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Health Disparities in the Context of Mixed Race

Challenging the Ideology of Race

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Debates are occurring about the relative contribution of genetic versus social factors to racial health disparities. An ideology of race is manifested in genetic arguments for the etiology of racial health disparities. There is also growing attention to people of mixed race since the 2000 US Census enabled them to be counted. Consideration of the complex issues raised by the existence of people of mixed race may bring clarity to the debates about racial health disparities, offer a challenge to the ideology of race, and afford important insights for the practice of research involving race. **Key words:** *health disparities, ideology of race, mixed race, race, social determinants*

THERE is growing awareness in nursing of the existence of health disparities in the United States, particularly with respect to disparate treatment by race and ethnicity.[1] There is also a dramatically expanding volume of research being published on racial disparities in health status. This article focuses primarily on the latter. Recently, sharp debates have occurred in reputable journals about the relative contribution of genetic versus social factors to racial health disparities. I maintain that an ideology of race is manifested in genetic arguments for the etiology of racial health disparities. Uncritical use of race as a variable in health disparities research can inadvertently reinforce the ideology of race, and the belief in genetic causes for those disparities. At the same time, there has been increased attention to people of mixed race subsequent to the change in policy allowing respondents to the 2000 US Census to identify with more than one racial group. Careful consideration of the complex issues raised by the existence of people of mixed racial ancestry may bring clarity to the debates about the etiology of racial health disparities, offer a challenge to the ideology of race, and provide nursing science with tools for better research and practice in a diverse society.

Research on racial and ethnic health disparities typically compares the rates of health problems of one or more of the groups categorized as nonwhite "races" to whites as the reference group, utilizing the Office of Management and Budget (OMB) racial categories used in the US Census. While "Hispanic" is considered an ethnicity in the OMB racial and ethnic taxonomy, and could encompass persons of any racial ancestry, comparisons between Hispanics and whites are also made in the disparities literature. Tracking social statistics according to the OMB racial classifications began largely as a consequence of civil rights legislation, to gauge discrimination and progress in such areas of life as housing, employment, and education. OMB Directive 15, which instituted the basic racial categories currently in use, specifically acknowledged that these categories were not scientifically based.[2] Ironically, a practice that was initiated to track the impact of racism has taken on a life of its own, reinforcing the belief in the reality and distinctness of the "races."

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In the year 2000, for the first time in the history of the US Census, respondents were permitted to self-identify as belonging to more than one race. The conundrum of how to understand the health profiles of people identifying with more than one race calls into question the basic assumptions upon which knowledge about racial health disparities is constructed. Implicit in much of the research on racial health disparities is a binary white/other model of comparison in which white is the standard against which the health of other "races" is measured. It is built on an assumption that the populations captured within our racial categories are homogeneous, distinct, and mutually exclusive. These assumptions are core tenets of the ideology of race. Nursing research in which race appears as a variable has too often been complicit in an uncritical acceptance of the standard racial categories without exploration of their complex meanings.[3] Recognition of the existence of people of mixed race has the potential to destabilize the entire racial structure that is the foundation of the ideology of race, and afford nursing science with fresh insights into the meaning of racial health disparities.

In this discussion, it is critically important to note that people of mixed race have been part of the United States essentially since populations from different continents first encountered each other on what is now US soil, but their existence has been masked by our rules for racial classifications, which have reinforced the idea of separate races. The dominant means of categorizing African Americans during the 20th century was the rule of hypodescent, or the "one-drop rule," which rendered anyone with any African ancestry whatsoever as black.[4] When whiteness was a prerequisite for citizenship, mixed Asian Americans with European ancestry were considered Asian, thus ineligible for citizenship.[5] Native Americans are a highly mixed population. Some estimates put the percentage of whites in the United States with some non-European ancestry as high as 30%.[6] The term *Hispanic* can encompass people whose ancestors come from Africa, Europe, Asia, and indigenous populations of the Americas. Thus, it is essential to remember that the *existing* racial categories are also "multiracial," a fact rarely acknowledged in research that employs them, and never addressed when genetic explanations are offered for health disparities between racialized minorities and whites.

Thus, when I use the term *mixed race* in this article, it is with full acknowledgment that mixed race is just as socially constructed as race. How racial categories are defined is an inherently political process. Changes in the census categories have mirrored the changing racial and ethnic politics over the 200+ years of their existence.[7] As with many of the changes in census categories, allowing people to check more than one box occurred as a result of pressure from interest groups, in this case, by mixed race organizations and activists. The fact that mixed race has finally entered the discourse of race can represent a challenge to the US ideology of race.

