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Race in Contemporary Life

Ideas and feelings about race are part of the perspectives of all individuals who are aware of racial difference. More than that, although race no longer has the backing in biological science it once did, it is so robust as a social construction tied to human kinship that individuals live out their racial identities in most or all of their relationships and social roles. Consider marriage, for example. Any married person either has a spouse of the same race or of a different race. If the person is married to someone of the same race, the couple is described as a white, black, Asian, Native American, Hispanic, or Middle Eastern couple. If the person is married to someone of a different race, the couple is described as a mixed or interracial couple. A same-race couple will likely have friends, relatives, and neighbors, who are mostly of their race. A mixed-race couple may have more diversity in relations, but they will be distinct in not being of the same race. In either case, the couple's race or races will affect where they live, the socioeconomic quality of their lives (in most cases), and their children's racial identities.

Race is not the most important thing in life in a society with a system of race—some would say money was, others moral character—but it is a substantial social "factor." If an individual ignores race, especially her own racial identity—other people will remind her of it, directly or indirectly. Race is more than a matter of ideas, feelings, and identity. Racial difference maps onto differences in social status and power. **Social status** is a person's position or rank in any given pecking order or hierarchy and it has to do with how others view one. **Power** is an ability to do something, influence others, or make things happen. **Authority** is recognition of power. People who have

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more power than others in institutions also have greater authority than those with less power. It's important to remember that institutional power is not the power of a person but power granted her by the rules of an institution or conferred on her by someone who has more power in the same institution. Institutional power and authority range over a larger number of contexts than social status, which varies from group to group and situation to situation. Given formal equality among races, social status associated with racial identity ought not to carry over into institutional power and authority. But in reality, it does. Social status associated with racial identity creeps into institutions, along with the racial identities of individuals.

In this chapter, we will consider only several ways in which race determines, influences, or is in other ways related to life in society. The idea is not to provide a comprehensive description of race in life, but to show how race is a substantial factor of life in society. Unless a person is isolated on a desert island or in a remote mountain cabin, we all live in society. We will begin with the institution of marriage, and then proceed through discussions of social class and medicine and health.

Marriage

Marriage is a basic social institution. *Psychology Today* offers this definition: "Marriage is the process by which two people make their relationship public, official, and permanent. It is the joining of two people in a bond that putatively lasts until death, but in practice is increasingly cut short by divorce" (Psychology Today 2017). Marriage confers tax, legal, residence, medical, social security, and insurance benefits, as well as resources for social interactions and connections (NOLO 2017). Marriage also confers positive benefits in wealth and income, access to and use of health care, longevity, psychological well-being, and the mental and physical health of children (Wood et al. 2007). However, opportunities to marry may be unequal, according to race.

Marriage Rates

According to the National Longitudinal Survey of Youth 1979 (NLSY79) that collected data in 2010 on Baby Boomers, born 1957–1964, most married before age 28 and 85% had married by age 46. African Americans married later and at one-third the rate of white Americans; Hispanics married earlier. About one-third of African Americans had never married,

compared to one-tenth of white Americans and one-sixth of Hispanics. The divorce rate of about 43% did not vary by race and ethnicity, although college graduates were less likely to divorce (Auginbaugh et al. 2013).

Marriage statistics for African Americans at least 35 years old began to change in the 1960s. After 1890, African Americans were more likely to be married than white Americans. But by 2010, African Americans who had never married increased from about 10 to 25% (compared to about 10% for white Americans) and those who did marry divorced more and did not remarry as much, as other groups. By 2014, only 29% of African Americans were married, compared to 48% of all Americans. Also, 50% of African Americans had never been married, compared to 33% of all Americans (Black Demographics.com 2017).

Although marriage rates for all racial and ethnic groups have declined in recent decades, there has been specific concern about the black rate. Some observers associate the decline in black marriage with high rates of incarceration after the War on Drugs (Black Demographics.com 2017). Others have blamed black women. Senator Daniel Patrick Moynihan (1927–2003) in *The Negro Family: The Case for National Action*, his 1965 research report when he was Assistant Secretary of Labor, claimed that black women preferred **matriarchy** to **patriarchy**. Moynihan was an academic sociologist before and during his political career. His claims that black women were responsible for the breakdown of the black family, because of their high rate of children born outside of marriage, were very influential (Moynihan 1965). He wrote:

> The fundamental problem, in which this is most clearly the case, is that of family structure. The evidence—not final, but powerfully persuasive—is that the Negro family in the urban ghettos is crumbling. A middle-class group has managed to save itself, but for vast numbers of the unskilled, poorly educated city working class the fabric of conventional social relationships has all but disintegrated. …

Moynihan ended his report by quoting the African American sociologist, E. Franklin Fraser (1894–1962):

