There's No Such Thing as Postracial Medicine

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There’s No Such Thing as Postracial Medicine

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Perez-Rodriguez and de la Fuente think that race should not be used in the biomedical sciences on the grounds that such use “perpetuates the fallacy of natural differences” (Perez-Rodriguez and de la Fuente 2017, 48). Primary concerns for Perez-Rodriguez and de la Fuente are (1) that there is no biological significance to race and (2) that using race as a biological parameter furthers racial stereotypes and negative connotations about race and racial groups. They understand race as a “social phenomenon” and claim that it is a waste of time to continue searching for a link between race and biology. Their recommendation is that race should be eliminated from clinical medical research and left to disciplines such as public health and medical sociology.

For Perez-Rodriguez and de la Fuente, the assumption that racial differences carry with them assumed biological implications is wrongheaded and potentially damaging. They take great pains to show where, in their estimation, the science falls short. However, it does not necessarily follow from what Perez-Rodriguez and de la Fuente show that biological notions of race have no place in biomedical research. At best, they have shown that the biological notions of race to which they appeal do not do the “heavy lifting” that many researchers assume they do. Perhaps one can defend a much more modest claim with regard to the use of race in the biomedical sciences. Efstathiou (2012) raises interesting questions about the “conundrum” posed by race related biomedical research:

(1) If race/ethnicity variables deliver interesting results in genetic epidemiology, is race a genetic category?
(2) If a nonscientific idea can be used in science, is it a scientific category?
(3) Can science work with ideas not based in science? (Efstathiou 2012, 704)

In other words, even if it turns out that there is no biological basis for race, might there still be circumstances in which it is still useful to appeal to race and racial categories in the biomedical sciences? Efstathiou thinks so, and I tend to agree.

In order to reconcile the seeming lack of biological support for many of our common race concepts, Efstathiou turns to found science. Found science claims that “ordinary ideas become usable in science if but only if they are transfigured appropriately” (Efstathiou 2012, 705). She concedes that the concepts that one “finds” and “transfigures” (including the concept of race) might be at the outset “vague,” “loaded,” or even “partially false” (Efstathiou 2012, 707). The upshot is an attempt to differentiate and appropriately use biorace concepts, or “concepts that attempt to articulate criteria in the logical core of an ordinary race concept (and/or other criteria) in biologically meaningful terms,” and sociorace concepts, or “concepts that attempt to articulate criteria in the logical core of an ordinary race concept (and/or added criteria) in sociologically meaningful terms” (Efstathiou 2012, 707). Rather than abandoning race altogether in biomedical research, given how firmly entrenched the ordinary concept of race is, it might be useful to think about how to deploy the concept in ways that make sense in both the biomedical and social sciences. One consequence of thinking about race and the biomedical sciences in this way is that one will have to abandon some of the (demonstrably false) assumptions that currently plague the use of race in biomedical sciences. The potential dangers arising from clinging to false notions about race are a significant (and legitimate) worry for Perez-Rodriguez and de la Fuente.

Despite all that Perez-Rodriguez say to dissuade the reader from the temptation to continue to advocate the use of race in the biomedical sciences, they wonder whether it is possible to practice the sort of postracial medicine that they suggest—either within the context of the patient–clinician encounter or within the realm of biomedical research. They conclude that in both contexts, the concept of race should be altogether abandoned in favor of variables such as socioeconomic status (SES), lifestyle choices, age, social support network, and so on. Yet they concede that “the overarching influence of race in any [emphasis mine] social activity in our times [sic] is undeniable” (Perez-Rodriguez and de la Fuente 2017, 43). Given how “overarching” and “undeniable” the influence of race is at least at this moment, it seems strange,
then, to push for abandoning it. Perez-Rodriguez and de la Fuente have at most made an argument against the overreliance on race while ignoring other factors. There is nothing inconsistent about paying more careful attention to other factors that may get short shrift in biomedical research programs that focus on race and in the patient–clinician realm while still acknowledging that race matters. What may need to change is not the question of whether race matters in these contexts, but how.

Perez-Rodriguez and de la Fuente see the “search for correlations between race and the biological parameters for disease” as distractions from what they see as the real targets: “public health and improved access to care as the cure for health disparities” (Perez-Rodriguez and de la Fuente 2017, 41). Dorothy Roberts takes this concern a step further when she argues that race-based medicine helps to promote a biological explanation for racial inequities that obscures their sociopolitical causes and requires individualized and market-based solutions rather than social change. By making black people’s subordinated status as a group seem natural, this view provides a ready logic for the staggering disenfranchisement of black citizens, as well as the perfect complement to colorblind social policies. (Roberts 2008, 538)

Roberts is firmly in the same camp as Perez-Rodriguez and de la Fuente—there is no biological significance attached to race. But I submit that even if it turns out that there is, just as in the case of sex, there may still be reasons to demand paying attention to other factors. For him and Kitcher’s views in order to show how race might be understood as biological. Understanding race as biological in this minimal sense does not release one from obligations to investigate all possible causes of racialized health disparities, including structural ones. Nor does it commit one to a notion of biological race as static or essentialist. To return to Elstathiou’s race concepts in biomedical sciences as “founded” scientific concepts, “race” in these instances might actually speak to a slightly different problem than the one raised by Perez-Rodriguez and de la Fuente (Elstathiou 2012, 710). However, this is why the vocabulary that one deploys should facilitate communication beyond disciplinary silos so that, for example, biomedical scientists can talk to bioethicists (Danis, Wilson, and White 2016, 5).

Finally, it is a mistake to abandon race in the biomedical sciences in favor of a “postracial” medicine because just as it is a mistake to over-rely on race as a variable, ignoring race altogether can lead one to miss important insights. Although Perez-Rodriguez and de la Fuente advocate shifting the focus from race to SES, lifestyle choices, and even personalized medicine and health care access, Jackson and Williams show that race is still an important variable in understanding health and disease in what they refer to as the “intersectionality paradox” of the black middle class. For example, the highest SES black women have equivalent or higher rates of infant mortality, low birth weight, and excess weight compared to the lowest SES white women (Jackson and Williams 2005,142). Whether this points to some genetic story about race or some other facet of racial classification (like structural racism), race must remain a variable that is taken seriously in the biomedical sciences.

**CONFLICTS OF INTEREST**

Dr. Wilson was a Visiting Scholar in the NIH Department of Bioethics last summer, and she is a Visiting Scholar again this summer. She also serves on the Clinical Ethics Committee at NIH and has given talks to a few units at NIH.

**REFERENCES**


