

When is the Racial Pharmacy Bad Medicine?

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GenSpec, a Florida-based company, has begun selling new lines of multivitamins targeted at African-Americans, Caucasians, and Hispanics, touting them as “the first genetically specific nutritional supplements.” This follows on the heels of the FDA’s June 2005 approval of BiDil®, a drug marketed by NitroMed to treat heart failure specifically in African-Americans.

Is this trend towards a racial pharmacy good or bad medicine? During a recent conference at MIT, the NAACP, NitroMed executives, and Black cardiologists heralded BiDil’s approval as a positive development for minority health care. In contrast, a number of sociologists and legal academics asserted that using race as a proxy for biological and genetic differences remains scientifically unproven and socially risky: it could reinforce the mistaken notion that race is fixed by genes and biology.

What we know for certain is that the claims of GenSpec and NitroMed are probably misleading. Francis Collins, the director of the National Human Genome Research Institute at the National Institutes of Health, has raised warning flags, arguing that “‘race’ and ‘ethnicity’ are poorly defined terms that serve as flawed surrogates for multiple environmental and genetic factors in disease causation, including ancestral geographical origins, socioeconomic status, education and access to health care.” And although BiDil has been widely cited as an example of the promise of “genomic medicine,” no distinctive genetic component of BiDil’s efficacy has been established.

Furthermore, NitroMed used an old study to provide the comparative racial data supporting its claim that Blacks suffer from heart failure twice as often as Whites. And as Jonathan Kahn, a legal scholar at Hamline University, has pointed out, those data came from a subgroup analysis of a group (men between the ages 45-64) that makes up only 6% of those suffering from heart failure.

Standing on even shakier ground are GenSpec’s racial vitamins, which show how pharmaceutical segregation is spreading to the less regulated supplements market. At the center of GenSpec’s business model is the claim that 100% of African-Americans and Hispanics tested in a Mayo Clinic study had a vitamin D deficiency linked to their dark skin blotting out too much sunlight. But that study’s utility is confounded by the fact that its patients all suffered from a painful condition that likely kept them indoors: all had a chronic musculoskeletal pain condition characterized by persistent neck, spine, and back pain that can severely limit physical activity.

Describing this vitamin D deficiency in genetic terms rather than skin tone is unnecessary and misleading. Assuming that self-identified ethnic categories map directly onto skin tone is a clear fallacy that could lead to mistreatment. Communities of color certainly suffer different health outcomes, but claiming to address complex social and environmental problems at the molecular level may do more harm than good.

The central concern here is as much about how people think about race and racial disparities as it is about particular health outcomes. Health care practices that fixate on molecular and genetic differences as the explanation of racial disparities in health

may deflect attention from known causes linked to economic class, social conditions, and health access. If it became entrenched, such thinking could open the door to other and more insidious forms of genetic reductionism.

Is there a way for policy to take into account both the potential health benefits of race-specific drugs and the attendant social risks of biologizing race in this way? We believe so, using constitutional law by analogy. In areas such as employment and education, the Supreme Court has subjected the state's use of racial categorization, even for facially benign purposes, to "strict scrutiny." In order to prevent harmful or needless promotion of racial classification, this doctrine requires the use of race to be "narrowly tailored to promote a compelling state interest."

It is true that drugs and vitamins for different sexes and ages are not uncommon. However, in light of the historic uses and abuses of racial science, we argue that the use or approval of race must be held to a heightened standard of proven efficacy, and be narrowly tailored—that is, used only when better proxies (such as specific genetic markers) are not available. Such an approach should apply both to drugs and supplements to help ensure that race-specific claims meet minorities' needs in meaningful ways rather than being driven by the commercial need to develop new markets.

Medicine should not be color blind, but it also should not be too quick to use race as a proxy for genes. Government has a strong interest in approving the use of race only when it is supported by robust scientific studies, not simply minimal

ones. Using racial categories in medicine and supplements will require remarkable sensitivity and responsibility on behalf of corporations, government, clinicians, and consumers. Sensible oversight now may very well prevent serious harms later. History shows that race and medicine can be deadly bedfellows.

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