

INTRODUCTION

In 2005, BiDil became the first drug ever approved by the U.S. Food and Drug Administration (FDA) for use in a specific race: it was indicated for heart failure in “self-identified black patients.” As such, it became fodder for both popular and academic debate about the role of race in medicine, and the nature of racial difference more broadly. As novel as its FDA indication was, this drug represents just one moment in a long-standing and dynamic interplay of race, pharmaceuticals, and heart disease in America. *Medicating Race* examines these. In the wake of BiDil’s commercial failure, this analytical contextualization helps to account for its allure and its unpalatability, as well as to open larger questions of medicine and American identities.

My analysis of race in medicine focuses on heart disease categories and their treatment. It highlights the complicated roles that physicians have long taken, advocating for the urgent needs of black patients on both scientific and social justice grounds. Whereas most scholars have situated BiDil within discussions of race and genetics and pharmaceutical marketing, I see the drug as part of narratives that precede and exceed any of these things. Enlarging the framework to pay attention to the intertwined trajectories of medical research and advocacy situates BiDil within a wider set of medical and racial ideas and practices.

The intersecting and mutually constituting trajectories of race, heart disease, and pharmaceuticals provide an excellent site to analyze what I conceptualize as the durability of preoccupations with race in medicine. Race in heart disease research and practice is *durable*: it cannot easily be gotten rid of. It is also a *preoccupation*: it cannot easily be let go. *Durable preoccupation* thus offers a dual concept with intrinsic tensions. Race in medicine provokes appeal and aversion, disassociation and solidarity, displacement and investment. In tracking the continuities and discontinuities of racialized heart disease discourses since the founding of American cardiology, we can see that the promise and danger heralded around BiDil tap into something deeper. Arguments over how to

medicate race reveal fundamental tensions in democratic and unequal American medicine and society. Close attention to this particular story has implications for global scholarly and activist conversations about pharmaceuticals, race, and justice.

My argument is threefold:

1. *Heart disease has been enrolled in articulating Americanness, and so racial preoccupations were present at the founding of American heart disease research and have both endured and transformed since then.* Since its inception as a field, heart disease research has been grappling with the dangers of the “modern American way of life,” access to which has been foundationally and fundamentally organized in terms of race. Also at stake has been access to cutting-edge medicine for both patients and practitioners. Articulations of inclusion and difference in cardiovascular research and pharmaceutical practices have been part of articulating democratic and racialized American ways of life.

2. *The durability of racialized disease categories—and the appeal of racialized drugs—does not rest on genetic determinism.* The appeal of race in medicine does not reduce to the appeal of genetics. Considerable epistemological eclecticism underlies notions of heart disease etiology, of which genetics is just one player. There are many ways to represent medically relevant racial difference besides genetics, and more important, medical practice is generally oriented around intervention. In order to give an accurate account of the role of race in medical research and practice and to gain new traction for critique, we need to move beyond situating genetics at the center and pay attention to how medicine not only arbitrates but also intervenes on difference.

3. *Medical treatment should be seen as a site of—rather than an alternative to—social and political contestation.* To understand mobilizations against health disparities, we should not assume that any particular action undertaken will fall cleanly into categories of biological or social, clinical or political. Paying attention to the complex and plural projects of clinician-researchers working in the area of race and medicine prevents any simple division between scientific reification, medical intervention, and social action. To understand the role of pharmaceuticals at this site, the context of market-oriented medicine should be a starting point for analysis rather than its end.

To lay out the book's argument more fully, I will attend to some of the key terms and topics, and describe the overall approach of the book in order to situate it within my scholarly field of science and technology studies (STS) and beyond. First, I will define and describe the processes that I am terming “medicating race,” highlighting the specificities of medicine as a field of research and its particular value as a site for inquiry into race. Next, I describe the overarching approach, which is to track durable preoccupations with difference. I will then address the value and importance of the three constituent elements of my narrative: heart disease, pharmaceuticals, and black-white difference. Finally, I provide an overview of the chapters of the book.

Medicating Race

This book draws from critique of race and science, but it more specifically grapples with the distinct status of medicine as a field. Medicine is “not a coherent whole,” but “rather, an amalgam of thoughts, a mixture of habits, an assemblage of techniques.”¹ A central heterogeneity in medicine that interests me is medicine's duality as both a science and a practice—one that does not merely reify difference but also seeks to act on it. Philosophers of science have drawn our attention to the productivity of “representing and intervening” in knowledge-making,² and this tension is fundamental to medical knowledge. Medicine both represents and intervenes on racialized bodies. There is a rich polysemy in the word “medicating” that I am interested in mining for its theoretical insights. Attending to the immanence of *medicating* and *mediating*,³ I argue that medicine is a field that *mediates* race, in the sense of arbitrating as well as intervening. Medical experts, disease categories, and pharmaceuticals all participate in *medicating* and *mediating* race.

The word “medicating” is in the present progressive tense because neither medicine nor its relationship with race is a settled thing granted by history or science. Medicine and race are emergent processes in motion in multiple spheres. Clinical medicine, like natural science that is the subject of much critical scholarship of race, cannot settle the debates about race at the nexus of the biological and the social. Race's relationship with medical practice remains messy both because medical data and efficacy are complicated notions that are hard to pin down and because clinical medicine is not independent

from other biological and social discourses. This makes medicine a rich site for an STS analysis that seeks to abandon a priori distinctions between natural and social events, as Michel Callon has canonically argued.⁴ To draw on Sheila Jasanoff's rich idiom, medicine is a site at which natural and social orders are *co-produced*.⁵ When bodies and technologies come together in medicine, neither precedes the other. In medicating practices, both social and natural orders have the capacity to be bolstered and/or transformed.

This book considers "medicating" in a broad sense, as a verb that refers to actions taken in and about medicine as a field of social relations. "Medicating" importantly includes the most obvious meaning of the word, the administration of medicines, but it also encompasses much more. In addition to the prescription of drugs, "medicating" refers to other linked actions that medical practitioners engage in, including setting parameters around diagnostic categories, administering a range of diagnostic tests and treatments, conducting longitudinal studies, and writing clinical guidelines.

