ARTICLE
“Stroke’s No Joke”: Race and the Cultural Coding of Stroke Risk

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Abstract

Stroke is a leading cause of death in the US that disproportionately affects African Americans. In a 2009 PSA campaign, the American Stroke Association’s Stroke’s No Joke campaign collaborated with African American stand-up comedians to promote symptom recognition and discourage delays in care seeking among African Americans. Rather than frankly articulating their disproportionate incidence of and death from stroke, however, this campaign hailed African Americans and their stroke risk using an overly broad construction of blackness. This article joins the others in this special feature in examining how blackness becomes an object of knowledge production in medicine by considering how stroke risk becomes racially and culturally coded.
Introduction

In August 2009, the American Stroke Association (ASA) began a public service announcement (PSA) campaign designed to inform African Americans about stroke warning signs and the need to seek immediate emergency medical care at their onset. The campaign, titled Stroke’s No Joke, featured African American stand-up comedians joking about family members delaying emergency medical care after the first signs of stroke. In addition to jests, the campaign deployed a direct camera address informing the viewer about the dangers of delays in care seeking. The Stroke’s No Joke campaign included television, radio, online, and billboard PSAs, using the tag line “Time lost is brain lost” to frame stroke as an urgent medical threat. Addressing both the disproportionate risk of stroke among African Americans and the deleterious effects of delays in seeking emergency care, Stroke’s No Joke represents a critical endeavor to reduce race-based disease disparities. Yet while the campaign was explicitly designed to target African Americans, its message to viewers curiously did not articulate racial disparities in stroke risk and death, instead deploying stand-up comedy as a means of shaping the informed African American patient.

In this article, I draw on theorizations of the cultural construction of race to examine knowledge production around African American stroke risk. Here I rely on the works of Janet K. Shim (2014) and Angela Jenks (2010), who illustrate how cultural concepts of race can depoliticize racial health disparities and frame them instead as neutral markers of racial difference. I take the Stroke’s No Joke campaign as my focus to analyze how avowed antiracist efforts to intervene in a persistent health inequity can essentialize race as a static marker of cultural difference. In examining African American stroke disparities and the institutional undertakings to address and mitigate them, I argue that this process of essentializing and racializing cultural difference positions both race and culture as apolitical and ahistorical risk factors, stripping such well-intentioned institutional interventions of their stated aims toward equity. In response to this depoliticization of biomedical knowledge production about
African American stroke risk, I consider how racial health disparities persist as part of structural, not just cultural, barriers to health equity, and call for a feminist biomedical knowledge production that discursively centers the bodies and lives for whom this knowledge is vital.

The “cultural coding” of biomedical knowledge production is part of a broad effort by health institutions to improve the efficacy of interventions into persistent disease disparities. With regard to racial disparities in stroke death, researchers at the Centers for Disease Control and Prevention (CDC) found that while stroke mortality declined substantially among different racial groups in the 1970s and 1980s, “little improvement was made in the 1990s” (Casper et al. 2003, p. 2). In addition to this slowed decline, they reported that stroke hospitalizations increased 18.6% from 1988 to 1997 (ibid.). In the Atlas of Stroke Mortality: Racial, Ethnic and Geographic Disparities in the United States, the CDC’s 2003 report responding to this ongoing crisis, the agency acknowledged the recognition among public health agencies for local interventions that could “provide more targeted and culturally appropriate stroke prevention programs and policies” to better address these racial disparities (ibid). Known as “cultural competence,” this model is intended to enable and improve cross-cultural and cross-racial communication in the context of care.

This framework of cultural competence works toward understanding the cultural and social influences that shape relationships between medical practitioners and patients as well as the quality of care given; it is also a tenet of institutional efforts to intervene in persistent racial disease disparities like African American stroke risk. Emerging from prominent organizations like the Department of Health and Human Services (HHS), the American Heart Association (AHA), and the CDC, this call to intervene in racial health and disease disparities reflects concerted institutional attempts to understand and correct individual, cultural, geographical, and structural causes of these disparities.

