(PLEASE NOTE: Transcribed automatically by Vimeo, mistakes are possible)

TRANSCRIPT - GR 05 28 21 The Fuss, Fuzziness and Factuality About Race and Kidney Function Neil Powe

00:12:43.620 --> 00:12:46.950

Alex Jepsen: Okay, everyone we're going to go ahead and get started we're a little past the hour.

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00:12:48.750 --> 00:12:57.000

Alex Jepsen: Today we are excited to have Dr Neil poe from ucsf nephrology here for grand rounds, to discuss race and kidney function.

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00:12:57.960 --> 00:13:03.870

Alex Jepsen: Dr pose distinguished career began at princeton or he graduated cloudy and biochemical sciences.

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00:13:04.140 --> 00:13:13.470

Alex Jepsen: He then went to Harvard where he obtained his medical degree, as well as a master's in public health, before going to the University of Pennsylvania, for his internal medicine training.

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00:13:13.950 --> 00:13:21.480

Alex Jepsen: While most of us would be quite worn out after obtaining two degrees and fishing residency Dr poll showed no signs of slowing down his academic drive.

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00:13:22.050 --> 00:13:26.460

Alex Jepsen: As he immediately went on to obtain an MBA and healthcare from the University of Pennsylvania.

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00:13:26.760 --> 00:13:30.720

Alex Jepsen: He then stayed on it, you pin where he completed his fellowship training and the for ology.

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00:13:30.990 --> 00:13:42.810

Alex Jepsen: And soon after joint faculty at Johns Hopkins where he quickly rose for the academic ranks became a professor and simultaneously served as a director of numerous programs dedicated to epidemiology and clinical research.

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00:13:43.290 --> 00:13:49.560

Alex Jepsen: He then made the long coast to coast move to take the positions of Chief of medicine at San Francisco general hospital.

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00:13:50.010 --> 00:13:59.280

Alex Jepsen: and vice, Chair of medicine at ucsf, both of which he continues to hold today, Dr poe his authored nearly 500 publications, you heard that number correctly.

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00:13:59.670 --> 00:14:05.040

Alex Jepsen: and has been the principal investigator of numerous studies involving surveillance and outcomes of kidney disease.

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00:14:05.790 --> 00:14:14.850

Alex Jepsen: He also has dedicated decades of his career to addressing racial racial and ethnic health care disparities and chronic kidney disease and it's given numerous talks on this subject.

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00:14:15.330 --> 00:14:25.830

Alex Jepsen: Despite his own very obviously busy academic endeavors Dr Joe has continued to dedicate a sustained effort to mentoring students residents fellows and junior faculty.

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00:14:26.190 --> 00:14:37.830

Alex Jepsen: He has been recognized countless times with awards for excellence in research humanity teaching and diversity leadership so without further ado, please join me in welcoming Dr Neil whoa.

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00:14:39.810 --> 00:14:47.100

Neil R. Powe: Thank you Alex for that introduction i'm pleased to be here today to.

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00:14:48.210 --> 00:14:51.690

Neil R. Powe: Talk to you pre Memorial Day weekend and.

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00:14:52.770 --> 00:15:00.420

Neil R. Powe: When mark of kusa invited me, he said, Neil i'd like you to talk about racial disparities and kidney disease.

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00:15:01.440 --> 00:15:06.390

Neil R. Powe: Something that as Alex said i've spent a portion of my life working on.

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00:15:07.650 --> 00:15:13.500

Neil R. Powe: And I thought I would, given that the interest and.

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00:15:14.550 --> 00:15:24.300

Neil R. Powe: And controversy around the use of race and clinical algorithms in kidney disease in in all areas of medicine, I thought that.

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00:15:24.900 --> 00:15:35.820

Neil R. Powe: I just couldn't avoid talking about this topic, because you probably would ask me about it in the Q amp a so I just said, let me talk about it for the whole talk so.

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00:15:36.930 --> 00:15:38.460

Neil R. Powe: So that's what i'm going to do.

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00:15:39.600 --> 00:15:56.820

Neil R. Powe: And I you know I entitled this breakfast the fuzziness and facts about race and kidney function you'll you'll see why I use that title so i'm my disclosures are one the slide up studio a second to read them, I have no.

97

00:15:57.900 --> 00:16:02.100

Neil R. Powe: associations with industry or for profit.

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00:16:03.270 --> 00:16:11.280

Neil R. Powe: Institutions and I it's important that I say this, that the conclusions and the opinions I express.

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00:16:12.000 --> 00:16:23.700

Neil R. Powe: During this talk art my own, they should not be construed to represent those of the national kidney foundation or American society and for all of your tasks for some reassessing the inclusion.

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00:16:24.240 --> 00:16:45.900

Neil R. Powe: of race in diagnose and kidney disease so, of which I am a member and co chair, so this was the bust and I like to start off with the racial and ethnic composition and United States, and you can see it in the United States about 61% of the population are Caucasian or white Americans.

101

00:16:46.920 --> 00:16:50.220

Neil R. Powe: And the other 39% are.

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00:16:51.270 --> 00:17:05.700

Neil R. Powe: Ethnic minorities and the fuss is that by 2050 in the United States it's thought that that will flip that actually collectively ethnic and racial minorities will.

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00:17:06.540 --> 00:17:18.000

Neil R. Powe: make up more than 50% and we'll be in the majority in California that happened in 2005 actually so that.

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00:17:18.780 --> 00:17:26.520

Neil R. Powe: Ethnic minorities are now in in the majority, collectively, and I just put here since i'm talking to you.

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00:17:27.030 --> 00:17:43.050

Neil R. Powe: in Virginia just give you contrast to what you look like it versus the whole United States you're very close to the United States in terms of the number of percentage of Caucasians and white, with a larger number of African Americans.

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00:17:44.070 --> 00:17:57.330

Neil R. Powe: in San Francisco you know where you know where my hospital is, you can see that there are a large proportion of ethnic and racial minorities, and then I did that for charlottesville Just to give you.

107

00:17:59.130 --> 00:18:17.100

Neil R. Powe: Some contrast that, and you can see that yeah African Americans makeup is same around Virginia as a whole, and then I showed the show you here, since i'm in a safety net institution in the city of church and my population at the hospital, which is very ethnically.

108

00:18:18.120 --> 00:18:23.850

Neil R. Powe: Diverse I say you know we have a quarter of every ethnic group.

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00:18:24.900 --> 00:18:40.230

Neil R. Powe: So this is the fuss last summer, when I heard a lot of the narrative going on about race and clinical algorithms I was a little disturbed and I decided to spend.

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00:18:41.310 --> 00:18:48.390

Neil R. Powe: Last, I think it was less July 4 weekend writing this paper wrote it over the.

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00:18:51.120 --> 00:18:59.730

Neil R. Powe: Over that weekend and I labeled it black kidney function matters use or misuse of race, and the reason I said.

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00:19:00.240 --> 00:19:11.040

Neil R. Powe: That black kidney function matters is because black adults in the US are nearly three times more likely to develop end stage kidney failure.

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00:19:11.850 --> 00:19:28.440

Neil R. Powe: And you can see this from the slide from the United States, we know data system that the incidence of of kidney failure in blacks is higher than whites it's also true for Native Americans likely Asians and for Hispanics.

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00:19:29.520 --> 00:19:37.320

Neil R. Powe: and on average in minorities, particularly African Americans that a kidney failure.

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00:19:38.370 --> 00:19:42.930

Neil R. Powe: occurs on average five years earlier, compared to white adults.

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00:19:44.760 --> 00:19:51.030

Neil R. Powe: Now cat like kidney function matters also because if you look at.