The concept of medicating is informed by, and in dialogue with, literatures of *medicalization*, but its emphasis on the emergent quality of medicine's relationship with social categories is central. Whereas medicalization can imply that there is some space essentially exterior to medicine that is being colonized and removed from other social spheres, such as morality or politics,⁶ medicating race need not posit that a boundary is being crossed between the appropriately and inappropriately medical. The relationship between medicating race and, for example, politicizing race can be combinatorial rather than opposed. Medicating is not an alternative to a social movement, or an example of a nefarious political agenda, but a way to understand the process and progress of agendas and movements that are simultaneously moral and political, commercial and professional, and which play a role in how things came to be understood as racial and medical.

I do not presuppose that medicating is an inherently less moral way of addressing problems than other ways, as is commonly suggested in medicalization literature and in the medical anthropology that draws on it,⁷ and in discussions of race and pharmaceuticals. The moral and the political are at stake in medicating as much as they are at stake in any other bio/social sphere. This becomes a particularly pressing issue in what Adele Clarke and her colleagues have termed the "biomedicalization era," in which "the focus is no longer on illness, disability, and disease as matters of fate, but on health as a matter of ongoing moral self-transformation."⁸ In this biopolitics, as the soci-

ologist David Skinner has argued, “confronting racism is not about the denial of biology but a struggle over it.”⁹ Medicating race is not an *alternative* to taking moral and political action, but a high-stakes component of it.

Indeed, medicating is an excellent analytical framework for the STS critique of race because medicine intervenes on the boundaries between social and biological, material and semiotic. Race is at stake at precisely these boundaries. Thus, analysis of this intersection contributes to theories of race as well as to the history and social studies of medicine. Racial difference in heart disease is material: the premature mortality of African Americans as a group compared with white Americans as a group, which the leading black cardiologist Richard Allen Williams has called “the death gap,”¹⁰ takes place in actual bodies in the world and, no matter what caveats we make about the trickiness of data and etiology, the terrain is necessarily in part about biology. Yet racial difference in heart disease is also semiotic: the data cannot be extricated from lenses of difference-oriented preoccupations, and arguments about race and disease become ways to articulate difference in other aspects of society and individual identity. Social movements can seek to intervene on both symbolic and embodied registers—as Alondra Nelson has shown in her work on the health activism of the Black Panther Party, social movements can recontextualize medical ideas in diverse ways as they mobilize for health care and against medical harms, as part of a larger vision of racial justice.¹¹

I argue that in order to understand the productivity of race in medicine, race needs to be understood as a category that is always a subject of the dual aspects of medicine’s mediation—bioscientific arbitration and pragmatic intervention. Race in biomedicine does not originate in the science and filter down to the doctors’ offices; neither does it simply filter up. It does slightly different work in each sphere, but gains its durability through its capacity to travel between them. The task for critical scholars should not be to seek out a true or innocent science, attempting to purge the material-semiotic category of race from biology, but to track plural noninnocent discourses at the nexus of the biological and the social. Critique that rests only on scientific reification without attending to clinical intervention is both a failure to engage and contributes to the durability of the categories that it ostensibly critiques. Explaining racial disparities in heart disease through appeals to other social or biological phenomena does not free us from the task of addressing race, because it is precisely the relevance of race across heterogeneous ways of categorizing bodies in the context of social inequality that makes it particularly durable. Dis-

placing race onto some supposedly more rigorously defined mode of accounting for difference—whether socioeconomic class, genetics, or something else—contributes to, rather than diminishes, the durability of race.

Medicating processes can become what the sociologists of race Michael Omi and Howard Winant have termed racial projects: “A racial project is simultaneously an interpretation, representation, or explanation of racial dynamics, and an effort to reorganize and redistribute resources along particular racial lines.”¹² To grapple with the accounts of those mobilized around race, pharmaceuticals, and heart disease, both the interpretive and the redistributive aspects matter. Interpretations, representations, and explanations for racial disparities in heart disease are mobilized in diverse ways, inseparable from demands for changing the distribution of resources such as pharmaceuticals and funding for longitudinal research and clinical trials.

Racial projects organized around disease categories and pharmaceuticals can take diverse forms, and pointing out that the discourse is racial is the start of the analysis rather than its end. Race is a dynamic and robust discourse that does not belong to those with a stake in perpetuating present inequalities alone, but rather to the terrain of the debate.¹³ For example, pharmaceutical companies or disparities advocates can argue for or against any particular mechanism that offers hope (or provokes alarm), such as full integration of African Americans into mainstream American medicine’s high levels of medication, or race-specific drugs. But we can tell that the discourse is a racial discourse, because no party in the conversation can talk about disease categories like coronary disease or hypertension, or drugs like thiazides or BiDil, without at least implicitly talking about race.

At the same time that medicine mediates race, it also mediates citizenship, and these processes are central to the constitution of biological citizenship in the United States. Whereas biological citizenship literature has generally focused either on rich countries in general or on particular resource-poor ones, this book attends to the distinctly American context. Some of the biological citizenship practices in the United States are like those in resource-poor settings. What Adriana Petryna has characterized in the Ukraine as “a massive demand for but selective access to a form of social welfare based on medical, scientific, and legal criteria that both acknowledge biological injury and compensate for it”¹⁴ applies to demands for black hospitals in the early part of my account and to the demands for access to pharmaceuticals in the later part. These coexist with biosocial aspirations that Nikolas Rose and his colleagues have argued are distinctive of those in contemporary liberal democracies.¹⁵

Rose is right that contemporary biological citizenship as it emerges in direct-to-consumer genetic genealogy testing need not be seen as part of a trajectory with eugenics, and I am deeply sympathetic with the open-endedness of Rose's sensibility. However, if we are to grapple with biological citizenship in the United States, both our famously consumerist medicine and our infamously unequal access to it are fundamental. The diverse forms of biological citizenship overlap and coexist. As the legal scholar Dorothy Roberts has argued, race is as fundamental to the new biocitizen as it was to the old.¹⁶ Paying attention to a broader historical terrain can give some texture to the continuities and discontinuities of how medicine has mediated race and citizenship in America.

The concept of medicating in this book encompasses, in addition to the processes of administering medicine and mediating biological and social orders, a valence of *meditating*. When doctors and others argue about how to medicate race, one thing that they are doing is *meditating upon* race, articulating emergent theories of the differentiated world through languages of medical terminology and data. In an elaboration of what the medical sociologist Stefan Timmermans has called a “second-order scientist,”¹⁷ my project involves second-order meditating: meditating upon the meditations of historical actors to theorize race and medicine.

