

# Cultura Obscura: Race, Power, and “Culture Talk” in the Health Sciences

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“The price of culture is a Lie.”<sup>1</sup>

*This Article advances a critical race approach to the health sciences by examining “culture talk” as a discursive repertoire that attributes distinct beliefs, behaviors, and dispositions to ethno-racialized groups. Culture talk entails a twofold process of obfuscation – concealing the social reality of the people it describes and hiding the positionality of those who employ cultural generalizations. After tracing how culture talk circulates and reproduces racist narratives in and beyond the health sciences, I examine how cultural competency training in medical schools and diversity initiatives in stem cell research use the idiom of culture to manage and manufacture group differences. From culturing cells in the lab to enculturing people in the clinic, I apply the concept of coproduction to argue that culture talk is a precondition and product of scientific knowledge construction.*

## I. INTRODUCTION

Headlines abound: White America’s Heroin Problem,<sup>2</sup> The Opioid Epidemic: For Whites Only?,<sup>3</sup> and Heroin Kills White People More Than Anyone Else—and Nobody is Sure Why.<sup>4</sup> If government officials were to approach the problem as they did a generation ago when the drug crisis was associated with the inner city, one could

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<sup>1</sup> W. E. B. Du Bois, *The Souls of Black Folk* 138 (Oxford Univ. Press, 2007) (1903).

<sup>2</sup> Goldie Taylor, *White America’s Heroin Problem*, THE DAILY BEAST (March 28, 2016), <http://www.thedailybeast.com/articles/2016/03/28/mr-president-it-s-time-to-end-the-racist-war-on-drugs.html> [https://perma.cc/TM64-GQKZ].

<sup>3</sup> Charles Lane, *The Opioid Epidemic: For Whites Only?*, THE WASHINGTON POST (April 18, 2016), [https://www.washingtonpost.com/blogs/post-partisan/wp/2016/08/18/the-opioid-epidemic-for-whites-only/?utm\\_term=.d42815c157bf](https://www.washingtonpost.com/blogs/post-partisan/wp/2016/08/18/the-opioid-epidemic-for-whites-only/?utm_term=.d42815c157bf) [https://perma.cc/C4GF-CZG8].

<sup>4</sup> Tess Owen, *Heroin Kills Whites People More Than Anyone Else—and Nobody is Sure Why*, VICE NEWS (Jan 27, 2016), <https://news.vice.com/article/heroin-kills-white-people-more-than-anyone-else-and-nobody-is-sure-why> [https://perma.cc/4WHN-CYFK].

imagine a federal report that sets out to explain how family dynamics in the suburb lead to unique cultural behaviors and pathologies, including addiction:

In our own time, the same sudden transition has produced the [White suburb]—different from, but hardly better than its predecessors, and fundamentally the result of the same process. . . . Family [alienation] among [Whites] in [suburbs] appears, then, to be one of the inevitable consequences of the impact of [suburban] life on the simple family organization and folk culture which the [White] has evolved in the [suburbs]. . . . In a word, most [White] youth are in *danger* of being caught up in the tangle of pathology that affects their world, and probably a majority are so entrapped. . . . Once or twice removed, it will be found to be the principal source of the most aberrant, inadequate, or antisocial behavior that did not establish, but now serves to perpetuate the cycle of [privilege] and [alienation, which fuels the heroin epidemic plaguing White communities today].<sup>5</sup>

Whereas a focus on “the White family” in this manner may appear absurd, this passage draws directly from a 1965 study called *The Negro Family: The Case for National Action*, better known as “The Moynihan Report”.<sup>6</sup> Authored by sociologist and politician Daniel Patrick Moynihan, the Moynihan Report sought to explain “the tangle of pathology” inherent to Black culture in the United States, and continues to influence public policy and racial discourse up to the present.<sup>7</sup>

In the wake of the current heroin epidemic, the fictional report on the White family turns the trope of dysfunctional Blackness on its head. This inversion draws directly on the work of critical race scholar and Harvard law professor, Derrick Bell, who urged analysts to use narrative and imagination to lay bare the distortions of intellectual and scientific racism.<sup>8</sup> Indeed, it speaks to the normalcy and dominance of Whiteness that one can only fully appreciate the absurdity of racist logic when it is applied to White Americans. The fictional report on the White family reveals how, unlike drug use in Black and Latino communities, the framing and regulation of the current phenomenon sweeping White America are strikingly different.<sup>9</sup> In his book *Dreamland: The True Tale of American’s Opioid Epidemic*, Sam Quinones wrote:

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<sup>5</sup> Daniel Geary, *The Moynihan Report: An Annotated Edition*, THE ATLANTIC (Sep. 14, 2015), <https://www.theatlantic.com/politics/archive/2015/09/the-moynihan-report-an-annotated-edition/404632/> [<https://perma.cc/JV6Y-UHK3>].

<sup>6</sup> OFFICE OF POLICY PLANNING AND RESEARCH, U.S. DEP’T OF LABOR, *THE NEGRO FAMILY: THE CASE FOR NATIONAL ACTION* (1965).

<sup>7</sup> Ta-Nehisi Coates, *The Black Family in the Age of Mass Incarceration*, THE ATLANTIC (Oct. 2015), <https://www.theatlantic.com/magazine/archive/2015/10/the-black-family-in-the-age-of-mass-incarceration/403246/> [<https://perma.cc/T9CG-6WV7>]; see Marjorie Valbrun, *Was the Moynihan Report Right? Sobering Findings After the 1965 Study is Revisited*, THE WASHINGTON POST (June 13, 2013), [https://www.washingtonpost.com/local/was-the-moynihan-report-right-sobering-findings-after-1965-study-is-revisited/2013/06/13/80eac980-d432-11e2-b05f-3ea3f0e7bb5a\\_story.html?utm\\_term=.76dd9eb989ef](https://www.washingtonpost.com/local/was-the-moynihan-report-right-sobering-findings-after-1965-study-is-revisited/2013/06/13/80eac980-d432-11e2-b05f-3ea3f0e7bb5a_story.html?utm_term=.76dd9eb989ef) [<https://perma.cc/2F4F-3VXC>]; see also Stephen Steinberg, *The Moynihan Report at Fifty*, BOSTON REVIEW (June 24, 2015), <http://bostonreview.net/us/stephen-steinberg-moynihan-report-black-families-nathan-glazer> [<https://perma.cc/U3KU-EF6Z>].