> As the result of family disorganization a large proportion of Negro children and youth have not undergone the socialization which only the family can provide. The disorganized families have failed to provide for their emotional needs and have not provided the discipline and habits which are necessary for personality development. Because the disorganized family has failed in its function as a socializing agency, it has handicapped the children in their relations to the institutions in the community. Moreover, family disorganization

> has been partially responsible for a large amount of juvenile delinquency and adult crime among Negroes. Since the widespread family disorganization among Negroes has resulted from the failure of the father to play the role in family life required by American society, the mitigation of this problem must await those changes in the Negro and American society which will enable the Negro father to play the role required of him. (Blackpast.org 2017)

Moynihan's assumption that in the United States only patriarchal family structures could thrive and successfully socialize children, is ironic, because he himself grew up in a female-headed household after he was nine years old (Wattenberg 2004).

Over half a century after Moynihan's report, scholars continue to consider the problems of black poverty and reject his model of pathology. In 1965, Moynihan was able to point to black women's high levels of birth outside of marriage. But in 2017, the Center for Disease Control reported that in 2015, 40.3% of all US births were outside of marriage, compared to 18.4% in 1980 (CDC 2017a, 2017b). Further studies have shown that among parents without college degrees, ages 26–31, 74% of mothers and 70% of fathers had children outside of marriage. Unwed birthrates are highest in areas of income inequality with high unemployment and few job opportunities (Cherlin et al. 2016).

Dwane Mouzon refers to current studies that debunk myths about black women's aversion toward marriage: In terms of values about marriage expectation and its importance for children, blacks were found to value marriage more than whites did; blacks and whites were equally critical of having children outside of marriage; 57% of whites compared to 65% of blacks and 72% of Latinos thought that a child needs two parents to grow up happily; more blacks than any other group thought that earning ability was important in husbands. Mouzon pinpoints the high value black women place on socioeconomic status, together with the disproportionately low earnings and wealth of black men, as the main cause of low rates of black marriage compared to white. Moreover, in 2012, there were only 91 black men for every 100 black women. (About 94% of married black women have black husbands and about 86% of married black men have black wives (Black Demographics.com 2017).) High unemployment and undereducation, as well as higher mortality and illness rates, reduce the marriageability of many black men. Mouzon's analysis and the underlying data support a structural or institutional perspective on the white–black marriage gap (Mouzon 2014). If marriage does continue to confer the benefits claimed by many, then African Americans are disadvantaged by factors beyond their control

as individuals. Also, insofar as other racial groups now share high birthrates outside of marriage, the idea of individual preference for remaining unmarried loses credibility.

However, as most people inside and outside of the academy know, the idea that marriage is desirable and beneficial is not a simple, universally accepted claim, so much as a ready-made rhetorical tool. The lower marriage rate for African Americans has been a basis for moral criticism of that group. But for Mexican Americans, a higher marriage rate and earlier marriage ages for women have been the basis for criticism on the grounds that Mexican American women are thereby deprived of educational opportunities and self-development. Familial cultural values emphasizing the traditional role of women are sometimes given, not as pathologizing forces, but as obstacles to higher education and greater earning power.

Working within a life cycle framework that relates marriage to migration and periods of transition. R. Kelly Raley, T. Elizabeth Durden, and Elizabeth Wildsmith, compared Mexican American marriage patterns to those of women in Mexico. Their results showed that Mexican immigrant women marry earlier than those who live in Mexico. But if family background influences associated with early marriage, such as parental education and school leavings, are kept constant, Mexican American immigrants married later than white Americans. Also, Mexican American women born in the United States do not marry earlier than Anglo-women (Raley et al. 2004).

Thus, differences in marriage rates for African Americans and marriage age for Mexican American immigrant women cannot plausibly be assigned to ethnicity or culture. In both cases, job and educational opportunities shaped by external social conditions influence the occurrence of marriage. The ongoing assumption throughout society that cultural deviance causes minority groups to fall short of statistical white norms depends on a superficial understanding of how race and ethnicity function in society. This superficial view of race as human variety or difference, rather than a social system based on status and power, also obscures how social class works.

Interracial Marriage

Many observers and scholars view mixed-race marriages and their acceptance as a barometer of race relations, generally. While mixed-race marriage rates do not mirror institutional or structural inequalities of race, they do indicate **racial climate**, the degree and extent of hearts-and-minds racism on individual-to-individual levels, in specific contexts. Attitudes toward racial

and ethnic intermarriage have been changing toward tolerance since 1967, when the US Supreme Court struck down so-called Anti-miscegenation laws in *Loving v. Virginia*. In 2015, 14% of nonblacks said they would oppose a close relative marrying a black person, compared to 63% in 1990. Also in 2015, one in six Americans married someone of a different race, five times the rate in 1967 before antistate miscegenation laws were abolished. Nonblack minority statistics mainly support the trend: 29% of Asians and 27% of Hispanics are married to someone of a different race or ethnicity. Among 2015 interracial newlyweds, 42%, the most common couples, consist of one Hispanic person and one white person. Still, between 1980 and 2015, black intermarriage increased from 5 to 18% and white intermarriage from 4 to 11%. Overall, one in seven newborns were born to interracial couples in 2015 (Bialik 2017).

