Introduction

Race has an unsettled status in contemporary medicine. Genetic interpretations of race are undergoing something of a renaissance as a result of the proliferation of large-scale genomic studies of human populations. Meanwhile, examinations of health and disease patterns among populations of self-identified Whites, American Indians, etc. reveal abundant evidence of disparities. Still, it remains unclear whether these are good enough reasons to use race concepts in medicine, given race's roots in antiquated biology and its long history of abusive uses (e.g., justifying slavery). This has inspired a debate. At two poles of the race-in-medicine debate are eliminativism and conservationism. Eliminativists see race's problems as being sufficient grounds to eject race from biomedicine. Conservationists see race's usefulness as being sufficient to justify its continued use in biomedicine. There is a broad spectrum of nuanced positions between these two poles. This chapter reviews the current status of the race-in-medicine debate and the related philosophy of medicine literature.

Race has many facets and, accordingly, so does philosophy of race, including identity (Shelby 2005), law (Darby 2009), epistemology (Sullivan and Tuana 2007), moral philosophy (Blum 2002), and more. Each of these areas has some amount of overlap with philosophy of medicine, but philosophy of medicine's concerns with the topic still only represent a portion of the race discussion. It is beyond the scope of this chapter to even fully review the various positions taken on race in medicine (and philosophy of medicine), or their detailed historical development. Instead, the chapter will review the key arguments and issues at stake in the debate, as a means of guiding readers through the landscape of the topic. Because race is a complex topic that is complicated by its history, scholars of the race-in-medicine debate have faced extraordinary pressures to be painstakingly precise in how they phrase their arguments; it is a debate driven by fine distinctions. Accordingly, this chapter will often directly quote key passages from relevant authors, in order to preserve important nuances in their positions.

In order to keep a single thread running through the many different subtopics covered in the chapter, it will pay particular attention to one case study that has inspired substantial race-in-medicine research and critique. The disparity in cardiovascular disease burden between White populations and Black populations in the U.S. is widely known, even outside of the medical community. Included in that cluster of cardiovascular diseases are disparities in rates of congestive heart failure (CHF): “among adults aged 45 to 84, blacks have approximately twice the incidence of CHF as whites” (Will et al. 2012). A public controversy broke out in the 2000s when a new drug for CHF in Black patients, BiDil (hydralazine hydrochloride and isosorbide dinitrate), became the first drug the U.S. Food and Drug Administration approved exclusively for use by a single race of patients (Ellison et al. 2008; Rusert and Royal 2011).
Bidil’s race-based prescribing rule has raised a number of concerns, largely related to its apparent effect of reinforcing the concept of biological race essentialism—the notion that all members of a racial grouping have some set of distinguishing traits, deeply dividing their biological makeup from that of other races. Life scientists and social scientists in the 18th and 19th centuries sought, and claimed to have found, distinctive physiological, intellectual, and behavioral characteristics in each race (Morning 2011). These purported characteristics, such as inferior intelligence in Blacks, were used to justify White supremacy and Black slavery. Today, there are still attempts to uncover modern scientific justifications for race essentialism, searching for behavioral genetics differences in features such as propensity to violence (Duster 2006; Perbal 2013) or molecular biological differences in DNA sequences (Morning 2011). Thus, a central concern is that using race concepts in medicine reinforces race essentialism and gives the false appearance of scientific objectivity to traditional racist prejudices. How should we responsibly reconcile these worries with the evidence of high rates of CHF in the Black population and the data suggesting BiDil helps to reduce that burden? These sorts of questions are rooted in philosophical judgments of ethics and evidence, as well as clinical practice.

What Is Race?

Race’s significance for medicine is ambiguous partly because it is unclear what race is. Is the White race a biological reality that has been discovered or a social phenomenon that has been invented? Although many social scientists hold race to be entirely “socially constructed”—i.e., a concept imagined into existence by human minds—the biological and anthropological communities each remain internally divided over whether race has a biological basis independent of human imagination (Morning 2011).

