
Critical Issues in Health and Medicine

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Mapping “Race”

**Critical Approaches to Health
Disparities Research**

Edited by

Laura E. Gómez and Nancy López

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Contents

	List of Figures and Tables	vii
	Foreword	ix
	R. Burciaga Valdez	
	Preface	xiii
Chapter 1	Introduction: Taking the Social Construction of Race Seriously in Health Disparities Research Laura E. Gómez	1
Part I	Charting the Problem	23
Chapter 2	The Politics of Framing Health Disparities: Markets and Justice Jonathan Kahn	25
Chapter 3	Looking at the World through "Race"-Colored Glasses: The Fallacy of Ascertainment Bias in Biomedical Research and Practice Joseph L. Graves Jr.	39
Chapter 4	Ethical Dilemmas in Statistical Practice: The Problem of Race in Biomedicine Jay S. Kaufman	53
Chapter 5	A Holistic Alternative to Current Survey Research Approaches to Race John A. Garcia	67
Part II	Navigating Diverse Empirical Settings	85
Chapter 6	Organizational Practice and Social Constraints: Problems of Racial Identity Data Collection in Cancer Care and Research Simon J. Craddock Lee	87

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Introduction

Taking the Social Construction of Race Seriously in Health Disparities Research

Typing the word “disparities” into the search engine of the American Diabetes Association web site generates nearly 1,700 hits that relate to racial and/or ethnic gaps in diabetes rates and care (<http://www.diabetes.org>, accessed July 5, 2012). Similarly, an agency of the U.S. Health and Human Services Department proclaims that the risk of diabetes is “much greater for minority populations than the white population” (“Diabetes Disparities among Racial and Ethnic Minorities Fact Sheet” 2012). These warnings reflect multiple biomedical studies that have identified differential rates of diabetes among Whites (6.2 percent), American Indians (9 percent), Mexican Americans (10.6 percent), and African Americans (10.8 percent; Mokdad et al. 2000), as well as those that have reported that some non-White groups have diabetes-related complications at rates as much as 50 percent higher than Whites (Carter et al. 1996). The temptation is to attribute such disparities to genetic differences because people often assume that “racial” groups correspond to biological differences. Moreover, in a capitalist society in which much medical research is driven by pharmaceutical companies’ pursuit of individualized solutions to health problems (see Kahn, this volume), we often look for a genetic basis for health outcomes.

Yet much data suggests that the notion of biological race is a poor proxy for other social dynamics. For example, epidemiologist Thomas LaVeist and colleagues have challenged the conventional wisdom that differential rates of diabetes reflect essential, biological differences (2009). They studied diabetes in a racially mixed Baltimore neighborhood that included large numbers of both African American and White residents who were of the same socioeconomic class and who had comparable access to healthcare. In contrast to the

government studies previously referenced, they found that African Americans and Whites in this neighborhood had quite similar rates of diabetes (LaVeist et al. 2009). "I don't mean to suggest that genetics play no role in race differences in health," LaVeist said, explaining the study's conclusions, "but before we can conclude that health disparities are mainly a matter of genetics we need to first identify a gene, polymorphism or gene mutation that exists in one race group and not others. And when that gene is found we need to then demonstrate that that gene is also associated with diabetes. On the other hand, there is [already] overwhelming evidence that behavior, medical care and the environment are huge drivers of race differences in health" ("Racial Disparities . . ." 2009). In other words, looking for race-based health disparities may at best jump-start a productive scientific inquiry when it leads researchers, policy makers, and health care providers to ask further questions about *why* race seems to be important in the context of a specific disease or health problem. But, at its worst, looking for race-based health disparities blinds us to seeing the full range of possible causes of health inequalities.

The broader point that we collectively make in this book goes a step further: we must be skeptical of claims about race-based health disparities precisely because "race" is the product of historically rooted ideas and political contestation (Gómez 2012). Anthropologist Michael Montoya puts it this way: "the ascertainment of ethnicity or race is a profoundly social enterprise anchored in contemporary history," and racial categories, both historically and today, "correspond best to the imaginations of the scientists and not the presumably defining and stable features being measured" (Montoya 2007). Using the example of diabetes in his book *Making the Mexican Diabetic*, Montoya explores how the process of racializing diabetes—that is, the process of scientists and health professionals learning to take for granted that diabetes has a distinct impact and perhaps even etiology in people of different races—has occurred in laboratories, in government funding circles, in peer-reviewed scientific publications, and in the practice of medicine (2011). What explains biomedical researchers' categorization of humans into groups, and then the linkage of those groups to specific health problems such as diabetes, is the social process of making race—of constituting race as socially, politically, and scientifically important. Thus, our research agenda must include actively studying this racialization process; says Montoya: "when we carefully examine the selection of a group to study, the labeling of that group, the representation of that group in scientific papers, we see a science of population labeling based squarely on sociocultural factors particular to each group, each region, and each historical period" (Montoya 2007).