Mid-twentieth century opposition to public school integration was accompanied by forceful rhetoric that such early interaction would lead to **miscegenation** (Godfrey 2003). The growing rate of interracial marriages not only fulfills that fearful prediction but the generally peaceful acceptance of interracial couples suggests that hearts-and-minds racism has drastically changed in this regard. However, contemporary interracial couples are more likely to be college educated and live in cities than rural areas. The combination of college degrees and urban lifestyles indicates middle-class status (Bialik 2017). This association of middle-class status with progress in race relations may be an important aspect of how racial difference functions in society, at this time.

Social Class

Historically, Americans have preferred to believe that the United States is a society without important distinctions based on social class. Compared to monarchies with royal families, or societies with caste systems, there are no hereditary distinctions associated with class in the traditional sense. Neither is a standard Marxist analysis that views society as a struggle of workers against owners, relevant, because there is no longer a self-conscious working class organized to advance its interests. Although most Americans are also aware of great income inequalities and new accounts of widespread stagnation and poverty, at the same time a new billionaire group rises with little or no opposition. There was a weak widespread complaint against those in the financial industry who had caused the bubble and collapse in real estate prices in 2008. But there was scarcely revolutionary or even rebellious

protest, unless one counts the newly emergent populism that culminated in the 2016 presidential election. Upward socioeconomic mobility is still believed to be available to everyone.

The question of whether there are broad economic differences associated with race is not only a matter of social science methodology or progressive versus conservative perspectives. In 2015, a staff writer for *Forbes* a premier US business publication (its motto is "The Capitalist Tool") wrote the following about racial differences in wealth and income, citing government and independent sources:

> The typical black household now has just 6% of the wealth of the typical white household; the typical Latino household has just 8%, according to a recent study called 'The Racial Wealth Gap: Why Policy Matters,' by Demos, a public policy organization promoting democracy and equality, and the Institute on Assets and Social Policy.
>
> In absolute terms, the median white household had $111,146 in wealth holdings in 2011, compared to $7,113 for the median black household and $8,348 for the median Latino household. (All figures come from the U.S. Census Bureau Survey of Income and Program Participation.)….
>
> In 2011, 34% of whites completed a four-year college degree, whereas just 20% of blacks and 13% of Hispanics did ….
>
> The typical white family earns $50,400, while the typical black family earns $32,038, and the typical Latino family, $36,840. (Shin 2015)

Whether or not a person of working age is employed is a fundamental indicator of their income, and income varies by race. Despite individual upward mobility, there seem to be broad patterns of employment and unemployment, correlated with race, which persist over time. One way to confirm that is by looking at how unemployment rates change, according to educational level, and whether racial gaps in those changes remain constant. After the Great Recession of 2007–2009, unemployment among college graduates reached all-time highs of 4.7, compared to 15% for those without a high school degree. Unemployment for minorities also increased, on top of high unemployment rates before the recession (Hout and Cumberworth 2012). There was, in time, an economic recovery. For recent young college graduates in 2016, the unemployment rate was 5.6% (compared to 5.5% in 2007, before the recession began), and the underemployment rate was 12.6% (compared with 9.6%, before the recession began). There were also differences related to race and ethnicity, in 2016. Young Hispanic and African-American graduates had higher unemployment than white non-Hispanics (9.4% for young black college graduates). There were also

higher rates of those unemployed and without further schooling, for both African Americans and Hispanics (Kroeger et al. 2016).

In 1978, sociologist William Julius Wilson argued in *the Declining Significance of Race* that because the civil rights legislation created opportunities for higher education and employment for African Americans, there was a black middle class, with greater social and economic distance from poor blacks than from middle-class whites. Wilson concluded that social class was a more important indicator of well-being than race (Wilson 1978). The persistence through the business cycle (times of prosperity-recession-prosperity), of a racial gap in employment, including college graduates, suggests that the effects of differences in race may be stronger than differences in social class, of which educational level is otherwise a key component. To put it simply, African-Americans and Hispanics with college degrees do not do as well economically as non-Hispanic whites with college degrees. This in turn suggests that although there are class differences within nonwhite groups, race is a more persistent indicator of economic well-being than class. Differences in race do not cancel out differences in class, such as income, wealth, and education, but they qualify them. In their 1997 *America in Black and White*, conservative analysts Abigail Thernstrom and Stephan Thernstrom argue over 700 pages that within any social class—as defined economically—African Americans are worse off in education, health, living circumstances, and many other factors of well-being (Thernstrom and Thernstrom 1997).