THE IDEOLOGY OF RACE

In her exhaustive accounting of the evolution of the concept of race as we know it, Smedley[8] notes that components of what she calls the racial world view are integral to US history and culture. She develops a comprehensive analysis of how the prevailing concept of race in the United States evolved from folk beliefs about human difference, and how Western science upheld and reinforced these concepts. Omi and Winant[9] echo Smedley in their description of the "racial dictatorship" of the United States, with the addition of the color line demarcating whites from people of color as the central organizing principle of American society. Elements of Smedley's racial world view and Omi and Winant's racial dictatorship persist in what I call the ideology of race. The ideology of race includes the following components:

1. The groups we call races are mutually exclusive, and have intrinsic characteristics and worth;

2. "Race" in popular discourse is generally assumed to be a property of people who are not white, with corresponding racial invisibility for whites;
3. An important symbolic boundary around whiteness constitutes the color line; and
4. Race is real, and has a biological/genetic basis.

Ideologies are critical to maintaining power relations.[10] In the United States, the ideology of race has played a fundamental role in justifying conquest and slavery in the past[11] and naturalizing inequality in the present.[12] It has been established and promoted through a combination of local practices and court decisions establishing definitions of whiteness, and thereby defining the boundary of the color line.[4,5] Countless acts of legislated discrimination institutionalized it throughout the structure of US society, engendering inequalities that still persist.

Racial classifications and taxonomies have been foundational in the architecture of the ideology of race through the creation of human hierarchy.[13] They provided for the structuring of knowledge and the basis for a discourse of race. The creation of race happened in a dialogical fashion between the structuring of knowledge and material practice. Race exists in the imaginary sphere, yet is notoriously concrete in its designation of physical bodies to classifications that have had enormous consequences for access to all the resources necessary for a decent human life.

Categories and classifications are not random, but are critical to the construction of knowledge, the promotion of ideology, and the maintenance of power.[14] Classification is never neutral, and when it has the weight of science behind it, plays the role of naturalizing hierarchy.[15] Although there have been fluctuations in the designations of particular groups to racial categories, the underlying basis of our racial categories do not differ appreciably from Linnaeus's classification of humanity in 1735 in the *Systemae Naturae* into a taxonomy based on continent of origin.[13] Linnaeus classified humanity into the Americanus, Asiaticus, Africanus, and Europeaus groups, each of which was designated certain behavioral traits, with the Europeaus the most favorable. Such classification schemes were very influential in naturalizing human difference and establishing a hierarchy of worth, all the more so because they were considered scientific. Unfortunately, science and medicine have played a constitutive role in the construction and perpetuation of the ideology of race that presumed the inherent inferiority of nonwhites.[8,16,17]

Clearly, people of mixed race represent a challenge to the ideology of race and have not been accounted for in the dominant discourse of race. According to the first tenet of the ideology of race, people of mixed race represent an impossibility, are inherently transgressive, and violative of the belief in the races as mutually exclusive. Those with European ancestry have the potential to disrupt the racial invisibility of whiteness and are living examples of the violation of the color line. Finally, the complexity of the ancestries of people who identify as mixed race challenges essentialist concepts of race as genetic.

THE DISCOURSE OF HEALTH DISPARITIES AND THE IDEOLOGY OF RACE

Unfortunately, the well-publicized disparities in health between whites and some minority groups can reinforce the belief that race is intrinsically meaningful, a core aspect of the ideology of race. In the discourse of health disparities, the meanings of race and racial categories are seldom critically interrogated. Discourse refers to how knowledge is constructed and reproduced through language and other forms of representation.[18] The emergence of a discourse is not random. It is one of the means by which ideology is articulated, and it "constitutes, naturalizes, sustains and changes significations of the world from diverse positions in power relations."[19(p67)] It is a complex process

involving the interaction of competing claims and power struggles over the construction of knowledge.[20]