My methods for tracking these meditations were diverse. The earlier, historical chapters rely mostly on published materials from the first half of the twentieth century, as well as archival sources.¹⁸ My understanding of these materials was enhanced by conversations with current and former researchers at the Framingham and Jackson heart studies. The later chapters draw from my main research process. I attended several conferences at which the intersection of race and heart disease was central, especially of the International Society for Hypertension in Blacks (ISHIB), and also the National Medical Association (NMA) and the Association of Black Cardiologists (ABC).¹⁹ In addition to interviews with some of the key figures, my analysis was deeply informed by listening to conversations in progress. I found myself most interested in statements directed not at me as an individual, but between physicians—both from the podium to an audience and at less formal sites such as conference meal tables. I learned from the ways that the physicians were meditating upon race both in the sessions themselves, where the presentations on these topics were explicit, and in the in-between times. Approaching the field in this way, rather than principally through archival or oral history approaches, made some of the mundane practices visible. In a sense, this approach is an extension of what Warwick Anderson has highlighted as the need to explore “how ideas of race

are deployed in the mundane practices of medical education,”²⁰ grappling with their role in *continuing* medical education. I did not get the chance to see how these doctors interacted with their patients, but I was able hear how they described their relationships with patients as they interacted with each other. Many were also very generous with me, explaining their field with enthusiasm and encouragement in ongoing conversations at, between, and outside these sites.

I also paid attention to invocations of race and pharmaceuticals that were happening outside medical contexts, enrolling these as sites of meditation upon intersections of race, pharmaceuticals, and heart disease. These range from a Coca-Cola Black History Month advertising campaign, to an episode of Oprah, to a cartoon by the incisive cartoonist Keith Knight. Attending to these kinds of sources is important because it picks up the broader salience of these issues of race in medicine. Including them is part of a co-productionist program for STS research that, as Sheila Jasanoff observes, “shifts our attention from *fact-making* (the traditional preserve of much work in science studies) to *sense-making* as a topic of overarching interest, with scientific sense-making as a particular, if highly significant, subcategory.”²¹

Later in the project, I also became directly involved in organizing sites for these meditations on and at the intersections of race, pharmaceuticals, and heart disease. As a doctoral fellow of the MIT Center for the Study of Diversity in Science, Technology and Medicine, I was part of the organizing committee for conferences that emerged in the context of the hype and outrage about BiDil.²² These conferences were sites of highly charged contestations among scholars from across the disciplines of history, social sciences, medicine, genetics, American studies, African American studies, and law, as well as pharmaceutical representatives and civil rights advocates. Exchanges that took place at these conferences became key sites for my own analytic engagement with the field.

Tracking Durable Preoccupations with Difference

In all of these mediations of and meditations on race and heart disease, I was struck by the *durability* of race. Durability is a concept that I use to capture the resilience of race in the face of critique. Compelling critiques of the use of race as a central organizing category from across the ideological spectrum—from conservative pundits who imagine a meritocracy that can be evacuated of its historical and current exclusions according to race, to the radical treatise

Against Race by the social theorist Paul Gilroy, which argues for a “planetary humanism”—have not weakened its appeal. Something is durable if it resists wear or decay, if it is resilient in the face of stress, age, attack, or changing circumstances. The very flexibility of race helps to make it highly resistant to destruction (yet amenable to deconstruction). Race is always changing and yet lasting and enduring, something that cannot be easily gotten rid of. This durability is the source of great frustration for many critics of race in medicine, who often operate as if race rises or falls on its scientific validity.

To grapple with the durability of race, it is essential to pay attention to it as simultaneously a central locus of power in the social world, and a site of discourse. Recent historiography of race has highlighted productive tensions within racial discourse, in which race is figured as both fixed and mutable, definite and unknowable. As Ann Laura Stoler has pointed out, “Ambiguity of those sets of relationships between the somatic and the inner self, the phenotype and the genotype, pigment shade and psychological sensibility are not slips in, or obstacles to, racial thinking but rather conditions for its proliferation and possibility.”²³ Contradictions within notions of race contribute to rather than inhibit its durability. On this point, Waltraud Ernst argues that idiosyncratic and contradictory discourses about race do not weaken them but rather are part of what makes them “work”: “Racial discourses work well not despite their logical inconsistencies, ambiguities and mixing up of premises but because of them. They are destructively all-pervasive precisely because they are overdetermined and multivariant, creating the possibility for different arguments or perspectives (moral, biological, cultural, etc.) to be accentuated within different contexts and depending on the aims pursued.”²⁴ The ambiguities and plural registers, then, are generative. And so it should be no surprise that discourses of connections between racialized bodies and disease are not always coherent, or that pieces of them are sometimes mobilized in unpredictable ways.

Racial discourses also change over time. Because race remains so important across history, this can foster the illusion that race is outside history, but as Barbara Fields points out, race is a “historical product,” not a “transhistorical” or “metaphysical” entity.²⁵ Moreover, even within any particular historical period, as the historians of race and science Evelyn Hammonds and Rebecca Herzog have argued, “even when race is the object of explicit study, its definition is rarely plain or stable.”²⁶ That is why attending to *how* race becomes durable in each era is so important.

That race emerges out of a historical context is simple enough to assert;

how it does so is far more interesting. In tracking the continuities and discontinuities in racial discourses around one disease, my project complements recent scholarship in the history of race and medicine, including Jonathan Metzl's account of how schizophrenia "became a black disease,"²⁷ and, especially, Keith Wailoo's account of how cancer "crossed the color line." Wailoo argues that "the story of cancer and the color line therefore becomes the story of cancer's transformation *and* racialization—by which I mean, the processes by which scientists used the disease to create narratives of difference."²⁸ Like Wailoo's account of cancer over much the same period, my account of heart disease provides an opportunity to see how some ideas about the relationship between race and disease are rejected, some are inverted, and others stand the test of time. This repetitive rearticulation of race in heart disease constitutes its durability.

The durability of race in medicine does not come from any one source. Acknowledging the epistemological eclecticism that underlies race helps us to see why various debates over the etiology of racialized heart disease have not undermined racial reification itself. When debates over the past century have focused on whether the category at hand—syphilitic heart disease in the early twentieth century, or hypertension since the postwar period, or heart failure since the emergence of BiDil—is due to inborn characteristics or to social experiences, they have not disrupted the reification of racialized black heart disease itself. This is where my account diverges from most critical race studies and science and technology studies accounts of BiDil. Whereas many scholars argue that deciding whether the cause of disparities is biological difference or social inequality determines who is responsible for what should be done about it,²⁹ I do not think that race in the world operates on this kind of logic. Diverse actors can accommodate considerable epistemological eclecticism underlying what is recorded as status as African American, and that ambiguity is not a slip in racial discourses but part of what makes their proliferation possible. Ambiguity does not impede diverse medical and social response but facilitates it.