As the diabetes example shows, there is a thriving literature documenting what appear to be enduring race-based health disparities in the United States. In their comprehensive review of the literature on health disparities, sociologist David Williams and his colleagues confirm that the long-standing gap between health outcomes among Whites and other racial groups has persisted into the twenty-first century (2010). In particular, a wide variety of data sources show a continuing gulf between Whites and Blacks; for example, as a general measure of health, consider life expectancy. Whites' life expectancy is 78.3 years, compared to 73.1 years for Blacks, so that it would take another quarter-century to close the current White/Black life expectancy gap (Williams et al. 2010, 70). Similarly, the data show widening contemporary disparities between Native Americans and Whites (Williams et al. 2010, 74). Although, for a variety of reasons, the data is more limited than for African Americans and Native Americans, other data show that Latinos and Asian Americans have inferior health outcomes relative to Whites in many categories (Williams et al. 2010, 71).¹

To a large extent, the current boom in the study of race-based health disparities is the result of the process of institutionalizing, at the federal level, research and data collection along gender and racial lines. Since 1990, Congress has mandated a number of policy changes that have impacted how biomedical researchers and social scientists study health disparities (C. Lee 2009). For example, in 1990 the National Institutes of Health (NIH) created the Office of Research on Minority Health (C. Lee 2009, 1185).² In 1993, when Congress funded the NIH, it directed the agency to require all grant awardees to include women of all races and minority men in clinical research (C. Lee 2009, 1185). During the same era, the federal government also created specialized departments to explore racial disparities within the Department of Health and Human Services and the Centers for Disease Control (Abu El-Haj 2007, 292–93). Sociologist Stephen Epstein (2007) has documented the fascinating political context and institutional dynamics that produced these changes, but no one doubts that these norms have become entrenched in today's biomedical research establishment.

If the federal government mandates various types of data collection to document such gaps and that data show racial gaps in health outcomes, what is wrong with health disparities research on race? Nothing, so long as that research is scientifically rigorous and accurate. The purpose of *Mapping "Race"* is to improve how health disparities research is conducted by challenging some central premises. The book's core argument is that biomedical researchers and social scientists have not sufficiently grappled with how the conceptualization of race as socially constructed implicates how we operationalize and analyze

race in health disparities research. Although they represent a variety of disciplines across the branches of the medical, biological, and social sciences and take varied methodological approaches, the authors in this book agree that serious negative consequences will result if researchers continue to follow the current course. Significantly, it is *not* our claim that research on race or race-based health disparities is illegitimate or inappropriate. We align ourselves with those scholars who have called for more and better research on race and racism (American Sociological Association 2003), rather than with those who have argued that the race is too complicated and fraught to be effectively studied scientifically (American Anthropological Association 1998).

Thinking Critically about Racial Disparities

In order to make the point that researchers must chart a different course, let us start with an example that seems to be a classic case of a race-based health disparity. While White women in Chicago are slightly more likely than Black women in Chicago to get breast cancer, Black women are twice as likely to die from it. As legal scholar Dorothy Roberts has noted, what is most shocking about this fact is that the Black/White gap emerged after 1980, when public awareness of breast cancer was at an apex and when there were great advances in detection and treatment (2011, 123). What happened between 1980 and the turn of the twenty-first century to widen the gap between White and Black women's breast cancer outcomes? If we were to think in narrow terms about "race," we might be tempted to explore genetic (or epigenetic) differences as a symbol of what many people believe to be the biological differences among racial groups.

A different approach is to think about the social context that produces racial disparities, which in turn involves thinking about race and racial dynamics as socially constructed. In Chicago, that means understanding the difference in access to health care that White and non-White women typically receive. When Roberts interviewed Dr. Steven Whitman, whose research first documented the breast cancer survival disparity, she did so in his office at Mount Sinai Hospital, which she described as "small and shabby" and without air conditioning. Roberts noted that the hospital is located in "an all-black community called North Lawndale on Chicago's West Side, a block from the border of South Lawndale, which is predominantly Mexican . . . The patient population here at Mount Sinai is about half black and half Mexican," Whitman told Roberts (2011, 124). He went on to say that Mount Sinai has, at most, one day of cash on hand to operate the hospital, compared to Northwestern University Hospital (located in majority-White, affluent Evanston, a northern

suburb of Chicago), which he estimated has four hundred days of cash on hand (and daily spends \$5 to \$10 million; Roberts 2011, 125); in the health care sector, hospitals are rated by bond agencies according to how many days of cash they have on hand.

Whitman interprets the data as showing that while Black women's breast cancer treatment stayed stagnant in the last two decades of the twentieth century, White women's breast cancer prognoses dramatically improved due to early detection via mammograms and advances in treatment including radiation therapy and new medication regimes (Roberts 2011, 125). Roberts found that Black neighborhoods in Chicago had few facilities with mammograms (so that women had to travel long distances to get them, decreasing the likelihood that they would do so); that public hospitals used older, inferior mammogram equipment (often lacking both digital technology and trained mammographers); that until the 2010 Patient Protection and Affordability Act (President Barack Obama's healthcare initiative), even middle-class women with insurance were deterred from getting mammograms because of high insurance copayments (the 2010 law mandated the elimination of payments for women over age fifty); and that racially segregated neighborhoods meant that White women more frequently had access to the best breast cancer treatment facilities, which Whitman said were usually located in "the fancy institutions—they are all in white neighborhoods" (2011, 125–27).