Whatever race may be, it is a common misconception that there is some stable and universally recognized set of races. In fact, how many races there are and who qualifies for each race category are both historically and locally contingent. In the United States, the number of races named on the census has grown and shrunk, with the current standards set by the Office of Management and Budget: a minimum of five races (e.g., “Native Hawaiian or Other Pacific Islander”), which are allowed to be further subdivided (e.g., “Samoan” and “Guamanian or Chamorro”) (Humes et al. 2011). The system has changed drastically over the years, with races on the census being revised (“Indian” became “American Indian” in 1960), added (“Chinese” first appeared in 1880), and subtracted (“Mexican” first appeared in 1930 then disappeared in 1940) until reaching 12 named races in 2010 (Humes et al. 2011; Nobles 2000). Meanwhile, the census also includes a question about respondents’ Hispanic ethnicity, entirely independent of race. By contrast, the UK and New Zealand censuses only recognize ethnicities (Valles et al. 2015), having the effect of emphasizing culture and community over just ancestry. Taking a third approach, Brazil recognizes “colors” instead of geographical races, explicitly referring to one’s appearance instead of descent (Nobles 2000). The net effect is that even a single term can have vastly different official meanings in different national contexts. In the U.S., “Black” is a race, in England it is an ethnicity, and in Brazil it is a racialized color (Nobles 2000; Valles et al. 2015).

Official national categorizations of race have so much power that they end up shaping everyday uses of race concepts. Spencer contends in his philosophical analysis of race’s meaning, “no racial discourse in the United States is more widely used than census racial discourse,” since Americans are so regularly exposed to them in government documents, loan applications, etc., and gradually learn “how to pigeonhole themselves into census races” (Spencer 2014a: 1027).
Variations in unofficial local race concepts can cause great confusion and distress for migrants traveling from one national context to another, such as Brazilian immigrants to the U.S. who are forced to adapt to American official and unofficial standards, including the widespread notion that having “one drop” of African ancestry means that a person cannot qualify as simply “White,” regardless of skin color (Fritz 2015).

Those hoping to get an overview of some of the various scholarly positions taken on the meaning of race can get an introduction in a chapter by Charles Mills, which offers a detailed typology of race concepts (Mills 1998). Mills acknowledges, though, that his use of certain terminology is sometimes at odds with other authors’ uses. For example, there are multiple senses in which race can be thought of as a “construction” (Mills 1998). To help clarify matters, Michael Hardimon distinguishes among four different race concepts that are deployed in medicine: “the ordinary concept of race,” “the populationist concept of race,” “the racialist concept of race,” and “SOCIALRACE” (Hardimon 2013).

Hardimon’s ordinary concept of race is a minimalist version of how “race” is used in day-to-day conversation, committed only to the view that groups called human races share sets of physical features, ancestries, and geographic origins. The populationist concept of race is a “scientized” version of the ordinary concept, reformulated to use technical biomedical terms and concepts to specify “phenotypic traits,” genetic ancestry, and “isolated founding populations” (Hardimon 2013). Both of those race concepts are different from the insidious racialist concept of race, which has the additional features of being essentialist (believing in strict criteria that make members of one race distinct from all other races) and “evaluatively hierarchical” (holding some races to be superior to others based on their essential traits). Finally, Hardimon offers SOCIALRACE as a new term for referring to races as social groups only, without committing to any biological assumptions. It stresses (in its name) that social features of race are quite real and can have real medical repercussions (Hardimon 2013). For example, a study of emergency room analgesia prescription patterns in the U.S. found an 8% gap between the percentage of White patients vs. racial/ethnic minority patients receiving opioid painkillers (Pletcher et al. 2008), a troubling disparity in how members of different races are treated by society.

**What Is the Current Status of Race in Biomedicine?**

Although physical anthropology and population genetics once shared authority over “race” in the scientific community, population genetics has recently gained unofficial pride of place as a result of genomic science’s rapid expansion in the wake of the Human Genome Project. In an account of teaching race in a medical school, Warwick Anderson lucidly narrates that genetics has acquired disciplinary primacy in medical students’ understandings of race, with anthropology and other social sciences pushed into the margins (Anderson 2008). Phenotype (skin color, physiological measures) has been deemphasized, and clustering of genotypes has become the center of disputes over the science of race. In population genetics, there were disputes during the mid-20th century about the precise technical meaning of race (e.g., to what extent are species and race distinctions arbitrary conveniences used by researchers, as opposed to real structural boundaries in nature?), and echoes of those debates remain now (Gannett 2013; Spencer 2013).