The approaches of science and technology studies have provided productive means to analyze the emergence of new scientific facts and technologies, and the concept of durability can bring an STS approach to bear on what might seem to be an old-fashioned topic such as race in medicine. In his essay "Technology Is Society Made Durable," Bruno Latour does not use "durability" as a technical term: his principal concern is actually with stabilization. Latour wants us to recognize that both human relations and mechanisms contribute to the relative stability of a particular assemblage, and that the dominance of

particular humans or mechanisms is the result of the stabilization, rather than the cause of it. Despite Latour's own aversion to paying attention to any categories that exceed the network being analyzed—and he is particularly resistant to including race, class, and gender in any account—we might fruitfully apply this approach to the analysis of race and medicine. Insofar as claims about race and heart disease achieve stability, they do so in relationship with networks of physicians and researchers, which overlap with networks of activists and state actors, as well as particular pharmacopeias and configurations of bodies in the world. Racialized medicine achieves its durability not from the power of racist ideology on the one hand or mechanistic understandings of bodies on the other, but because many people—in government, in social activism, in medicine, and beyond—have coalesced around it as a way to articulate their visions of what to do.

These multiple imbrications are precisely why the durability of race need not be a source of hopelessness in a world of injustice. Durability is also flexibility. Recorded difference can be employed both to tell stories about existing inequality and to make demands for medical intervention and social change. Since the force of racial discourse becomes realized not in notions of fixity alone but in combustible combinations of fixity and fluidity, to understand the terrain of racialized pharmaceuticals and racialized medicine as a whole, we should attend to the ways that these debates render race both stable and malleable, both naturalize it and mobilize it. A conception of race as simultaneously resilient and changing is a better terrain for critique than one that merely decries its resilience, because it opens up possibilities for critical scholars to be part of articulating change.

Understanding durability in terms of a famous STS concept that Latour and others explore—the black box—can also be productive.³⁰ When race is operationalized as a variable—whether in the statistical reports of the early twentieth century, or more systematically in longitudinal health research, or in disease categories and prescription practices—it necessarily becomes for a fleeting moment what Latour would call a black box. In the Food and Drug Administration's indication of BiDil for heart failure in “self-identified black patients,” all of the heterogeneous aspects that led to racially disparate heart failure are black-boxed. The prescribing physician may believe that black heart failure is caused by genetics, or by a high-salt diet, or by psychosocial stress, or by inadequate treatment of hypertension, but etiology can be black-boxed and the diagnosis itself used for action. That so few physicians do prescribe BiDil shows that the statements of the FDA or the pharmaceutical company do not

have the power to dominate on their own. And yet, racialized disease categories are importantly different from the types of claims that Latour tracks, such as “the structure of DNA is a double-helix.”³¹ Racialized disease categories—from “diseases of modernity” at the beginning of the twentieth century to “heart failure in self-identified black patients” at the beginning of the twenty-first—never become fully stabilized. The black box keeps on being reopened, sometimes even by the same people who use it as a step stool.

Durability is not an inevitable state of affairs, and it must be constantly propped up and sustained. One thing that can feed durability is preoccupation. Together with physical objects in the world (such as pharmaceuticals and bodies), and facts (such as the results of clinical trials), *preoccupation* can prop up durability. *Durable preoccupations* are where fact and affect come together, and are particularly important for understanding medicating as a site of accounting for and protesting inequality in society.

The concept of preoccupation offers a way to consider not merely the facts of a disease, but how the mind becomes engrossed, how the attention and the intellect can be commanded in debates over disease categories and identities in a way that is viscerally charged. Preoccupations are *affective*: they require us to grapple with how “activities of the body and mind are simultaneously engaged,” and “reason and passion, intelligence and feeling are employed together.”³² Affect refers to “bodily capacities to affect and be affected,” and yet it is not presocial, because, as Patricia Clough evocatively argues, “there is a reflux back from conscious experience to affect.”³³ Since both cardiovascular events and pharmaceuticals to reduce cardiovascular risk can induce sensations of “reflux” in a physiological sense, preoccupations with heart disease are a rich site at which to consider Clough’s proposition that affect is not only in human bodies and consciousness, but also in technologies.

Much of this book addresses the ideas of physicians for whom engagement in these practices is part of their daily work, and so preoccupation is also connected with *occupation*, both as a term for a profession and as a way to label the tasks that fill the day. The emergence of cardiology as an occupation and heart disease as a preoccupation have always been intertwined.

At the intersection of a disease category and a social identity, we have the opportunity to think through both the material and the semiotic aspects of our lived experiences. Ideas become our preoccupations when they engross our attention, to the exclusion of other ideas and in a way that is viscerally charged. This visceral charge, more than the metaphoric language per se, is what Susan Sontag’s classic *Illness as Metaphor* most valuably alerted us to.

For example, as I have argued elsewhere, breast cancer gives American women at the turn of the twenty-first century an opportunity to talk about how many children we've had, or haven't had, our sexuality, our beauty, our ethnicity, our mothers, our toxic environments, and more.³⁴ Breast cancer is not somehow naturally or inevitably available for narration in this way, but came to be so in the wake of feminism's second wave.³⁵ Many women have followed the lead of such public figures as Audre Lorde in telling stories of their bodies and their lives through this disease.³⁶ Yet preoccupation is not a matter of direct personal experience, which is neither necessary (as the appeal of breast cancer activism for those without breast cancer has shown)³⁷ nor sufficient (not every disease experience will become narrated as central to a life story). Indeed, as the sociologist Kate Weiner argues, heart disease may be less conducive to identity practices in part because of its perceived ordinariness and ubiquity.³⁸ This book attends to the ways that stories of identity and difference have been told through heart health and heart disease.