<sup>8</sup> Derrick A. Bell, *Who’s Afraid of Critical Race Theory?*, 1995 U. ILL. L. REV. 893, 893-98 (1995) (“Radical assessment can encompass illustration, anecdote, allegory, and imagination, as well as analysis of applicable doctrine and authorities. . . . To understand the motivation for and the likely intent of racial policies in America, one need only be willing to reverse the racial composition of the major components of those policies. To see things as they really are, you must imagine them for what they might be.”).

<sup>9</sup> Helena Hansen & Samuel K. Roberts, *Two Tiers of Biomedicalization: Methadone, Buprenorphine, and the Racial Politics of Addiction Treatment*, in *CRITICAL PERSPECTIVES ON*

The epidemic involved more users and far more death than the crack plague of the 1990s, or the heroin plague in the 1970s, but it was happening quietly. . . . Via pills, heroin had entered the mainstream. The new addicts were football players and cheerleaders. . . . Kids got hooked in college and died there. Some of these addicts were from the rough corners of rural Appalachia. But many more were from the U.S. middle class. They lived in communities where the driveways were clean, the cars were new, and the shopping centers attracted congregations of Starbucks, Home Depot, CVS, and Applebee's. They were the daughters of preachers, the sons of cops and doctors, the children of contractors and teachers and business owners and bankers.<sup>10</sup>

Unlike the U.S. War on Drugs, which criminalizes Black and Latino drug users, the current White epidemic is met with an entirely different apparatus that medicalizes drug use, treating addicts like patients rather than threats.<sup>11</sup> A carceral approach to addiction involves, not simply the neglect of individuals' medical needs, but surveilling and punishing entire communities.<sup>12</sup> As Helena Hansen and Julie Netherland explain:

In the context of public concern that White Americans are turning to heroin, policymakers are calling for reduced sentencing for nonviolent illicit drug offenses and the expansion of access to addiction treatment. At the same time, in Black and Latino communities, many drug-addicted individuals continue to be incarcerated rather than treated for their addiction.<sup>13</sup>

Black drug addiction is presented as one of many dysfunctions inherent to ghetto life, whereas White drug addiction is often framed sympathetically – the tragedy of individual families or the byproduct of structural factors that have “given US White patients the ‘privilege’ of unparalleled access to prescription opioids.”<sup>14</sup> In short, depending on the social location of a health problem, the language of cultural pathology becomes more or less salient. As one report put it, “When heroin use hit the suburbs, everything changed”<sup>15</sup>:

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ADDICTION (ADVANCES IN MEDICAL SOCIOLOGY, VOLUME 14) 79, 79-102 (Julie Netherland ed., 2012).

<sup>10</sup> SAM QUINONES, *DREAMLAND: THE TRUE TALE OF AMERICA'S OPIATE EPIDEMIC* (2016).

<sup>11</sup> When the focus was on Black users, New York City Mayor Ed Koch, a Democrat, told an audience at the 1989 U.S. Conference of Mayors gathering, “Those people belong in jail. Those people who are users, I have no sympathy for them. None at all. Maybe in the past we did. It has gone on too long.” Todd Bookman, *Addiction, Compassion, Race: Looking back at the Crack Epidemic*, NEWSWORKS (Feb. 24, 2016), <http://www.newsworks.org/index.php/local/the-pulse/91223-addiction-compassion-race-looking-back-at-the-crack-epidemic> [https://perma.cc/CR9L-DZSF].

<sup>12</sup> “It is a stunning turnaround of humanization, of reaching out, of undermining blameworthiness, and of talking about drugs as a medical problem, and a public health problem, rather than a pathology and weakness within a community,” says Ekow Yankah, a professor at Cardozo Law School in Manhattan.” *Id.*; see David Armstrong, *52 weeks, 52 faces*, STAT (Dec. 20, 2016), <https://www.statnews.com/feature/opioid-epidemic/obituaries/> [https://perma.cc/C6Y2-S5UX].

<sup>13</sup> Helena Hansen & Julie Netherland, *Is the Prescription Opioid Epidemic a White Problem?*, 106 AM. J. PUBLIC HEALTH 2127, 2128 (2016).

<sup>14</sup> *Id.* at 2127.

<sup>15</sup> Stephen Lerner & Nelini Stamp, *When Heroin Use Hit the Suburbs, Everything Changed*, THE WASHINGTON POST (May 16, 2014), [https://www.washingtonpost.com/opinions/when-heroin-use-hit-the-suburbs-everything-changed/2014/05/16/187dcce2-d79e-11e3-95d3-3bcd77cd4e11\\_story.html?utm\\_term=.2ffdc319496](https://www.washingtonpost.com/opinions/when-heroin-use-hit-the-suburbs-everything-changed/2014/05/16/187dcce2-d79e-11e3-95d3-3bcd77cd4e11_story.html?utm_term=.2ffdc319496) [https://perma.cc/7RBC-3JE4].

Clearly, new attention to heroin use in White, affluent areas is changing the perceptions and politics of drug addiction. No longer are the addicts “desperate and hardened.” Apparently, heroin use isn’t the result of bad parenting, the rise of single-parent families or something sick or deviant in *White culture*. It isn’t an incurable plague that is impossible to treat except with jail time. Drug addicts no longer are predatory monsters. In short, the root problem is *not the degeneracy of a group of Americans*.<sup>16</sup>

Whether it is drug addiction or other health behaviors, cultural explanations for disparate outcomes is an ever-ready lexicon with deeply racist roots. In fact, the intertwining of cultural and genetic traits to identify and hierarchize groups has been integral to scientific racism.<sup>17</sup> Culture is typically posited as the mechanism through which genetic differences operate.<sup>18</sup> As such, “culture talk”<sup>19</sup> obscures the social reality of those it purports to describe and hides the positionality of those who engage in such descriptions.