Philosophers are now vigorously debating the status of race’s biological meaning in light of recent genomics research. That debate is captured in the ongoing dialogue among Quayshawn Spencer, Jonathan Kaplan, Rasmus Winther, and Adam Hochman (among others) (Hochman 2014; Kaplan and Winther 2014; Spencer 2014a). They dispute how to interpret
genomic evidence that purports to show human populations can be clustered into genetic groups that—at least in some studies—approximately line up with the five races in the U.S. federal guidelines (Spencer 2014b). Similar to Kaplan and Winther (2014), Hochman finds such data to be weak supporting evidence for the view that races are real biological entities (Kaplan and Winther 2014: 1046–1047). By contrast, Spencer judges it to be stronger evidence (Spencer 2014b). All of these authors face the daunting challenge of articulating what precisely it would mean for race to be objective, real, or biological in the first place. Interpreting the meaning of the genomic evidence is made more difficult by common confusions about the biological concepts involved.

Lisa Gannett is critical of the view that the biological and the social are polar opposites. She surmises that there are indeed correlations between racial categories and certain traits:

... but we can expect such correlations to be statistical not universal, local not global, contingent not necessary, and accidental not lawful, and expect their corresponding cuts in nature to be interest-relative not mind-independent, dynamic not static, indeterminate not determinate, many not few, overlapping not nonoverlapping, and superficial not deep. The dichotomous choice of race as either “underlying” biological reality or “mere” social construction thereby becomes meaningless.

(Gannett 2010: 382–383)

In sum, the current status of the genetic basis of race is muddled. This lack of clarity translates into confusion for biomedical scholars and practitioners.

In the biomedical community, by 2005, “ethnicity” had overtaken “race” as the most frequently used term in the MEDLINE database, while a new pair of hybrid terms, “race-ethnicity” and “race/ethnicity” began growing in popularity. Unfortunately, interview data indicate that both “race” and “ethnicity” have ambiguous meanings for the medical researchers who so clearly need to understand them (Baer et al. 2013; Hunt and Megyesi 2008).

Why Use “Race” in Medicine?

Given the many problems associated with using race in medicine, from its historical and philosophical foundations to its application in biomedicine, any argument in favor of using race in medicine despite those problems must somehow be more compelling. The most compelling motivator for keeping race in biomedicine is the enormous body of evidence showing “health disparities” among racial groups:

Black infants in the United States are more than twice as likely as white infants to die before their first birthday.

(Woolf and Aron 2013: 40)

Injury victims are more likely to die at hospitals with a large percentage of minority patients, and this risk is compounded if they are uninsured.

(Woolf and Aron 2013: 120)

U.S. assault victims brought to high-level trauma centers were more likely to die if they were black, even after adjusting for other variables.

(Woolf and Aron 2013: 120)
Given such disparities, Raj Bhopal, a public health scholar, contends that judicious use of race concepts in medicine is a necessary means of achieving the central goals of biomedicine:

The goal of improving the health and well-being of minority groups and therefore the population as a whole is central to the responsible use of the racial and ethnic categories. When that goal is embraced politically and socially, it is irresponsible not to acquire and use race and ethnicity data to tackle the nation’s need to improve health in both absolute and relative terms.

(Bhopal 2006: 505)

Under this view, rather than putting advocates of race in medicine on the spot for needing to defend their use of dubious scientific concepts, it instead presents the use of racial concepts as an ethical necessity that overrides worries about the concepts themselves. Priority is given to people’s health needs, and concerns about race concepts are made secondary. Bhopal demonstrates openness to viewing race-in-medicine debate through the lens of social and ethical considerations, but other advocates of such work wish to separate the research itself from its social and ethical interpretations.

A team of scholars of race/ethnicity in genetic epidemiology, Neil Risch, Esteban Burchard, and Hua Tang, insist that differences among races are biological facts worthy of study, and they only become socially problematic when those facts are used in pernicious value-laden ways for political ends (Risch et al. 2002).

We believe that identifying genetics differences between races and ethnic groups, be they for random genetic markers, genes that lead to susceptibility or variation in drug response, is scientifically appropriate. What is not scientific is a value system attached to any such findings. Great abuse has occurred in the past with notions of “genetic superiority” of one group over another. The notion of superiority is not scientific, only political, and can only be used for political purposes.