There are specific aspects of the discourse of racial health disparities that reinforce the ideology of race. For example, the binary white/other model of comparison that is commonly used in health disparities research reproduces the color line, and reinforces the invisibility of whiteness. Binary oppositions are rarely neutral; they represent relations of power in which one side is usually dominant.[21] As British sociologist Stuart Hall observes, "We should really write, **white/***black*, **men/***women*, **masculine/***feminine*, **upper class/***lower class*, **British/***alien* to capture this power dimension in discourse."[22(p235)] As the implicit norm against which other groups are measured, whiteness remains invisible, but no less dominant. In fact, scholars have pointed out that it is exactly this invisibility that is one of the core privileges of whiteness.[23]

The discourse of racial health disparities is contested and still evolving, as evidenced by the debates about their etiology. To distill the essence of these debates, they revolve around whether or not race is "real" and whether poorer health for racialized minorities has an intrinsic, that is, genetic, basis or not. These debates are not new. Public recognition in the United States that race is a social construction is a fairly recent development historically speaking, although it has been long noted by those experiencing the injustices of racial inequality.[17] Some of the strongest international statements against the existence of race were produced subsequent to World War II in response to the horrors of the Holocaust, culminating in 1949 when United Nations Educational, Scientific, and Cultural Organization (UNESCO) convened the committee to create the first UNESCO Statement on Race headed by Ashley Montagu, the author of Man's Most Dangerous Myth: The Fallacy of Race, first printed in 1942. Even then, Montagu's position that race is a social myth produced a great deal of controversy, resulting in a much more measured statement by UNESCO in 1951.[24]

CURRENT DEBATES

Nurses and other health professionals face contested perspectives on the meaning of race and racial health disparities. Several of these conflicts have taken place in scholarly journals. For example, in 2000, a dialogue transpired in *Demography* over an analysis of differences in birth weights between black and white infants by Van den Ord and Rowe[25] in which critics of the original article noted that the authors had presumed a genetic basis for those differences without supporting evidence.[26] Two articles in the March 20, 2003, *New England Journal of Medicine* (*NEJM*) differed sharply in their analyses of what race is and its relevance to health.[27,28] It is interesting to note that in the *NEJM* articles, at least one citation in both reference lists was used to support opposing conclusions. Clearly, this debate is not going away, and it provides an excellent example of how supposedly objective science is filtered through each of our ideological lenses.

There has been a recent resurgence of interest in the genetics of race[6] and particular interest in pharmacogenomics.[29] The cardiac drug Bidil, a combination of isorbide dinitrate and hydralazine, which has been specifically targeted to African Americans for heart failure, has been approved by the Food and Drug Administration for use in *African Americans only*, the first such racially targeted drug, supposedly because of its enhanced effectiveness in that population.[30] The scientific basis for, and ethical implications of, racially targeted drugs in general and the development of BiDil in particular are highly controversial.[31,32] The publicity surrounding the supposed success of this drug with African Americans has never mentioned how "African American" was defined for the purposes of the research. In addition, alternative hypotheses to inherent

genetic difference explaining the favorable response to this drug by African Americans have not been offered. For example, evolutionary biologist Joseph Graves argues that *if* the pathophysiology of heart failure does indeed differ between whites and African Americans, this may be explained by the effects of the stress of social dominance experienced by African Americans, rather than genetic differences (J. L. Graves Jr, oral communication, February 3, 2005). The history of the US racial classification system, with the rule of hypodescent, whereby any "drop" of African ancestry resulted in being categorized as black, has meant that people with diverse backgrounds have been absorbed into the African American community.[3] The population racially categorized as African American in the United States is highly mixed, and it is conservatively estimated that as much as 30% of the African American gene pool comes from non-African ancestry.[33] Considering this diversity within the African American population, Graves argument seems at least as plausible as assuming inherent genetic differences between blacks and whites.

While the large disparities in health and disease between majority and minority populations in the United States have led to a search for contributing genetic factors, most research on health disparities strongly implicates social causes for them, through such pathways as racial discrimination, residential segregation, poverty, and educational, behavioral, and cultural factors.[34,35] The position that race is a social construction, subject to fluctuating classification systems and relations of power, is widely held by most social scientists, and is increasingly articulated by nursing scholars.[36]

Population genetics also supports the view of race as imprecise and unscientific, and that our racial categories do not correspond neatly to discrete populations. Race is a poor proxy for the relatively small amount of human genetic variation that occurs in a graded fashion across the globe. Existing genetic variations are not neatly demarcated by the boundaries of our racial classifications. It has been confirmed that there is more genetic diversity within the groups we call races than between them.[37]