To elaborate this twofold process of obfuscation, this Article builds upon a somewhat cryptic statement in *The Souls of Black Folk*, in which W. E. B. Du Bois warns, “The price of culture is a Lie [sic]”.<sup>20</sup> In this passage, he describes how Black people are forced to repress their true thoughts, aspirations, and criticisms in order to participate in modern life; rather than be outspoken, honest, and self-assertive, they must flatter, smile, and be pleasant.<sup>21</sup> Assimilation, in short, requires squeezing into a mold created by the White imagination of what it means to be, shall we say, “a good Black.”<sup>22</sup> Extending this point, I suggest we not only concern ourselves with the way that cultural determinism flattens the complexity and humanity of people, thereby *failing* to produce adequate representations of how and why disparities persist. Rather, following Du Bois, it is vital to examine all that culture talk *successfully* produces – distorted understandings, “alternative facts,”<sup>23</sup> that is, Lies. In the same way that biology has been used as an alibi, according to Albert Memmi, as a “general way to turn things upside down,”<sup>24</sup> so too have cultural explanations.<sup>25</sup> Culture talk functions as an elaborate alibi, or a proof of innocence, letting institutionalized racism and

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<sup>16</sup> *Id.* (emphasis added).

<sup>17</sup> NICHOLAS WADE, A TROUBLESOME INHERITANCE 9, 13 (2014) (suggesting that not only distinct social groups, but entire civilizations may have developed based on their genetic predisposition: “Genes do not determine human behavior; they merely predispose people to act in certain ways. . . . [S]ome societies have achieved much more than others, perhaps through minor differences in social behavior. . . . Economists and historians have described many factors that contributed to Europe’s awakening. One that is seldom considered is the possibility of an evolutionary change, that the European population, in adapting to its particular local circumstances, happened to evolve a kind of society that was highly favorable to innovation.”).

<sup>18</sup> Graham Coop et al, *Letters: “A Troublesome Inheritance”*, STANFORD UNIVERSITY (Aug. 8, 2014), <https://cehg.stanford.edu/letter-from-population-geneticists> [<https://perma.cc/MY6B-7RMJ>] (expressing “full agreement that there is no support from the field of population genetics for Wade’s conjectures.”).

<sup>19</sup> Mahmood Mamdani, *Good Muslim, Bad Muslim: A Political Perspective on Culture and Terrorism*, 104 AM. ANTHROPOLOGIST 766, 766 (2002).

<sup>20</sup> DU BOIS, *supra* note 1.

<sup>21</sup> *Id.*

<sup>22</sup> See, e.g., PAUL BARRETT, THE GOOD BLACK: A TRUE STORY OF RACE IN AMERICA (1999).

<sup>23</sup> *Meet the Press with Chuck Todd* (NBC television broadcast Jan. 22, 2017) (interview with Kellyanne Conway) (“You’re saying it’s a falsehood. . . . Sean Spicer, our Press Secretary, gave alternative facts to that.”).

<sup>24</sup> ALBERT MEMMI, RACISM 18 (2000).

<sup>25</sup> *Id.*

structural inequality off the hook, as much for health disparities as other forms of injustice.<sup>26</sup>

The following discussion advances a critical race approach to the health sciences by examining culture talk as a discursive repertoire that attributes distinct beliefs, behaviors, and dispositions to ethno-racialized groups. After first tracing how cultural framings circulate and reproduce racist narratives in and beyond the health sciences, I examine how cultural competency training in medical schools and diversity initiatives in stem cell research employ culture talk to manage and manufacture group differences. From culturing cells in the lab to enculturing people in the clinical context, I apply the concept of “coproduction” to argue that culture talk is a precondition and product of scientific knowledge construction.

## II. GOOD CULTURE, BAD CULTURE

In *Good Muslim, Bad Muslim*, Mahmood Mamdani introduces culture talk as “the predilection to define cultures according to their presumed ‘essential’ characteristics.”<sup>27</sup> This discursive repertoire produces “museumized peoples” whose “identities are shaped entirely by the supposedly unchanging culture in which they are born.”<sup>28</sup> Fittingly, in discussing the pathologization of Islam in popular media, Mamdani uses the language of public health to argue for the need to “lift the quarantine” that separates the Western from the non-Western world and good from bad members of the group.<sup>29</sup> The clinic, and health sciences more broadly, are a key site of *cultural quarantine*, insofar as people’s beliefs and behaviors, along with their bodies, are placed under strict examination and evaluation.<sup>30</sup>

One reason culture talk persists across a wide variety of social arenas is that it allows one to recognize the seemingly obvious differences that exist across groups without fully grappling with the processes of domination and subordination that produce and rank said differences. It is a variant of what Joyce Bell and Douglas Hartmann call “happy talk,” which entails a willingness to acknowledge and even celebrate cultural diversity, without seriously grappling with structural inequality.<sup>31</sup> Culture talk should also be understood in the context of organizations and institutions working to “manage racial integration and exclusion in the post-civil rights period.”<sup>32</sup> In the *Enigma of Diversity*, Ellen Berry reminds us that racial integration was not simply a top down event that involved the passage of laws; rather, it is an ongoing, politicized process of incorporating people of color in predominantly White organizations and communities.<sup>33</sup> As such, those who champion diversity have “redefined racial progress for the post-civil rights era, from a legal fight for equal rights to a celebration of cultural difference as a competitive advantage” in which everyone wins.<sup>34</sup>

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<sup>26</sup> *Id.*

<sup>27</sup> Mamdani, *supra* note 19, at 766.

<sup>28</sup> *Id.* at 767.

<sup>29</sup> *Id.* at 766.

<sup>30</sup> Differences and conflicts that are typically rendered inherent and immutable through the language of culture, are better understood as “born of an encounter” that is historical and political. *Id.* at 767.