How are we to understand the role of race in the Chicago breast cancer example? The typical approach is to view race as an individual characteristic. For example, researchers often speak of self-identified race, wherein a research subject selects her or his racial category from a list of limited options (which almost always correspond to the Office of Management and Budget [OMB] racial categories, themselves derived from U.S. Census categories). The OMB categories include "five racial categories (White, Black, American Indian or Alaskan Native, Asian, and Native Hawaiian and other Pacific Islander) and one ethnic category (Hispanic)," which most biomedical researchers collapse into six categories of "self-identified race" that respondents may choose from among (Williams et al. 2010, 70). When researchers view race as an individual characteristic, they often fall into the pattern of biologizing race in terms of ancestry or genetics. This in turn invites the tendency to view health disparities as a question of individual failure (for less healthy individuals) or individual success (for more healthy individuals) and to identify solutions to disparities that focus on the individual body, such as pharmaceutical solutions (see Kahn, this volume).

But Roberts tells a very different story about the racial disparity in breast cancer survival in Chicago. She urges us to think about how racial discrimination

has structured all sorts of inequalities, including health inequities. In her narrative, the emphasis is on how Chicago's existing pattern of residential segregation of African Americans produces tangible gaps at every stage of healthcare. In a similar way, Williams and colleagues offer a nuanced picture of how neighborhood segregation leads to poor health via six "pathways":

First, segregation limits socioeconomic mobility by limiting access to quality elementary and high school education, preparation for higher education and employment opportunities. Second, the conditions created by concentrated poverty and segregation make it more difficult for residents to adhere to good health practices. . . . Third, the concentration of poverty can lead to exposure to elevated levels of economic hardship and acute stressors at the individual, household and neighborhood level. Fourth, the weakened community and neighborhood infrastructure in segregated areas can also adversely affect interpersonal relationships and trust among neighbors. Fifth, the institutional neglect and disinvestment in poor, segregated communities contributes to increased exposure to environmental toxins, poor quality housing and criminal victimization. Finally, segregation adversely affects both access to care and the quality of care. (2010, 79)

An even broader context would situate current residential segregation as part of a larger history of government-sponsored, legally enforced policies that created today's urban spaces. In this broader narrative, today's health disparities are inextricably intertwined with the past because that past has direct impacts today—via laws that restricted Blacks, other non-Whites (and sometimes Jews) from buying houses in certain neighborhoods (racially restrictive covenants); via federal housing policies and agencies that created White-only suburbs, supported the redlining of Black neighborhoods by banks and insurance companies, and that destroyed vibrant minority neighborhoods with the placement of highways and public transportation axes; and via neighborhood-based public schools that created a system of "naturally" occurring segregated schools that themselves became a self-fulfilling prophecy for marking neighborhoods as "good" (White) and "bad" (non-White).

The starting point for Dorothy Roberts's analysis is the claim that "race is not a biological category that is politically charged [but rather it] is a political category that has been disguised as a biological one" (2011, 4). It is the cumulative, *social* meaning of race in particular times and places that has shaped and continues to shape both racial discrimination (and racism) and racial meaning. To put it another way, we should not consider racial disparities in

any isolated sense but instead consider the social context of racial categories and racial discrimination. Thinking about race-based health disparities, then, must also involve engaging the social meaning of race and racism—the objective of this book.³

Mapping "Race" asserts that we must think critically about how ideas about race are used in making claims about health disparities. We focus on three common deficits in the health disparities literature: (1) the failure to adequately define and/or conceptualize "race;"⁴ (2) the frequent and uncritical use of race as a control variable; and (3) the analytical slippage that often results when scholars (who have often engaged in the first two problematic steps) overstate or misrepresent the effects of race. The combined effect of these three weaknesses in the current literature on race-based health disparities is to lead researchers and policymakers to think of race as fixed and biologically rooted.

And this, in turn, leads to two major flaws that have significant public health implications. First, as Pamela Sankar and colleagues have noted, there are real dangers in taking an overly simplistic view of race, including the tendency to privilege genetics rather than environmental factors and the tendency to "blame the victim" by attributing poor health outcomes to particular racial groups (2004, 2987–88). Moreover, at the level of large-scale public health interventions, misidentifying race as the culprit leads to misplaced government resources coupled with the failure to implement genuine solutions. Let me illustrate the problem by returning to the example of diabetes that opened the chapter. Today, our approach is largely one of education to encourage early medical intervention, testing, and treatment; in other words, we spend a great deal of money widely publicizing to African Americans, Latinos, and Native Americans that they are especially susceptible to diabetes. But if LaVeist and colleagues are correct that diabetes rates more likely reflect patterns of social class and neighborhood/environmental factors that often are linked to race and racial discrimination at the macro-, meso-, and micro levels, then we are not effectively addressing the problem. Instead, an overly simplistic focus on individual-level race masks the actual causes of health disparities—the racialized-gendered social determinants of health (see López, this volume)—that policies should address. Our education efforts would be better spent targeting the populations most vulnerable to poor access to healthcare, rather than using racial group membership as a crude proxy. Moreover, this approach involves thinking about how racial status and racism interact with socioeconomic status and discrimination in a complex, mutually constitutive way (rather than thinking about social class as determining race, as has been historically prevalent in the literature; see Takeuchi and Gage 2003, 439).

Mapping "Race" asks students and scholars of health inequalities to make the following four commitments in their research. First, they should work hard to understand what it means to say that race is socially constructed as part of interrogating and explicating their own conception of race. Second, they should understand the substantial scientific costs of continuing to mismeasure race in their research; in other words, they must be accountable for the limitations of their findings, given their reliance on a cramped measurement of race rather than one that corresponds to a robust notion of socially constructed race. Third, no matter what toolbox of methods they deploy, researchers must become proactive in seeking ways to measure race that more accurately reflect their chosen conceptualization. Finally, scholars of health disparities should be cautious when they make claims about race-based disparities. In other words, they should avoid making claims that attribute causation to race without sufficiently exhausting other causes—particularly social and environmental causes and structural racism—and they should acknowledge the ways in which race is inextricably intertwined with other causes of health inequalities.