The proceedings of an important conference held at the National Human Genome Center at Howard University on the relationship between race, ethnicity, genetics, and health were published in Nature Genetics Supplement in November 2004. The majority of the papers presented portrayed the concept of race as inadequate for completely accounting for human variation. As Royal and Dunston state in their commentary, "Today, scientists are faced with this situation in genomics, where existing biological models or paradigms of 'racial' and 'ethnic' categorizations cannot accommodate the uniqueness of the individual and universality of humankind that is evident in new knowledge emerging from human genome sequence variation research and molecular anthropological research."[38(pS5)] Most of the articles in this issue articulated the limitations of the use of race as a proxy for population-based genetic variation, which is primarily geographical and on a gradient without fixed boundaries. However, the issue was reported in the Science section of the *New York Times* as if there were a balance of conference participants who felt race was not useful with those who felt racial categories offered sufficient correspondence to genetic difference to justify their use.[39] In general, there is disproportionately greater media attention given to those who promote the idea that race is genetically real, and that the genetics of race are important in the discussion of health disparities, reflecting the degree to which powerful interests still promote the ideology of race.

Nursing has been slow to enter these debates, and a survey of nursing research using race and ethnicity as variables revealed a largely unproblematized acceptance of race, with few studies defining the meaning of the racial/ethnic categories used, and the reasons for their use.[3] However, there is also growing recognition in nursing science of the

contingent nature of race as a social construction, influenced by power and historical context, and of the critical role language plays in its conceptualization.[36]

PEOPLE OF MIXED RACE AND HEALTH DISPARITIES

As I have pointed out previously, the fact that people may now self-identify and be counted as mixed race represents but the tip of the iceberg of racial heterogeneity. Yet, the acknowledgment of mixed race, and its entry into the discourse of race, can represent an important advance in deconstructing myths that emanate from the ideology of race. With the advent of the new census rules allowing respondents to self-identify with more than one race, almost 7 million people indicated that they belonged to more than one racial group in the year 2000 US Census.[40] The population identified as multiracial in the census is young and highly diverse, with the most frequent combination (more than 70%) being "White and Some other race."[41] The population identifying as multiracial will undoubtedly increase, and projections are that it may be as high as 21% by 2050.[42] Health-related research on mixed race people is in its infancy. Very little is known about this population, because prior to 2000, they were not distinguished from the standard racial groups. The small amount of published health research to date on people of mixed race has focused on infants[43,44] and adolescents.[45] The study of adolescents found that those who identified with more than one racial group were at higher risk for health and behavioral problems. A qualitative study of older people of mixed race noted that the study participants experienced a persistent sense of difference due largely to the extremely racialized environment of the United States, in which one is expected to be one race.[46] Much more research is needed on the diverse population of people identifying with more than one race.

I have touched on some specific ways that people of mixed race challenge the ideology of race in the existing discourse of health disparities throughout this article. I would like to further explicate them and how they might expose the many contradictions in how we categorize and conceptualize race in our analysis of health disparities.

DISRUPTING THE BINARY MODEL

By using data on whites as the "gold standard" to which the health profiles of other groups are compared, current approaches to studying racial health disparities may inadvertently reinforce the racial invisibility of whites, and their status as "normal" and others as deviant. People of mixed race who claim white ancestry call into question the meaning of whiteness, as well as the other race(s) they claim. They present the possibility of decentering whiteness, and its corresponding presumptions of racial purity. They disrupt the color line of the ideology of race. People of all racial mixtures are living, breathing proof that distinct races are a fiction. They make apparent the fact that the US population can no longer be neatly divided into either/or categories.

HOW MANY PARTS DOES IT TAKE TO BE "REAL"?

Trying to quantify the different racial "parts" of individuals can lead to a kind of *reductio ad absurdem* regarding genetic theories of race. The multiracial population is incredibly diverse, and the next generation will be even more so as multiracial people have their own children. In the 2000 census, almost 7% of the population identifying with more than one race claimed more than 2 races in their ancestry.[41] Trying to quantify these combinations genetically leads to a dead end. The challenges of quantifying the multitude of possible racial combinations hopefully will force us to look at more significant aspects of lived experience and how they interface with health, such as experiences of racism, residential segregation, identity, culture, and all the

other social psychological, and economic factors coming to bear on health.