<sup>31</sup> See Joyce M. Bell & Douglas Hartmann, *Diversity in Everyday Discourse: The Cultural Ambiguities and Consequences of “Happy Talk”*, 72 AM. SOCIOLOGICAL REV. 895, 911 (2007).

<sup>32</sup> ELLEN BERRY, *THE ENIGMA OF DIVERSITY: THE LANGUAGE OF RACE AND THE LIMITS OF RACIAL JUSTICE* 3 (2015).

<sup>33</sup> *See id.*

<sup>34</sup> *Id.* at 7.

But, in practice, everyone does *not* win. Kamala Visweswaran argues that “because everyone ‘talks culture’ (that is to say, has access to the concept of culture), its relativist outlines have been increasingly filled by racist content.”<sup>35</sup> She draws upon Walter Benn Michaels formulation that, “[o]ur sense of culture is characteristically meant to displace race, but . . . culture has turned out to be a way of continuing rather than repudiating racial thought.”<sup>36</sup> Applying this to the clinical context, Khiara Bridges interrogates how cultural determinism thrives in the day to day practice of medicine.<sup>37</sup> She describes how physicians’ “ideas about [their patients’ ‘cultures’] contribute to health disparities,” and argues that “cultural stereotypes and beliefs in the way people from certain cultures ‘just are’ can be just as dangerous—and just as racist—as racism.”<sup>38</sup> Indeed, as discussed below with respect to opioid use, the danger of racist stereotypes affects not only those who are denigrated in medical settings, but also those who are presumed to be inherently “good.”

Perhaps, most fundamentally, those who engage in culture talk typically see themselves as free of contamination, as laying claim to a “culture of no culture.”<sup>39</sup> Drawing on Sharon Traweek’s classic formation, Janelle Taylor argues that the medical community is “defined by the shared cultural conviction that its shared convictions were not in the least cultural, but, rather, timeless truths . . . . Medical knowledge is understood to be not merely ‘cultural’ knowledge but *real* knowledge.”<sup>40</sup> Therefore, to make the *culture of no culture* visible and treatable, it must be named and diagnosed.

Health practitioners and scientists, like everyone else, enact culture in its broadest sense—“a meaning making process produced through human agency and shaped by social relations, power dynamics, competitive markets, and institutional interests and other forces.”<sup>41</sup> This understanding of cultural meaning-making is different from the designation of a static and stereotypical “list of traits” through culture talk.<sup>42</sup> Instead, the understanding involves grounding human behavior in a view of “society as a social hierarchy,”<sup>43</sup> and need not be reductionist. Janet Shim’s notion of *cultural health capital*, for instance, is a “framework for understanding how broad social inequalities operate in patient-provider interactions, and shape the content and tone of health encounters.”<sup>44</sup> Likewise, Imani Perry describes a U.S. *national* culture that is animated by practices of inequality and racial narratives.<sup>45</sup> These narratives “can encompass the rational, the affective, the physical, and the spiritual dimensions of human experience .

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<sup>35</sup> Kamala Visweswaran, *Race and the Culture of Anthropology*, 100 AM. ANTHROPOLOGIST 70, 76 (1998).

<sup>36</sup> Benn Walter Michaels, *Race into Culture: A Critical Genealogy of Cultural Identity*, 18 CRITICAL INQUIRY 655, 684 (1992).

<sup>37</sup> See KHIARA M. BRIDGES, *REPRODUCING RACE: AN ETHNOGRAPHY OF PREGNANCY AS A SITE OF RACIALIZATION* (2011).

<sup>38</sup> *Id.* at 131, 135.

<sup>39</sup> SHARON TRAWEEK, *BEAMTIMES AND LIFETIMES: THE WORLD OF HIGH ENERGY PHYSICISTS*, 162 (1992).

<sup>40</sup> Janelle S. Taylor, Ph.D., *Confronting “Culture” in Medicine’s “Culture of No Culture”*, 78 ACAD. MED. 555, 556 (2003).

<sup>41</sup> BERRY, *supra* note 32, at 3.

<sup>42</sup> See Angela C. Jenks, *From “List of Traits” to “Open-Mindedness”: Emerging Issues in Cultural Competence Education*, 35 CULTURE, MED., & PSYCHIATRY 209, 209 (2011).

<sup>43</sup> Janet K. Shim, *Cultural Health Capital: A Theoretical Approach to Understanding Health Care Interactions and the Dynamics of Unequal Treatment*, 51 J. HEALTH & SOC. BEHAV. 1, 3 (2010).

<sup>44</sup> *Id.* at 1-2 (arguing that “certain socially-transmitted and differentially distributed skills and resources are critical to the ability to effectively engage and communicate with clinical providers.”).

<sup>45</sup> See IMANI PERRY, *MORE BEAUTIFUL AND MORE TERRIBLE: THE EMBRACE AND TRANSCENDENCE OF RACIAL INEQUALITY IN THE UNITED STATES* (2011).

. . . Narrative literally shapes the way we are governed.”<sup>46</sup> Racial narratives, in turn, pervade the teaching and practice of medicine and science, even in efforts to “include” marginalized groups.<sup>47</sup> The next section examines how dominant approaches to cultural competency in the health sciences exacerbate disparities by obscuring the sociopolitical context of health and wellness.