A key aspect of preoccupations is that they precede any particular piece of data. Data do not determine preoccupations, and mere prevalence does not make a disease relevant for politicization or for cultural or identity practices. Rare diseases, such as bird flu, often attract considerably more viscerally charged energy than common, and deadly, ones such as pneumonia. In fact, preoccupations precede data. For example, a long-standing preoccupation surrounds masculinity and heart disease, and so its toll on women is consistently framed as new or surprising, regardless of the data. In the insistence that "women get heart disease, too," it is worthwhile to linger on the "too." It points to preoccupation with the implicit masculinity of the category, and articulates the preoccupation even as it contests it.

There is a generative tension in the framing of the leading cause of death as an exception. In the insistence of such actors as the founder of the Association of Black Cardiologists that "African Americans get coronary heart disease, too," it is similarly worth lingering on the "too." It points to preoccupation with the implicit whiteness of the category, and articulates the preoccupation even as it contests it. Throughout the period I describe here, racial preoccupations are both articulated and contested in diverse ways—in physicians refusing in the early twentieth century to recognize the African American cardiovascular disease in front of them, in longitudinal investigators both claiming and disavowing representation of a larger body politic, in arguments over disease categories and drugs that are variously understood as genetic or social, cheap, or cutting-edge.

One question that is central to this book is how difference comes to make a difference. Two aspects of racial difference are pertinent: that racial difference is amenable to durability because it is *recordable*; and that preoccupations with racial difference cannot be understood as separate from lived experiences of racial inequality.

Categories of difference need not be *measurable* to be operationalized in medicine, and many differences that are central to medical practice are recorded rather than measured, such as age, gender, family history, and more. The durability of racial difference draws on its *recordability*—not its measurability or elusive lack thereof. Attending to ways that difference is recordable, as opposed to measurable, is also a way to grapple with another dual aspect of difference: difference suggests diversity, but codifying difference according to discrete characteristics narrows the scope of the definition of diversity. That is, difference is about othering, but the othering is not so total as to exclude some common ground on which degrees of difference between things can be judged.

I am attentive to what the parameters of difference are imagined to be. Throughout the century of research that I discuss, there has been a tension in the idea of inclusion: whether African Americans should be included because they are part of an American public, or because they are distinct. One meaning of difference is *distinguishing characteristic*, and various types of heart disease have been held up as corresponding to various types of Americans. The construction of those distinctions has increasingly drawn on statistics from longitudinal research and clinical trials. By attending to some of the same issues that Steven Epstein, a sociologist and science and technology studies scholar, characterizes as the “inclusion and difference paradigm,”³⁹ I track ways in which participation in medical knowledge and pharmaceutical practice have become part of articulating inclusion and difference in American ways of life. These articulations emerge in the context of a society that is at once unequal and democratic. The historical trajectory of constructing and contesting difference in the United States is distinctly rooted both in slavery, and in its abolition—in both the perpetuation of white supremacy, and its contestation.

When difference occurs in the context of inequality, difference becomes disparity. This book is in dialogue with the interdisciplinary literatures of disparities, including those of historians, health professionals, civil rights activists, and policy makers. The medical historian David Jones, writing about American Indian epidemics, has pointed out that the meaning of disparities is not transparent: “Disparities can be seen as proof of natural hierarchy, as products of misbehavior, or as evidence of social injustice.”⁴⁰ There has been

tension in critiques of racialized medicine between the tendency to emphasize the severity of racial disparities to call for justice and the tendency to try to remove race by drawing on other factors to explain the disparities in a less socially loaded way.

Differences provide fodder for preoccupations when they correspond with situations of dominance. As the feminist legal theorist Catharine MacKinnon has pointed out, any observations of difference are not separable from conditions of dominance.⁴¹ Attention to the relationship between difference and dominance helps one to see why, for example, though ethnic difference among whites was recorded early in the Framingham Heart Study, it came to be no longer so. Preoccupations with racial difference in medicine—especially black compared with white—have remained durable not because of the compelling statistics about difference but because of the continued social reality of conditions of unequal access to power. This is why this recordable difference becomes not only an opportunity for taxonomy but also a mandate for advocating action against present inequalities.

In order to track durable preoccupations with difference in medicine, I have chosen to organize my analysis around a series of intersections of three elements: heart disease, pharmaceuticals, and black-white difference. This is a choice among many potential paths of inquiry. I will now explore each of the three elements to highlight how they have distinct value, in their own right, and in combination.

Why Heart Disease?

As historians and sociologists of heart disease have argued, the category of heart disease is itself multiple and elusive, exceeding objective and subjective grasp.⁴² And yet heart disease is an apt venue for critical studies of medicine because it offers an opportunity to critique medicine not at its fringes but at its core. Critical race feminists have drawn attention to the ways that reproductive medicine participates in and perpetuates racial discourse,⁴³ and this kind of analysis should also be applied to the traditionally masculine category of heart disease. For all of its demographic and medical research import, heart disease has been generally understudied by srs and critical studies of medicine more broadly. In the long-standing productive interest in genetic topics, and the current flourishing of neuroscientific ones,⁴⁴ there has been relatively little interest in heart disease as a field, but there should be. The literature attending to identity practices around heart disease is small relative to that investigating

reproductive, psychiatric, and genetic disease, but it is rich—especially attending to gender, and also to race and class.⁴⁵ Part of my project is to interrogate how heart disease articulates individual and social bodies in ways that are both like and distinct from other disease categories.

Like all disease, heart disease has been the subject of existential debates, that is, the extent to which it actually exists. For example, there has been debate about whether risk factors such as hypertension should properly be considered diseases and/or be so widely treated with pharmaceuticals. In a medicalization framework, a diagnosis of “elevated blood pressure” can be seen as an example of “defining a naturally occurring attribute as a medical problem.”⁴⁶ However, in contrast to psychiatric disease, critiques of medicalization of heart disease do not extend to challenging its very existence, to denying that problems with our hearts can make us sick and die. As well, in contrast to such disease categories as sexual dysfunction, heart disease is also not vulnerable to claims that it belongs only outside medicine. Thus, heart disease poses a worthy challenge. In the words of the physician and historian Robert Aronowitz: “A physician colleague of mine, wanting to stress the absurdity of relativist arguments about disease, thought she might deliver the coup de grâce by saying, ‘Now you’re going to tell me that heart attacks are socially constructed.’”⁴⁷ It is precisely because no one can deny the existence of some biological reality to heart disease that thinking through the nature of social construction here can be particularly productive.