There is upward economic mobility on individual levels, but there is also downward mobility and both are influenced by race. Half of African Americans born into poverty remain poor by age 40, compared to less than a quarter of white Americans (Rodrigue and Reeves 2015). Moreover, a 2014 study from the Federal Reserve Bank of Chicago suggests that among middle-class families, 60% of African Americans become worse off economically than their parents, compared to 36% of whites (Mazumder 2014).

There is a puzzle here, because the popular association of social class with money and education suggests that once African Americans attain a level of income and degrees equal to those of whites, they should have the same class advantages. However, class is more complicated than economics and education. Instead of using traditional ideas of classes, Wendy Bottero and other contemporary sociologists work with the idea of stratification, in showing "how where we start in life affects where we end up." The positions of parents affect their children, but there also are other influences, involving both individual choice and external social structures (Bottero 2005, pp. 4–6). The French sociologist Pierre Bourdieu has provided an idea of social class that

includes different kinds of "capital"—economic (the usual wealth/income), social (who a person knows), and cultural (tastes in a consumer economy) (Holt 1998). Bottero writes of a new notion of class as "an individualized process of hierarchical distinction":

> 'Class' processes have become more implicit and less visible, but the effects of class are no less pervasive in people's lives. This is a radical shift in how class is seen to operate. Rather than the polar terms of 'class in itself' giving rise to 'class for itself' in which inequality triggered consciousness and action, this new model sets out a reverse process, where explicit class identification and awareness dissolve, leaving behind a hierarchical version of 'class', implicitly encoded in identity through practice…The importance of this theoretical change cannot be over-emphasized, since it offers a fundamentally different way of thinking about how inequality works. (Bottero 2004, p. 1001)

Both Bourdieu and Bottero provide theories of class that depend on individual choices and behavior, rather than group goals. The **cultural capital** of individuals may identify them in class terms as elite or nonelite, but such capital is not entirely the result of socioeconomic group membership, as in earlier theories of class. Choices of food, clothing, habits of travel, including foreign travel, knowledge about art, music, and even popular culture, and hobbies requiring special skills, as well as many other matters of taste, are components of an individual's cultural capital. Individuals are naturally drawn to those with similar kinds and amounts of cultural capital and achieve social status on the basis of the recognized rarity of their cultural capital (Holt 1998).

In an apparently classless society, when and where class does in fact still operate through individual taste and implicit judgments and assessments, racial difference can be a barrier to full class equality, even when requirements of income and education are in place. Job opportunities and job security occur within institutions, where in most cases white Americans have more power and authority than nonwhites. Their subtle preferences, inclusions, and exclusions may depend on cultural capital rather than direct racial sameness and difference. From the standpoint of nonwhites within such institutions or in contact with them, issues of racial climate will be experienced that do not amount to either institutional or hearts-and-minds racism, but which nevertheless impede their access or success, as individuals, in very specific ways. That is, race can be an obstacle to real and lasting upward socioeconomic mobility for nonwhites, because individual functioning on all socioeconomic levels requires that individuals interact with other individuals. In most institutions and organizations where nonwhites might rise

socioeconomically, white individuals are already dominant and have more power than nonwhites. Insofar as the cultural capital related to their racial identity determines how those whites with power shape institutions, they may choose to share power with only some other whites and fewer nonwhites. For example, whites who play tennis or regularly travel abroad may have higher status than people of color, as well as other whites who do not have those interests or resources.

Health and Medicine

There are significant disparities in health according to race. In 2013, in its second minority health report after 2011, the Director of the CDC (Center for Disease Control), issued this overview:

> Cardiovascular disease is the leading cause of death in the United States. Non-Hispanic black adults are at least 50% more likely to die of heart disease or stroke prematurely (i.e., before age 75 years) than their non-Hispanic white counterparts (5).
>
> The prevalence of adult diabetes is higher among Hispanics, non-Hispanic blacks, and those of other or mixed races than among Asians and non-Hispanic whites. Prevalence is also higher among adults without college degrees and those with lower household incomes
>
> The infant mortality rate for non-Hispanic blacks is more than double the rate for non-Hispanic whites. Rates also vary geographically, with higher rates in the South and Midwest than in other parts of the country. (Frieden 2013)

There are also differences in health care by race, ethnicity, and language. A 2002 study of a national sample of insured Americans between the ages of 18–64 found differences in physician or mental health visits, influenza vaccines, and mammograms, during the past year. English-speaking Hispanic patients did not differ significantly from non-Hispanic white patients. But Spanish-speaking Hispanic patients were significantly less likely to have physician visits, mental health visits, or influenza vaccines. Black patients had lower health care use across all measures (Fiscella et al. 2002). The following may or may not be related to such lower rates of health care: African Americans have higher incidence and mortality rates from many cancers that are amenable to early diagnosis and treatment. African-American are underrepresented in cancer trials and less likely than whites to survive prostate cancer, breast cancer, and lung cancer. Only 68% of Hispanics are insured, compared to 88% of whites and 78% of blacks. Hispanic women contract

cervical cancer at twice the rate of white women. Overweight and obesity in American Indian and Alaska Native preschoolers, school-aged children, and adults is higher than that for any other racial or ethnic group. American Indian and Alaska Native women have twice the rate of stroke than white women. In a group with the highest rate of posttraumatic stress disorders, Asian-American women have the highest suicide rate of all women over age 65 in the United States (Russell 2010).