### III. CULTURAL COMPETENCY AND BEYOND

Today approximately ninety percent of U.S. medical schools incorporate cultural competency training in their programs.<sup>48</sup> In *What's the Use of Culture?* Angela Jenks explains how, initially, the “deployment of the culture concept” was intended to challenge biologically reductionist notions of racial difference to the extent that “disparities within the health care system have been understood to reflect a cultural disconnect between physicians and their patients.”<sup>49</sup> But, she argues, “in practice, the use of culture can have a similar effect as the use of biological race, shifting attention from politicized disparities to a more neutral understanding of difference.”<sup>50</sup> She explains that, in the early days of the cultural competency movement, practitioners were given handbooks, tip sheets, and pocket guides that they could presumably pull out when needed and “flip to the appropriate section to learn pertinent information.”<sup>51</sup> This has changed somewhat, so that now culture is individualized and treated as a combination of personality traits—all that “makes you unique.”<sup>52</sup> In most cases, the culture of biomedicine is ignored while the focus remains on overcoming “the obstacles created by the patient’s culture.”<sup>53</sup>

In response, a number of curricular interventions, programs, and calls to action have worked to shift the locus of intervention—*cultural humility*,<sup>54</sup> *insurgent multiculturalism*,<sup>55</sup> *critical consciousness*,<sup>56</sup> *structural vulnerability*,<sup>57</sup> and *structural competency*,<sup>58</sup> among others. Helena Hansen and Jonathan Metzl define structural competency as,

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<sup>46</sup> *Id.* at 44. Importantly, Perry distinguishes *narrative* from *stereotype*. Whereas the latter conjures a totalizing image of a group, a narrative tells you “what follows from that meaning . . . racial narratives have a greater potential to intervene in deliberation and decision making because they both operate in people’s minds as knowledge and also seem less ideological.” *Id.* at 46.

<sup>47</sup> *See id.* at 36-48.

<sup>48</sup> Carla Boutin-Foster, M.D. et al., *Viewpoint: Physician, Know Thyself: The Professional Culture of Medicine as a Framework for Teaching Cultural Competence*, 83 *ACAD. MED.* 106, 106 (2008).

<sup>49</sup> Angela C. Jenks, *What's the Use of Culture?: Health Disparities and the Development of Culturally Competent Health Care*, in *WHAT'S THE USE OF RACE? MODERN GOVERNANCE AND THE BIOLOGY OF DIFFERENCE* 207, 210 (Ian Whitmarsh & David S. Jones eds., 2010).

<sup>50</sup> *Id.* at 211.

<sup>51</sup> *Id.* at 212.

<sup>52</sup> *Id.* at 219.

<sup>53</sup> *Id.* at 219.

<sup>54</sup> Melanie Tervalon & Jann Murray-Garcia, *Cultural Humility Versus Cultural Competence: A Critical Distinction in Defining Physician Training Outcomes in Multicultural Education*, 9 *J. OF HEALTH CARE FOR THE POOR AND UNDERSERVED* 117 (1998).

<sup>55</sup> Delese Wear, *Insurgent Multiculturalism: Rethinking How and Why We Teach Culture in Medical Education*, 78 *ACAD. MED.* 549 (2003).

<sup>56</sup> Arno K. Kumagai & Monica L. Lypton, *Beyond Cultural Competence: Critical Consciousness, Social Justice, and Multicultural Education*, 84 *ACAD. MED.* 782 (2009).

<sup>57</sup> James Quesada et al., *Structural Vulnerability and Health: Latino Migrant Laborers in the United States*, 30 *MED. ANTHROPOLOGY* 339 (2011).

<sup>58</sup> Jonathan M. Metzl & Helena Hansen, *Structural Competency: Theorizing a New Medical Engagement with Stigma and Inequality*, 103 *SOC. SCI. & MED.* 126 (2014).

the trained ability to discern how a host of issues defined clinically as symptoms, attitudes, or diseases . . . also represent the downstream implications of a number of upstream decisions about such matters as health care and food delivery systems, zoning laws, urban and rural infrastructures, medicalization, or even about the very definitions of illness and health.<sup>59</sup>

Hansen and Metzl argue that, “Over time, medical education then begins to develop a richer vocabulary for rendering structural mechanisms of stigma and marginalization visible, while at the same time shifting diagnostic focus from the ‘culture’ of individual patients to the cultures of privilege and oppression that structures, like human constructions, represent.”<sup>60</sup> Acknowledging that the language of “competency,” even when it is connected to a structural analysis, may lead to a false sense of mastery and hubris, Hansen and Metzl draw upon the work of Tervalon and Murray-Garcia,<sup>61</sup> who emphasize the need for humility in clinical encounters.<sup>62</sup> Taken together, this approach offers conceptual tools to address the twofold process of obfuscation described in this Article, in which culture talk distorts both knowers and known: *structural competency* brings to light the interlocking constraints that impact people who are the object of culture talk and *cultural humility* lays bare the assumptions and biases of practitioners who typically engage in culture talk.<sup>63</sup> In the next section, I examine how this set of interventions is relevant to diversity initiatives in stem cell research.

#### IV. DESCRIBING DIFFERENCE

From 2005 to 2007 I conducted a multi-sited, mixed method qualitative study of the California Stem Cell Research and Cures Initiative.<sup>64</sup> During my fieldwork at the Garvey Stem Cell Transplant Program, which banked cord blood for families with a child affected by sickle cell disease and thalassemia, I observed the director and other staff in the program working to make sense of the different transplant rates among eligible patient families, where sixty percent of beta-thalassemia patient families agreed to a transplant compared to six percent of eligible sickle cell patient families.<sup>65</sup> The former were predominantly Asian American and the latter were predominantly African American, and the lead caseworker at the time explained the different transplantation rates in these terms:

Although it’s rather crude, sickle cell patients act like they don’t have any control over what happens—fatalistic—and it may be that they don’t

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<sup>59</sup> *Id.* at 128.

<sup>60</sup> *Id.* at 130; see Taylor, *supra* note 40, at 559 (“Cultural competence curricula will, perhaps, achieve their greatest success if and when they put themselves out of business—if and when, that is, medical competence itself is transformed to such a degree that it is no longer possible to imagine it as not also being ‘cultural.’”).

<sup>61</sup> Metzl & Hansen, *supra* note 58, at 128.

<sup>62</sup> Tervalon & Murray-Garcia, *supra* note 54.

<sup>63</sup> Metzl & Hansen, *supra* note 58, at 108 (“[Medical students] may find difficulty in viewing medicine as a culture because the culture of medicine is not a topic that is formally discussed in medical school education. The culture of medicine is most often learned through the hidden curriculum and through role-modeling. Although it is not a part of the formal curriculum, the hidden curriculum often dictates certain customs, rituals, and rules of conduct thereby, defining the cultural milieu of medicine.”); see Carla Boutin-Foster, Jordan C. Foster & Lyuba Konopasek, *Physician, Know Thyself: The Professional Culture of Medicine as a Framework for Teaching Cultural Competence*, 83 ACAD. MED. 106, 107 (2008).