Where discussions of psychiatric diseases can too often be bogged down in polarized exchanges about whether or not they have a biological existence, discussions of heart disease can begin in the nexus of biological and social realities. Where arguments for the social construction of psychiatric diseases can be misinterpreted as suggesting their spontaneous invention or unreality, arguments for the social construction of heart disease foreground the real embodied experience of social construction. The challenge Aronowitz accepts, to explore the ways that coronary heart disease “has been as much negotiated as it has been discovered” and the way that its “name, definition, classification, and ultimate meaning . . . have been contingent on social factors as much as strictly biological ones,”⁴⁸ is inspiring to those in the emerging field of history and social science of somatic disease. This book is deeply indebted to Aronowitz’s call. By considering the social construction of heart disease together with that of race and of pharmaceuticals, this book elaborates and extends his attentiveness to the contingencies in the social and biological.

Organizing my analysis around heart disease is a way to make it more tangi-

ble, even as it elides considerable heterogeneity within the term. In some sense heart disease has always existed—atherosclerosis has been described in Egyptian mummies, and efforts to understand the heart in health and disease have ancient roots⁴⁹—but it is also distinctly modern. A symptom profile recognizable as angina pectoris was first described in Georgian England, and fifty years later in Europe and the United States.⁵⁰ Heart disease came to prominence in both the United Kingdom and the United States in the first half of the twentieth century, and the modern specialty of cardiology becomes recognizable in both countries by the 1920s;⁵¹ that is the period in which this book’s story begins.

Since the stabilization of heart disease as a field of research, heart disease has been an umbrella disease category that includes heterogeneous phenomena of a few major types that increase the burden on the heart and/or cause it to fail.⁵² Of course, as Joel Howell has argued, “the structure and content of cardiology, like that of all specialties and subspecialties, is historically mediated and constantly changing.”⁵³ In the chronological presentation of the chapters of this book, different categories of heart disease alternate as a focus of attention. In early cardiology, coronary heart disease was primary, and it was principally contrasted with infectious heart disease. Indeed, coronary disease has remained the principal focus of cardiology, and refers to those disease categories that are related to hardening and physical blockages of arteries, including arteriosclerosis, coronary thrombosis, and ischemic heart disease. In the Framingham study just after the Second World War, coronary disease was still the focus, but, through the study, hypertension became defined as both a risk factor for coronary disease and as its own etiological model of heart disease. Hypertension as a disease category and African American hypertension as a disease category emerged together, in the 1950s, 1960s, and 1970s, and the “slavery hypothesis” that emerged in the 1980s and 1990s has become a theory of differences in hypertension. The distinctions between heart disease categories have been enrolled in racial discourses—coronary heart disease has been associated with whiteness, and infectious heart disease and later hypertension has been associated with blackness.

The drugs that I consider are for distinct forms of heart disease. The first, a class of drugs called thiazide diuretics, is for hypertension (in all patients, and as we will see, especially in black patients). The second, BiDil, is for heart failure in “self-identified black patients.” Heart failure can be understood as the end stage of heart disease, whether hypertensive or coronary in etiology. In the evolution of what heart disease has been understood to encompass, there has

been both continuity and discontinuity in articulations of race in heart disease, and in its medical approaches and treatments.

Heart disease has long been a particularly prominent and lucrative site for pharmaceutical development. Drugs to reduce heart disease risk played a key role in the historical development of the blockbuster drug model, which as Joseph Dumit has pointed out, generally operates on a logic not of curing illness but of making normality dependent on drugs.⁵⁴ Amid the growing interest in the role of pharmaceuticalization in transformations of health,⁵⁵ this makes heart disease a rich site for inquiry.

Heart disease also has promise as a site for inquiry into bioscience, because it has long resisted geneticization.⁵⁶ As we grapple with an increasingly post-genomic biology,⁵⁷ race and heart disease can provide a distinctive site. As Evelyn Fox Keller presciently argued in 2000, “Genes have had a glorious run in the 20th century,” but “these very advances will necessitate the introduction of other concepts, other terms, and other ways of thinking about biological organization, thereby inevitably loosening the grip that genes have had on the imagination of the life sciences these many decades.”⁵⁸ Sickle cell anemia has been a particularly rich site for analyzing race in what Keller called “the century of the gene”; the historian of medicine Keith Wailoo, for example, has used that disease to anchor his account of the politics of race and health in the ascendance of, and disillusionment around, genetic medicine.⁵⁹ Scholars working in contemporary bioscience areas such as epigenetics have shown that models in the life sciences are shifting from conceptualizing genes as deterministic, to understanding them as necessarily contextual,⁶⁰ and the sociologist and STS scholar Jenny Reardon has considered “the postgenomic condition” with particular attention to race.⁶¹

Heart disease provides a useful taking-off point for analyzing race in the postgenomic era. There is already a glimmer that the intersection of race and heart disease is a fruitful site: Anne Fausto-Sterling, a biologist and STS scholar, has provided an intriguing discussion of how developmental systems theory matters for understanding race and hypertension.⁶² If science and technology studies analysis of race does not move beyond genetics as deterministic, it will be stuck in nature/nurture frameworks out of step with contemporary work both in biomedicine and in the historical and social studies thereof. Starting from a focus on heart disease, rather than on genetics or even post-genomics per se, can provide a fresh route to bring race into conversation with current medicine, cutting-edge science, and critical scholarship.

Why Pharmaceuticals?

Pharmaceuticals are objects that are very readily recognized as material-semiotic, where it is easy to make the case for the capacity of objects to carry both matter and meaning. Race is also a material-semiotic category, one that takes on a peculiar ontological status at its intersection with heart disease and pharmaceuticals. Racial disparities could conceptually be medicated away, in the sense that differences in such biomarkers of risk as blood pressure could be eliminated with medications. Yet racial difference cannot quite be medicated away, in the sense that preoccupations with racial differences always exceed the data itself. Using disease categories and pharmaceuticals to think through race is productive if we accept that race, too, is irredeemably material-semiotic, and cannot be purged of either aspect.

