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RESEARCH ARTICLE

# Beyond Race: Toward an Ethically Integrated Model of Healthcare Justice

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## ABSTRACT

Despite advances in medicine, race continues to be used as a diagnostic and therapeutic heuristic in clinical practice, perpetuating harmful health disparities. This article examines how Dr. Andrea Deyrup's pioneering work at Duke University has exposed the scientific inadequacy of race-based medicine, demonstrating that racialized health disparities stem from socioeconomic and structural determinants rather than inherent biological differences. Drawing on ecosocial theory, liberation theology, and the therapeutic vision articulated in my work at jyungar.com, we propose a healing model that centers justice, narrative presence, and sacred advocacy—one that displaces racial typologies with relational, context-based care that honors the patient as sacred text.

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## Introduction

Gilbert and DeCaille emphasize that achieving health justice requires addressing fundamental structural issues: "segregation, poverty, quality education, and chronic unemployment uniquely affect communities of color and have shortened the life expectancy of Black males." [1]. These interconnected systems of oppression "pose a set of intersecting risks and reflect systemic injustices that can only be changed with meaningful and committed partnerships, collaborations, and community engagement that seek to achieve equity and systemic reform by undoing racism embedded within these structures." [1]

This systemic approach aligns with the theological understanding of tikkun olam—the sacred work of repairing the world. Medical practice becomes part of this repair work when it recognizes that individual healing cannot be separated from community healing, and that clinical interventions must address the social body alongside the individual body. As I have argued in my work on "The Profit Paradox" and "Capitalism and Health Care," the commodification of healing perpetuates the very inequities that sacred advocacy seeks to address.

The health justice movement thus provides a practical framework for implementing sacred advocacy at scale. Rather than viewing community engagement as an add-on to clinical care, this approach recognizes that authentic healing requires what Gilbert and DeCaille call "meaningful and committed partnerships" that address root causes of illness [1]. This partnership model transforms healthcare from a technical service industry into a collaborative movement for social transformation.

The persistence of race-based diagnostic assumptions in medicine exemplifies a crisis of both science and ethics. Medical textbooks and board exams continue to teach aspiring doctors that certain races are more prone to specific illnesses, from cystic fibrosis in white patients to sickle cell disease in black patients, despite mounting evidence that these associations are rooted in 19th-century beliefs rather than contemporary science [2]. This article synthesizes the foundational work of Dr. Andrea Deyrup and other scholars to expose the harms of race-based medicine while proposing a redemptive vision grounded in justice-oriented healing that treats each patient encounter as a sacred act of interpretation and repair.

### The Scientific Dismantling of Race-Based Medicine

Dr. Andrea Deyrup, a professor in the Department of Pathology at Duke University and co-editor of Robbins Basic Pathology,

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has been at the forefront of challenging race as a legitimate biological variable in medicine [3]. Her journey began when a medical student asked for clarification of racial disparities in hypertension, launching a field-defining investigation that revealed how medical education perpetuates scientifically unfounded racial categories.

Deyrup argues that race-based medical guidelines often misdirect care and overlook the true causes of health disparities—namely, structural racism and socioeconomic deprivation. In her influential New England Journal of Medicine article with Joseph L. Graves Jr., she demonstrates that while health disparities are real, they are "wrongly attributed to innate racial biology rather than to the lived consequences of inequality" [3].

Working alongside evolutionary biologist Joseph L. Graves Jr.—the first African American to earn a PhD in evolutionary biology—Deyrup has presented to nearly 30 institutions in various clinical departments, fundamentally challenging medical education's approach to race [3]. Through her website pathologycentral.org, she offers videos for each disease entity associated with socially defined race in the 10th edition of Robbins Basic Pathology, which she's revising with particular focus on racial equity [4].

## The Evidence Base Against Biological Race

Joseph L. Graves Jr. explains that "diseases fall into several general categories," with simple genetic diseases varying in prevalence globally but being generally rare because mutations that impact evolutionary fitness are driven to low frequencies by natural selection [5]. The mutation rate in humans is relatively constant across populations, undermining claims of fundamental racial differences in disease susceptibility [6].

Research has exposed the disturbing consequences of race-based thinking: in a 2017 analysis of widely used medical test preparation materials, Deyrup found that nearly every time Native Americans were mentioned, it was in the context of a "Native American disease," while white patients were mentioned 86% of the time—far more than their 62% share of the U.S. population [7]. This centering of whiteness as medical norm leads to dangerous diagnostic delays, such as an 8-year-old African American girl who went undiagnosed with cystic fibrosis for years because "African Americans don't get cystic fibrosis" was the prevailing medical wisdom [7].