The collective work of these agencies frames persistent disease disparities as the product of individual behaviors, such as delays in care
seeking; of cultural beliefs, such as distrust of medical institutions; and of structural barriers to care, such as a lack of local access to emergency services. Calls to action recognize racial health disparities as the product of a combination of these factors, advocating for interventions that take each into account. Rather than articulating African American stroke risk as such, the logic of Stroke’s No Joke attributes African American stroke disparities only to individual risk factors and cultural differences, while evading more pernicious structural inequalities and barriers to care. Rather than engaging with the complex social determinants of health and illness that shape this persistent disparity, the campaign reconstructs blackness, here via stand-up comedy, as both an object of and a vehicle for biomedical knowledge production.

“Stroke’s no joke”: The campaign

Stroke is a leading cause of death among Americans in general, and among African Americans in particular. According to the CDC, a stroke occurs “when a clot blocks the blood supply to the brain or when a blood vessel in the brain bursts” (Know the facts about stroke). Immediately following the onset of a stroke, there is a three-hour window during which treatment is most effective in preventing cognitive impairment and death. Interventions seeking to reduce stroke mortality through increased patient awareness focus on improving patients’ recognition of stroke symptoms and promoting immediate action during this critical window of time. The CDC reports that more than 795,000 people in the United States suffer a stroke annually, and that stroke kills almost 130,000 Americans each year (Stroke facts). Of the nearly 800,000 strokes reported annually, about 610,000 are first or new strokes and approximately 185,000 strokes occur in people who have had a previous stroke. Furthermore, the ASA reports that annually, women have more strokes than men, and that stroke kills more women than men (Understanding stroke risk). According to data from 2010, the most recent year from which these statistics are available, roughly 55,000 more women than men had a stroke, and 77,109 women—
as compared to 52,367 men—died as a result of stroke (Women face higher risk of stroke). It is estimated that stroke costs the United States $36.5 billion each year in health care services, medications, and missed days of work (Understanding stroke risk). Given its significant rates of morbidity and mortality, addressing the enormous toll of stroke on the individual and national body as well as its disparate incidence among African Americans is vital. Equally pressing, I argue, is the need to understand the means by which African American stroke risk is communicated, and what this reveals about the politics of knowledge production in racial disease disparity interventions.

The commercials televised for the Stroke’s No Joke campaign feature African American comedians Alonzo Bodden and George Willborn each performing stand-up routines in front of a laughing audience. They perform inside a comedy club, dimly lit with a brick wall backing the stage. Aside from minor differences in the jokes told, the Bodden and Willborn commercials are effectively identical. In both their jokes, an uncle phones and complains about experiencing symptoms that the PSA would later indicate are stroke symptoms. In both acts, the comedians urge their uncles to seek emergency medical care without delay. Bodden, for example, relates to the audience that his uncle experiences dizziness and loss of balance, but after offering to take him to a doctor, his uncle replies, “No, I’m gonna look up the symptoms.” Bodden appears incredulous, saying to his uncle, “Your symptoms are you’re dizzy and you’re losing your balance!” The audience laughs, and Bodden continues that his uncle now complains of an inability to search his symptoms online because his arm has become numb. Still exasperated, Bodden replies, “Well use your good arm and dial 9-1-1!” Bodden’s response is, once again, met with laughter as the camera pans the room to show the silhouettes of laughing audience members.

Following his “routine,” the campaign’s insignia appears on screen as Bodden begins his direct camera address: “Stroke’s no joke. If you or someone you love is showing symptoms of stroke, don’t wait ‘cause it might be too late. Dial 9-1-1. Time lost is brain lost.” As Bodden delivers
this information, the campaign’s web address, strokesnojoke.org, followed by the insignia for both the Ad Council and the American Heart and Stroke Associations appear on screen, this same script replayed in the commercial featuring George Willborn. In the latter, the camera pans over a laughing audience before landing on Willborn on stage, who jokes that his uncle had called a series of family members before reaching him. After complaining of stroke symptoms and being encouraged by Willborn to seek immediate emergency care, his uncle nonetheless decides to wait until Willborn returns from out of town to seek help. And like the commercial featuring Bodden, the camera then cuts to a direct camera address where Willborn urges viewers to seek emergency care at the first signs of stroke. Notably, women are absent from this conversation about African American stroke risk; in both the Bodden and Wilborn commercials, the relatives who are suffering stroke symptoms and the family members who urge immediate emergency care are all men.