Flaws in the Current Approach

Much empirical research on race shares a common problem—the tendency to conceptualize race narrowly as phenotype and to crudely measure race via subject self-identification from a closed list of options. This is a weakness in health disparities research as well as in a variety of other subfields and disciplines.⁵ In essence, there are two problems. The first is that scholars use race without saying what they mean by the term, without articulating a particular conception of race, and without justifying why race matters in their analysis. The second is that, when they attempt to operationalize race in the context of their research, too many scholars fall into a default mode in which race is a “control variable” or, in qualitative studies, a background variable that has not been adequately conceptualized and specified (C. Lee 2009).

For example, in their review of more than one thousand articles published in the *American Sociological Review (ASR)*, Martin and Yeung found that, between 1937 and 1999, the number of ASR articles became increasingly quantitative (mostly relying on regression analyses) and that these studies increasingly used race as a control variable. The rise of regression methods increased the likelihood that scholars would take race into account, and yet scholars’ tendency to “simply add race as a control variable in a regression model” implicitly is a very narrow way of conceptualizing race. They conclude that this way of introducing race into the analysis “implies that, while race makes a difference, it is not a profound one, in that race does not affect the relationships

between other variables” (Martin and Yeung 2003, 532). Anthropologists Clarence Gravlee and Elizabeth Sweet contend that similar problems characterize the health disparities literature, where many researchers reflexively (rather than self-consciously) use race as a proxy “for some unspecified combination of environmental, behavioral, and genetic factors” (2008, 49). They identify two resulting problems as the tendency to obscure the actual causes of health inequities and the promotion (explicit or implicit) of the idea that racial differences are genetic and innate (Gravlee and Sweet 2008, 49).

Studies that use race in this or similarly narrow ways have had several, perhaps unintended, consequences. For one thing, these studies have cumulatively contributed to the popularization of a simplistic measure of race as a dichotomous variable (Black/White or White/non-White) usually based on either bureaucratic assignment (racial assignment by someone collecting government data, such as a county coroner) or subject self-identification. This common approach to race has in turn contributed to the idea, accreted over time, that race is fixed and biologically rooted. In this respect, scholars’ frequent, but unremarked upon use of race (especially as an independent variable) mimics the social phenomenon of Americans being repeatedly asked to report their race in a variety of life contexts, as noted by sociologist Ann Morning (2011). Framing the question as a simple one (with which of these listed groups do you identify racially?) and asking it repeatedly have led Americans to see race “as a permanent and individual characteristic: something that is embedded within us and [that] does not change over time” (Morning 2011, 3–4)—in other words, to reify race, rather than to see race as a complex and dynamic set of social processes.

The problem of failing to conceptualize and/or define race spans the methodological spectrum. Sociologist Edward Morris argues for “greater transparency in how race is measured in qualitative studies and increased reflection on this concept as it is socially situated” (2007, 411). It is not enough, he contends, to simply declare that race is a social construction; he urges scholars to go further by expressly acknowledging “how they choose to identify race as well as recognizing the limitations of this choice and being attentive to the enactment of race in a particular context” (Morris 2007, 422). In other words, scholars who include race as a facet of their studies (whether a major or minor facet) should deliberately conceptualize race, regardless of their chosen methods.

While such problems certainly transcend methodological orientation, there appear to be particular limitations with the tendency, in quantitative research, to use race as a control variable or as a crude proxy for some other social fact or process. Political scientist Taeku Lee has characterized the fundamental problem succinctly: “Although we acknowledge that race, like ethnicity, is a

social construct marked by fluidity, multiplicity, and contingency, we continue to measure racial and ethnic identities as fixed, categorical variables" (T. Lee 2009, 113). He has been most critical of his own brand of quantitative political science—"multivariate statistical models in which some political variable of interest is explained by including a dummy variable for a given racial/ethnic category" (T. Lee 2008, 462)—due to the trio of methodological problems it presents. First, this logic assumes that self-identified race influences the dependent variable (such as the health outcome), without any explanation or justification (T. Lee 2008, 462). Second, it makes the unwarranted assumption that self-identified race does not covary with other independent variables in the model (T. Lee 2008, 462). Third, such research typically fails to consider how self-identified race (or some other measure of race) could be unreliable because of such factors as how the subject's racial self-identification might vary depending on the race of the person asking the question (same or other race of subject), the place where the question was asked (home, work, or school), the language of the question, or myriad other circumstances (T. Lee 2008, 463).

Some scholars make the mistake of assuming that what "race" means is obvious. Yet we should make the opposite assumption: what "race" means is highly contested in popular culture, politics, law, and, as a result, science. In her research on how laypeople and scientists conceptualize race, sociologist Ann Morning (2009) finds three popular, contemporary conceptions of race: a biological notion, a culture-based notion, and the idea that race is socially constructed. Moreover, she finds that people do not hold one conception of race to the exclusion of others but move back and forth between these three conceptions in order to explain different situations they encounter where race is relevant. In a similar way, major institutions such as the federal and state courts move back and forth among several conceptions of race, even within a particular time period or legal area (see Gotanda 1991; Haney López 1996; Pascoe 2009).