## The Social Construction of Medical Categories

The critique of race-based medicine gains additional depth when viewed through the lens of scholars who have examined how medical discourse creates and maintains social categories. Thomas Szasz's analysis of the "myth of mental illness" provides a parallel framework for understanding how medicine transforms social problems into individual pathologies [8]. Szasz argued that psychiatric categories function as mechanisms of social control, pathologizing behaviors that challenge social norms rather than identifying genuine medical conditions [8].

Similarly, race-based medicine transforms the social reality of structural racism into individual biological differences, thereby obscuring the true causes of health disparities. As Szasz demonstrated with mental illness, the reification of race as a medical category serves ideological rather than therapeutic purposes, allowing society to avoid addressing the systemic inequities that produce differential health outcomes [8].

## Socioeconomic Roots of Health Disparities

Nancy Krieger's ecosocial theory of disease distribution provides a comprehensive framework for understanding how people literally "embody" social conditions, generating inequitable population distributions of health [9,10]. The theory identifies major pathways through which discrimination becomes embodied: economic and social deprivation; excess exposure to toxins, hazards, and pathogens; social trauma; health-harming responses to discrimination; targeted marketing of harmful commodities; inadequate medical care; and ecosystem degradation [10].

Rather than viewing social factors as mere "determinants," Krieger's framework emphasizes "social determination"—an active process that asks "who is doing the determining?" [10]. This shift from passive risk factors to active social forces aligns with the theological understanding of healing as an act of justice that I have developed in my essays at jyungar.com, particularly in works such as "Sacred and Profane Space in the Therapeutic Encounter" and "Hermeneutic Approaches to Medicine: From Objective Evidence to Patient as Sacred Text." [11,12].

## Public Health Critical Race Theory

Complementing Krieger's ecosocial approach, Gilbert and DeCaille introduce Public Health Critical Race Theory (PHCRT) as another vital framework for dismantling race-based medicine [1]. PHCRT provides three essential analytical tools that align with sacred advocacy principles:

First, PHCRT calls into question research that "creates inopportunity and renders communities invisible," challenging how medical literature describes the criminalization of Black communities, justifies over-policing, reinforces dangerous stereotypes, and supports disinvestment policies [1]. This critical stance mirrors the theological concept of speaking truth to power that underlies prophetic medicine.

Second, PHCRT examines how public health challenges inequitably limit health-promoting opportunities, recognizing that "criminalizing Black males limits healthy racial and gender identity formations and poses a threat and risk to healthy lifestyles." [1]. This analysis reveals how systemic racism operates through medical and social institutions to constrain human flourishing.

Third, PHCRT requires researchers and practitioners to promote equitable outcomes that include social, structural, and ecological determinants of health—goals perfectly aligned with health justice movements [19]. This framework structures approaches to health equity research that facilitate access to healthcare services while preventing the reproduction of policing within medical settings.

## Legal and Social Analysis

Dorothy Roberts, professor of Africana Studies, Law, and Sociology at the University of Pennsylvania, argues that race-based medicine "diverts attention and resources from the social determinants that cause appalling racial gaps in health—lack of access to high-quality medical care, food deserts in poor neighborhoods, exposure to environmental toxins, high rates of incarceration and experiencing the stress of racial discrimination" [13,14].

Roberts emphasizes that "race is not a biological category that naturally produces these health disparities because of genetic difference. Race is a social category that has staggering biological consequences but because of the impact of social inequality on people's health" [14]. This understanding reframes medical encounters from biological assessments to recognition of embodied injustice—a perspective that opens space for what I term "sacred advocacy" in the therapeutic relationship [11].

## Epistemic Justice in Maternal Health

Recent work by Zakama and colleagues demonstrates how this theoretical framework translates into clinical practice. Their 2024 study on cardiovascular disease in pregnancy exemplifies the shift from race-based to racism-based understanding of health disparities [15]. Working with four Black women as "lived experience experts" (LEEs), they employed a participatory framework that centers Black voices as authorities on their own experience of anti-Black racism and its health impacts.