<sup>64</sup> RUHA BENJAMIN, PEOPLE’S SCIENCE: BODIES AND RIGHTS ON THE STEM CELL FRONTIER (2013).

<sup>65</sup> *Id.*



trust medicine and science. But then thalassemia patients are so controlling. They have a completely different perspective on medicine and science. They absolutely trust it.<sup>66</sup>

Here the caseworker is invoking popular, racialized notions about science-philia among Asian Americans contrasted with science-phobia among African Americans, suggesting possible cultural differences among these patient populations to explain the disparity in transplantation rates. This and similar deployments of culture talk have a long history within social scientific literature, as the earlier discussion of *The Moynihan Report* reveals, so such statements are not born of simple ignorance. Many such notions circulate precisely because institutions have tried to develop various forms of cultural competency training.<sup>67</sup> Even so, it is important to vigorously question received and simplistic notions of what differences exist and how they are produced, starting with the conceptual innovations in the previous section.<sup>68</sup> As I have discussed elsewhere, a beta-thalassemia diagnosis entails much more certainty as to the progression of the illness and the available forms of care, whereas for sickle cell anemia there is much more variability in symptoms and treatments.<sup>69</sup> For sickle cell patient families, therefore, the uncertainty of the transplant outcome is set against the uncertainty of the illness itself, compounding what cannot be known in advance. Rather than reverting to static notions of culturally-based distrust towards vague ideas of “science” and “medicine,” parents’ *ambivalence-in-action* is informed by and produced through ongoing interaction with a host of different practitioners, diagnoses, treatment options, and institutions.<sup>70</sup> In short, the same careful attention that is reserved for diagnosing biological processes should also be applied to understanding dynamic social processes.

Later in my fieldwork as I was attending one of many meetings on “diversity in stem cell research,” scientists and clinicians were grappling with how to recruit “hard to reach” populations to donate tissue and eventually participate in clinical trials.<sup>71</sup> One of the speakers described the problem in these terms:

African-Americans tend to have the *lowest level* of trust in the health care system because of historical abuses. Chinese-Americans also have *trust issues*, as well as *problems* with English and, for older members of the community and recent immigrants, a *lack of understanding* of the underlying concepts of clinical research. Latinos also face *language barriers*, as well as a fear on the part of immigrants—legal or otherwise—that participation could bring negative consequences for them and their families. Southeast Asians share many of these issues,

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<sup>66</sup> *Id.* at 115.

<sup>67</sup> BENJAMIN, *supra* note 64, at 115-16.

<sup>68</sup> See Jessica Gregg & Somnath Saha, *Losing Culture on the Way to Competence: The Use and Misuse of Culture in Medical Education*, 81 ACAD. MED. 542, 543 (2006) (“Acknowledging that it is important for clinicians to understand that both they and their patients have cultural filters that color their interpretations of both health and disease, it is equally important to appreciate the complex ways in which these filters operate. Otherwise, cultural competence programs run the risk of reinforcing cultural stereotypes and biases, and of seeing stable cultural norms or predictable culturally based behaviors where none exist. Yet within the cultural competence movement, culture *is* frequently defined in a rather uncomplicated fashion—as a fixed, knowable entity that guides individuals’ behavior in linear ways.”).

<sup>69</sup> BENJAMIN, *supra* note 64.

<sup>70</sup> Ruha Benjamin, *Organized Ambivalence: When Sickle Cell Disease and Stem Cell Research Converge*, 15 ETHNICITY AND HEALTH 447, 450 (2011).

<sup>71</sup> See e.g., Georgia Robins Sandler, Hau-Chen Lee, Rod Seung-Hwan Lim & Judith Fullerton, *Recruiting Hard-to-Reach United States Population Sub-Groups Via Adaptations of Snowball Sampling Strategy*, in 12 NURSE HEALTH SCI. 1 (2010).

along with, for many groups, a *fear of authority* bred by a variety of traumas.<sup>72</sup>

A deficit approach to diagnosing “trust issues” is evidenced in the italicized phrases, whereby the problems that require fixing are attached to specific groups. Despite the fact that all the race-ethnicities listed above are purportedly plagued by some kind of deficiency, culture talk still insists on framing distrust *as the exception* when, in fact, it appears to be much more of the rule. Why, then, are trust issues conceived of as a cultural trait and anomaly to be “overcome”—rather than a perfectly rational, even incisive, disposition toward biomedicine in a socially stratified society? Employing a methodological reversal, a critical race approach to the health sciences would require reorienting ourselves—away from a fixation with distrust and towards the problem of institutional trustworthiness.<sup>73</sup>

## V. CULTURING COPRODUCTION

During my study of the California Stem Cell Research and Cures Initiative, I also observed growing concern among some stem cell scientists that there was a “lack of diversity” in existing stem cell lines. Ethnicity, in this context, was a proxy for genetic diversity. Some researchers, in turn, started mapping the ethnic origin of existing stem cell lines as a precursor to broadening ethnic representation in biobanks (see Fig. 1).<sup>74</sup>

Figure 1. Map of the geographic location of the source institution of hESC and hiPSC lines<sup>75</sup>



<sup>72</sup> STEVEN EPSTEIN, *IMPURE SCIENCE: AIDS, ACTIVISM, AND THE POLITICS OF KNOWLEDGE* 350 (1996), noted in RUHA BENJAMIN, *PEOPLE’S SCIENCE: BODIES AND RIGHTS ON THE STEM CELL FRONTIER* 145 (2013).

<sup>73</sup> Wear, *supra* note 55, at 551 (“[Medical] students would also learn to identify and analyze unequal distributions of power that allow some groups, but not others, to acquire and keep resources, which would also include the rituals, policies, attitudes, and protocols of the very institution educating them.”).