Without making a conscious effort to do so, scholars are no more able to put aside folk notions of race than are laypeople. As Morning contends, "Despite the special authority that scientists enjoy, their beliefs are by no means independent of the broader society in which they train and practice. If lay people are influenced by what 'experts' say about race, the reverse is true too: scientific notions of race are informed by the broader political and social currents of their times" (2011, 4; see also Almaguer and Jung 1999, 234). In the context of the contemporary assault on race-conscious law and policy and the entrenchment of color-blind ideology in law and politics, it becomes all the more important for scholars to make clear the conception of race that they employ. Research that fails to expressly define race implicitly endorses a notion of race as fixed

and biologically rooted—a position that does not fit comfortably with the conception of race as socially constructed.

Benefits of Viewing Race as Socially Constructed

Thinking of race as socially constructed presents a stark alternative to this way of thinking about race (or, more accurately, the default mode of *not* thinking carefully about race). To say that race is socially constructed is to acknowledge that we use phenotype or other visible characteristics to sort people into social groups, that we impute qualities of good and bad to these groups, and that the resulting racial order structurally and ideological supports a system of racial stratification that is socially contingent and historically rooted (Omi and Winant 1994). Rather than conceiving of race as shorthand for some essential, biologically rooted human difference, the constructionist view of race foregrounds the use of racial categories to justify racial hierarchy and inequality in particular times and places. This should lead us to focus on the effects of racial categories and racial ideology, namely, racial stratification, racial discrimination, and racism.

An important aspect of the constructionist account has to do with historically situating scientific racism (in the social, biological, and medical sciences) as having played a critical role by creating and promoting biological claims about race in order to justify Whites' racial domination of people of color (Hartigan 2008, 185; Taekuchi and Gage 2003, 436). Anthropologist John Hartigan Jr. makes the point that from "the earliest developments of colonialism to the current, emergent operations of biocapital," the effort to differentiate the world's populations on the basis of usually racialized biological characteristics has been the basis for justifying the sorting of distinctly racial labor pools (2008, 185). According to him, "Current assertions that race is socially constructed do important work by keeping both this history and these contemporary misuses of race in view, while also challenging the evidentiary ground for making claims about linkages between race and genetics" (Hartigan 2008, 185). This is a point worth emphasizing: viewing race as socially constructed foregrounds the racist nature of past conceptions of race, including those embraced by scientists.

From the sociological vantage point, the claim that race is socially constructed has salience at all three levels of analysis: micro (individual), meso (community and organizational), and macro (institutional and structural). At the micro level, a constructionist approach acknowledges that race is dynamic over the life course (as one ages and develops) and that race varies by situation (for example, one might describe one's racial identity differently at work or at

school than one would in the context of one's neighborhood or extended family). At the meso level, a constructionist approach treats race as the product of organizational policies and practices that institutionalize ideas about race and that form a racial hierarchy that, over time, become natural and taken for granted by members of the organization. At the macro level, a constructionist approach to race directs our attention to aspects of the social structure that help reproduce the racial order and that justify that racial order as both right and inevitable. Let me illustrate each with an example.

Consider a study by sociologists Andrew Penner and Aliya Saperstein; they used a random sample of nearly 13,000 Americans to test whether racial perceptions were, in fact, fixed or fluid (Penner and Saperstein 2008; see also Saperstein and Penner 2010). Respondents were interviewed annually over two decades and were asked to self-identify their race, and Penner and Saperstein used these responses to code the subjects as "White," "Black," or "Other" (2008, 19630). In addition to this measure of racial self-identification in the dataset, interviewers were instructed to classify the subjects' race at the end of the interview, using the same categories ("White," "Black," or "Other") (2008, 19629–30). If race was fixed and rooted in objectively understood phenotype, we would expect little change in the interviewer-ascribed race of the 13,000 respondents. Instead, 20 percent of the individuals experienced at least one change in how interviewers classified them (2008, 19628). Penner and Saperstein found that, even when controlling for a wide array of possible factors, three characteristics of the respondent stood out as statistically significant predictors of the interviewers' switching a respondent's racial category: incarceration, unemployment, and income below the poverty line. The study suggests, then, that knowing one of those facts (about incarceration history, unemployment status, or poverty status) changed whether the interviewer saw the study participant as more or less "White" or more or less "Black," suggesting that racial status is far from fixed and uncontested in one-on-one interactions. Moreover, the magnitude of change in racial perception was significant, affecting two in ten study participants in this large, random sample.

As an example of meso-level dynamics, sociologist Nancy López's ethnographic research on New York City schools illustrates how socially constructed race works—via "formal and informal institutional practices within schools"—to racialize students (2003, 41). For example, she found that hyper-segregated urban schools usually had "dumbed down curriculums" boring to students who responded by "engaging in willful laziness," thereby perpetuating a cycle in which mostly White teachers thought of their students, all of whom were people of color in this school, as intellectually incapable (2003,

42). Another way that schools harden racial and gender boundaries is under the guise of "discipline." López spent extensive time at a Manhattan high school that was characterized by hyper-policing despite the fact that security officials told her that most student-to-student disputes were fights about property and that there had not been a single gun incident in more than five years. For example, the school's head of security explained that enforcement of the rule against wearing hats was motivated by his need to demand respect from students. The rule was enforced selectively, only against male students (all of whom were Black and Latino), and it became a site for hardening racial categories because the boys took as many opportunities as they could to resist the rule (2003, 76–77). Overall, López concludes that the school's discipline policies constitute a pipeline between over-policed public urban high schools and the larger society's criminalization of men of color via the prison industrial complex (2003, 76–77). In this way, we see schools' powerful work to reproduce racial hierarchy and racial ideology. One by-product is that young men of color are primed to experience greater stress and racist microaggressions that will contribute to a lifetime of stress that will feed into various mental and physical health problems (for example, see the chapters by Geronimus and Helms and Mereish, this volume).