After delivering jokes about delaying emergency medical treatment, Bodden and Wilborn use the direct camera address to emphasize the importance of seeking immediate care. Employing what Robin Nabi et al. (2007) call a “restoration of gravity,” the PSA shifts from the comedians’ light-hearted material to the campaign’s central message. Nabi and her co-authors argue that humorous social issue messages typically promote more message discounting among viewers than serious messages; thus, the authors suggest that the conclusion of a humorous message should “reestablish serious intent” to maximize the efficacy of humor as a functional element in serious contexts, and to minimize the extent to which audiences resist or discount the information being communicated (p. 50-51). The comedians make explicit the need to view the onset of stroke symptoms as a cardiac and neurological emergency, emphasizing that action must be taken immediately following symptom onset. As the comedians remind viewers, “Time lost is brain lost.”

Aside from the glaring absence of women, the commercials themselves are striking for two particular reasons: the absence of an explicit acknowledgement of the racial disease disparities in stroke
incidence spurring this campaign, and the ambivalence of using stand-up comedy both as an efficient channel through which African Americans can be addressed and an instrument of health communication that can potentially undermine the seriousness of a message. The Stroke’s No Joke campaign is part of the AHA’s broader efforts to address African American stroke risk and mitigate racial disease disparity. The AHA’s 2011 Diversity Report, a public account of the agency’s attempts to improve health equity across racial groups, specifically notes that the campaign’s multimedia campaign is “dedicated to reaching African Americans about stroke warning signs and the need to seek emergency medical care at the first sign(s) of stroke” (p. 4). However, this message about racial disease disparity is made implicit in the campaign’s televised commercials, which are more focused on addressing individual behavior. While I find this implicit gesturing to be inadequate to the task of raising public awareness of stroke risk, the commercials’ failure to make explicit the campaign’s intentions is not what is most troublesome here; rather, by addressing the problem implicitly, the PSA—the public face of larger, institutional interventions into African American stroke risk—individualizes and therefore depoliticizes heart health and care.

According to the CDC, stroke is the third leading cause of death among African Americans, behind heart disease and cancer, respectively. The CDC reports that the risk of having a first stroke is nearly twice as high for blacks than it is for whites; further, blacks are more likely to die from a stroke than are whites. Significantly, this research also makes a distinction between disparities in the incidence of stroke and disparities in treatment-seeking behavior. The work of eliminating persistent racial disease disparities rightly begins with locating the causes of these disparities. For example, the CDC’s 2003 Atlas report traces how stroke hospitalizations and stroke mortality among racial and ethnic groups persist over time. Importantly, the Atlas also traces what these data reveal about geographic and racial disparities in stroke, representing on both local and national maps the alarming concentrations of stroke death in the southeastern US in what is called the “stroke belt” and among African
Americans (p. 2). The strength of this intervention is its investment in understanding the myriad factors that contribute to such health disparities. In particular, the Atlas makes a case for identifying the social determinants of health among populations that suffer most acutely from these disparities, and for adopting interventions that reflect their many causes.

Disparities in treatment-seeking behavior may reflect the longstanding cultural and structural effects of race and racism in biomedicine. Citing for example social injustices like the 1932 Tuskegee Syphilis Study where African American subjects were denied treatment for decades under the guise of studying the “natural history” of the disease, as well as racial health inequalities emerging from medical segregation and discrimination in twentieth-century America, scholarship at the intersection of biomedicine and culture examines the social and political contexts that produce these disparities. Possible causes include past and continued distrust of physicians and medical institutions, the effectiveness of patient-provider communication, cultural differences in symptom response, and access to emergency medical services as both a socioeconomic and geographical issue (Casper et al., 2003; Moser et al., 2006; Nelson, 2011; Pollock, 2012).

Stroke prevention research also identifies a series of controllable risk and “lifestyle” factors that increase the risk of stroke. The National Stroke Association (NSA) (Medical risk factors) notes that high blood pressure, atrial fibrillation, high cholesterol, diabetes, sickle cell disease, and artery diseases like atherosclerosis, carotid and peripheral artery disease can and should be treated to manage the risk of stroke. So-called lifestyle factors that may increase the risk of stroke include tobacco use and smoking, alcohol use, poor diet, physical inactivity, and obesity. These controllable risk factors are considered alongside uncontrollable factors like age; family history; gender; prior stroke, transient ischemic attacks, and heart attacks; and, most relevant here, race. Considered in full, the current understanding of the many contributing factors leading to stroke involve both individual and social determinants of disease, illustrating how both individual behaviors and the individual’s social
environment work together to shape stroke risk. But as this campaign reveals, knowledge production about biomedical risk does not always reflect this understanding.