The study reveals three essential lessons that align with sacred advocacy principles: (1) framing cardiovascular disease risk as anti-Black racism rather than racial predisposition is congruent with lived experience, (2) maintaining a health equity framework is imperative, and (3) accessible patient education materials must be co-created with communities [15]. This approach recognizes that "it is not race itself—being Black—that predisposes individuals to increased cardiovascular risks during pregnancy and beyond. Instead, it is the multifaceted and pervasive nature of anti-Black racism that creates the environment in which these health inequities are forged" [15].

Zakama's work demonstrates epistemic justice in action—valuing Black individuals as experts on the lived consequences of anti-Black racism and fostering "a more integrative approach to counseling patients about their CVD risk." [18]. This collaborative strategy merges healthcare professional expertise with community knowledge, ensuring comprehensive understanding that moves beyond crude racial categorization to structural analysis.

## Community Engagement

Gilbert and DeCaille's work further illuminates how community engagement can transform healthcare delivery through what they term a "continuum of partnership approaches." [1]. At one end lies "community-placed" research, which occurs in settings like churches, barbershops, schools, or youth-serving organizations but minimally engages communities, relying on these settings primarily for participant recruitment and retention [19]. At the other end are "community-based" interventions that fully engage communities by incorporating culture, language, and community representatives in developing, implementing, evaluating, and disseminating findings. Gilbert and DeCaille note that "the closer our work focuses and integrates principles of community-based research, the more equitable and inclusive community-engaged processes become. Ultimately, this right-sizes power imbalances, and structures communities as the drivers of these partnerships." [19].

This continuum aligns perfectly with the sacred advocacy model, which insists that healing must emerge from authentic relationship rather than paternalistic intervention. As Gilbert and DeCaille emphasize, "Placing community first and allowing them to drive solutions-based strategies is imperative to the health justice movement." [19]. This principle embodies the theological understanding that true healing requires recognizing the sacred wisdom present within marginalized communities rather than imposing external solutions.

## Toward a Sacred Model of Healthcare Justice

The ethical framework I propose draws on liberation theology, Jewish mystical concepts of tikkun (repair), and medical anthropology to reconceptualize healing as sacred work. Paul Farmer, who co-founded Partners in Health, was deeply influenced by liberation theology's "preferential option for the poor," arguing that "any serious examination of epidemic disease has always shown that microbes also make a preferential option for the poor" [16,17].

Farmer's approach, informed by liberation theology's methodology of "observe, judge, act," demonstrates how medical practice can become an instrument of justice rather than perpetuation of inequality [17]. As I have argued in my work on "The Dialectical Divine" and "Sacred Listening as Experiential Encounter," the therapeutic encounter becomes a space where the practitioner serves as witness to suffering and agent of repair [11,12].

## From Race-Based Categories to Sacred Listening

In my essay "Applying Hermeneutics to the Therapeutic Interaction," I propose that we approach the patient history as a sacred text requiring careful interpretation rather than categorical assessment [12]. This "sacred listening" moves beyond the crude shortcuts of racial classification to engage the deeper narrative of how social forces have shaped illness. As Deyrup emphasizes, we must "remove the racial glasses through which clinicians first see patients" and replace them with structural lenses [3].

This paradigm asks not "What race is this patient?" but rather: What forces shaped this patient's illness? How do social structures manifest in this body? How can the therapeutic encounter become an act of repair rather than reproduction of harm? Such questions align with my concept of "Evidence Distortion and Clinical Decision-Making," where I examine how industry influence and cognitive bias can be countered through deeper attentiveness to patient narrative [12].

## The Clinical Gaze and Human Dignity

Michel Foucault's analysis of "the birth of the clinic" illuminates how medical discourse transforms persons into objects of knowledge and control [18]. Foucault demonstrated how the clinical gaze reduces patients to collections of symptoms and pathologies, stripping away their humanity in service of medical classification [18]. Race-based medicine represents a particularly pernicious form of this objectification, as it pre-determines patient identity before the encounter even begins.

Erving Goffman's work on stigma provides crucial insight into how medical categorization affects patient identity and social interaction [19]. Goffman showed how stigmatizing categories become "master statuses" that overshadow all other aspects of a person's identity, creating what he termed "spoiled identity" [19]. When physicians approach patients through racial categories, they risk transforming race into such a master status, reducing complex human beings to presumed biological essences.

The therapeutic encounter thus becomes what Goffman would recognize as a "presentation of self" in which both patient and provider negotiate identity and meaning [19]. Sacred advocacy requires clinicians to resist the institutional pressure to categorize and instead create what Goffman called "face-saving" interactions that preserve human dignity. This means approaching each patient as bearing sacred wisdom about their own experience rather than as exemplars of racial categories.