It is not surprising that life expectancy differs according to race and ethnicity, as illustrated in (Fig. 8.1) from the Center for Disease Control.

In popular thought, health differences according to race are often associated with older ideas of ethnicity or race, according to which certain ancestral backgrounds predispose members of racial and ethnic groups to some ills rather than others. This situation is analogous to the assumption discussed in the foregoing section on marriage (e.g., that Hispanic American women marry earlier for cultural familial reasons, instead of in reaction to their educational and economic circumstances as immigrants).

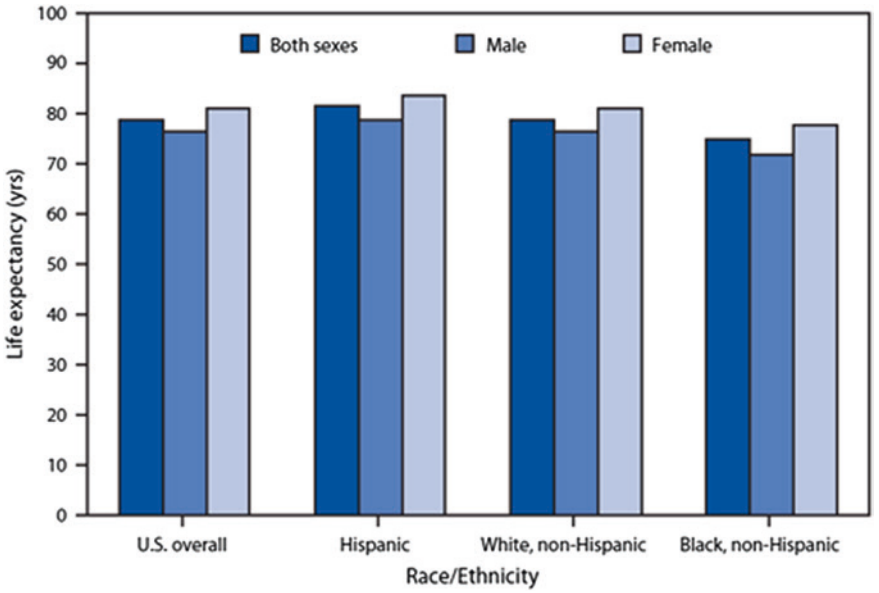

Fig. 8.1 *QuickStats*: Life expectancy at birth, by sex and race/ethnicity—United States, 2011. In 2011, life expectancy at birth was 78.7 years for the total US population, 76.3 years for males, and 81.1 years for females. Life expectancy was highest for Hispanics for both males and females. In each racial/ethnic group, females had higher life expectancies than males. Life expectancy ranged from 71.7 years for non-Hispanic black males to 83.7 years for Hispanic females (Minino 2014)

There are three analogous examples for thinking about race and health: The so-called Black heart drug, BiDil, the evolutionary account of sickle cell anemia, and obesity among the Pima Indians in Arizona.

BiDil

There was a sensationalistic report in *The New York Times* on June 13, 2005, "U.S. to Review Heart Drug intended for One Race" (Saul 2005a), with a follow-up on June 24, "F.D.A. Approves a Heart Drug for African-Americans" (Saul 2005b). About five million Americans, including 450,000 African Americans, have heart failure, an often fatal condition in which the heart does not pump enough blood. In the 1980s, NitroMed Inc. conducted a study of heart failure patients at veterans hospitals using BiDil, a drug that combined the existing drugs isosorbide and hydralazine in a fixed dose. The results were inconclusive but the African American subjects did better than others. BiDil was rejected by the FDA in 1997, because the results were inconclusive and because it went against its policy to not approve existing drugs in new combinations—that is, BiDil was not a new drug. NitroMed did not have funds to conduct a broader study.

However, in 2001, the FDA told NitroMed that BiDil could be approved as a treatment for African Americans if a study confined to African Americans showed it was effective. NitroMed contacted several African American political and scientific groups and it paid the Association of Black Cardiologists $200,000 to help organize further clinical research. NitroMed then conducted a new "African-American Heart Failure Study" on 1050 African Americans. BiDil reduced deaths by 43%.