CHALLENGES TO MONORACIAL CATEGORIES

Perhaps most important, having a population identified as mixed calls into question assumptions about the meaning of the existing racial categories used in disparities research, and the meaning of race itself. For example, how do people who self-identify as mixed and have one parent who identifies as black and the other who identifies as white differ from people of mixed ancestry who self-identify as black, but have 2 parents with both European and African ancestry? If one were to quantify the genetic "parts" of their ancestries, they might add up very similarly. Yet the social, cultural, and economic environments they inhabit might differ considerably, thereby potentially affecting their health quite differently. The first person would be captured in statistics as mixed race, the second as African American. Clearly, genetic interpretations alone will not suffice. Instead, researchers will be forced to examine the life circumstances of the people they study. We rarely see research that discusses how people were assigned to racial categories, and more important, what those categories mean.[3,47] Having to face race critically might explode the assumption that these categories signify internally homogeneous, mutually exclusive populations, and produce more responsible and informative use of racial categories.

OTHER CONCERNS

I have outlined some of the ways that people of mixed race offer a potential challenge to genetic essentialist interpretations of health disparities and the ideology of race. Let me also clarify what mixed race cannot do. There is an idealistic discourse that mixed race offers the solution to our racial problems and that if people just keep intermarrying, race will eventually disappear, and so will our nation's race problems. Some are less sanguine about the future. For example, noting that outmarriage rates for blacks are lower compared to other racial groups and hypothesizing that this is due to enduring prejudice against African Americans, Michael Lind envisions a future multiracial society that is no longer racially defined by the white/nonwhite dichotomy, but by black and non-black, or in Lind's words "The beige and the black," in which African Americans are still left out of the American melting pot.[48] Using the growth of the mixed race population as an indication that race "no longer matters" would be indulging in color-blind racism, in which the language of equal opportunity is used to justify failure to engage in proactive measures to rectify racial inequality.[49]

Should the disparities model, and the comparison of health statistics by race be given up altogether? The idea is tempting, given the potential harm done by data that if used uncritically can reinforce some of the worst aspects of the ideology of race. Yet abandoning the use of racial categories to track disparities prematurely would mean the loss of the ability to address the very inequalities *producing* them.[50] Ironically, for the time being, we need to use race to do away with race. What we can control is *how* we use race. Research on racial health disparities is extremely important, if for no other reason than to document the *effects* of racialization. I want to make clear that I am not arguing in favor of eliminating research that compares the health of racially categorized populations. Rather, my goal is to offer a potential means for framing racial health disparities in a way that challenges the ideology of race. With that in mind, I make some suggestions, echoing other scholars, for the use of race in health research:[3,32,35,47]

- Use alternative terms, such as *racialized groups* or *racialized populations*, rather than *race* whenever possible, thereby emphasizing that race is something that is imposed upon people, rather than an intrinsic quality.
- When doing research in which race is used, explain the reason(s) for its

use and its significance for the research questions.

- When results are reported by racial groups, describe what the racial categories mean, and how those meanings relate to the results. Specifically, when we find that racialized minorities are in poorer health, we must engage in a critical interrogation of the causes, and be willing to implicate such factors as institutional racism and marginalization.
- Explore the use of mixed methods, using qualitative approaches to explore the context for racial health disparities identified through quantitative methods.
- Analyze other forms of social disadvantage that intersect with race so as to better identify the multiple pathways to racial health disparities.
- Search for new methodologies that compare "racial" groups without defaulting to the use of whites as the reference group.
- Finally, to better understand the health issues of people of mixed race, and indeed all people, there is a need for more qualitative research that transcends categorizing by precise racial combinations and thoroughly explores the complexity of the lives and social locations of the research participants.

CONCLUSION

It is important for nursing to recognize that the racial landscape of the United States is changing and becoming more complex. This coincides with increased attention to the problem of racial health disparities and debates about their causes. Genetic explanations for health disparities reinforce an ideology of race that views race as inherently real. People of mixed race challenge the ideology of race through their very existence. Accounting for people of mixed race can move the conversation on health disparities in nursing science toward the complexity of the many factors affecting health and away from genetic racial essentialisms. It is premature to abandon the health disparities model, although its binary white/other structure is problematic. Hopefully the long overdue acknowledgment of people of mixed race will serve as a catalyst to promote research on health disparities that encompasses the contradictions and complexities of race for all racialized groups.

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