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00:19:52.530 --> 00:19:58.080

Neil R. Powe: Early referral to a nephrologist when someone develops chronic kidney disease.

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00:19:59.550 --> 00:20:12.750

Neil R. Powe: In this slide shows this that African Americans and Hispanics are less likely to receive care from from the frog just before the start of kidney replacement therapy.

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00:20:14.070 --> 00:20:25.110

Neil R. Powe: And, and also, if you look at weightlifting patients who are on dialysis receiving a kidney.

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00:20:27.120 --> 00:20:38.970

Neil R. Powe: deceased donor kidney within one year of their started kidney failure African Americans and Hispanics are less likely than whites to receive the transplant.

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00:20:40.680 --> 00:21:04.080

Neil R. Powe: So i'm more of the fuss there's a claim that using racing clinical algorithms, such as those for measuring estimated goal Marilyn filtration rates institutionalizes racism and it's incorporation causes despair that is really the claim and the controversy out there.

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00:21:05.220 --> 00:21:19.770

Neil R. Powe: So what's the fuzziness about this well race is a social construct, it does not reflect biological function gsr is biological therefore Ray should not be used to estimate.

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00:21:21.060 --> 00:21:39.180

Neil R. Powe: And so well what our race definitions here's to the one that's been in webster's new world dictionary that even school kids can read it to group of people, united are classified together on the basis of common history, nationality or geographic distribution.

124

00:21:40.320 --> 00:21:59.280

Neil R. Powe: In 2003 the National Academy of Medicine or report said that race is a construct of human variability based on perceived and I keep saying that perceived christie's differences in biology this quote parents and behavior not a biological reality.

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00:22:00.540 --> 00:22:09.150

Neil R. Powe: So I think both of those affirm that that race is not a biological contract, it is a social construct.

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00:22:10.830 --> 00:22:23.550

Neil R. Powe: The other fussiness about this is people say that race is difficult to obtain and ascertain, and that interracial ethnicity persons are increasing in the US, so that makes this.

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00:22:24.900 --> 00:22:34.080

Neil R. Powe: Very fuzzy as to how you classify individuals according to race so let's examine that a little this is some data from.

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00:22:35.160 --> 00:22:42.480

Neil R. Powe: A demographer and it shows raised in ethnic contributions to the change in the US population.

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00:22:44.430 --> 00:22:44.760

Neil R. Powe: From.

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00:22:47.970 --> 00:22:58.410

Neil R. Powe: And the largest group growing is really Latin Latin next folks or Hispanics followed by agents, followed by African Americans and then.

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00:22:59.040 --> 00:23:07.140

Neil R. Powe: In the fourth places those who have two or more races fifth is a American Indians Native Americans are Alaskan.

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00:23:07.830 --> 00:23:17.640

Neil R. Powe: natives, in fact, as I said, from the statistics with say that the Caucasian population which drink tonight is it has shrunk over the decades.

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00:23:18.240 --> 00:23:31.530

Neil R. Powe: If you look at the population under the age age 25 you see slight differences so so the Latin Latin next or Hispanic folks that that still is.

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00:23:32.040 --> 00:23:54.030

Neil R. Powe: The biggest contributor to growth in the US population, but then then it's two or more races, followed by Asian Americans that you can see here and see decreases and actually African Americans and and as well as Caucasians so that's that's kind of the truth about what.

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00:23:55.350 --> 00:24:10.230

Neil R. Powe: How race inter racial ethnicity persons are increasing, so the big question is should race be part of patient care and clinical decision making that's really the crux of the issue.

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00:24:11.010 --> 00:24:21.000

Neil R. Powe: And so, this was the chatter or the narrative that I was hearing when I decided to write my article last summer, they said.

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00:24:22.140 --> 00:24:26.400

Neil R. Powe: That race was introduced a measurement of kidney function to be racist.

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00:24:27.660 --> 00:24:43.080

Neil R. Powe: I heard that disparities and specialist referral and weightlifting were caused by putting race in the equations to estimate vfr I heard the black person's do not have different create new levels than white.

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00:24:44.130 --> 00:24:57.690

Neil R. Powe: That investigators assign race in the studies that develop the equation, so that that fuzziness even about ascertaining race was an issue and that, if we just normalized.

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00:24:58.770 --> 00:25:05.100

Neil R. Powe: Black patients to the white person stand that would just solve and eliminate this problem.

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00:25:06.420 --> 00:25:22.710

Neil R. Powe: And so what I, what I want to talk about is I is that I think all of these are myths and i'm going to try to go through why I why I think they are with some evidence, so this, these are what I believe.

142

00:25:23.790 --> 00:25:40.080

Neil R. Powe: Are the facts from the Pam going to go over them from the past, to now and i'd like to think that the art is that, as Martin Luther King said don't work with a neuro more universities long but it bends toward.

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00:25:41.220 --> 00:25:43.500

Neil R. Powe: Health equity and health justice.

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00:25:44.790 --> 00:25:57.000

Neil R. Powe: So here are the facts, and this is, I know this is a busy slide, but I want to give you a sense of the timeline of events and how evidence around kidney function was developed.

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00:25:57.720 --> 00:26:21.150

Neil R. Powe: So if we go back to 1976 the coc off rod equation was published and that equation was built and developed on 249 white men and then was extrapolated to both women and all other ethnic groups in the United States.

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00:26:22.800 --> 00:26:28.380

Neil R. Powe: In 1982 the statistics that I showed you about.

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00:26:29.430 --> 00:26:46.380

Neil R. Powe: African Americans having more kidney failure were published in the New England journal Sentinel steady I by Ross Graham really for the first time documenting these profound disparities in kidney disease and calling attention to that.

148

00:26:47.730 --> 00:26:48.330

Neil R. Powe: And then.

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00:26:49.650 --> 00:26:57.210

Neil R. Powe: Over the late 1980s and into the 1990s.

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00:26:59.040 --> 00:27:05.610

Neil R. Powe: Number a couple of reports came out that should there were African American disparities and weightlifting and the frog ology.

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00:27:07.920 --> 00:27:12.750

Neil R. Powe: Referral and i'm going to show you a couple of those studies on the left hand side.

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00:27:13.770 --> 00:27:22.380

Neil R. Powe: Is a steady about weightlifting for transplantation within one year kidney failure, yes, and this is Paul eggers, who was a government scientist.

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00:27:23.100 --> 00:27:39.480

Neil R. Powe: Who collected statistics about kidney failure really was was the person who did this for a couple decades and now has become part of the US army, yes, and you can see that as far back in 1988 in this article that he published that.

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00:27:40.170 --> 00:27:48.240

Neil R. Powe: The percent of African Americans who were whitelisted was less than for Native Americans.

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00:27:49.710 --> 00:28:02.460

Neil R. Powe: and white, and you can see, it was not changing over time into the you know next decade, the 1990s, when the right hand side is a is a study.

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00:28:03.030 --> 00:28:12.240

Neil R. Powe: That I like called the choice steady and this is one of my fellows Craig kenton who published studies in the annals of internal medicine think.

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00:28:12.810 --> 00:28:30.300

Neil R. Powe: One of the early studies that documented that African Americans received a late evaluation by a nephrologist patients were standing from 1995 to 1998 and you can see that this is by sex and race that black men and black women.

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00:28:31.560 --> 00:28:35.790

Neil R. Powe: Were we're much more likely to receive a week evaluation by and.

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00:28:37.830 --> 00:28:39.600

Neil R. Powe: So back to our timeline.

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00:28:40.980 --> 00:28:43.650

Neil R. Powe: Then in 1998.

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00:28:44.700 --> 00:28:49.110

Neil R. Powe: I think there was a Sentinel steady that not many people know about.