The dynamic nature of racial categories and racial ideology is also observable at the macro, or societywide, level. For example, my analysis of how Mexican Americans were incorporated into the American racial hierarchy in the nineteenth-century Southwest shows that time and place matter and that "race" is not the same across space, time, or groups (Gómez 2007). Largely because doing so served the interests of the national campaign to invade Mexico and take its northern territory in order to reach the Pacific (often justified by the rhetoric of Manifest Destiny), 115,000 Mexican Americans living in the former Mexico became naturalized American citizens overnight in 1848. This occurred despite the fact that, at the time, U.S. laws excluded all non-Whites from becoming citizens; in this sense, Mexican Americans were recognized as *legally* White. At the same time, there were multiple ways in which Mexican Americans and Mexicans were treated as racially subordinate and non-White between 1848, when the war with Mexico came to an end, and 1912, when Congress made New Mexico a state despite its majority-Mexican, Spanish-speaking population (Gómez 2007). Mexican Americans came to play a role as what I term an off-White wedge group on the national scene, between African Americans below them (who were both socially and legally marked as racially inferior) and Whites above them (who were both socially and legally marked as racially superior), as well as in the more specific racial order in New Mexico, in

which Mexican Americans were an intermediate group between Native Americans below them and Whites above them.

To say that race is socially constructed means to acknowledge that racial status is dynamic and situational: rather than being fixed at birth, life has any number of feedback loops that can change one's race at the level of individual interactions, at the level of how organizations and communities operate, and at the level of societywide structure and ideology. The view that race is socially constructed has become the dominant approach in the social sciences (American Anthropological Association 1998; American Sociological Association 2003; Hartigan 2008; C. Lee 2009), and the idea has gained traction in many other fields and even in popular discourse (Morning 2009, 1171).⁶ Indeed, the constructionist view of race has become so popular that it has been embraced by proponents of a color-blind perspective in many domains, from popular culture to medicine and law. According to this color-blind world view, the fact that race is socially constructed means that race is not "real," and therefore it should never be the basis of government policies such as affirmative action.

This position deeply misunderstands the basic premise of sociology and anthropology: the fact that how we collectively understand the world powerfully shapes how we interact in it and therefore reality as we know and experience it (Berger and Luckmann 1967). For example, proponents of the color-blind view often emphasize the role of individual preferences and market behavior, and yet, these aspects of social life are themselves key aspects of the socially constructed social fabric: Ideas, norms, and rituals evolve at the group or societal level and help to constitute individual identities, needs, preferences, and behavior. Individual action cannot be understood apart from the social environment that gives meaning to that action. Both "preferences" and market behavior are governed by taken-for-granted notions of what is natural, right, and rational (Edelman 2004, 186). With respect to race, enduring notions about the biological basis for race support and interact with other racial ideas to create the taken-for-granted, natural world in which racial identity and racial categories persist, in which we routinely (and often without thinking) classify people whom we encounter into racial categories, and in which we make a host of decisions (conscious and unconscious) based on those categorizations. Or, as epidemiologist Jay Kaufman puts it, "Despite this widespread understanding that racial categories are a product of our cultural imagination, we are still no more able to dismiss them. Race is not in our heads because it is real, but rather it is real because it is in our heads" (1999, 101).

The fact that biology—or what we often use as proxies for biology, such as ancestry, phenotype, genes—is seen as related to race and even, in many

people's contemporary understandings of race, what produces racial difference, is indeed an important part of the social meaning of race. Yet biology is no less socially constructed, as sociologist Troy Duster has noted, emphasizing that the social meanings of race and racial interactions themselves have "feedback loops" into the biochemical, neurophysiological, and cellular aspects of bodies that can just as readily be studied scientifically (Duster 2003; Duster 2004). In other words, when human beings define situations as real, they can and often do have real social and biological consequences, consequences that can be translated into social facts that we as researchers can attempt to study and understand. Thus, saying race is socially constructed is not the same as saying that biology is irrelevant to race.

As Hartigan suggests, rather "than deploying 'social construction' to reassert a distinction between the 'biological' and the 'social' or to assail the return of 'atavistic beliefs' about race, the more important move is to establish the primacy of cultural dynamics at work in shaping not just the genetic evidence and its interpretation, but the very interests and desires related to race that inform how this controversy unfolds both within and outside of the lab" (2008, 186; see also Gravlee 2009). Anthropologist Michael Montoya (2011) does some of this work in the context of unpacking how scientists, Mexican-origin DNA donors, and health professionals all came together in recent decades to construct diabetes as "a Mexican problem," with the pharmacogenetic implications that such a view entails. Montoya warns,

What requires explanation are not the processes and practices that technoscientists reiterate in the making of the three or five "races of man." Although necessary, this is an unsatisfactory level of resolution if we are to understand and transform those material and semiotic assemblages that perpetuate inequity. Rather, what demands explanations are why this occurs in spite of the scientific, ethical, social, and political consequences so carefully detailed by scholars and analysts from a spectrum of fields across the social and biological sciences and humanities. (Montoya 2011, 180)