<sup>74</sup> Louise C. Laurent et al., *Restricted Ethnic Diversity in Human Embryonic Stem Cell Lines*, 7 *NATURE METHODS* 6 (2010).

<sup>75</sup> *Id.* at 6-7.

Culture talk, I argue, links the process of ascribing cultural traits to people in a clinical context and the practice of culturing cells in the lab.<sup>76</sup> Theoretically, this relationship is best viewed through the lens of *coproduction*—a Science and Technology Studies (STS) approach that is used “to make sense of the untidy, uneven processes through which the production of science and technology becomes entangled with social norms and hierarches.”<sup>77</sup> The stem cell lab director who published the ethnic origins map of stem cell lines, above, argued that, “Ethnic origin is a critical piece of information that should come with every cell line.”<sup>78</sup> Everyone who works with stem cells should be doing this kind of analysis<sup>79</sup>:

The team’s analysis of a variety of human embryonic stem cell lines currently in use in research laboratories around the world found that these cells originated largely from Caucasian and East Asian populations, with little representation from populations originating in Africa. In response to these results, the scientists used skin cells from an individual of West African Yoruba heritage to create a new stem cell line, the first to carry the genetic profile of this ethnic group.<sup>80</sup>

Not only did her team determine the ethnic origin of dozens of existing cell lines, they also generated “the first Yoruba hiPSC line.”<sup>81</sup> This, I learned, was derived using a skin sample from the only Black researcher in the lab. The major justification for ethnic representation is that as cell lines become the basis of testing the safety and efficacy of pharmaceuticals, genetic differences across ethnoracial groups could lead to skewed results (and, I would add, a contracted market) if the tests are only done on samples from European and East Asian donors.<sup>82</sup>

Taking seriously the coproductionist insight that scientific knowledge is “not a transcendent mirror of reality” nor simply a byproduct of social and political ideology, but rather a result of the “interconnectivity of nature and society,”<sup>83</sup> then it is important to examine the connections and interests that underlie an ethnic mapping of cell lines.<sup>84</sup> For example, the drive to diversify biobanks is heavily influenced by federal legislation.<sup>85</sup> This fuels a “vexing and time consuming body hunt” because researchers find it difficult to recruit a representative sample of participants.<sup>86</sup> This purported lack

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<sup>76</sup> *What is Cell Culture*, CORIELL INST., <https://www.coriell.org/research-services/cell-culture/what-is-cell-culture> [<https://perma.cc/8GS4-W6QK>] (“In its simplest form, cell culture involves the dispersal of cells in an artificial environment composed of nutrient solutions, a suitable surface to support the growth of cells, and ideal conditions of temperature, humidity, and gaseous atmosphere. In such a system, a researcher can precisely measure the response of the cell’s alterations in culture, prospective drugs, the presence or absence of other kinds of cells, carcinogenic agents, and viruses.”).

<sup>77</sup> STATES OF KNOWLEDGE: THE CO-PRODUCTION OF SCIENCE AND SOCIAL ORDER 2 (Sheila Jasanoff ed., 2004).

<sup>78</sup> J. Lenner, *Scientists Develop Technique to Determine Ethnic Origin of Stem Cell Lines*, STEM CELL INSTITUTE (Dec. 31, 2009), <https://www.cellmedicine.com/ethnic-origin> [<https://perma.cc/KR4S-E7A2>].

<sup>79</sup> Press Release, Scripps Research Institute, Team Led by Scripps Research Scientists Develops Technique to Determine Ethnic Origin of Stem Cell Lines (Dec. 29, 2009), <http://www.scripps.edu/news/press/2009/122909.html> [<https://perma.cc/JH98-RUPN>].

<sup>80</sup> *Id.*

<sup>81</sup> Laurent et al., *supra* note 75, at 7.

<sup>82</sup> SU Yasuda et al., *The Role of Ethnicity in Variability in Response to Drugs: Focus on Clinical Pharmacology Studies*, 84 CLINICAL PHARMACOLOGY & THERAPEUTICS, 417, 417 (2008).

<sup>83</sup> STATES OF KNOWLEDGE, *supra* note 78, at 3.

<sup>84</sup> *Id.* at 4.

<sup>85</sup> See, e.g., The National Institutes of Health Revitalization Act of 1993, Pub. L. No. 103-43, § 492B(a) (ensuring that medical research includes a racially diverse population).

<sup>86</sup> Steven Epstein, *The Rise of ‘Recruitmentology’: Clinical Research, Racial Knowledge, and the Politics of Inclusion and Difference*, 38 SOC. STUD. SCI. 801, 806 (2008).

of racial representation also causes anxiety in fields that require human tissue samples to hone treatments.<sup>87</sup> In the arena of human stem cell research, some observers are concerned that the inability of stem cell banks to obtain tissue from a racially diverse population will ultimately make it harder for non-Whites to obtain a tissue match if and when therapies are developed.<sup>88</sup>

As one Hastings Center Report contends, “Stem cell therapies should be available to people of all ethnicities. However, most cells used in the clinic will probably come from lines of cells stored in stem cell banks, which may end up benefiting the majority group most.”<sup>89</sup> Yet, social scientists and human geneticists have demonstrated how this and similar statements mistakenly conflate racial-ethnic classifications with genetic diversity.<sup>90</sup> Critical race approaches to the health sciences call in to question the “problematic assumptions”<sup>91</sup> that underlie the use of racial and ethnic categories in health research:

Study designs commonly take it for granted that racial/ethnic categories are clearly and consistently defined; that individual race/ethnicity can be easily, validly, and reliably determined; and that categories capture population groups that are so inherently different from each other that a racial/ethnic difference found in any given study is automatically generalizable to the US population as a whole.<sup>92</sup>

Indeed, the scientific capacity to create cell lines, which may be useful for therapeutic purposes, has fueled the diversification of biobanks so that people from different ethnic groups will have access to cell therapies. This, in turn, has heightened the need for researchers to overcome barriers to attracting tissue donors from subordinated ethnoracial groups who, for a variety of reasons, may not want or be able to supply samples. “Culture talk” is a way to describe these reasons as endemic to groups rather than the larger structures of medicine and science (Fig. 2).