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00:28:50.490 --> 00:29:05.820

Neil R. Powe: That showed that mean, create new values were hiring us non Hispanic blacks and I just want to show you that data, this was done by Dr Camille Jones who was then, and you know, an African American.

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00:29:07.050 --> 00:29:13.200

Neil R. Powe: epidemiologist who was working at the NIH and, at the end ID DK and and.

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00:29:14.310 --> 00:29:24.240

Neil R. Powe: She led this study you'd actually invited her sister, who was then also physician and getting a PhD in epidemiology and it is actually as a noted scholar.

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00:29:24.840 --> 00:29:35.550

Neil R. Powe: on racism and i'll show you some of the work that she's done a minute, but what you see here is cm creating US population by race by age and by sex.

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00:29:36.330 --> 00:29:51.480

Neil R. Powe: And what they showed, is that you can see that non Hispanic black men at every age had higher serum reactants the non Hispanic white men, and that was true for.

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00:29:52.350 --> 00:30:05.580

Neil R. Powe: Women as well, these data come from you know in haines, which is the data that we use as a nationally representative population, for which we get health statistics around the nation.

168

00:30:07.050 --> 00:30:21.870

Neil R. Powe: This is the work that her sister comrade Jones has put out actually that's a really wonderful piece on the levels of racism internalized racism personally mediated racism and institutional.

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00:30:22.950 --> 00:30:37.860

Neil R. Powe: Racism it's an allegory of gardeners tale that helps you understand what what levels of racism are, but this is what they said in the conclusion of that article.

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00:30:38.670 --> 00:30:48.990

Neil R. Powe: In the absence of information on go marry a local trades right they met measure or lean body mass it's not clear to what extent the variability by sex ethnicity.

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00:30:49.500 --> 00:30:54.600

Neil R. Powe: And age reflects normal physiologic differences, rather than than the presence of kidney disease.

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00:30:55.290 --> 00:31:15.120

Neil R. Powe: And until this information is known, the use of the single cut point to define elevated serum Ariadne value, maybe misleading, so they were costing about normalizing create name values to talk to one rigs cautioning about that.

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00:31:16.500 --> 00:31:30.060

Neil R. Powe: So um what's remarkable is that study was published a year before the study that led to the first reported the first race based equation.

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00:31:30.780 --> 00:31:40.620

Neil R. Powe: In the empty RD equation often called the levy equation developed by handy levy published in 1999 manuals internal medicine, where they studied.

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00:31:41.370 --> 00:31:57.390

Neil R. Powe: And now had measured gsr compared measure G4 estimated ship aren't developed a equation that we all know, includes now co creativity, as well as a SEC self reported.

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00:31:58.770 --> 00:32:13.320

Neil R. Powe: race, but you know what's remarkable is that we, for the for the first time we had inclusion of women and blacks in equations to measure kidney function.

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00:32:14.700 --> 00:32:30.570

Neil R. Powe: And i'm going to show you this is this is really important data, because they had measured gsr which is shown on the walk on the X axis and then serum creating concentrations on the y axis and for both men and women.

178

00:32:32.070 --> 00:32:49.440

Neil R. Powe: That blacks in the open circles had higher serum creatinine levels, then their white counterparts, and these are results have been confirmed and other studies, such as the African American studies kidney disease.

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00:32:50.610 --> 00:32:51.630

Neil R. Powe: as well.

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00:32:52.680 --> 00:33:00.030

Neil R. Powe: So this is the empty RD equation, which you can take see it contains here and create mean age.

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00:33:01.230 --> 00:33:08.250

Neil R. Powe: sex and also the race coefficient and on the right hand side, what you see one that on.

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00:33:08.640 --> 00:33:20.280

Neil R. Powe: The X axis this estimated gsr and then the difference between measured and estimated gsr showing the bias and measurement and what you see is a large at higher levels of vfr.

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00:33:20.820 --> 00:33:35.310

Neil R. Powe: Actually, the scatter is is quite quite large and at lower levels, and I think this speaks to you know the the precision that we all often attached to.

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00:33:36.420 --> 00:33:46.800

Neil R. Powe: You know I would say it appropriately attached to gsr measurement, but the question is, is this race based or is this evidence, based medicine.

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00:33:48.690 --> 00:33:55.770

Neil R. Powe: And so, one show you a porn thing about how long it takes for medical check this change because.

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00:33:56.340 --> 00:34:08.250

Neil R. Powe: Even though the equation were first developed in 1999 and then there was a big push to use the equation, rather than just looking at Sam create me and alone.

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00:34:08.820 --> 00:34:19.170

Neil R. Powe: And it took eight years to get 50% penetration of egfr recording and US laboratories is shown in in the lower left hand graph and slide.

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00:34:20.550 --> 00:34:25.200

Neil R. Powe: So it takes time for practice to change and then in 2009.

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00:34:26.250 --> 00:34:28.050

Neil R. Powe: The developers of the equation.

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00:34:29.490 --> 00:34:43.350

Neil R. Powe: did some refinement they actually got together a larger group of people, and also included even not only Women in Black but extra few Asians and Hispanics.

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00:34:43.920 --> 00:34:52.470

Neil R. Powe: We estimated equation and got a modified coefficient of one for race of 1.1 6000 from one point to one.

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00:34:53.280 --> 00:35:06.630

Neil R. Powe: And so here's some of the data about the ck the EPI equation derivation you can see, they had a development cohort than a validation cohort everyone had measured tfr as well as Co create me.

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00:35:07.890 --> 00:35:19.800

Neil R. Powe: blacks were 30% of the derivation cohort to 12% of the validation cohort a large number of them were from the African American studies kidney disease races this it was self recorded.

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00:35:21.180 --> 00:35:41.730

Neil R. Powe: And in the extra see the the data set coefficients and that's actually a paper this paper by Stevens that that actually showed that there was possibly a coefficient also for agents and perhaps even Hispanic and Native Americans that were put together as a group.

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00:35:42.810 --> 00:35:53.460

Neil R. Powe: Because of the small numbers of people steadied I think the author stuff that they they had the normalized or values to the reference Andrew.

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00:35:54.060 --> 00:36:05.370

Neil R. Powe: We do know, however, there's some data that egfr equations did not perform well in some populations from Africa and Asia, with the race coefficient included.

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00:36:06.750 --> 00:36:07.260

Neil R. Powe: So.

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00:36:10.440 --> 00:36:23.940

Neil R. Powe: You know, this is an attempt to get a broader population in their mentor regression and then 2012 and I know my journal they publish a ck the EPI combined equation now, including.

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00:36:24.840 --> 00:36:35.370

Neil R. Powe: serum status see, in addition to the marker serum creativity and not surprisingly, the risk coefficient became smaller but was still President 1.08.

200

00:36:36.360 --> 00:36:52.890

Neil R. Powe: And you know in 2013 we finally in the United States achieved 90% penetration of egfr recording in US laboratories okay that's how long it took for the uptake of reporting gsr.

201

00:36:53.580 --> 00:37:07.860

Neil R. Powe: And in that same year, the kidney disease, improving global outcomes guidelines committee standardized the assessment of kidney function incorporating these equations into practice guidelines.

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00:37:09.750 --> 00:37:12.210

Neil R. Powe: what's interesting also, if you look at.

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00:37:13.980 --> 00:37:14.940

Neil R. Powe: agents are being used.

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00:37:16.590 --> 00:37:21.240

Neil R. Powe: The predominant equation is the md our equation developed into.

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00:37:22.320 --> 00:37:30.300

Neil R. Powe: In 1999 and only a third laboratories reporting that more modernized ck tip equation.