(Risch et al. 2002: 11)

The authors’ attempt at a clean separation between facts and values clashes with contemporary philosophy of science, particularly as it seemingly manifests the so-called value-free ideal (of science that can be and should be unspoiled by interference from human values), which is contested by some philosophers specializing in science and values (Hicks 2014).

Jay Cohn, the cardiologist who owned the original methodology patent for using BiDil to treat heart failure and led the clinical trials testing it (Roberts 2011: 169), calls upon the pragmatic nature of medicine to justify the use of race despite its scientific weaknesses:

Observed racial differences in disease frequency may be genetically, rather than racially or geographically determined, but in the absence of more refined technology, the racial designation, crude as it is, serves as a useful and available surrogate.

(Cohn 2006, 552)

As noted by Katikireddi and Valles, the choice of proxy variable (e.g., using race as a variable that stands in for genetic and environmental variables) to be used in research practice raises epistemic (evidentiary) questions and ethical questions that are tightly intertwined (Katikireddi and Valles 2015). The BiDil case illustrates this amply.
To Cohn, the existence of clinical trial data suggesting that the identified “African American” population (one often neglected by biomedicine) would benefit from the drug is sufficient reason to use that race data in the clinical practice.

The benefit of BiDil ultimately shown in the A-HeFT Trial was so profound that it would be irresponsible to deny the favorable effect and deprive a population historically underserved by our medical system of the resultant improvement in medical management.

(Cohn 2006: 553)

Despite this evidence of benefits, criticism arose over the implicit aspects of how the benefits were calculated and communicated. As Kahn notes in his book chronicling the BiDil story, the drug’s owner at the time (NitroMed) had specifically sought narrow FDA approval for only African American patients after the strongest data supporting BiDil’s merits came from A-HeFT, the study cited above by Cohn, which included only African American subjects (Kahn 2013: 48–49). This study was pursued after earlier BiDil clinical trials, which included Black and White patients, failed to convince the FDA of the drug’s effectiveness, so Cohn and other researchers reanalyzed those trials’ data to determine if the effects appeared stronger within individual racial groups. It indeed appeared more effective in African Americans and led to the A-HeFT follow-up study of only African American patients (Rusert and Royal 2011). Given that there is a long history of selling pharmaceuticals to African American patients after testing them on primarily or exclusively White subjects, the FDA’s 2005 decision to grant NitroMed’s African American–specific labeling troublingly implied that somehow African American health benefits cannot be conversely generalized to White populations (Kahn 2013: 49–50). Thus, even the process of investigating and responding to the health needs of racial minority populations with underserved needs—seemingly the most compelling cases of appropriate use of race in medicine—can still raise serious concerns about race’s appropriateness in medicine.

Why Not Use “Race” in Medicine?

Judged on the basis of its effects, race has been a disastrous concept in biomedicine. It has overstated, over-extrapolated, and essentialized. It served as a rationalization for hundreds of years of colonialism, institutional deprivations, marriage restrictions, and a host of other de jure and de facto atrocities (Washington 2006). However, as such a powerful feature of social life (setting aside the contested genetic aspects), it is also woven into individual and group identities. For example, the ugly history of the “one-drop rule” for delineating who qualifies as “Black” (previously used to distinguish those who could be owned as slaves) continues to influence the way many people form their “Black” identities, and those identities must be acknowledged and respected regardless of that troubling history (Khanna 2010). Race-in-medicine eliminativists take into account these historical and contemporary facts, ultimately judging that race must be dropped from biomedical research and practice.

As understood by contemporary social scientists of race, race is social and fluid, rather than innate and stable (Aspinall and Song 2013). This fluidity is a source of skepticism about its utility in medicine (Rotimi 2004). In one illustration of race’s fluidity, Aliya Saperstein and Andrew Penner found in the U.S. that not only does one’s race impact one’s social status, but conversely, one’s social status also impacts one’s race. That is, “nonwhites who achieve high status are more likely to subsequently be seen as and identify as white” (Saperstein and Penner 2012: 701), while:
having been unemployed for a long spell, in poverty, incarcerated, and on welfare all have statistically significant effects, such that people who have had each of these experiences are more likely to be seen by others and identify themselves as black and less likely to be seen by others and identify themselves as white.