Implications for Health Disparities Research

Consider that, of nearly 136,000 articles published in biomedicine (human research studies only), a whopping 51,039 used the concept "Negroid," while 37,044 used the concept "Caucasian," and 20,656 used the term "Mongoloid" (Graves 2010, 43). As biologist Joseph Graves has pointed out, while we know today that, on the one hand, these terms do not correspond to any discrete

population groups (so they could not correspond to mutually exclusive categories that scientists could study), on the other hand, biomedical researchers (and laypersons) continue to deploy these terms ubiquitously and casually. Building on the just noted calls by Hartigan and Montoya, and in response to scientists' continued use of these terms despite their lack of validity, our agenda should be to ask a different set of scientific questions: why do these terms persist (in science and in the popular imagination) as racial designations? What political work does continuing to talk in terms of "Negroids," "Caucasians," and "Mongoloids" do in the contemporary discourse about race and racial difference? As an intellectual inquiry, such an analysis would involve conceiving of race as socially constructed—as a product of a particular place and time—as well as considering how racism and racial subordination have been and are promoted by this kind of language and categorization that is anything but scientifically neutral.

This way of thinking about race as principally about socially created (and politically sustained) hierarchy and subordination differs dramatically from an approach that emphasizes race as an essential individual characteristic. Consider Dr. Sally Satel, who has gained notoriety by describing herself as a doctor who engages in "racial profiling": "In practicing medicine, I am not colorblind. I always take note of my patient's race. So do most of my colleagues. We do it because certain diseases and treatment responses cluster by ethnicity. Recognizing these patterns can help us diagnose disease more efficiently and prescribe medications more effectively. When it comes to practicing medicine, stereotyping often works" (Satel 2002, 56). Satel's comments in the *New York Times* deserve unpacking, for they have the potential to do serious damage. In an era when racial stereotyping is decried by almost everyone and when colorblindness has become the mantra of conservatives in politics, law, and popular culture (Bonilla-Silva 2010), Satel makes the provocative claim that race matters.⁷ Yet Satel's claim that race improves disease diagnosis and medication treatment is largely unsupported by the biomedical research.

It is precisely the type of claim that *Mapping "Race"* seeks to counter: the evidence simply does not suggest that self-identified race today maps onto disease and treatment models in meaningful ways. We must recognize that what Satel is really asking us to do is think about race-based health disparities in a simplistic, scientifically crude way that has fundamental implications. This way of seeing "race" presupposes that race is an individual characteristic about a patient that tells a health care provider something meaningful, implying that race is an essential characteristic, a fixed characteristic, and a biologically rooted characteristic (conjuring notions, in Satel's narrative, of genetic

or ancestral significance). As biologists Joseph Graves and Michael Rose have noted, this view of race in the clinical context may be quite dangerous because, "in addition to fostering social inequality by underscoring racial classification, racial medicine might kill people by neglecting the substantial genetic variation within, and genetic overlap between, human populations" (2006, 492). Furthermore, and as many chapters in this book illustrate, it is no simple matter for a doctor to assign her patient to a racial category or even to ask a patient to self-identify racially, making the act of racial categorization in the biomedical context challenging (see López, this volume). For example, research shows that physicians and other health care personnel often are embarrassed or otherwise unwilling to directly ask a patient to identify her or his race, so that a health care provider might well be guessing a patient's race based on inappropriate criteria (see Lee, this volume).

An alternative approach to health inequalities that departs from the constructionist viewpoint is founded on two different realities. First, "race" is complex and inherently hard for researchers to measure or operationalize. Second, health disparities researchers must be extremely cautious about attributing outcomes to self-identified race because seeming racially inflected dynamics often reflect larger process of racism and other forms of social inequality. For example, best practices for doing research on health disparities should include avoiding the assumption that race is important in favor of the premise that race is hard to measure and might be significant (for other approaches to making race more complicated, see the chapters by Garcia, López, and Saperstein, this volume).

Consider the strategy taken by anthropologist Clarence Gravlee, whose research team set out to explore the connections between hypertension and race and, specifically, the claim that Blacks are more likely than Whites to experience high blood pressure and associated health problems (see Gravlee and Dressler 2005; Gravlee et al. 2005). Once they picked their research site in southeastern Puerto Rico, they implemented a three-stage, multi-method research design: first, using ethnographic methods, they assessed social norms about color and race in Puerto Rico; second, using interviews and surveys, they measured those ideas in the subject sample; and, third, using reflectometry, they objectively measured subjects' skin pigment. Gravlee and his colleagues conclude that: "both self-rated and culturally ascribed color—but not skin pigmentation—were associated with blood pressure through an interaction with income and education" (Gravlee and Dressler 2005). In other words, middle- and high-income people perceived by others as Black were more likely than those with objectively darker skin tone (at least as measured by the objective reflectometry test) or than those who were perceived as Black but who were

low-income, to have hypertension. This finding suggests many public health questions about how we ought to think about identifying those at risk for high blood pressure and treating the disease. The authors also suggest that more research needs to be done to explore the dynamics of race-based microaggressions and structural racism that affect the mental and physical well-being of people of color, including hypertension, in ways that we are only beginning to understand.