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00:37:31.650 --> 00:37:39.540

Neil R. Powe: So i'd like to talk a little bit about another some other interesting work of what about CRM create mean and.

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00:37:40.320 --> 00:37:52.050

Neil R. Powe: African ancestry genetic African answer shoes two studies that really address the site elegance daddy's one comes out of Mount sign on the left hand panel and a large database didn't have.

208

00:37:52.860 --> 00:38:11.400

Neil R. Powe: That was pulled together for genetic studies of diverse population and what the study is it on the X axis, it says, the proportion of African ancestry and on the y axis the log of serum creativity and this and in both Hispanic and latinx.

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00:38:13.620 --> 00:38:24.780

Neil R. Powe: People, as well as African Americans shows that there is a linear relation between the proportion of African ancestry and CRM reality.

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00:38:26.070 --> 00:38:34.170

Neil R. Powe: The study on the right was done by Carmen peralta my institution, who was working with the Cardio steady.

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00:38:35.340 --> 00:38:54.900

Neil R. Powe: On cardiac risk factors and young adults and she did the same thing, where she looked at the odds ratio of an elevated serum Ariadne in both men and women by African ancestry if you look at the adjusted odds ratio panel on the far right.

212

00:38:55.920 --> 00:39:00.090

Neil R. Powe: You can see that a higher proportion of African ancestry.

213

00:39:02.130 --> 00:39:03.390

Neil R. Powe: The the higher.

214

00:39:04.560 --> 00:39:14.370

Neil R. Powe: elevated to create it for both men and women, much more kind of dose response actually in in men.

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00:39:15.870 --> 00:39:17.280

Neil R. Powe: Well, why might that be.

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00:39:18.480 --> 00:39:37.350

Neil R. Powe: Again, think about this, so I looked at some study about the car spawned it's between self reported race and ethnicity and genetic ancestry and my colleague neal rich here at ucsf long been doing working in their genetics did this study of 100,000 people in Kaiser permanente.

217

00:39:38.550 --> 00:39:56.460

Neil R. Powe: And you know, he asked people, what are you know, have you self identify in terms of your race, ethnicity and then he had genetic ancestry data from DNA from home and 100% who identified this European or West station had European West as you asked us.

218

00:39:57.480 --> 00:40:00.450

Neil R. Powe: And then I put here in green that nearly.

219

00:40:01.650 --> 00:40:09.480

Neil R. Powe: 100% self identifying it Africa African or African American had African ancestry.

220

00:40:10.620 --> 00:40:14.070

Neil R. Powe: So they're able, you know African Americans are able to.

221

00:40:15.120 --> 00:40:17.580

Neil R. Powe: identify the day they have African ancestry but.

222

00:40:19.440 --> 00:40:24.720

Neil R. Powe: You would not surprising 91% had some European ancestry.

223

00:40:25.800 --> 00:40:38.610

Neil R. Powe: And we now know from you know modern genetic states that about the proportion of African ancestry and African Americans across the United States is somewhere between 70 and 80%.

224

00:40:39.210 --> 00:40:53.280

Neil R. Powe: But it varies actually by geographic region, and we know that this reflects historical unwilling, and in recent meeting practices and the effects of Jeanette geography on genetic variation.

225

00:40:54.930 --> 00:41:08.310

Neil R. Powe: But it's important to realize that ancestral genes may or may not have important functional significance and it's worthy of morstead so I look at it this way when these associations.

226

00:41:09.390 --> 00:41:17.970

Neil R. Powe: With ancestry you know, or even you say race do not prove causality of the possible drivers of creating.

227

00:41:18.750 --> 00:41:29.730

Neil R. Powe: or vfr because when we're hearing it not knowing what's happening underlying this when we're peering through the lens of race and ethnicity, you could be looking at today, again, especially.

228

00:41:30.120 --> 00:41:35.520

Neil R. Powe: When we look through the lens of genetic ancestry you could be looking at race because they're hiring highly correlated.

229

00:41:36.300 --> 00:41:44.430

Neil R. Powe: And so the reasons that these create mean elevations you know, are they biological you know a lot of people put.

230

00:41:44.970 --> 00:41:57.000

Neil R. Powe: their faith and muscle mass and probably get appropriately so in to build their differences and tubular secretion extra means elimination to push secretion maybe also affected by drugs and then there's diet.

231

00:41:58.110 --> 00:42:11.520

Neil R. Powe: Which, which is certainly not biological animal diets can race co creating levels, so this is still poorly understood, so we really need more work in this area.

232

00:42:12.210 --> 00:42:29.100

Neil R. Powe: So let's go back to the timeline in 2017 2018 saw the first calls for race removal from egfr report and in 2020 we saw more calls and institutions began removing race from egfr reporting.

233

00:42:29.880 --> 00:42:41.430

Neil R. Powe: And then the national kidney foundation, the American society of the fraud decided to put together a task force for this and in 2021 the task force.

234

00:42:42.900 --> 00:42:49.590

Neil R. Powe: Just a month ago released an interim report i'll share that with you in a minute, but let me, let me make some key points here.

235

00:42:50.460 --> 00:43:05.940

Neil R. Powe: First disparities existed before the race equations were quick in existence, as I showed you second equation development followed up on health statistics data.

236

00:43:06.540 --> 00:43:13.410

Neil R. Powe: and evolved to increase diversity and to reflect the non gsr determinants of Sierra creating.

237

00:43:14.370 --> 00:43:29.010

Neil R. Powe: Really, you know that's what we've been calling for for decades to have more diverse groups in clinical trials and clinical research that that the populations that we treat we're relying on data that includes all of them.

238

00:43:30.030 --> 00:43:30.570

Neil R. Powe: And then.

239

00:43:31.800 --> 00:43:41.520

Neil R. Powe: I if you know I emphasized that research standards adoption into practice takes time long time to get uptake of even recording of.

240

00:43:42.330 --> 00:43:55.800

Neil R. Powe: Jia far and practice, and I want to make the point that much of what's going on and race, removing and report is race we're moving in reporting, not in the underlying calculations.

241

00:43:56.520 --> 00:44:04.380

Neil R. Powe: But, but how things are reported out and i'll show you more than that so So this is the article that was published in April night.

242

00:44:05.220 --> 00:44:20.790

Neil R. Powe: by the task force, I encourage all of you to read it and read that editorial written by it was published jointly by in American drone kidney disease and also told her consignment project editorial written by both of the editors.

243

00:44:22.110 --> 00:44:30.600

Neil R. Powe: These are the task force members, they include a variety of people that have done work around race and ethnic disparities body composition.

244

00:44:32.820 --> 00:44:37.350

Neil R. Powe: We have people in who've done working drugs and lab medicine, the frog ology.

245

00:44:38.850 --> 00:44:54.000

Neil R. Powe: A really diverse group, you know when my co chair and I got the committee Committee was appointed by the societies, but it was at there were there was something that was absent, and that was the presence of patients and.

246

00:44:55.230 --> 00:45:05.850

Neil R. Powe: We push to have two patients actually on the panel Glenda Roberts and curtis warfield may fit been very helpful in our deliberations.

247

00:45:06.510 --> 00:45:16.650

Neil R. Powe: So this is what the intro report says what we did we saw was a wide range of evidence and views with diverse representation, we had 16 sessions, where we heard from 90 people.

248

00:45:17.040 --> 00:45:35.700

Neil R. Powe: From 19 US State sing and countries in seven countries we held three Community forums that included trainees providers and patients and after that we assembled the evidence and looked at our own values, you know, based on almost 100 references.