Ongoing threats to health equity including the lack of access to quality care, exposure to environmental toxins, distrust of the medical establishment, high rates of incarceration, food “deserts” in impoverished areas, and the stress of discrimination, can all play a role in the persistence of racial disease disparities. In the context of disease disparities such as this one, race is significant as an indicator of, to borrow from Herman Gray (2013), a structural position that organizes collective disadvantage (p. 772). It is a marker of inequity along a series of axes, defined by risk factors both controllable and not. Race, in other words, is the nexus of complex and intersecting social determinants of disease. Rather than communicating these structural issues around stroke risk, however, the PSA reduces these disparities in stroke risk to the level of personal responsibility, while reducing the role of race in this disparity to an empty signifier of difference. The use of stand-up comedy here becomes a surrogate for a much more complex conversation about race and the social determinants of health.

Deploying black stand-up comedians to communicate health risks to black populations trades on the notion that comedy, and by extension the African American humor tradition, is an effective channel through which black populations can be interpellated. The African American humor tradition is rooted in social commentary and critique that speak to the lived experiences of African Americans, functioning as a lens through which race and difference are mediated (Haggins, 2007; Kretting, 2014; Watkins, 1994; Zoglin, 2009). Before it became mainstream in the late 1980s and early 1990s, black stand-up comedy thrived in local clubs catering to black audiences. Clubs like The Comedy Act Theatre in Los Angeles, founded by Michael Williams in the 1980s, gave black comedians a space to perform at a time when promoters and bookers for national, mainstream—i.e. white—comedy clubs would not book them; as Williams explained to me, mainstream comedy clubs typically did not book
many black stand-up comedians because they did not believe there to be a demand for black performers within their clubs (Personal communication, 2008).

Since that time, black stand-up comedy as a genre of performance has become far more accessible to mainstream audiences. This greater accessibility was fostered by what Bambi Haggins (2007) identifies as black comedians’ crossover comic personae. As Haggins writes, the black comic persona has become “firmly ensconced in contemporary mainstream American popular consciousness” (p. 2). Black comedic social discourses went from circulating within very prescribed spaces to becoming part of a broader mediascape. Part of this “crossover” into mainstream popular consciousness, as Haggins writes, is the construction of a comic persona that utilizes black experiences in a manner that is accessible to wider audiences. So while comedians like Dick Gregory, Richard Pryor, Paul Mooney, Dave Chappelle, Chris Rock, W. Kamau Bell, and Jerrod Carmichael have all worked within the traditions of black stand-up comedy—at times using stand-up to critique systemic racism and structural inequality—they have largely done so while speaking to large, mainstream audiences.

The use of black stand-up comedy in the context of this campaign is distinct from this tradition in that it is being deployed as an instrument of institutional, prescriptive communication. Black stand-up comedy functions here as a vehicle to promote what Nikolas Rose (2007) calls biological citizenship. Rose writes that life in the twenty-first century is understood through a biomedical paradigm, and that these “biological senses of identification and affiliation” make ethical demands on the self, kin, community, and society (p. 133). In this PSA, black stand-up comedy is used by the state to communicate to African Americans the need to understand the African American body as always at risk of disease. Hence, the PSA’s commercials are not black stand-up comedy, exactly; rather, they perform an idea of black stand-up comedy to fashion an informed and responsible biocitizen.
The cultural competence and entertainment-education models of risk

