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This presentation will examine the question of whether or not modern human populations structure into races (subspecies). This is relevant to labeling any medication as being a group (or so-called "race") specific drug, something that smacks of a kind of determinism that science has shown to be untenable. Modern humans do not structure into subspecies (races) based on the kind of phylogenetic criteria used by evolutionary geneticists. Labeling a medication as race specific implies that all adult biology is inherited and that all members of demographics are more similar than different due to inherited biology, and that this will not/cannot change over time. Given that the official agencies have shown reluctance to label all but a few drugs as even sex specific, where differences are usually obvious, a so-called "race" specific drug is even more tenuous. Medications work on pathophysiology and clinical phenotypes, not group labels or degrees of ancestry.

A given sociodemographic group may have a greater prevalence of a particular clinical phenotype with particular origins, but these origins are not ontologically related to the origins of the group and cannot be labeled in this typological fashion. Clinical phenotypes may result primarily from early intrauterine or childhood microenvironmental experiences as explained by the foetal programming or developmental hypothesis. A genetic role is possible, but yet to be elucidated; however in this society the hidden assumption when the word race is [incorrectly] applied to groups is that the differences are deeply ancestral—even in groups where the identifying ancestry may be minimal!

We should treat clinical phenotypes not sociodemographic labels; this is good science. We should identify the various pathways to heart failure and the resulting pathophysiology and clinical phenotypes, and the drugs useful in treating them. Thus any individual from any group can be treated appropriately, and thus benefit.