BiDil is believed to work by increasing levels of nitrous oxide, a naturally occurring compound in the body. Many who suffer from heart failure have nitric oxide deficiency, which is more common in African Americans. But heart failure is also associated with high blood pressure and diabetes, as underlying causes which are not addressed by BiDil. Before BiDil was approved, many cardiologists noted that nitric oxide deficiency is not limited to African Americans and some said they would prescribe BiDil to any patients with the deficiency. (Once a drug is FDA approved, it can be prescribed for other purposes in "off-label" use.) (Brody and Hunt, 2006).

NitroMed's stock went up, quadrupling during pending and actual FDA approval of BiDil. It was able to extend its patent by 13 years, to 2020, on the basis of the drug's racially specific approval (Kahn 2014). Contemporary ads for BiDil show an African American father and son, with a sentimental caption (BiDil 2017). Critics have been astute at showing how BiDil was

brought on the market in a racially exploitative spirit. NitroMed freely admitted that it had not used any scientific methods besides self-reporting for selecting the race of its subjects and knew that the effects of BiDil were not limited to African Americans (Blacker 2010; Kahn 2014). Relevant here is Ian Hacking's distinction between race-based and race-targeted medicine (Hacking 2005). **Race-based medicine** is based on distinct physical characteristics of a specific racial group and there is no evidence for its foundation. **Race-targeted medicine** may be appropriate for members of a specific racial group, but not because of anything biologically *racial* about them (see Chapter 3). BiDil is race-targeted medicine.

Nevertheless, BiDil was welcomed by African Americans because of a broad perception that the standard pharmaceutical patient is a white male and nonwhites are underserved by the medical community (Lee 2005). Troy Duster, a sociologist at New York University (who is the grandson of African American antilynching activist and suffragist Ida B. Wells (1862–1931)), said the following about BiDil's FDA approval in a 2005 *New York Times* interview:

> I've heard geneticists say: "We're not concerned whether or not a person is in a higher or lower class position, or if they are white or black. We want to know what basic processes are going on." But few of these basic processes happen outside a social context. I believe you can't be creating ethnically based medicines, which is what a lot of biomedical research is about, without also doing some sociology. …Much of the racial genetic research is focused on finding drugs for diseases. I go to national meetings and I'm constantly facing geneticists who say to me: "Oh you sociologists, all you do is criticize. We're trying to save lives."
>
> I'm certainly for saving lives. But I wonder if this one-sided type of research will actually do that. When you're talking about genetic diseases, there's usually something in the environment that triggers their onset. Shouldn't we be talking about the trigger? Take the case of black men and prostate cancer. African-American males have twice the prostate cancer rate that whites do. Right now, the National Cancer Institute is searching for cancer genes among black men. They're not asking, How come black men in the Caribbean and in sub-Saharan Africa have much lower prostate cancer rates than all American men?
>
> A balanced approach might involve asking, Is there something in the American environment triggering these high rates? Is it diet, stress or what? The same thing goes for hypertension. All the studies on hypertension show that you reduce it when you take people out of stressful situations. American blacks have higher hypertension rates than whites. And it's undeniable that African-Americans face daily situations that are inherently stressful. They are routinely profiled when driving, shopping, applying for bank loans or

> seeking relief from a natural disaster like Hurricane Katrina. A lot of money is currently being spent to try to find a drug for black hypertension. That's a lot cheaper than a war on poverty, which might alleviate the root cause of a lot of the hypertension.

When the reporter related that BiDil was being marketed as beneficial to black patients and asked Duster, "Would you take the drug?," he replied:

> Actually, my brother is taking it. If I had a nitric oxide deficiency, which is what it is said to be effective for, I would, too. I'm opposed to the way it got to be marketed. BiDil came to market after a test where it was found to be ineffective for congestive heart failure in a large population. In the original test, there was the slight suggestion that it might help African-Americans. Rather than develop a clinical trial to show whites, Asians and blacks had different responses to the drug, the manufacturers went right to the F.D.A. and said, "Now let's try it on 1,050 black people." Good science is supposedly based on comparing things. (Dreifus 2005)

Duster's approach to BiDil is both practical and theoretical: Black people should take the drug if it helps them. (But so should people of any race.) Everyone should refuse a race-based approach to health that ignores social factors that ultimately cause differences in health according to race. Ignoring such social factors not only exaggerates myths and misunderstanding about race, but is an obstacle to research and public policy that would focus on real underlying causes and cures for many diseases.