249

00:45:36.780 --> 00:45:48.960

Neil R. Powe: And these statements really I think our cornerstone forging a path forward those statements are around equity of disparities race and racism gsr measurement estimation laboratory standardization.

250

00:45:49.590 --> 00:45:56.910

Neil R. Powe: and patient perspective and we came up with an inventory of 26 different approaches to estimating and reporting.

251

00:45:58.440 --> 00:46:07.770

Neil R. Powe: kidney function now i'm at the say if 26 different ways were used in practice.

252

00:46:09.000 --> 00:46:24.780

Neil R. Powe: We would have chaos and we are having chaos, I think now because of the standardization and the way that institutions are doing this we'll talk more about that, and then we came up with attributes that be considered and making final recommendation.

253

00:46:25.950 --> 00:46:36.540

Neil R. Powe: Among these alternative approaches, so that that's kind of our approach to do this, I want to go back to this article, because at the end of my article I wrote in the summer I said.

254

00:46:37.080 --> 00:46:49.530

Neil R. Powe: That the estimation of a central physiologic processes such as kidney function with variables that do not incorporate race and are more accurate than race is ain't worth the aspiration.

255

00:46:50.040 --> 00:46:59.160

Neil R. Powe: But those estimating tool should have equal or greater precision be Sally grounded in evidence on health outcomes and be acceptable to patients.

256

00:47:00.180 --> 00:47:10.650

Neil R. Powe: So I want to talk about some of the approaches and there's 26 approaches actually back in summer I kind of summarize them into kind of groups.

257

00:47:11.910 --> 00:47:32.520

Neil R. Powe: and of the possible ways we could get ourselves out of this crisis, I don't think we want to return to the past of just recordings here and create new levels alone that are are far less accurate were to go back to the coc off God or the gods used, you know in pharmacy for drug dosing.

258

00:47:34.050 --> 00:47:47.520

Neil R. Powe: And then measure tfr with i'll found is done in the research studies just takes it laborious and just takes too much time and it's really can't be used in in regular clinical practice.

259

00:47:48.570 --> 00:47:56.160

Neil R. Powe: So these in the green are really what I group of the approaches into and i'm going to go through each of these.

260

00:47:56.730 --> 00:48:06.750

Neil R. Powe: I laid them out in my article in a table in the appendix of the article you want to see that in more detail, so the first approach is the approach.

261

00:48:07.260 --> 00:48:13.140

Neil R. Powe: That I call the dominant race stranded, which is normalization the whites, and this is where.

262

00:48:13.680 --> 00:48:30.060

Neil R. Powe: The race coefficient it's discarded from the equation, and we report, the non black estimates for all i've listed a few of the institutions in the country that have done this well This removes race and reporting, but not in the computation.

263

00:48:31.530 --> 00:48:40.080

Neil R. Powe: And it's my point of view that it's discriminatory because it ignores to create new data on person for black person's from studies included.

264

00:48:40.710 --> 00:48:55.110

Neil R. Powe: In equation derivation and it's less likely accurate for blacks and so I believe that it it actually institutionalizes by doing this, the exclusion of black person's in research for clinical decision making.

265

00:48:55.860 --> 00:49:09.540

Neil R. Powe: And let me, let me just show you this with a metaphor, that we have the ck dsp equation with African American race, but we remove it, and what we're doing is we're removing.

266

00:49:10.050 --> 00:49:25.170

Neil R. Powe: The contract or discounting the contribution of the create new data contributed by 31% of blacks in the 26 pooled studies and normalizing that to the white creating value.

267

00:49:26.010 --> 00:49:37.500

Neil R. Powe: And I liken this you know, on the top to what the equation development, but then you know many of you may know who you know, maybe older people that.

268

00:49:38.070 --> 00:49:52.290

Neil R. Powe: In the audience that we had the framingham heart study for five decades it collected data on European Americans and put out, you know risk estimate equations that would generalize the entire population.

269

00:49:53.190 --> 00:50:06.030

Neil R. Powe: And in the 1990s, the US Government decided, well, we need a framingham study for African Americans today he started the Jackson heart study in Jackson Tennessee.

270

00:50:06.990 --> 00:50:21.600

Neil R. Powe: So you would say, well, if we do this practice what we're doing is we're just ignoring that data and we don't really care about the data on African Americans if if we don't use it decision make.

271

00:50:22.770 --> 00:50:34.500

Neil R. Powe: But I think the biggest issue and how we look at a change is what impact will it have on patients That to me is the crux of the issue.

272

00:50:35.100 --> 00:50:46.740

Neil R. Powe: What are the potential clinical and health consequences, we know that removing the race coefficient will lead to an increase in persons who have chronic kidney disease and it more severe.

273

00:50:48.150 --> 00:51:03.840

Neil R. Powe: But what does that mean, does that mean in the past, it was under diagnosis, or with change is it over diagnosis, and so we have to look at the balance sheet, we have to look what are the benefits and harms of removing race, so the benefits.

274

00:51:04.950 --> 00:51:13.110

Neil R. Powe: As as the narrative has gone, is that it would increase referral to a specialist or access to the transplant waiting list and may increase also.

275

00:51:13.440 --> 00:51:29.160

Neil R. Powe: Access to medicare services or lead to more aggressive ck the management for disease that I showed you affects African Americans in terms of the severe stages, much more than whites and earlier age, but the harms.

276

00:51:30.240 --> 00:51:41.010

Neil R. Powe: Also, are that it might lead to less kidney donation African Americans, because they would deem to have more ck D.

277

00:51:41.820 --> 00:51:46.020

Neil R. Powe: and, more importantly, I think how it might affect drug use or toasting.

278

00:51:46.650 --> 00:51:55.980

Neil R. Powe: Drugs for which, for example, pain medications there are numerous studies showing that African Americans are under dosed with pain medications.

279

00:51:56.370 --> 00:52:06.750

Neil R. Powe: are also dated dated in black women, showing that black women who have ovarian cancer resume smaller doses of carbo platen therapy for ovarian cancer.

280

00:52:07.230 --> 00:52:18.390

Neil R. Powe: And it could lease the doctor decrease contrast imaging procedures, access to clinical trials and even anxiety from labeling with a ck D diagnosis actually could affect even.

281

00:52:19.020 --> 00:52:38.700

Neil R. Powe: Life things like life insurance, and this was one of the studies done by my colleague maka in anya the University of Pennsylvania, that really I think shook shook the United States because this thought experiment show that if you remove the race coefficient.

282

00:52:39.780 --> 00:52:47.400

Neil R. Powe: You could actually you know the difference between two egfr measurements could flip people from.

283

00:52:48.570 --> 00:52:54.060

Neil R. Powe: Having a nephrology referral or a kidney transplant waitlist eligibility.

284

00:52:55.440 --> 00:53:07.470

Neil R. Powe: So that drew a lot of attention, but if you go and you look at the data about waitlist and I, and I still do weightlifting for African Americans.

285

00:53:08.640 --> 00:53:22.020

Neil R. Powe: was less before the race equations for us and this shows when they were introduced and the line for African Americans being below others if anything it's gone up.

286

00:53:22.800 --> 00:53:40.530

Neil R. Powe: So you can't really say that this called the equation caused this you know this this phenomena, if anything, it's going up and in in this data from the United States, we have data system we go further into the future, this just reiterates that.

287

00:53:42.120 --> 00:54:02.520

Neil R. Powe: And you can also look at this and trends in nephrology referral, and you see here that, in fact, those trends have remained the same and what's interesting where there's no race coefficient and Hispanics the rates of the prodigy or two for ology referral haven't gotten better as well.

288

00:54:03.540 --> 00:54:08.730

Neil R. Powe: But here how many African Americans would be effective on the harms and the benefit side.