But the caution that a constructionist account raises is, who is in what “racial” category? “Whether people from Syria or the Indian subcontinent are placed in the ‘white’ group, whether Haitians, West Africans, or Cubans are categorized as ‘black’—these are questions for which there are no materially valid answers, only vagarious compromises of one kind or another” (Kaufman 1999, 102). Kaufman would revert to self-identified race as “the gold standard”—“that people are who they say they are” (1999, 103), but this too has its limits, as I have noted.

At the end of the day, one of the main reasons for thinking about race as socially constructed is so that we can recognize the ways in which race thinking operates to solidify stratification and racial subordination. In particular, in the health context, the focus on race as measured via static self-identification obscures the ways in which racism operates to create inequities in health outcomes and access to health care. If we understand racial categories as socially constructed to serve political purposes, then we are better positioned to identify and combat racism. Epidemiologist and physician Camara Jones and colleagues counsel that “it is vitally important that we develop a detailed understanding of the characteristics and manifestations of racism,” including institutionalized racism, personally mediated racism, and internalized racism (1991; see also Williams et al. 2010). At least part of the solution lies in adjusting our research studies in order to make race more complex so that it looks more like race in the real world.

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Notes

1. A range of limitations plague federal data collection for non-Black minority group members, and especially for Latinos and Asian Americans. Williams and colleagues report that “national data on mortality are more accurate for blacks and whites than for Hispanics, Asians, and Native Americans. A major problem affecting the quality of mortality data is related to the undercount in the number of deaths because of misclassification of nontrivial proportions of Hispanics, Asians, and especially American Indians as white on death certificates” (2010, 71). Nationwide data for Latinos and Asian Americans was not systematically collected before 1980, when immigrants from Latin America and Asia became significant nationally after the lifting of pre-1965 restrictions on immigration from these regions (see also Takeuchi and Gage 2003, 440 [noting that social scientists did not historically treat Latinos and Asians in a racial framework]). Moreover, since both groups combine many different national origin subgroups, the data is subject to more variation and interpretive debate (for two studies that explore intragroup differences with the Latino and Asian American categories, respectively, see Sanchez and Ybarra and Iwamoto, Kindaichi, and Miller, this volume). There are a variety of structural reasons for ongoing misclassification, however, including the historical racial ambiguity of Mexican Americans (see Gómez 2007) and other non-Black minority groups. In addition, data such as that on birth and death certificates is subject to substantial regional variation in the United States (Pascoe 2009), further adding to the possible misclassification by race.
2. As noted in the preface, the NIH Office of Research on Minority Health funded the 2011 workshop that was the catalyst for this book.
3. Note that this inequality or social justice view of the cause (and solution) to race-based health disparities is the minority view in both the scientific literature and the popular media. One study of almost four thousand articles on health disparities that appeared in forty major newspapers between 1996 and 2005 concluded that only rarely were race-based health disparities framed by the media as a question of social injustice—that theme appeared in less than 4 percent of the articles (Kim et al. 2010, S229).
4. Sociologist Catherine Lee makes the important point that the failure of researchers to define race is simply bad science because it is “antithetical to the tenets of scientific research, which, in its ideal form, demands that analytical variables be consistent and their categories mutually exclusive” (2009, 1183).
5. For example, these authors have identified this weakness in the following fields: Gómez 2012 (socio-legal studies); Gravlee and Sweet 2008 (medical anthropology); Harrison 1999 (cultural anthropology); Helms 2007 (psychology); Jones et al. 1991 (epidemiology); C. Lee 2009 (biomedical research); T. Lee 2009 (political science); Martin and Yeung 2003 (sociology); Morris 2007 (sociology); Mukhopadhyay and Moses 1997 (cultural anthropology); Saperstein 2008 (demography).
6. At the same time, Morning contends that the social constructionist conception of race has by no means completely displaced essentialist views of race rooted in biology. In fact, she finds that, among scientists who teach at the university level, an essentialist view of race as rooted in biology remains alive and well (2011, 6, 38–47, 221).
7. Of course, this claim has been made historically by those advocating for race-conscious legal remedies and government policies to alleviate racial discrimination.

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Part I

Charting the Problem

This section of *Mapping "Race"* charts the scope of the problem identified in chapter 1: not adequately conceptualizing "race" as socially constructed leads to weaknesses in terms of both how we assess and attempt to redress health disparities linked to race. This section features four chapters written by scholars who approach the topic from vantage points in diverse positions across the humanities, biological, medical, and social sciences.

Legal scholar and historian Jonathan Kahn begins our dialogue by asserting that where one locates the source of health disparities is crucial because it determines whether the observed racial disparity is identified as being in individual human bodies or in social conditions. Kahn compares the historical development of approaches to race and racial difference over the course of more than a century. According to the neoliberal frame that has been ascendant for some time, health care is a consumer good that can be bought and sold by individuals and, by extension, health disparities are a function of individual biological difference that can be addressed via market-oriented rather than government-sponsored interventions. Kahn argues that the pernicious impact of this framing is to absolve the state of responsibility for the systemic health inequalities experienced by large sectors of the American population over long periods of time.

Evolutionary biologist Joseph Graves Jr. argues that genetic variation among humans is explained by geography rather than what is erroneously assumed to be genetic race. Genetic reductionism to explain racial health disparities is particularly problematic because it ignores the complexity of the interaction of genetic, environmental, and chance effects in producing health outcomes. Graves also identifies the fallacy of ascertainment bias (non-random sampling) as occurring