Sickle Cell Anemia

In his 2005 *New York Times* interview, Troy Duster also observed the following:

> There are genetic diseases in population groups. I don't believe they are race based. These diseases are a marker for the regions where certain populations originated. Sickle cell anemia, for instance, is thought of as a black disease. But it's also to be found among Greeks who hail from a swampy area north of Athens and among people from the Arabian Peninsula.
>
> Conversely, cystic fibrosis is thought of as a white disease, though some African-Americans have it, too. I've been in a clinic where a black man with cystic fibrosis was told, "I believe you're in the wrong section of this hospital." So again, unless we're mindful of these variations, we're going to harm people. (Dreifus 2005)

Sickle cell anemia is a serious disease and the most common hereditary disease in the United States. In the early twenty-first century, average life expectancy for those who have it has been extended from 21 to 50 years, mainly through a vaccine that protects against pneumonia. About 1 in 13 African-American babies is born with sickle cell trait and 1 in 365 is born with sickle cell disease. One in 16,300 Hispanic-American babies is born with sickle cell disease, as are smaller numbers in the United States with ancestry from South America, the Caribbean, Central America, Saudi Arabia, India, and Mediterranean countries such as Turkey, Greece, and Italy (CDC 2017b). Approximately 100,000 people have sickle cell disease, and 2 million have sickle cell trait (North Alabama Sickle Cell Foundation 2017).

Two genes are relevant for the trait and the disease. Those who inherit one sickle cell gene and one normal gene have sickle cell trait (SCT) and they do not usually have symptoms of sickle cell disease (SCD), although their children can inherit either their normal gene or SCT gene. SCD is one or more of four red blood cell disorders. Red blood cells carry oxygen throughout the body. Normal red blood cells are round but an SCD red blood cell tends to have the shape of a C-shaped farm "sickle." In someone who has SCD, the red blood cells become hard and sticky and die early, resulting in a shortage of red blood cells and oxygen. Sickle cells also get stuck in small arteries and clog the flow of blood, which can cause stroke, as well as pain and infection. The only definitive cures are bone marrow or stem cell transplants (CDC 2017b).

For many years, it was popularly assumed that because African Americans suffered from sickle cell anemia, it was a race-based disease. In time, researchers identified it in individuals with Middle Eastern and southern European ancestry, as well as African Americans, which expanded their idea of the racial base for the disease. However, the scientific community also realized that there was no reliable means for determining race, so in the early 1990s, routine screening at birth came to include sickle cell testing (American Academy of Pediatrics 2002). Of course, such screening merely identifies SCD and does not disclose its origins.

In the 1940s, doctors in Africa noticed that patients with sickle cell anemia were more likely to survive malaria, which killed over a million people a year. A sickle cell mutation was identified in the hemoglobin gene (changing Hb to HbS), in either one or two copies of that gene, with one copy resulting in sickle cell trait, as described. In high malaria areas, up to 40% of the population had SCT. Those with HbS had resistance to malaria because when their sickle cells were destroyed in the spleen, the malaria parasite was destroyed along with them (Serjeant 2001; PBS 2001). Malaria itself is

believed to have coevolved with humans as a result of stressed environmental and changed agricultural conditions, such as deforestation resulting in standing pools of water where mosquitos bearing malaria breed. While most severe in sub-Saharan Africa, due to ecological destruction under colonialism, HbS has occurred in other situations of great poverty and upheaval (Packard 2007). It is also interesting, in confirmation of the evolutionary account, that African Americans who have been in non-malarial environments for generations, have lower rates of SCT than their counterparts still living in the same sub-Saharan areas as their ancestors. In a non-malarial environment, HbS does not confer any special advantage (Relethford 1997, pp. 93–4).

The Pima Indians of Arizona and Mexico

In 1965, The National Institute of Diabetes and Digestive and Kidney Diseases began a longitudinal study of type 2 diabetes and obesity among the Pima Indians on the Gila River Reservation near Phoenix, Arizona. In 1991, the study was extended to genetically similar Pima Indians in Maycoba, Mexico. Both Pima groups descended from Hohokam who lived in the Sonoran desert and Sierra Madre regions before 300 BC, but the groups separated in 1853. The Pima in Arizona used irrigation canals to grow corn, beans, squash, and cotton until about 1900, when white settlers diverted their water supply and they could no longer farm. Their lifestyle changed from active to sedentary and from a low-fat to a high-fat diet, with periods of famine. Diabetes was documented at normal rates in 1937 but increased ten-fold by the 1950s, and by 1965, the Pima in Arizona had the highest rate of diabetes in any population ever recorded. A longitudinal study showed that they had nineteen times the rate of diabetes of a sample white population in Rochester, Minnesota. By 1970, 40% of Pimas age 35 and older had type 2 diabetes and by 1990 the rate was 50%. Pimas also had higher rates of obesity and a genetic cause was sought for both conditions. It was proposed that given the famine in their history, surviving Pimas had inherited a "thrifty gene" that had enabled them to efficiently store calories in times of famine. They also had variable resting metabolic rates that researchers believed contributed to "thrifty metabolism." Without famine, type 2 diabetes and obesity resulted.