289

00:54:09.420 --> 00:54:28.890

Neil R. Powe: And you can see if, in terms of ck D diagnosis kidney donation and drug dosing there are a large number of much for large number of individuals that might be harmed then actually might benefit from specialist referral or kidney transplant or medicaid medicare coverage for services.

290

00:54:29.910 --> 00:54:35.610

Neil R. Powe: This is a recent study published couple weeks ago at a Stanford showing the number of black adults.

291

00:54:37.320 --> 00:54:56.280

Neil R. Powe: That with a prescription that might require those adjustment for kidney function and you could see for metformin and gabba pitting that 24% of 41% of total medication users, whose egfr with rat race adjustment crosses the threshold that could lead.

292

00:54:57.360 --> 00:55:06.300

Neil R. Powe: To you know to changes in dosing for that medication it's also been shown for a variety of other medications here to.

293

00:55:07.410 --> 00:55:17.850

Neil R. Powe: The employee and new dose reduction or contraindications when you remove race from the equation, and this is an interesting.

294

00:55:18.750 --> 00:55:27.300

Neil R. Powe: Steady outcome steady you know before on metformin you know before we move forward with with first approved by the FDA.

295

00:55:28.140 --> 00:55:43.500

Neil R. Powe: The guidelines were based on CRM create me and alone, without any grace, you know adjustment year and this that he tried to look at them to change what happened after the label change to reporting em gee of egfr.

296

00:55:44.340 --> 00:56:05.640

Neil R. Powe: For metformin prescribing so there was a disparity when you use serum crappy low doses a gsr for the prescription of metformin and when then egfr was used with the race coefficient those disparities actually were eliminated from the bottom slide just shows you a control group for.

297

00:56:06.780 --> 00:56:07.380

Neil R. Powe: For.

298

00:56:08.820 --> 00:56:14.310

Neil R. Powe: sulphonylurea sewing this wasn't just due to changes in overall practice.

299

00:56:15.330 --> 00:56:15.930

Neil R. Powe: So.

300

00:56:17.490 --> 00:56:34.260

Neil R. Powe: that's race removal, what about other approaches so other approaches that have been suggested substituting the low muscle mass and high muscle mass for non black and black and actually a group of petitioners lobby to change this at my hospital.

301

00:56:35.400 --> 00:56:42.630

Neil R. Powe: And what I believe it removes racing reporting it recognizes the participation of blacks and derivation steady.

302

00:56:43.260 --> 00:57:00.420

Neil R. Powe: But the problem with this is it assumes races a proxy for muscle mass and thereby stereotyping all blacks is having high muscle mass and it's just less likely accurate for blacks so institutionalizes stereotyping.

303

00:57:01.980 --> 00:57:11.100

Neil R. Powe: i'm so um here's another approach which I call the race plus range reporting report to values currently generated by the equation.

304

00:57:11.550 --> 00:57:16.590

Neil R. Powe: But don't openly tag them with race to scriptures descriptor so you.

305

00:57:17.340 --> 00:57:27.900

Neil R. Powe: And this was non existent done by a variety hospitals actually beth Israel deaconess medical Center did this back in 2017 it's one of the first institutions to take race out of JFK airport.

306

00:57:28.620 --> 00:57:42.390

Neil R. Powe: And it removes racing reporting recognizes the participation of blacks the underlying race distinction remains below the surface and at least clinical correlation nephrology consultation and shared decision making to ordering physicians.

307

00:57:44.760 --> 00:58:05.250

Neil R. Powe: And I think it emphasizes this data that one measure gsr differences in metric tfr over time and this study it won't go into detail, but it says that 12% of values of measure gsr at two different times.

308

00:58:06.690 --> 00:58:24.240

Neil R. Powe: You know, can have differences, particularly at higher vfr level so speaks to really even how precise gsr measurement and stable, it is you know, in a fizzy as a fizzy dynamic physiologic process.

309

00:58:25.260 --> 00:58:33.870

Neil R. Powe: So then there's the blender race there this This is where you would develop a new equation from the data that has been used before.

310

00:58:34.800 --> 00:58:46.530

Neil R. Powe: And you essentially blend the race values together that removes race, it does require agreement on the racial composition of the sample.

311

00:58:47.130 --> 00:58:59.460

Neil R. Powe: And it's interesting it's less likely in the core forms likely less performance for both black and non black patient, but it may be equitable and acceptable.

312

00:59:00.300 --> 00:59:15.450

Neil R. Powe: And then there is newer graceless markers such as suspect and see for which race doesn't add greater precision standardization is improving, for these they are higher cost, they can be three times higher cost of staffing see versus.

313

00:59:16.920 --> 00:59:24.840

Neil R. Powe: Creativity and they're not widely available now and, importantly, we know so much about serum cretney but.

314

00:59:25.740 --> 00:59:42.000

Neil R. Powe: Sarah to Staten see has been studying ambulatory populations, and it has uncertain performance and very ill patients, but we could use this when decision making could affect health in a sequential fashion, after using creativity.

315

00:59:43.110 --> 00:59:53.490

Neil R. Powe: So let me summarize what i've tried to talk to you about today that race and kidney function is a political, social and biologic conundrum.

316

00:59:54.210 --> 01:00:14.220

Neil R. Powe: The elimination of race for egfr is a worthy aspiration, but the consequences are far reaching making changes is not a trivial task we seek the correct diagnosis not under overdiagnosis and we want to avoid doing more harm than good.

317

01:00:15.240 --> 01:00:29.430

Neil R. Powe: And, as I showed you egfr equations are likely as a major cause of disparity and weightlifting or spurt specialist referral there's evidence that they actually helped eliminate metformin describe that prescribing disparities.

318

01:00:30.630 --> 01:00:38.520

Neil R. Powe: And I think the danger now we have is that the use of many approaches across the US will make it difficult to understand.

319

01:00:38.940 --> 01:00:50.220

Neil R. Powe: gsr change when a patient receives care in different settings or institutions in Boston now you could be in one hospital and then go to a hospital three blocks away.

320

01:00:50.940 --> 01:00:59.190

Neil R. Powe: And you could have kidney function diagnose that one hospital, but not in another, and that I think it's just chaos.

321

01:00:59.850 --> 01:01:09.330

Neil R. Powe: And to some approaches promulgated to remove race institutionalized discrimination and we're may be racist themselves and the solution should be consistent.

322

01:01:09.750 --> 01:01:24.390

Neil R. Powe: durable evidence based and device with the input of priority of stakeholders and what we really need to do is try to elucidate better the relation between biology, social and environmental factors.

323

01:01:24.930 --> 01:01:40.470

Neil R. Powe: um you know if you think all this is fuzzy yo its social factors are also very fuzzy and difficult to study and we just need more research that that brings all of what we know about science together.

324

01:01:42.210 --> 01:01:58.500

Neil R. Powe: I show this because i'm the slide because you know I i've been involved in disparities worked with kidney disease looking at you know specialist furrow transplantation differences in diet differences to access to.

325

01:01:59.670 --> 01:02:07.830

Neil R. Powe: Different procedures were African Americans and other racial and ethnic minorities and.

326

01:02:08.730 --> 01:02:16.110

Neil R. Powe: You know I think what bothers me a little, is that what we need to do is is that health equity is the goal.

327

01:02:16.830 --> 01:02:34.200

Neil R. Powe: And everybody now there site is set on these egfr equations as a cause of disparity, but we know that the drivers of these disparities are complex and there are many more that probably contribute to.

328

01:02:35.160 --> 01:02:50.040

Neil R. Powe: That you know not us not achieving health equity and that's where we really need to put our focus, so I want to thank everyone for listening in if we have some time off to you for questions.