A key insight of the burgeoning focus of science and technology studies scholarship on pharmaceuticals has been the creative productivity of the intersections of human identities with pharmaceutical practices, and it is therefore no surprise that the investigation of psychopharmaceuticals has been particularly rich.⁶³ The development of and contestation over the Pill on the one hand, and antiretrovirals on the other, have also provided fodder for these issues, and work on gendered diseases and especially HIV/AIDS is an important model for my work because it provides insight into mobilizations of identity-based social movements embracing and resisting disease categories and pharmaceuticals.⁶⁴ Historians within science and technology studies have attended to the reconfiguring connections between research science, marketing, and distributions of pharmaceuticals for both psychological and somatic disease through the twentieth century.⁶⁵ The anthropologist and STS scholar Joseph Dumit has highlighted the role of pharmaceutical advertisements in constituting new grammars of identity in health and disease,⁶⁶ and as the cultural studies theorist Kane Race has argued, all medicines are “re-creational,” sites for re-creating ourselves and our world.⁶⁷

Of course, as for example Alondra Nelson’s subtle account of race and genetic ancestry testing has shown, genetic facts can also be fodder for creative identity practices.⁶⁸ And as scholars interrogating the particular implications of genetics research on indigenous peoples have shown, the stakes for identity can be very high: the stories told by geneticists matter not only for the individuals involved, but also for group identities and relationships with nation-states.⁶⁹ Forensic DNA has tremendous power, in imprisoning and freeing from prison, and in the adjudication of human rights claims and postconflict states.⁷⁰

Yet pharmaceuticals are a distinctive site for the analysis of race, because of the primacy of intervention simultaneously on the social and the biological. Paying attention to pharmaceutical practices can highlight the ways that medicating is not isomorphic with geneticizing or biologizing. In too many critical studies of race and medicine, the terms “genetic,” “deterministic,” and “biological” are treated as synonyms. However, if we put pharmaceuticals at the center of the analysis and take their material and semiotic aspects seriously, we have the opportunity to foreground the ways in which biological bodies are shaped by social experience and amenable to medical intervention. That is why pharmaceuticals are key to my analysis, not only in the later chapters, which specifically analyze particular pharmaceuticals, but also in chapters about the durability of African American hypertension as a disease category, and about a genetic theory for the cause of African American hypertension. The immanence of the categorization of African American hypertension, and the therapeutic intervention of thiazide diuretics, is vital for understanding why and how diverse antiracist actors invoke distinctly African American disease.

The “thinginess” of pharmaceuticals is also crucial to understanding their appeal; they operate on the symbolic order at the same time that they “make disease concrete.”⁷¹ Paying attention to the ways that pharmaceuticals become sites of exchange of both commerce and meaning-making gives us the opportunity to see how markets and meanings are coproduced. Rather than participating in nostalgia for a less commercialized medical era, we have the opportunity to interrogate profit-driven medicine. Because analytical attention to the commodity fetishism of drugs has overwhelmingly focused attention on highly profitable blockbuster drugs, profit has been given too much explanatory power. Attending to a generic drug class (thiazide diuretics) and a commercially unsuccessful drug (BiDil) provides fresh terrain to consider both the possibilities presented by and the resistances to market logics.

Notes on Terminology: Why So Black and White?

Readers may notice some slippery terminology and anachronistic framing in my account, on two levels: using current terms such as “African American” even when describing early cardiology, and using a bifurcated black-white framework in a multicultural America.

The first anachronism can be addressed quite succinctly: because I am centrally interested in how arguments about the past are enrolled in arguments in the present, I do not change quotes that describe ideas like “Negro health,”

but, in addition to putting them into historical context, I also bring them into contemporary terms. Moreover, overattention to fidelity to terminology of a historical period can create the false sense that the definition of race was more stable and circumscribed in the past than it is now—that everyone mobilized around “Negro health” shared a coherent understanding of what “Negro” signified—whereas I want to emphasize that the meanings of race have always been unstable and contested in each period.

The second potential anachronism is more complicated to address. Although the word “America” can refer to an entire hemisphere, in the discourses I track and in my own use, “America” refers to the United States. The U.S. context is central to why I focus on black-white difference. Of course, even within the United States, not all notions of racial difference are black and white. The articulations of Asian immunity and risk throughout the period—from a 1931 invocation of “the calm, accepting Chinaman” by one early cardiologist,⁷² to the inclusion of a special session on Japanese populations parallel to the special session on African Americans at the 2005 American Society for Hypertension Meeting—could be the site of a comprehensive analysis of its own. Such an analysis would capture different aspects of American citizenship and disease than mine does, because the citizenship of Asian Americans has been constituted so differently from that of African Americans.⁷³ Attention to Hispanic/Latino heart disease is increasingly prominent, and, as Michael Montoya has demonstrated in his account of diabetes research, a fertile site for scholarly analysis.⁷⁴

And yet, because the discourse of race and cardiovascular disease in the United States has overwhelmingly been one of black-white differences, those are justifiably central. Indeed, the racial preoccupations of articulations of heart disease, especially in the earlier period being described here but also today, reflect a broader situation. As Michael Brown and his colleagues argue, the “relationship of African Americans to whites therefore remains fundamental to any analysis of racial inequality.”⁷⁵ They write of racism: “It persists, in large part, because ‘whiteness’ has always been important in defining who is and who is not an American. The original legislation that specified who could become a naturalized American was unequivocal: naturalization was restricted to white males. To further complicate matters, whiteness in the United States has never been simply a matter of skin color. Being white is also a measure, as Lani Guinier and Gerald Torres put it, ‘of one’s social distance from blackness.’ In other words, whiteness in America has been ideologically constructed mostly to mean ‘not black.’”⁷⁶

As we will see, in discourses of race and heart disease, Americanness has often been at stake. As Warwick Anderson has argued with regard to whiteness in the history of racial science and medicine in Australia, “the clinic and the laboratory should be added to those sites where the nation—any nation—may be imagined.”⁷⁷ In the early period when degenerative forms of heart disease were defined as typical of modern Americans, that was imagined to apply to whites, and—sometimes implicitly and sometimes explicitly—not to blacks. In the middle of the century when the Framingham Study longitudinally tracked a “normal or unselected” population, the whiteness was originally plural and attentive to the possibility of differences among white ethnic groups, but reflected a broad sense that coronary disease was something that affected “the white population.” If that was understood as something that excluded “non-whites,” both longitudinal research and pharmaceutical practice has at the same time and increasingly since been centrally interested in the category of “nonblacks.”

In all of this, my definition of race is purposely imprecise. Indeed, I believe that precision in definition is the wrong goal for any account of race in a society in which race is so complicatedly bound up with access to resources and power. For my purposes, the term “race” is a common noun that appears on census forms and on the medical histories that are so central to medical practice, a word with wide circulation in medical spheres and well beyond. If this seems a rather simplistic definition, it is because I am less interested in how race is defined or ascertained than in how it is mobilized. (As Teresa De Lauretis asks with regard to gender: do you tick the box or does the box tick you?)⁷⁸ I am looking at race as *discourse* (in a Foucauldian sense),⁷⁹ which is of course not to say that race is merely discursive—not in a context in which race plays such a central role in access to resources and broader lived experience.