(Saperstein and Penner 2012: 698)

Extending beyond the US, across Latin American countries, socioeconomic status affects racial self-identification (Telles and Paschel 2014). People of mixed racial or ethnic backgrounds often shift identities over their lifetimes, including in response to the day-to-day demands of social situations (Aspinall and Song 2013).

Evolutionary biologists Joseph Graves and Michael Rose have decried race as an impediment to medicine obtaining precise understandings of environmental factors and genetic factors affecting health: “medicine should take both social environment and population genetics into account, not spurious ‘human races’ that inappropriately conflate the two” (Graves and Rose 2006: 481). Somewhat similarly, Mildred Cho argues that the combination of the fluidity and the varying definitions of race mean that race is hopeless as a biomedical tool, except for the purpose of studying perceptions of race (Cho 2006). Keita et al. (2004) take a similar position.

BiDil has served as a lightning rod for critiques of the use of racial categories in differentiating medical treatments. The aforementioned fluidity of race categories has drawn BiDil criticism like that articulated by Rotimi, a genetic epidemiologist:

The label used to designate the African American population in studies like the clinical trial for BiDil is too imprecise to be relevant for individual therapy. Some members of this population “supergroup” with heart failure will benefit from this drug, and others will not.

(Rotimi 2004: S45)

In a detailed analysis of the process of testing and approving BiDil for only African Americans, Ellison et al. make clear that the FDA failed to live up to its own goals and interests (e.g., when it encouraged the development of the single-race A-HeFT clinical trial for BiDil) (Ellison et al. 2008). It is no surprise that the FDA makes at least sporadic errors during the long process of approving drugs. This fallibility opens the door for financial interests to drive the process, with race serving as a means to earn profits while patients’ interests get deprioritized. In this case, BiDil’s first patent as a heart failure treatment was filed in 1989, with no mention of race (Roberts 2011: 171). Filing new patent paperwork 10 years later for BiDil as a treatment specifically for heart failure in African Americans—technically a new use—allowed BiDil to get 13 additional years of intellectual property protection (Roberts 2011: 171). In Dorothy Roberts’ assessment, “the reason why BiDil was marketed according to race has more to do with its commercial appeal than its medical benefits” (Roberts 2011: 168).

**Why Have Restricted Uses of “Race” in Medicine?**

Virtually all scholars who advocate for the continued use of race concepts in medicine (conservationists, taken broadly) seem to favor cautious deployment of such concepts, for ethical reasons, evidentiary reasons, or both. Biomedicine’s powerful influence over race discourse makes caution necessary.

Almost every aspect of racism that can be cognitively expressed originated in earlier ideas of race that were accepted on the scientific authority of their day. The biological
sciences have constantly revised themselves in this regard, although common sense has lagged. (Zack 2010: 883)

The enduring influence of biomedical science, including the echoes of outdated biomedical science, is one of the motivators for seeking particular rules or guidelines for how that biomedical science does its work.

Some critics of the use of race in medicine have targeted overly simplistic uses of race concepts, rather than seeking to eliminate racial terms altogether. Valles (2012) illustrates how racial descriptions of high-risk populations can sometimes inappropriately replace more nuanced descriptions of which specific people are at risk: “the privileging of data at the level of broad racial categories is an important obstacle to pursuing more nuanced representations of the heterogeneity of risk within racial categories” (Valles 2012: 406). This is demonstrated in two case studies where public health guidelines are made for the dietary salt intake of “African Americans” and for cystic fibrosis gene carrier screening of “Caucasians.” In both cases, the guidelines ignore long-standing evidence of known subpopulations that have entirely different health risks, and hence that more fine-grained (but still simple) population descriptions would be more accurate and ethically responsible: U.S.-born African Americans in the former case and non-Finnish Whites in the latter (Valles 2012). It is not the race concepts that are inherently unacceptable; it is their incautious use despite contradictory evidence and ethical considerations.

The above position’s encouragement of pursuing further specificity, when feasible, is similar to the recommendations of a 2009 report from the Institute of Medicine, which advised the collection of not only broad race/ethnicity data but also locally relevant “granular ethnicity” (Ulmer et al. 2009). For example, a hospital might collect data showing it has almost exclusively White patients, but such data would not allow differentiation between the potentially vastly different health experiences and needs of the hospital’s large subpopulation of ethnically Italian patients and its large subpopulation of ethnically Albanian patients; the race data by itself would be inadequate.