329

01:02:52.770 --> 01:02:56.790

Alex Jepsen: All right, thank you so much, Dr PO for that fantastic talk, we do have.

330

01:02:57.390 --> 01:03:09.030

Alex Jepsen: A few minutes for questions, and so, if anyone has any questions, please go ahead and send them to me in the chat or you can also message me and request that you ask your own question.

331

01:03:09.540 --> 01:03:15.570

Alex Jepsen: One that came in earlier that wants to go ahead and start with was Dr Joe you mentioned multiple times.

332

01:03:16.440 --> 01:03:27.540

Alex Jepsen: You know, having input from patients themselves as part of these groups and making this decision just if you could lay out more what was the impetus for having the patients involved themselves.

333

01:03:27.990 --> 01:03:36.300

Alex Jepsen: And, and also does it matter what the like at the composition of the patients involved in those discussions are right.

334

01:03:37.020 --> 01:03:49.260

Neil R. Powe: Good good question, so I do think, I do think it matters that you know the reason is is is, we need to always keep the patient in the Center.

335

01:03:49.800 --> 01:04:12.420

Neil R. Powe: And the narrative and the people who were putting out the narrative absent was the patient's quotes that there was nowhere was the patient voices in in this this wasn't a call by you know patients, you know to dis dismantle.

336

01:04:13.440 --> 01:04:19.530

Neil R. Powe: Racism race reporting, although you know many on both sides have jumped into this debate.

337

01:04:20.820 --> 01:04:23.370

Neil R. Powe: The reason that we included.

338

01:04:24.390 --> 01:04:42.660

Neil R. Powe: African American patients on the task force, because the central issue here was for African Americans should African Americans have a different value than others, although you know, the majority of data in the equation development was on.

339

01:04:44.850 --> 01:04:45.750

Neil R. Powe: was on.

340

01:04:50.310 --> 01:05:06.480

Neil R. Powe: You know one or white as as the largest group um I will say that on the task force there, there are a number of people of Latin X descent, you know who are experts.

341

01:05:07.830 --> 01:05:17.580

Neil R. Powe: And, not all of them are actually physicians they aren't patients but they we chose them for their expertise of having working in this area.

342

01:05:18.750 --> 01:05:24.330

Neil R. Powe: And we've heard you know from a wide group we've heard from trainees, we heard from.

343

01:05:25.980 --> 01:05:34.260

Neil R. Powe: Professionals health professionals and and we heard from patients as well, so we really you know wanted to incorporate.

344

01:05:35.430 --> 01:05:47.070

Neil R. Powe: A lot of the voices out there, rather than have one group dominate the conversation and that conversation not be drawn by evidence.

345

01:05:50.400 --> 01:06:01.650

Alex Jepsen: Right Thank you so much, another one of the questions was relating to just that it was interesting to see how different institutions what approach they took as you laid out in your in your chart.

346

01:06:02.190 --> 01:06:10.440

Alex Jepsen: Did you have any information on how each institution came to the decision of how they were going to report vfr yeah.

347

01:06:11.220 --> 01:06:15.210

Neil R. Powe: um I can't I don't.

348

01:06:16.320 --> 01:06:29.100

Neil R. Powe: I don't do is a process that each institution much of that process was actually led by trainees by medical students.

349

01:06:30.240 --> 01:06:33.000

Neil R. Powe: You know, predominantly i'm.

350

01:06:34.590 --> 01:06:44.610

Neil R. Powe: approaching it administration, the hospitals and saying this is race based medicine, we need to get rid of it, of course, you all know that.

351

01:06:45.930 --> 01:06:55.560

Neil R. Powe: This is, you know, this is not just in this call for restorative justice and racial.

352

01:06:57.090 --> 01:07:11.820

Neil R. Powe: Justice is not just in the health sector as a result of you know, the the deaths of numerous African Americans, you know by the police, which during this pandemic.

353

01:07:12.900 --> 01:07:26.700

Neil R. Powe: You know, start this up and so um you know this call for restorative justice everywhere, so this doesn't not only medicine, but I think well intentioned and well intentioned effort.

354

01:07:27.960 --> 01:07:44.820

Neil R. Powe: But as you see, I i've tried to explain how not looking at all the ramifications and consequences could lead to unintended unintended consequences that could harm patients.

355

01:07:46.320 --> 01:08:00.480

Neil R. Powe: And there was a process each of the processes has are very different, I know a little about the beth Israel it did it in 2017 and they convened, it was actually brought up by medical students at Harvard Medical School and.

356

01:08:01.530 --> 01:08:16.890

Neil R. Powe: Mel Mel they honing have long talk pathophysiology we don't pathophysiology at Harvard Medical School took this to the beth Israel and they discussed it brought in multiple stakeholders.

357

01:08:18.060 --> 01:08:23.340

Neil R. Powe: and discuss how they might approach this and they came up with that graceless range reporting.

358

01:08:26.640 --> 01:08:33.270

Alex Jepsen: hey Thank you so much, I have another pre tax question here, and then someone else would like to unmute for a question after that.

359

01:08:33.810 --> 01:08:47.130

Alex Jepsen: This first question is, do you ever recommendation about how to address egfr and multicenter clinical trials so as an example and it Kobe trial, we were a part of this year, each Center was instructed to use whatever equations they liked.

360

01:08:47.460 --> 01:08:55.260

Alex Jepsen: Provided the Center was internally consistent, given the different approaches a different institutions this didn't seem like an optimal optimal approach.

361

01:08:56.400 --> 01:09:06.270

Neil R. Powe: I certainly agree with that I couldn't agree with that more this has led to not only confusion and clinical practice, but it will lead to confusion research.

362

01:09:06.630 --> 01:09:15.480

Neil R. Powe: and any changes that have to be made in the future, it has it has ramifications for, for example.

363

01:09:16.380 --> 01:09:21.690

Neil R. Powe: Where you to remove the race coefficient it would lead to more individuals having ck D.

364

01:09:22.170 --> 01:09:30.720

Neil R. Powe: In certain trials for certain drugs that would exclude people from the trial, so you would exclude African Americans from a trial right.

365

01:09:31.050 --> 01:09:54.330

Neil R. Powe: Where you might have to in the midst of changing the egfr definition might then say, well, we, we have to take them out of the stead right um, and so this this really creates turmoil in in research as well that's why we really need to just.

366

01:09:55.380 --> 01:10:03.810

Neil R. Powe: Wait let's get a recommendation that we all can be comfortable with a unified recommendation for the country.

367

01:10:05.310 --> 01:10:21.900

Neil R. Powe: You know so so that we don't have all this variation out there and I worry, as you know, the the variation hurting patients that's that's the goal here right not to provide health equity for patients.

368

01:10:23.190 --> 01:10:24.420

Neil R. Powe: I think my good friend.

369

01:10:25.470 --> 01:10:26.190

Neil R. Powe: Rashid.

370

01:10:28.650 --> 01:10:31.290

Rasheed A Balogun: Thank you so much, Neil is so good to see you.

371

01:10:31.290 --> 01:10:36.870

Rasheed A Balogun: Again, and hopefully we'll be back to doing these missions in person soon.

372

01:10:38.370 --> 01:10:52.530

Rasheed A Balogun: I have to really quick questions, one is that there's a whole big continent of Africa that has patience and there's a lot of back and forth going on there, based on your walk.

373

01:10:55.620 --> 01:11:10.350

Rasheed A Balogun: The walk the walk that you are doing in kf on the SN and my question is is there hasn't been any look at what the modifications would be.