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<sup>87</sup> Mai H. Oushy et. al., *To Share or Not to Share? A survey of Biomedical Research in the U.S. Southwest, and Ethnically Diverse Region*, PLOS ONE, Sept. 17, 2015, at 1, 4.

<sup>88</sup> Ruth R. Faden et al., *Public Stem Cell Banks: Considerations of Justice in Stem Cell Research and Therapy*, 33 HASTINGS CTR. REP. 13, 27 (2003).

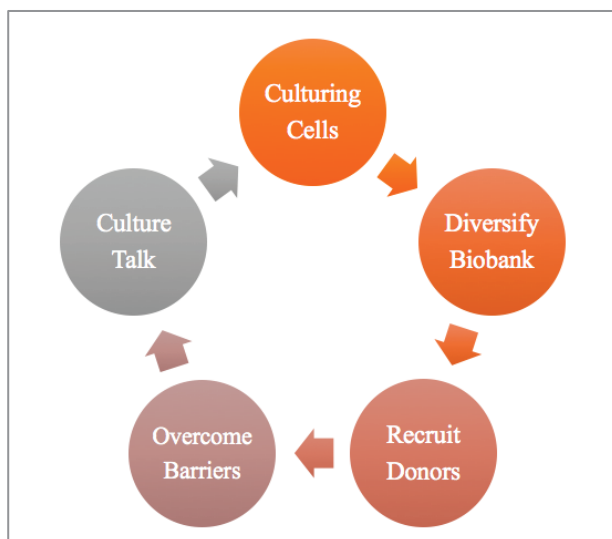
<sup>89</sup> Mark Greene, *To Restore Faith and Trust: Justice and Biological Access to Cellular Therapies*, 36 HASTINGS CTR. REP. 57, 57 (2006).

<sup>90</sup> See Osagie K. Obasogie, *Playing the Gene Card?: A Report on Race and Human Biotechnology*, CTR. FOR GENETICS & SOC’Y (2009), [http://www.geneticsandsociety.org/downloads/complete\\_PTGC.pdf](http://www.geneticsandsociety.org/downloads/complete_PTGC.pdf) [<https://perma.cc/U3UR-BQRT>].

<sup>91</sup> Judith B. Kaplan, *The Quality of Data on “Race” and “Ethnicity”: Implications for Health Researchers, Policy Makers, and Practitioners*, 6 RACE SOC. PROBS. 214, 214 (2014).

<sup>92</sup> *Id.* at 214-15.

Figure 2. Culturing Coproduction



Culture talk, in short, is part of a feedback loop – an input and output of cell science in the way that it frames the need for diverse biobanks and addresses the presumed cultural barriers of doing so. In this process, discrete biological entities and distinct ethnoracial groups are managed and manufactured. Returning to Du Bois’s warning that “the price of culture is a Lie,”<sup>93</sup> I also propose that the *value of culture* — as a way of marking biology without mentioning race and marketing medicine without upsetting racism — is what lends this discursive repertoire such enduring power well beyond any single field.

## VI. CONCLUSION

In the context of public health, too, we can observe how culture talk shapes and grows out of health policy in a dynamic feedback loop that changes dramatically depending on how target populations are represented. We know, for example, that Black patients who are stereotyped as chronically drug-seeking, routinely receive less pain treatment than their White counterparts with the same conditions.<sup>94</sup> In the cultural framework of U.S. racism, Black pain is consistently represented as fraudulent, which has devastating consequences in medical practice.<sup>95</sup> When it comes to drug treatment, not only do we observe stark differences in the *criminalization* of Blacks and Latinos compared to the *medicalization* of Whites, but even when addiction is biomedicalized for all, different regulatory schemes are triggered -- treatment associated with Black and Latino users, namely methadone, is far more regulated and stigmatized than treatment associated with middle class White users, namely buprenorphine. The latter is supplied by private physician offices allowing patients to experience far less

<sup>93</sup> DU BOIS, *supra* note 1, at 138.

<sup>94</sup> Kelly M. Hoffman et al., *Racial Bias in Pain Assessment and Treatment Recommendations, and False Beliefs About Biological Differences Between Blacks and Whites*, 113 PROC. NAT’L ACAD. SCI. U.S. 4296, 4296 (2016).

<sup>95</sup> See KEITH WAILOO, *PAIN: A POLITICAL HISTORY* (2014).

scrutiny and far more access: “the very project of destigmatizing treatment for some leads to intensified stigma for others.”<sup>96</sup> The racial imagery associated with white and black addiction produces this “two tier” policy framework that, in turn, relegates Blacks and Latinos to greater surveillance and punishment, reinforcing notions of inherent criminality.<sup>97</sup> By contrast, culture talk that presumes the inherent uprightness of Whites ensures that their drug use is categorized differently and treated less punitively – *cultural innocence* begetting *judicial innocence*.

In this way, cultural explanations for group differences tend to mimic the logic of genetics by attributing inherent traits to an underlying cultural code, which purportedly shapes individuals’ beliefs, behaviors, and dispositions. In this way, it obscures the complex social reality that leads to drug addiction and other health issues and conceals the assumptions and biases of those claiming to decipher the code. The irony of culture talk is that, not only does it stifle a fair and accurate depiction of the crises facing subjugated populations, but it masks the potential dangers that await those coded as inherently good. Namely, those “overserved” by private physicians who choose not to suspect them of abusing drugs, are not truly served by a system built upon racist assumptions even if, on the surface, they seem to benefit. Hence, in a perverse fashion, the current drug crisis reveals how culture talk produces white innocence *and* white death, offering yet one more reason to lay flat cultural conceptions of group difference to rest.

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<sup>96</sup> HANSEN & ROBERTS, *supra* note 9, at 98.

<sup>97</sup> Julie Netherland & Helena Hansen, *White opioids: Pharmaceutical Race and the War on Drugs That Wasn't*, BIOSOCIETIES, Jan. 11, 2016, at 1, 14.