Race-in-medicine debates struggle with a series of empirical claims: (1) race is a social reality; (2) race is a genetic reality; and (3) race is a biological reality. Echoing the rationale for Hardimon’s aforementioned SocialRace concept, Kaplan cautions against conflating (2) and (3), reconsiders the meaning of (3), and argues that the causal relationship between (1) and (3) is the reverse of what racialists contend (Kaplan 2010).

... taking self-identified race into account in medical decision making might make sense locally, given that self-identified race is a good predictor of one’s experience with racial discrimination, prejudice, and racism more generally. The objection that to do so reifies race is, in essence, correct—self-identified race is real (it is socially contingent, but no less causally powerful for that) and, if the above is correct, it is also biological. But to be biological is not to be genetic, nor does biology make race. Race is biological because racism (and more generally a society organized by race) has profound biological effects.

(Kaplan 2010)

Race can be biological without being genetic. A social environment constructed to include racist patterns of health benefits and detriments (e.g., access to affordable mortgages and safe housing) creates biological differences among racial groups.
Krieger, a public health scholar, similarly focuses on racism during conversations about the utility of race in medicine, arguing that the responsible use of “race” concepts in biomedicine includes a requirement to specifically study racism in biomedicine.

Neglecting study of the health impact of racism means that explanations for and interventions to alter population distributions of health, disease, and well-being will be incomplete and potentially misleading, if not outright harmful. Of course, work in this field will, inevitably, be fraught with controversy; because the exposure raises important themes of accountability, agency, and human rights.

(Krieger 2003: 197)

Adequately explaining or responding to health disparities between races is simply not possible without examining the underlying problem that Kaplan identifies as a root cause of those disparities: racism. Even if examining racism is controversial, it remains necessary nonetheless.

As this chapter nears its conclusion, it seems appropriate to include a detailed set of rules for the responsible use of race in medicine, an abridged version of the rules laid out by Koffi Maglo.

“The Cluster Stability Rule”: Researchers can investigate particular populations in medical research, but they must not assume that findings in one subgroup of a continental grouping (e.g., the Hmong ethnic group in southeast Asia) applies to all subgroups in that continental grouping (e.g., all Asians) (Maglo 2010: 366–367). In the same vein as Kahn’s above point about BiDil and Valles’s above point about heterogeneous subpopulations, it is essential to be cautious when making race-level (or continental population–level) generalizations based on data sampled from only a subset of patients (Kahn 2013: 49–50; Valles 2012).

“The Patient Standpoint Rule”: Individual patients’ needs and interests deserve the highest priority, unless serving those interests would hurt other individual patients’ interests (Maglo 2010: 367). Since medicine’s goal is to serve the needs of patients, considerations of patient care supersede any qualms researchers or practitioners might have with using race concepts.

“The Excluded Beneficiary Rule”: When one must choose between alternative models for health patterns or different potential designs of clinical trials, preference should be given to options that benefit subpopulations that would otherwise be neglected (Maglo 2010: 367). As noted by Bhopal above (2006), medicine should be concerned with not only the health of the whole population but also the health of oft-neglected minority populations that might have atypical health needs. When we do not know how to proceed, we ought to err on the side of helping groups that otherwise tend to be ignored. See, for example, Valles et al.’s recommendations for altering medical research design and analysis practices that (unintentionally) tend to under-report and under-analyze data from mixed-race and mixed-ethnicity patients (Valles et al. 2015).

“The Permissibility Principle”: It is acceptable to prevent a subpopulation of patients from getting a treatment that would improve their health, in the sense of “species-typical normal functioning,” if getting that treatment would harm the “species-typical normal functioning” of other patients (Maglo 2010: 367). Medical resources are limited, and the provision of resources to one population will often lead to fewer resources for other populations. Given the above criticisms that BiDil was approved for treating African Americans on the basis of very limited clinical research, and given that African Americans have such a disproportionate burden of heart failure, some redistribution of resources may be ethically necessary. Some of the clinical resources being directed to less burdened populations could be ethically shifted over to treating the more burdened populations, and in some cases this would indeed mean less/worse care for the former population. Because this chapter is in a philosophy of medicine handbook, it is
worth noting that this last principle incorporates a philosophical commitment to a naturalist concept of health, a disputed position featured in Part I of this volume (see also: Carel and Cooper 2014). In this principle, Maglo takes health to be an objective fact of the world and human biology, not something that is open to social negotiation and value judgments. The race-in-medicine debate does not exist in a vacuum; it intersects with other philosophy of medicine debates, just as the BiDil controversy intersects with questions about the appropriateness of treating medicine as a commodity (see Chapter 47).