The Stroke’s No Joke campaign constitutes one of a series of race-based health interventions launched by the ASA and the AHA, interventions employing cultural competence as a framework for promoting health equity as both an institutional and public concern. As the AHA states in its 2007-2008 Diversity Report, the agency aims to increase cultural competency “through cause initiatives that reach a specific population group, through programs that outreach to high-risk audiences and through targeted advertising and communication efforts” (p. vi). Cultural competence has been the dominant framework through which physicians and epidemiologic researchers have sought to account for and mitigate the role of race in disease disparities, stigma, and biases in treatment decisions. By being sensitive to socioeconomic differences causing these disparities, the clinician can ostensibly develop a competence or understanding of the “cultural variables” fostering these disparities. This thinking plays a prominent role in medical education and in policies put forward by organizations like the AHA and CDC. As Angela Jenks (2010) notes, cultural competence emerges from a “strongly antiracist agenda that seeks to counteract the differential access to quality care that many believe has led to extreme health disparities in the United States” (p. 220). And it is because of the importance of this agenda that the means by which stroke prevention is made “culturally sensitive” must be scrutinized. Antiracist intentions notwithstanding, cultural competence interventions like Stroke’s No Joke can frame such disparities as a matter of a “natural, and unavoidable, difference of cross-cultural communication and can become a way to avoid difficult conversations about racism” (Jenks, p. 221). This is helpful to keep in mind when considering the Stroke’s No Joke campaign within broader institutional efforts to fix or alleviate this disparity.

In addition to the Stroke’s No Joke campaign, the ASA and AHA deployed two community-based education programs, Search Your Heart and Conozca Su Corazón, to deliver biomedical knowledge, promote
behavior change, and reduce heart disease risk factors among African Americans and Latinos, respectively. These programs put into action research-driven interventions on racial stroke disparities. They take a comprehensive approach to promoting behavior change, using community health workers, heart disease health assessments, online support through social media campaigns, as well as work place- and home-wellness models to provide their target populations with biomedical knowledge about their risk of stroke morbidity and mortality. It is important to situate the Stroke’s No Joke campaign within this context to understand how the antiracist intentions of cultural competence, after which these community programs were also modeled, inform and constrain PSAs like Stroke’s No Joke.

The Stroke’s No Joke campaign was created by the ASA, the Ad Council, and Burrell Communications, the latter a marketing communications firm specializing in “insight-based” marketing that targets African American audiences. Following from the same body of research that fostered the community education programs preceding it, the Stroke’s campaign was designed to reduce prehospital patient delay and, somewhat less explicitly, to promote the benefits of early treatment of stroke. This is a critical message because, as a 2006 AHA scientific statement finds, “most individuals who experience symptoms delay substantially before seeking treatment” (Moser et al., p. 169). According to this same document, most delays occur in the following phases of treatment-seeking: the first phase lasts from symptom-onset to the decision to seek medical attention; the second phase lasts from the decision to seek medical attention to the first medical contact; and the third phase lasts from first medical contact to hospital arrival (ibid.). The scientific statement indicates that the longest delays occur in the third phase, between symptom recognition to the decision to seek care.

Patient delay in seeking treatment for stroke is a persistent problem in the United States. And because stroke disproportionately affects African Americans, institutions like the AHA and the CDC target this high-risk population with race-based health promotion campaigns, which are
called upon to increase their efficacy in promoting health equity. The AHA’s scientific statement noted that public education campaigns until that point had been ineffective in reducing patient delay. The failure to eliminate these disparities, the AHA statement argues, reflects a preoccupation with symptom recognition and insufficient attention to “the urgency of immediate emergency transport and treatment within the context of the potential therapeutic benefits of reducing prehospital delay” (p. 176, emphasis in original). Further, citing epidemiologic research indicating racial disparities in both the incidence of stroke and in patient delay, the report recommends that future public education strategies focus on minority populations to make “significant gains” in reducing delays to treatment: “Blacks may recognize ACS [Acute Coronary Syndrome] and stroke symptoms less readily than whites, delay longer in seeking treatment, be less likely to reach an emergency room via ambulance in some communities, and yet have a greater risk of death from both ACS and stroke at an earlier age than the rest of the population” (p. 176). The authors of the scientific statement and the CDC’s Atlas argue that the best interventions going forward will be those that target high-risk populations with the goal of reducing prehospital delay.

