that enrolled patients from 1968 to 1990. But this equation had its limitations. It relied on race as a risk factor (established as having no scientific validity), which often led to the over- or underestimation of risk in certain populations. Similarly, the equation had less accuracy in determining risk for women and those from low socioeconomic backgrounds.

Clinically, the PCE also had limitations in its applicability to our evolving understanding of heart disease. Heart disease is not monolithic: Our kidney health, our risk of diabetes, our family history, and our lived experiences all factor into the health of our hearts. Therefore, this year the American Heart Association and American College of Cardiology released new guidelines for clinicians that replaced the old PCE with the new PREVENT equations.

The PREVENT equations are truly novel. They include kidney health, diabetes, access to medication, and zip code in their risk assessment. They were derived and validated from data on 6 million patients across the United States, including women, ethnically diverse subgroups, and those 30 to 79 years old (compared with 40 to 75 for the PCE). This modification of the age range is important given heart disease's increasing prevalence in younger people. The equations can calculate risk for cardiovascular disease 10 and 30 years in the future for more precise longitudinal risk assessment. They can calculate a composite risk score for developing cardiovascular disease and heart failure, increasing our ability to capture risk for more cardiac illnesses. Overall, the PREVENT equations offer a race-neutral, highly accurate, and patient-informed approach to assessing our population's risk for heart disease.

The PREVENT equations are just one of medicine's recent developments that offer a glimpse of a future in which race-neutral equations are the norm, and health equity is the standard in our profession. Another is the story of the estimated glomerular filtration rate, or eGFR, which measures kidney function. Historically, the level of creatinine — a by-product of muscle breakdown — in the blood was the primary measure to determine someone's eGFR. Due to racist assumptions about Black people's inherently greater muscle mass, a race-based algorithm was applied that ultimately made Black people's kidneys look healthier than they were. This led to delays in advanced kidney care and access to kidney transplants. Thankfully, the work of activists, clinicians, and kidney health advocates led to the removal of this race-corrective factor at labs across the country. Recent studies suggest that these efforts have potentially saved lives by increasing equitable and timely access to kidney transplants for Black people.

This critical dialogue also increased the widespread use of the protein cystatin C as an alternative to creatinine as the basis for eGFR. Cystatin C is not as influenced by muscle mass and can offer a

more accurate measure of kidney function for the elderly and those with leaner body tone. Data also suggests that the use of cystatin C in lieu of creatinine may reduce mortality for patients in certain clinical scenarios.

It seems that once race was removed from the equation, the science got more accurate. For centuries race has been used as a heuristic in medicine — a pesky variable we track in our studies, without real understanding of what it represents. This gap of misunderstanding became filled with the racist ideologies of anti-Black inferiority that permeate medicine and society today. But when we combat this bigotry disguised as biology with critical thinking, medical evidence, and structural competence, the product is medical excellence with a standard that improves care for all patients. These advancements demonstrate that clinicians' and researchers' understanding of the sociopolitical determinants of health and their impact on health outcomes is critical for providing high quality care for all.

While this is a step in the right direction, we still have work to do. For example, while guidelines for the management of hypertension were updated last year to remove the suggestion of unique treatment for Black patients, some clinicians have not made this change in practice. (Previous guidelines relied, in part, on the idea that salt sensitivity in this group possibly improved their survival during the transatlantic slave trade.) And today, you can still find race-based guidelines for the treatment of heart failure, just as there are political tailwinds pushing our institutions to remove structural competency and healthy equity curricula from medical education. We must resist these forces and remain vigilant in our pursuit against race-based medicine as we work toward a future where the question of "Black, White, or other?" doesn't determine a patient's shot at a long, healthy life.

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