Before Bidil’s approval was secured, sociologist of race Troy Duster had recommended taking a long view on the situation. In his view, it was not just a matter of whether the FDA approved BiDil, but also a matter of what future steps would be taken to move past the reliance on race as a proxy for unknown biological mechanisms.

If the FDA approves BiDil, it should do so only under the condition that further research be conducted to find the markers that have the actual functional association with drug responsiveness—thus assuring that the drug be approved for everyone with those markers, regardless of their ancestry, or even of their ancestral informative markers.

(Duster 2005: 1051)

In this way, Duster’s position is surprisingly not all that different from that of Cohn, who affirmed that more research on heart failure is desperately needed to help guide treatment decisions (Cohn 2006). In the race-in-medicine debate, one finds interesting convergences of positions as often as one finds interesting divergences.

Conclusion

This chapter has provided a brief overview of a topic that is expansive and always changing. Given that race is embedded in social life and in biomedicine, it is perhaps not so surprising that the debate is multifaceted and evolving. The biomedical race research conducted in any time and place is influenced powerfully, even if subtly, by its social context, as is phrased elegantly in Duster’s (2006) prediction of the future:

. . . the next decade will witness an outburst of behavioral genetics research, buttressed by the molecular reinscription of race tying crime to biological processes, and then correlating those biological processes to race. It is not beyond conjecture that it will be an African-American who will lead the charge, fully supported by the Pioneer Fund or some equivalent well-funded, conservative think tank or funding source. The banner will be the academic and intellectual freedom to fearlessly pursue a topic wherever it may lead. Most people will fail to recognize that such work will be driven by the prevailing winds, the Zeitgeist. Those winds will be perceived as natural and normal. “The spirit of the times” will be taken for granted.

(Duster 2006: 495)

And so it has come to pass that in recent years, behavioral geneticists have been drawn to research on the gene coding for monoamine oxidase A (MAOA; Tabery 2014), variants of which have been associated with violent or antisocial behavior (sometimes given the media-friendly label “the warrior gene”), which were then used to explain minority crime rates (Perbal 2013). Journalist Nicholas Wade features MAOA research prominently in his controversial
new book on racial differences (Wade 2014). Individual researchers might wish to believe that their decisions about if/when/how/why to research race, based on the above considerations, are ultimately their choice. As Duster illustrates in his prediction, the prevailing winds of the zeitgeist—the spirit of the times—will push the ship no matter what one does below deck. Interestingly, the zeitgeist may be shifting once again since Wade’s book was forcefully rejected by the very biologists whose work he drew from to make his case (Coop et al. 2014). Meanwhile, even though Black and White U.S. primary care physicians (unsurprisingly) differ in their comfort with discussing racism and racial health disparities, they share an “excitement and anticipation regarding genomic medicine” (Bonham et al. 2009: 284).

The current status of the race-in-medicine debate can be interpreted either optimistically or pessimistically. Optimistically, a plurality of different views are now on the table, being debated by a large multidisciplinary group of scholars who care deeply about having an exacting dialogue and about the implications of the dialogue for patients. Pessimistically, the debate is problematic for both scholars and laypeople: scholars remain divided into camps and sub-camps, and laypeople face a daunting challenge if they wish to formulate an educated judgment about their own stances. Sociologist Ann Morning’s (2011) book offers a detailed review of current race views through a combination of theoretical analysis, interviews with biology and anthropology faculty and students, as well as analysis of high school textbooks. One key finding is, “social and biological scientists hold a wide range of beliefs about the nature of racial difference contrary to some scholars’ expectations, they are far from any consensus, either within or between disciplines” (Morning 2011: 221). Such is the current state of the debate over race’s status in biomedicine: unsettled.

References


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Further Reading