Given the pressing need to intervene in the racial disparity in stroke incidence and mortality, as well as in the high incidence of prehospital delay, why not make the stakes of an intervention like Stroke’s No Joke explicit? Why, in other words, would such a campaign be raced-based but without clearly articulating the urgent threat facing African Americans in particular? According to Healthy People 2020, a document produced by HHS which sets 10-year national objectives to improve health, establish benchmarks, and monitor progress toward these objectives, achieving health equity and eliminating health disparities is a pressing, overarching goal. But while deploying stand-up comedy and the African American humor tradition to raise stroke awareness among African Americans, the Stroke’s No Jokes campaign does not articulate this goal even as it communicates individual behavioral changes that would presumably meet it; instead, this focus on the individual rather than the structural
reconfigures the political category of race into a natural classification of bodies (Roberts, 2011).

Generally speaking, the PSA’s mobilization of stand-up comedy reflects the success of the Entertainment-Education model of health communication, wherein health messages are embedded within entertainment media, which is assumed to form an efficient means of providing accurate information to viewing publics (Brodie et al., 2001; Kennedy et al., 2004; Murphy et al., 2008; Singhal & Rogers, 2001). Entertainment media have long been used to communicate health information. Dating back to the nineteenth century when broadsides and public health posters were used to identify disease risk factors and promote behavior change, public health and military training films, primetime television, pharmaceutical advertisements, medical reality television, and the Internet have all been used to hail subjects and foster risk-aware subjectivities (Dumit, 2012; Ostherr, 2013; Serlin et al., 2010). Studies conducted by the CDC, as well as the Kaiser Family Foundation and the USC Annenberg Norman Lear Center’s Hollywood, Health, & Society program, have provided empirical evidence demonstrating the efficacy of these efforts, particularly in addressing disease disparities along the lines of race and socioeconomic status (Moser et al., 2003; Murphy et al., 2008).

In a report produced by the Kaiser Family Foundation and Hollywood, Health, & Society, Murphy et al. (2008) found that many Americans rely on television as an important, and often primary, source of health information. Their research focuses on the role of health content in primetime television programming, but their analysis is useful in understanding the importance of the healthscape as a site for biomedical knowledge distribution: “According to one survey, 26% of the public cited entertainment television as being among their top three sources of health information, and half (52%) said they consider the health information contained in these programs to be accurate” (p. 1). Members of racial and ethnic groups in particular, they found, stand to benefit from this brand of health communication:
The heaviest consumers of television—low socioeconomic status African American and Hispanic women—are at a disproportionately higher risk for life threatening ailments such as certain cancers, diabetes and heart disease. Moreover, evidence suggests that minority viewers are also the most likely to act on information learned on television. (Murphy et al., 2008, p. 2) The report suggests that the Entertainment-Education model offers a unique opportunity to educate viewers about scores of health conditions, while also instructing viewers on how they might handle their own illnesses.

The Stroke’s No Joke campaign, then, follows from these calls to action in its aims to curb the disparate incidence of stroke among African Americans. It is coded to be “culturally appropriate,” following the recommendation of publications like the Atlas of Stroke Mortality, aiming to address African American stroke risk. Likewise, it balances the use of humor with the restoration of gravity to minimize message discounting by viewers. The campaign’s very premise aims to eliminate prehospital delays in treatment-seeking among African Americans, a significant factor in the racial disparity of stroke deaths in the US. However, by emphasizing individual responses to a deeply structural health issue, the Stroke’s No Joke campaign risked defining race as a static marker of difference independent of larger, socioeconomic factors. The campaign, and the broader politics of racialized biomedical knowledge production it exemplifies, illustrates the limited and limiting means by which blackness is studied and deployed in biomedical knowledge production.

**Biologizing race through treatment**

The intersections of blackness and stroke risk dovetail into contemporary definitions and uses of race in biomedicine. These negotiated meanings, among epidemiologists and scholars of the social determinants of health, reveal how understandings of the relationship between race and risk evolve and remain contentious over time. Frequently, these debates about risk focus on two competing understandings of race: one is a
biological or genomic definition of race as a predisposition or innate, individual-level pathology, and the other is a culturalist understanding of race as a social construct responsible for real and devastating health disparities (Braun, 2014; Kahn, 2013; Pollock, 2012; Roberts, 2011; Shim, 2014). Janet K. Shim (2014) writes that the latter, this “cultural prism”—namely, “its discursive opposition to biology, its perceived observability and verifiability, its resonance with health promotion ideologies, and finally its conceptual flexibility”—makes it a “popular, and scientifically and politically safe, construction of race” (p. 194). Yet the constructivist model of race has limitations for explaining racial health disparities. Mainly, while it rejects the notion of race as an innate pathology, the model also creates a context in which the medical significance of race is unclear and, in particular, blackness is clumsily articulated and targeted as a health risk.

