

NYT. Science F2. October 18, 2005. A Conversation With Troy Duster  
A Sociologist Confronts 'the Messy Stuff' By CLAUDIA DREIFUS

Troy Duster is emphatic: the genomic revolution is moving way too fast. In more than a dozen books and articles, Dr. Duster, immediate past president of the American Sociological Association, urges geneticists to slow down and check their methods as they search for links between genes, disease and race. A professor of sociology at New York University, Dr. Duster, 69, wrote "Backdoor to Eugenics" and contributed to "Whitewashing Race: The Myth of a Color-Blind Society," both appearing in 2003. Advocacy, it appears, runs in his family. His grandmother was the anti-lynching leader Ida B. Wells, and his mother was a social worker on the South Side of Chicago. "My grandmother probably would think I'm not militant enough," Dr. Duster said at a lunch at Chelsea Piers in Manhattan. "I try to do my part in my own way."

Q. Much of your work has been a cautionary cry against genetic research based on race. Why oppose it?

A. I'm not against it, per se. I'm against the way some biologists interpret it and act as if genetics has all the answers to medical problems that people in some ethnic groups suffer. In some ways, this is the old nature versus nurture debate that's been argued for eons. However, since the genomic revolution has gathered steam, it seems as if many scientists have stopped considering the nurture part. I think there's been a recent tendency for geneticists to believe they are doing deep science when they look at race, genes and disease. By looking at what's in the blood, they avoid the messy stuff that happens when humans interact with each other. It's easier to look inside the body because genes, proteins and SNP patterns are far more measurable than the complex dynamics of society. I've heard geneticists say: "We're not concerned whether or not a person is in a higher or lower class position, or if they are white or black. We want to know what basic processes are going on." But few of these basic processes happen outside a social context. I believe you can't be creating ethnically based medicines, which is what a lot of biomedical research is about, without also doing some sociology.

Q. Your efforts suggest that you're looking to create jobs for sociologists. Are you?

A. I think I'm talking common sense. Listen, much of the racial genetic research is focused on finding drugs for diseases. I go to national meetings and I'm constantly facing geneticists who say to me: "Oh you sociologists, all you do is criticize. We're trying to save lives." I'm certainly for saving lives. But I wonder if this one-sided type of research will actually do that. When you're talking about genetic diseases, there's usually something in the environment that triggers their onset. Shouldn't we be talking about the trigger? Take the case of black men and prostate cancer. African-American males have twice the prostate cancer rate that whites do. Right now, the National Cancer Institute is searching for cancer genes among black men. They're not asking, How come black men in the Caribbean and in sub-Saharan Africa have much lower prostate cancer rates than all American men? A balanced approach might involve asking, Is there something in the American environment triggering these high rates? Is it diet, stress or what? The same thing goes for hypertension. All the studies on hypertension show that you reduce it when you take people out of stressful situations. American blacks have higher hypertension rates than whites. And it's undeniable that African-Americans face daily situations that are inherently stressful. They are routinely profiled when driving, shopping, applying for bank loans or seeking relief from a natural disaster like Hurricane Katrina. A lot of money is currently being spent to try to find a drug for black hypertension. That's a lot cheaper than a war on poverty, which might alleviate the root cause of a lot of the hypertension.

Q. The F.D.A. has just approved BiDil as the country's first "racial drug." According to the press release, the compound was found to be ineffective in "the general population of severe heart failure patients, but suggested a benefit in black patients." Would you take the drug?

A. Actually, my brother is taking it. If I had a nitric oxide deficiency, which is what it is said to be effective for, I would, too. I'm opposed to the way it got to be marketed. BiDil came to market after a test

where it was found to be ineffective for congestive heart failure in a large population. In the original test, there was the slight suggestion that it might help African-Americans. Rather than develop a clinical trial to show whites, Asians and blacks had different responses to the drug, the manufacturers went right to the F.D.A. and said, "Now let's try it on 1,050 black people." Good science is supposedly based on comparing things.

Q. After decades of civil rights struggle, does the new discussion of race and biology make you uncomfortable?

A. Our country has had an unhappy history with race. This research doesn't happen outside of that history. Definitions of race are constantly changing. Not all that long ago, Jews and Armenians were considered separate racial groups. Today, they are white. Genetically, is Strom Thurmond's daughter white or black? Millions of Americans have her mixed genetic history written within them. In a time when most physicians see their patients for only brief moments, if they're using these definitions of race in prescribing pills or treatments, they're bound to make mistakes.

Q. Are you claiming there is no such thing as an ethnically based disease?

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

Q. Ida B. Wells, the journalist and anti-lynching leader, was your grandmother. Was it hard growing up in the shadow of such a legend?

A. Actually, my grandmother died five years before I was born. My mother told many stories about her. My grandmother was, apparently, a very tough personality. She had this strict measuring stick. Unless you were fiercely on the right side of truth, beauty and justice, you didn't count with her. My grandmother had fights with W. E. B. Du Bois, Booker T. Washington and Frederick Douglass, although she apologized to him later.

Q. Maybe your grandmother's toughness was necessary for a woman in leadership in the early 1900's?

A. My grandmother had to be who she was to make herself heard. The main thing about Ida B. Wells was that she saw lynching for what it was, a means of controlling blacks in the post-reconstructionist South. She understood that lynching wasn't about rape. The victims often were blacks who owned stores and land. My grandmother saw lynching as a means to terrorize an entire people. In other words, Grandma thought like a sociologist.