374

01:11:11.040 --> 01:11:27.450

Rasheed A Balogun: on the African continent of what your walk is bringing up up and the other is is there i'm vaguely aware there's one of the editors in my different be the editor in chief of the mindset.

375

01:11:28.260 --> 01:11:28.830

Rasheed A Balogun: might be.

376

01:11:28.950 --> 01:11:34.530

Rasheed A Balogun: One of the people that are pushing against this business of i'm.

377

01:11:37.590 --> 01:12:00.090

Rasheed A Balogun: not considering race at all when we're doing clinical work, do you think the man presentation of a patient as 24 year old African American man who come, who comes to the ED for this should we even be mentioned in grace at all when we're presenting a patient in the clinic call realm.

378

01:12:01.110 --> 01:12:17.850

Neil R. Powe: Okay, so two questions I think the first one was kind of How do people in other countries, you know that say the effort co or continents or or even like their studies in Brazil that show the use of the race coefficient doesn't work, the way it does, the United States.

379

01:12:19.230 --> 01:12:26.610

Neil R. Powe: I have to say that the task force is the national kidney Foundation and the American society nephrology.

380

01:12:27.030 --> 01:12:38.850

Neil R. Powe: So we're not making a recommendation for the world we are making a recommendation for the United States, but you know, as you know, when things get done here they you know.

381

01:12:39.240 --> 01:13:01.650

Neil R. Powe: They metastasize to other places, but that's not unusual like the FDA requires you know us studies, one on patients so and and I actually believe that you know we don't know that this could be social factors such as dietary practices that may be, you know, affecting this.

382

01:13:02.700 --> 01:13:14.970

Neil R. Powe: or other social life, I don't know the reason for for why we observed these differences in serum creativity, but they're real they're real and the question is, do we ignore them.

383

01:13:16.470 --> 01:13:24.090

Neil R. Powe: You know, completely ignore them and they could vary across different countries, so I don't I don't know what to do with that other than, say.

384

01:13:24.600 --> 01:13:33.840

Neil R. Powe: You know, we need, we need more studies in Africa right, I mean when we came out when the human genome was sequence that we began doing studies of.

385

01:13:34.200 --> 01:13:47.760

Neil R. Powe: ancestry we started out in your P in countries so European European ancestry became the norm, the norm and then people said well you know, we need to study Asians and Africans and.

386

01:13:48.240 --> 01:14:03.540

Neil R. Powe: You know, and then they get like Oh, that is, the mutant population, the norm is your period answer so we just need more studies that more studies and more information about that your second question.

387

01:14:04.890 --> 01:14:13.560

Neil R. Powe: Was the use of race, so I could tell you this, have you spent 23 years that at Johns Hopkins where we did exactly what you said, where we.

388

01:14:14.340 --> 01:14:31.110

Neil R. Powe: You know, said 24 year old African American male Thompson to the emergency room, you know with with weakness to you know serum potassium of six and is in end stage kidney failure and.

389

01:14:32.430 --> 01:14:54.150

Neil R. Powe: When I got to the west coast immediately we didn't use race at all and we don't use the race when describing it a patient in the chief complaint, where we do is we talk about we get to the social history we talk about what is what is a person to answer so where did they come from.

390

01:14:55.200 --> 01:14:59.040

Neil R. Powe: And that is part of the the social history.

391

01:15:00.150 --> 01:15:07.440

Neil R. Powe: So, with the feeling that we don't we don't want to bias or or put people down a heuristic that.

392

01:15:08.460 --> 01:15:22.050

Neil R. Powe: You know around around race when you know thinking about you know diagnosing someone so that's the way we do and I like I actually think that's.

393

01:15:22.800 --> 01:15:34.080

Neil R. Powe: A more thoughtful approach but i've seen it, you know seen it on on different coasts and it's different in the different institutions so that's what I that's what I would say thank you.

394

01:15:37.710 --> 01:15:42.510

Alex Jepsen: Right I believe any any other questions, Dr kusa were you wanting to ask a question.

395

01:15:42.810 --> 01:15:49.260

Mark Okusa: Yes, i'd like to ask a question, first of all um you know Thank you so much for a terrific talk and for taking the time to.

396

01:15:50.010 --> 01:16:04.020

Mark Okusa: To to virtually come here to charlottesville you know serum craning has been around for such a long time and i'm old enough to know that we've struggled with it from the get go and and.

397

01:16:05.250 --> 01:16:16.470

Mark Okusa: And in my field, the acute kidney injury row we've struggled with serum kraton si K D world has to and we've studied so much in terms of what you're doing and others.

398

01:16:17.490 --> 01:16:22.050

Mark Okusa: Yet we still deal with this flawed parameter.

399

01:16:23.160 --> 01:16:30.210

Mark Okusa: And I understand that we know so much about it, we want to continue to to tweak it and learn how to use it.

400

01:16:30.720 --> 01:16:38.070

Mark Okusa: But why not just cut bait and try to find something that is better, you know you've mentioned system and see but the cost of.

401

01:16:38.760 --> 01:16:50.970

Mark Okusa: Why not improve that in terms of cost real time gsr that's what really, really, one is a real measure of gsr, why not just focus our efforts on that, rather than working with something that's so flawed.

402

01:16:52.080 --> 01:17:12.000

Neil R. Powe: uh huh no, I think I think that's important we we should be moving with the science, I mean there's a you know, we know that actually using multiple markers it's far it's far more accurate and there was a steady with beta trace protein and.

403

01:17:13.170 --> 01:17:16.050

Neil R. Powe: A variety of other markers.

404

01:17:17.370 --> 01:17:30.960

Neil R. Powe: And it it performs very well, the problem is those those things those tests and essays aren't available in hospitals throughout the country, so we would have the year up to do that.

405

01:17:32.160 --> 01:17:43.890

Neil R. Powe: And you know real time gsr approaches, you know, measured novel approaches using measured through the skin are showing some promise so.

406

01:17:44.430 --> 01:17:53.970

Neil R. Powe: yeah we need, we need to push the frontier of that whether they're ready for prime time and whether they can be rolled out now.

407

01:17:54.360 --> 01:18:05.310

Neil R. Powe: In response to the calls, you know for Racial justice, I did I don't think we can change that over overnight, as I showed you practice takes a long time to change.

408

01:18:05.880 --> 01:18:20.940

Neil R. Powe: Even if we have the will to do it there's so much inertia out there and I think even when our task force comes forth with something we're going to need really strong implementation efforts to get uptake of.

409

01:18:22.140 --> 01:18:27.570

Neil R. Powe: Recommendation so um I love what you're saying let's let's.

410

01:18:28.440 --> 01:18:41.730

Neil R. Powe: New you know search for for new markers that don't have these flaws, I think, as we study more things we're going to find they have more they have flaws in and of themselves too, but that science that that is science and evidence and.

411

01:18:42.150 --> 01:18:47.820

Neil R. Powe: You know the evolution of science and we need desperately need to do that.

412

01:18:49.680 --> 01:18:50.130

Mark Okusa: Thank you.

413

01:18:53.040 --> 01:18:56.910

Alex Jepsen: Right, I think we're about the end of the time, are there any last questions.

414

01:19:00.090 --> 01:19:10.830

Neil R. Powe: Well, thank you all for inviting me pre Memorial Day, and I hope everyone has a safe and you know happy Memorial Day than last year, so.

415

01:19:11.550 --> 01:19:14.850

Alex Jepsen: Thank you so much for coming Dr Paul it's been a pleasure to listen to you today.

416

01:19:15.780 --> 01:19:17.610

Neil R. Powe: Thank you, my pleasure.

417

01:19:17.970 --> 01:19:18.660

Mark Okusa: Thank you, Neil.