The Stroke’s No Joke campaign demonstrates how biomedical risk becomes racialized. The campaign grew out of the same marketing infrastructure targeting African Americans as potential-consumers in market segments for hair products, alcohol and cigarettes, music, and athletic shoes; indeed, the AHA’s 2007-2008 Diversity Report identifies its Search Your Heart education program for African Americans as one of its culturally competent “consumer initiatives.” The ubiquity of this marketing infrastructure is telling. Since the 1970s, the marketing of race and blackness—as a coveted demographic subgroup and consumer market—has participated in the reinforcement of discrete and consistent racial categories outside the realm of consumerism (Roberts, p.165). Burrell Communications, the marketing firm that produced this campaign, built its reputation and clientele by targeting African American consumers for corporate entities like Procter and Gamble, Toyota, and McDonald’s. The choice to use Burrell to produce this campaign, perhaps seen by the sponsoring agencies as a strategic move to reach and promote behavior change within African American patient populations, reveals the ways in which racial categories are uncritically reproduced using the language and strategies of the market.

The internal logic of this race-based marketing infrastructure is
identical to that of racialized medicine in heart disease disparities. The marketing of the pharmaceutical drug BiDil, a combination drug designed to treat heart failure, is perhaps the most notable example of this enterprise. BiDil was tested in the African-American Heart Failure Trial (A-HeFT), a clinical trial that enrolled 1,050 self-identified African Americans suffering from heart failure. In 2005, after showing a remarkable increase in survival rates among its users, the makers of BiDil applied for and received FDA approval to market the drug as a race-specific treatment for heart failure. Despite little evidence that race mattered to the drug’s efficacy, as well as the opacity of interpreting racial self-identification in a clinical trial, race was used to market BiDil as a pharmaceutical solution to a persistent disease disparity. Part of a growing trend in developing pharmacogenomic therapies capable of being tailored to a person’s genetic make-up, BiDil was controversially touted as an “ethnic drug.” With no empirical data supporting its claim to be more effective in black patients than in non-black patients, BiDil’s eventual commercial failure revealed the central problem with racialized medicine: a reification of race tethered to beneficial medical developments. BiDil became, as Anne Pollock (2012) writes, a pharmakon, both remedy and poison (p. 156).

The core critique of BiDil—that it naturalizes racial disparities by treating race not as a dynamic and complex social construct but rather as a genetic reality—can be levied here against the use of race as a marker of cultural difference in stroke risk and prevention. Pollock points out that racial differences in heart disease are both material and semiotic (p. 5). The disparate incidence of and premature mortality from heart disease and stroke among African Americans are evident. By redefining race through certain notions of disease and treatment, the Stroke’s No Joke campaign reproduces the racial narratives about BiDil that naturalize race and that paper over broader social and environment factors influencing health disparities.

Practically speaking, using race as a proxy or shorthand to screen for and treat disease disparities can seem like an efficient use of physicians’ and epidemiologists’ efforts. Physicians often discuss this
shorthand as a potentially problematic but ultimately valuable tool; when the goal is to save lives and minimize biomedical risks to high-risk populations, the ends are thought to justify the means. But as Dorothy Roberts (2011) points out, race is a bad proxy that can hinder physicians and researchers from considering other evidence-based symptoms and clinical measures. Using race categorically to treat patients differently—based on either a patient’s self-identification or a clinician’s perception of a patient’s race—constitutes an imprecise treatment plan. Further, race-based treatments can leave patients open to potential harm emerging from biases and stereotypes, diverting attention and resources away from social determinants of health and therefore reproducing rather than alleviating persistent disparities.

This effort to marshal a responsible, efficient, and “culturally appropriate” health intervention relies too heavily on an understanding of race as a static, universally applicable variable while ignoring the broader context in which race becomes medically significant. Reports like the Atlas of Stroke Mortality call for solutions to racial disease disparities that rely on changes in personal behavior and structural inequalities. As Shim explains, “in order to better understand the kinds of factors that determine heart disease incidence and distribution, research must consider multiple levels of causation at the same time” (p. 200). I argue that this attention to multiple factors of causation must extend beyond the realm of research to include the means by which disease and treatment are communicated to at-risk populations. In other words, it’s not enough to establish community-based health education programs like Know Your Heart and Conozca Su Corazón; institutions like the AHA and ASA must also be mindful of how they represent to target populations and the wider public the relationships between race and biomedicine.