## The Medicalization of Race

Foucault's concept of biopower provides perhaps the most comprehensive framework for understanding how race-based medicine functions as a mechanism of social control [20]. Biopower operates through the production of knowledge about populations, creating categories of normal and abnormal that justify differential treatment and resource allocation [20]. Race-based medicine exemplifies this process by transforming socially constructed racial categories into seemingly objective medical facts.

As Foucault demonstrated, modern power operates not primarily through prohibition but through the production of knowledge, subjectivity, and desire [20]. Race-based medicine produces knowledge about racial differences that appears scientific while actually serving to maintain racial hierarchies. It creates medical subjects who internalize racial categories as biological truths, making resistance more difficult because the categories appear natural rather than constructed.

This analysis converges with Szasz's critique of the "therapeutic state" and Goffman's analysis of institutional control [8,19]. Together, these theorists reveal how medical institutions can function as mechanisms of social control that appear benevolent while actually reinforcing inequality. Race-based medicine transforms structural racism into individual pathology; shifts focus from social change to medical intervention and legitimizes differential treatment through scientific authority.

Sacred advocacy represents a fundamental challenge to this biopower by refusing to accept medical categories as given and instead interrogating the social forces that produce both illness and healing. By treating patients as sacred texts rather than racial exemplars, sacred advocacy disrupts the medical gaze and creates space for authentic relationship and social transformation.

## The Practice of Sacred Advocacy

Sacred advocacy, as I have developed this concept in my work on "A New Model for Healing" and "The Therapeutic Vision Non-Conventional Healing," represents a fundamental reorientation of medical practice [21]. Rather than viewing symptoms as isolated biological phenomena, sacred advocacy recognizes that "most of the health disparities we observe result from differential exposure to the biological and physical aspects of the environments that humans live in" [6].

For example, studies have found Black children have about twice the amount of lead in their blood compared to white children—a disparity that reflects housing policy, environmental racism, and economic inequality rather than genetic predisposition [6]. Sacred advocacy requires practitioners to address these root causes while providing clinical care, transforming medicine from a primarily technical intervention to a holistic practice of justice.

This approach directly challenges what Foucault identified as the clinical gaze that reduces patients to objects of medical knowledge [18]. Instead of asking "What racial category does this patient represent?" sacred advocacy asks, "What story of resilience and suffering does this person carry?" This shift from categorization to narration, from objectification to relationship, embodies the theological principle that every person bears the image of the divine and deserves to be heard rather than simply diagnosed.

Sacred advocacy also addresses Goffman's concern about stigmatizing medical encounters by creating what he would recognize as "face-saving" interactions that affirm rather than diminish patient dignity [19]. By approaching illness as embodied injustice rather than individual pathology, this model validates patient experience while working toward structural change.

## Restructuring Curricula and Clinical Training

Deyrup's work includes rewriting key pathology textbooks and creating accessible educational resources to help clinicians unlearn race-based heuristics [4]. This effort must be scaled across all medical disciplines, requiring systematic review of curricula, examination materials, and clinical algorithms.

As Deyrup notes, "Educating the educators is critical for systemic change. Medical students and residents feel supported when they see our presentation, since they recognize the pervasiveness of systemic racism in medicine but often feel vulnerable when questioning what they see" [7]. This educational transformation must include not only the removal of race-based content but the positive integration of structural competency and what I call "hermeneutic medicine"—the practice of interpreting patient stories within their full social and spiritual context [12].

### Clinical Reforms for Sacred Practice

Implementation requires concrete changes in clinical practice that integrate health justice frameworks:

*Elimination of race-based corrections in diagnostic algorithms, such as the problematic eGFR adjustments that have delayed kidney care for Black patients [22]*

*Integration of social work, chaplaincy, and narrative medicine into primary care teams, creating space for the sacred dimension of healing [21]*

*Structural competency training that helps clinicians recognize and address social determinants of health [9,10]*

*Sacred listening protocols that approach patient histories as complex texts requiring careful interpretation rather than categorical assessment [12]*

*Community partnership models that embed healthcare within broader justice movements, following Farmer's example of "pragmatic solidarity" [16,17]*

*Participatory research and care frameworks that center patient communities as lived experience experts, as demonstrated in Zakama's work with Black women in maternal health [15]*

*Health justice integration that creates collaborative approaches minimizing duplicative services and building sustainable relationships for systemic change, following Gilbert and DeCaille's community-based intervention model [1]*

*Anti-racism training that moves beyond cultural competency to address how medical institutions perpetuate criminalization, over-policing, and disinvestment in Black communities [1]*

These reforms require what Gilbert and DeCaille call "transformative public health work that includes a health justice framing [which] creates structures to think about capacity building and advocacy opportunities to affect family, community, and local change." Such transformation addresses root causes rather than symptoms, working toward "health outcomes and access to health care and social services, which improves population health outcomes, and narrows disparities caused by systemic and structural racism." [1].

