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Medicalisation of Race
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The Medical (Ir)Relevance of Race and Ethnicity in a Multiethnic Society

Race and ethnicity have always generated a significant amount of controversy in medicine. The recent approval of a combination of isosorbide-dinitrate and hydralazine (BiDil) for the treatment of heart failure in African Americans by the Food and Drug Administration (FDA) has generated much discussion. In a press release of the FDA, BiDil is 'hailed' as a 'step toward personalized medicine'. The FDA approval was partly based on the African American Heart Failure Trial (A-HeFT), which showed a 43% reduction in deaths.

Duster, in his article on Medicalisation of Race, discusses the FDA approval of BiDil. He states that the FDA approval was not based on convincing evidence, but on 3 assumptions about race and medicine that were made by NitroMed, the manufacturer of BiDil. The first assumption is that the risk of developing and dying from heart failure is substantially greater for African Americans. The differences in heart failure mortality between African Americans and Caucasian American is often quoted as 2 to 1. Duster argues that this ratio is outdated and that the current ratio should be nearer to 1.2 to 1. The second assumption is that BiDil has a greater effect on African Americans, but no clinical trials have yet been conducted to investigate the racial disparities of BiDil. The third assumption is the age-specific disparity in mortality. African Americans are 2.5 times more likely to die from a heart failure between the ages of 45 and 64 years. But according to Duster, this age group accounts for only 6% of deaths from heart failure, whereas the >65 age group accounts for 93.7%.

Duster also refers to the study of Klag et al. [1], which showed that a darker skin color correlates with a higher rate of hypertension. The observed correlation was not biological or genetic in origin but rather biological in effect of stress-related outcomes to reduced access to valued social goods, such as employment, promotion or housing. In a study by Cooper et al. [2], significantly smaller racial disparities in blood pressure were observed in Brazil, Trinidad and Cuba compared to North America. These findings prove to Duster that racial genetic disparities of hypertension are neglectable and interventions should focus on the preventable causes, related to socioeconomic status. Duster explains the focus on race as a marketing strategy. The FDA approval for racial-specific BiDil gives NitroMed the opportunity to extend the patent for the non-racial-specific BiDil from 2007 to 2020. According to

Duster, racialized drugs will enhance the disparities in morbidity and mortality, and will lead to discrimination.

Comments

Ethnicity, race and ancestry are still a taboo in the medical world. Usage of these characteristics in medicine leads to the fear of promoting discrimination and giving racism a biological basis. Medical care in the civilized Western world is based on clinical trials conducted with male Caucasians. Ethnic minorities and women are underrepresented in these studies. The outcomes of these studies provide the best medical care for the Caucasian male. Ethnic minorities are given the same care as the natives and therefore do not necessarily receive adequate medical care.

Duster argues that the FDA approval of BiDil as a racial drug is a marketing strategy of the pharmaceutical industry. He states that the racial disparity of heart failure mortality is exaggerated in medicine and that an age group-related racial disparity of 2.5 for African Americans affects only a small insignificant group. However, these results clearly indicate that there are disparities between races.

Duster does not discriminate between the terms race, ethnicity and social class. Race, ethnicity and social class are not interchangeable. Ethnicity and low social economical class appear to have a synergetic effect. A distinction can be made between race and ethnicity. Race is mainly associated with ancestry and genetics, whereas ethnicity is associated with the self-identification of a person with a subpopulation. It is known that allele frequencies of functional variants often differ substantially among groups that have different geographic ancestries [3]. The aspects of ethnicity are those of a self-identification of a person. Ethnicity captures important dimensions of a person's culture, diet and health behaviors, which may affect both drug response measurements and dosing ranges for safety [4].

The FDA approval of BiDil as racial drug is a milestone in medicine; a beginning has been made in giving ethnicity and race a prominent place in medicine. Race and ethnicity are essential in the diagnosis, treatment and medical care for patients in a multi-ethnic society.

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References

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