**Feminist biomedical knowledge production**

The racialization of biomedical knowledge production limits the rhetoric used to address biomedical risk. The campaign’s framing of African
American stroke disparity as an individual- and cultural-level failing wholly ignores the role of social and structural barriers to health equity, including why race is correlated with disease disparity in the first place. And further, it undermines the AHA’s deployment of an antiracist approach to cultural competence in its Know Your Heart and Conozca Su Corazón programs. The question of how best to understand the persistence of racial disease disparities is important to consider as biomedicine continues to grapple with the medical significance of race.

This flattening of the complexities of race into a narrow reproduction of race-as-difference illustrates how race itself can become a hypervisible, if somewhat empty, signifier of difference. The coding of race in Stroke’s No Joke illustrates what Herman Gray calls a “cultural politics of diversity,” where visibility, rather than a struggle over the social, economic, and cultural basis of disadvantage, is an end in itself (p. 772). In the televised campaign, attention is being paid to African American stroke risk in ways that invisibilize structural determinants of health inequities. The irony here, of course, is that the cultural prism—and, indeed, the very notion of race as a cultural, not biological, phenomenon—is held up as a laudable alternative to the reductive essentialism of biological race. As Shim writes, this discursive opposition to biological race frames the cultural prism as a “safe,” apolitical way to examine the social determinants of disparity (p. 90). It is this apolitical conceptualization, however, that fails to capture “the full measure of complex causal pathways” by which we know disease disparities to persist (p. 110).

The depoliticization of persistent racial disease disparities as a matter of cultural difference or individual lapses in self-care illustrates the need for what I term feminist biomedical knowledge production. Despite the findings of institutions like the CDC and AHA indicating that persistent racial disease disparities are the product of numerous causal factors that include structural barriers to care, the urgency of communicating stroke as a leading cause of death for African Americans is elided in favor of a marketing pitch to a segment of consumers. Perhaps the problem, then, is that for the Ad Council, Burrell Communications and, somewhat
surprisingly, the AHA, African Americans here are primarily consumers rather than biological citizens subject to a set of forces causing their death.

Feminist biomedical knowledge production is vital for science and technology scholars who aim to interrogate not only how disease disparities are reproduced, but also how racialized knowledge production helps generate these disparities as well as what biological citizens might do about them. Feminist biomedical knowledge production could help illuminate the assumptions about race and cultural difference made in campaigns like Stroke’s No Joke, and in the practice of racialized medicine more generally. For guidance here, we might look to scholars like Dorothy Roberts, who has written effectively on the implications of imagining race as a primarily biological or consumerist means of classification. Framing race as an essentialist cluster of genetic predispositions or behaviors that aggravate the already-disparate incidence of disease validates beliefs in an intrinsic racial difference; the politics of this kind of knowledge production renders invisible the black lives that are lived in light of pernicious structural barriers to equity, and the black bodies on which these disparities take their toll.

Likewise, feminist biomedical knowledge production could discursively center the lives, bodies, and experiences of the biological citizens subject to these disparities, representing those presently erased by the misguided, even if well-meaning, assumptions of cultural competence. In a moment when biological citizens so often become agents of their own care in self-help groups, on illness blogs, and through user-generated health discourses on platforms like YouTube, perhaps the depoliticization of disease disparities will create an opening, as David Serlin (2010) writes of online illness narratives about HPV, for a proliferation of user-generated discourses about stroke. Under this paradigm of knowledge production, women’s status as sufferers of a disparate incidence of stroke and stroke death, as well as the entirely political nature of racial disease disparities could be foregrounded. As Roberts (2011) writes, “If its function as a political system is recognized, race can have a valid use in scientific research to locate, understand, and
eliminate the effects of racism” (p. 311). The trick, it seems, is to build and sustain a nuanced understanding of what race means in the context of health disparities, and to resist the urge to simplify that understanding in the transition from knowledge production to knowledge distribution.

References


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Bio

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