### The Prophetic Vision of Medicine

Drawing on my work in "The Crisis of Language in Therapeutic Practice" and "Sacred and Profane Space in the Therapeutic Encounter," I propose that medicine must recover its prophetic dimension [11]. The Hebrew prophets called their communities to account for injustice; contemporary medicine must similarly examine how clinical practice either perpetuates or challenges structural violence.

As Farmer wrote, drawing on liberation theology: "The secular world needs to understand that what would 'free us from all anxiety' is opening up to the poor and otherwise marginalized the chance to flourish" [17]. This flourishing requires not merely the absence of disease but the presence of justice—what I term the "dialectical divine" that holds both transcendence and immanence in therapeutic relationship [11].

The Jewish concept of tikkun olam—repairing the world—provides a framework for understanding medicine's ultimate purpose. Each clinical encounter becomes an opportunity for repair, not merely of individual pathology but of the social fabric that produces illness. As Dorothy Roberts argues, "It would always be better for the doctor to learn that something else" rather than relying on racial categories that obscure rather than illuminate the true sources of suffering [14].

This vision challenges medicine to become what I call in my work a "healing space for caregiver and patient"—a sacred environment where both practitioner and patient are transformed through the encounter with suffering and the work of repair [21].

### The Moral Imperative of Our Time

As Joseph Graves concludes, "Our current problem in understanding health disparities does not reside in an absence of the science required to make sense of this ongoing problem. Rather it is generated from the deeply held misconceptions about race and human variation that Americans are marinated in throughout their lives" [6]. The scientific evidence is clear: race-based medicine is not only scientifically unfounded but ethically untenable.

Dr. Andrea Deyrup's pioneering work provides the empirical foundation for dismantling these harmful practices, while frameworks like Public Health Critical Race Theory and the health justice movement offer comprehensive visions for medicine's transformation [1,3,11]. The social science insights of Szasz, Goffman, and Foucault further illuminate how race-based medicine functions as a mechanism of social control through medicalization, stigmatization, and biopower [8,18-20]. Contemporary examples, such as Zakama's maternal health work and Gilbert and DeCaille's community-based interventions, demonstrate how epistemic justice and community partnership can transform clinical practice from racial categorization to structural analysis and systemic change [1,15]. In this model, we are not merely treating disease but engaging in the sacred work of tikkun—repairing both individual bodies and the social body that shapes health and illness.

The path forward requires courage to abandon comfortable but harmful shortcuts in favor of the harder work of understanding how social forces become embodied in human suffering [9,10]. It demands what I call in my essays "sacred listening"—the practice of hearing patient stories as complex texts that reveal the intersection of biography and social structure [12]. As Gilbert and DeCaille emphasize, this transformation requires "pushing research past description and identifying causal factors" through "community-engaged models that achieve social justice and health equity." [1].

Most fundamentally, it requires recognizing that medicine, properly understood, is always already a form of advocacy—either for justice or for the status quo that produces preventable suffering. As the maternal health researchers emphasize, we must ask: "In a world where the inequities of racism persist and are coupled with the stigmatization of Blackness, how do patients want us to discuss this risk?" [15]. This question embodies the shift from paternalistic medicine to participatory healing that honors patient expertise and community wisdom while addressing what Gilbert and DeCaille identify as the "intersecting risks" that "reflect systemic injustices." [1].

The choice before contemporary medicine is clear: continue to perpetuate the scientific racism of previous centuries or embrace a vision of healing that honors both the complexity of human biology and the sacred dignity of every person who seeks care. [2,23]. In making this choice, we determine not only the future of medicine but our fundamental understanding of what it means to heal and be healed in a broken but redeemable world. As the health justice movement demonstrates, this redemption requires "placing community first and allowing them to drive solutions-based strategies," recognizing that true healing emerges from authentic partnership rather than professional paternalism [1].

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