The Pimas in Maycoba, Mexico had a subsistence, labor-intensive farming lifestyle when health investigators arrived in 1991. Nineteen men and 16 women were measured for weight, height, body fat, plasma glucose,

cholesterol, and other factors, for comparison with the Pimas in Arizona. Only two women and one man had type 2 diabetes. A larger study began in 1994 and it was determined that the two Pima groups had the same gene pool. Results concluded that type 2 diabetes among the Mexican Pimas was less than one-fifth of the Arizona Pimas. Obesity was similarly lower, and the Mexican Pima had activity levels 2.5 times greater among men and 7 times greater among women. There were dietary differences in less fat and more fiber in the Mexican group. Researchers concluded that these lifestyle differences accounted for differences in diabetes 2 and obesity between the two Pima groups, despite a common gene pool (Schulz and Chaudharim 2015).

The history of the change in lifestyle imposed on the Pima Indians in Arizona and the comparative evidence that their health issues are lifestyle related together cry out for education and dietary and exercise habit changes. According to a 2014 "Needs and Assets Report," 30% of this population live in poverty, which is higher than state and national percentages. (Frances Mc Clelland Institute for Children, Youth, and Families 2014).

Social science researchers frequently refer to positive correlations between wealth/income, education, and health: The more money people have, the higher their education. Wealth/income and education combined, or separately, are positively correlated with health. With qualifications, this is referred to as the **education-health gradient** and **the wealth-health gradient** (Conti 2010). In some ways, this relates health to issues of social class, although it is not social class in the old sense of fixed groups, but social class in ways that get expressed and recognized through taste and consumption (cultural capital). And in addition the health-wealth gradient is affected by geography. For instance, there is a 20-year gap in US life expectancy between white men in the healthiest counties and black men in the unhealthiest counties (Murray et al. 1998).

Conclusion

Although race is a social construction, it is strongly bonded to family genealogy, so as to continually create intergenerational groups and identities for individuals. Beneficial social indicators, such as marriage rates, vary with race, although more due to external social and economic factors than ethnic or racial culture or the preferences or values of individuals. Social class persists in a classless society but in many indirect ways that sociologists now

claim includes the cultural capital of tastes and preferences. This means that as African Americans and other minorities apply or gain entry to institutions in which whites have the most power, their full upward mobility may stall, as reflected in persistently higher rates of unemployment compared to whites among recent young college graduates. Racial and ethnic health disparities can no longer be viewed as the effects of group cultures or biology, but need to be understood as the results of environmental restrictions on opportunities and/or causes of stress. Thus, BiDil, the so-called Black Heart Drug counteracts nitrous oxide deficiency that is not limited to blacks; sickle cell anemia provided resistance to malaria in sub-Saharan African groups; and Arizona Pima Indians had higher rates of diabetes and obesity than their genetic counterparts in Mexico. Overall, statistical views of well-being vary according to race and ethnicity, because health, education, and wealth/income are positively correlated, along with cultural capital, which vary among groups.

Glossary

authority—the recognition of power.
cultural capital—class status of individuals based on their preferences and practices in consumer society.
health-wealth gradient—gradual increase in health as wealth and income increase.
matriarchy—family and social structure in which women have the most power and resources, as well as resources and wealth.
patriarchy—family and social structure in which men have the most power and resources, as well as resources and wealth.
power—the ability to do something, influence others, or make things happen.
social status—a person's position or rank in any given pecking order or hierarchy that has to do with how others view them.
race-based medicine—medicine developed and applied because of hereditary or physiological differences among racial groups.
race-targeted medicine—medicine developed for and applied to a specific racial group, based on disease rates within that group.
racial climate—the degree and extent of hearts-and-minds racism on individual-to-individual levels, in specific contexts.
stratification—sociological analysis of "how where we start in life affects where we end up."

Discussion Questions

1. Do the low marriage rates for African American women indicate a "preference" for remaining unmarried? Explain the external factors.
2. If immigrant Mexican American women marry at younger ages, why is "ethnic culture" not a good explanation?
3. What does increasing interracial marriage indicate about white attitudes toward nonwhites, in your opinion? Explain how this is different from past ideas about miscegenation during segregation.
4. Why do older, Marxist notions of social class no longer apply?
5. If our ideas of social class are expanded to include cultural capital, how does that effect prospects for upward socioeconomic mobility among minorities?
6. Explain the difference between race-based and race-targeted medicine in reference to how BiDil was developed.
7. It what sense is sickle cell anemia related to racial identity and in what ways is it independent of even social ideas of race?
8. What does the difference in health among Pima Indians in Arizona and Mexico indicate about lifestyles and disease, more broadly?
9. How are education, wealth/income, and health related? Apart from the statistics can you imagine a concrete example, in narrative form?
10. If race in life plays out in comparatively disadvantaged ways for U.S. nonwhites, what can individuals do about this? Give specific examples.

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