I do not put the term *race* in scare quotes, even though I am sympathetic with many who do. I do not think that what Catherine Eagan has called “undermining quotation marks” do any such thing.⁸⁰ Such quotes, in the words of one linguist, disavow responsibility: “What the writer is doing here is *distancing* himself from the term in quotes. That is, he’s saying ‘Look, that’s what they call it. I’m not responsible for this term.’”⁸¹ But my goal in this book is not to create distance from medical invocations of race, but rather to engage with them. Many scholars who use scare quotes in reference to race do so to posit something of a straw man: some other who “really believes” in the racial categories that antiracist scholars know better than to believe in.

This illusion that scare quotes can distance the speaker from responsibility

for terms is similar to what the theorist Slavoj Žižek describes in Lacan's lectures on atheism: since the true site of beliefs is not in conscious acts but in the unconscious—not just “deep in me” but “out there” in “my practices, rituals, and interactions”⁸²—professing not to believe becomes much more complicated. And indeed, division between those with critical notions of race and those with uncritical ones does not correspond with any particular terminology choice, and straddles any medical/social science line. I am interested in tracking both the mobilizations of and retreats from characterizing disparities as racial.

The fear of being responsible for race is one better addressed directly than disavowed. As Jacques Derrida reminds us, we are guilty insofar as we are responsible.⁸³ As I argue most explicitly in my conclusion, innocence is not a possible moral stance for anyone participating in discourses of race, and so our subject position must be, in Donna Haraway's terms, “noninnocent.”⁸⁴ We should not try to shirk responsibility.

Overview

The structure of this book is roughly chronological, beginning early in the twentieth century. Chapter 1 considers preoccupations with coronary heart disease, race, and modernity of the founders of cardiology and their contemporaries in the period between 1910 and the Second World War. I suggest that existing explanations of cardiology's rise can be both enriched and problematized by analyzing the ways in which these accounts are imbued with the racial frameworks of the period. I read founders of cardiology as theorists of a cardiovascularized modernity, in which both cardiovascularity and modernity are racialized. Claims of racial difference in heart disease etiology were present at the founding of heart disease research. The taxonomy of differential etiology by race of the period—that posited whiteness as connected to (noninfectious) coronary disease and blackness as connected to (infectious) rheumatic and especially syphilitic heart disease—was part of broader narratives about white degeneration and progress, and black infectiousness and uplift. Thus, ongoing contestations that African Americans *do* get coronary disease are part of laying claim to participation by African American patients in the modern American way of life, and by African American physicians in modern American medicine.

Chapter 2 analyzes the contingent and emergent racialization of the Framingham Heart Study, an extremely influential longitudinal study that began

in a Massachusetts town just after the Second World War. The chapter argues that the homogeneous whiteness of Framingham emerged only as its early investigators both disavowed the imperative to representation and maintained their embrace of extrapolation, and as intrawhite ethnic difference was becoming less salient in describing difference among Americans. The chapter also draws the Framingham Study into comparative relief with the all-black Jackson Heart Study, which began in 2000 and continues into the present. The latter study does not merely repeat Framingham in a new population, but is rather a self-consciously postmodern repetition with a difference. The Jackson Heart Study both supplements and fragments notions of who can stand in as a typical enough American from whom to extrapolate.

Chapter 3 grapples with the durability of African American hypertension as a disease category. Hypertension has been a principal site of disparities research, and physicians and many others have used African American hypertension as a way to both articulate difference and advocate intervention. The chapter is centrally interested in why it is that clinician-researchers in the area of African American hypertension alternate between opening up the disease for scientific inquiry—asking wide-ranging questions about the etiology of disparities—and setting aside the ambiguities to advocate treatment. It describes the historical emergence of African American hypertension in the 1960s and '70s at the confluence of the emergence of hypertension as a risk factor, rearticulations of older, racialized infectious-versus-coronary distinctions, and civil rights discourses. It was appealing as a site of physician mobilization, both because it allowed them to participate in cutting-edge medical research and practice, and allowed them to use newly available pharmaceutical treatments to decrease the heart disease risk of their patients. The chapter also outlines ongoing etiological debates, and shows that doubts about the relative role of socioeconomic class, psychosocial stress, and other factors, do not undermine the durability of race, but rather bolster it. Amid alternative ways of understanding the etiology of disparities, the *recordability* of race makes it more durable than any alternative, distinctly amenable to being enrolled in demands for action.

The fourth chapter focuses on one particular theory of African American hypertension that has drawn particularly vociferous critique, the slavery hypothesis, and argues that it should be understood in the context of epistemological eclecticism and interventionist medicine, rather than genetic determinism. It provides close readings of invocations of the theory in diverse venues,

ranging from epidemiology journals to the *Oprah Winfrey Show*. The chapter unpacks these invocations of the slavery hypothesis both to illustrate the heterogeneity of ideas about race and about medicine that can be enrolled in racialized invocations of disease, and to argue that although the evidentiary basis for the theory is indeed weak, efforts to stamp out the theory may be a misplaced use of antiracist energy. The chapter attends particularly closely to an invocation of the theory outside of a medical or clinical encounter, in which Henry Louis Gates Jr. responds to a presentation of the theory by reporting his own consumption of hydrochlorothiazide and identifying himself as a “salt-saving Negro.” This provides a bridge to the next chapter, which brings attention to that drug class to the fore.

Chapter 5 moves the focus more centrally to pharmaceuticals by attending to medical debates about thiazide diuretics, a class of antihypertensive drugs that has been linked to African American hypertension as a disease category. Recent government-funded research has promoted thiazides as an affordable and efficacious way to treat hypertension in everyone, and especially in black patients, and I describe a debate in which that research is contested. Because thiazides are generic, attending to the commodity fetishism around them provides the opportunity to see that drugs’ relationships with preoccupations with difference exceeds their role in narrow economic interests. Attention to the commodity aspects of thiazides—especially the inextricability of their use value (efficacy) and their exchange value (price)—shows that the appeal of (or aversion to) drugs is not limited to marketing. Because of the confluence of the drug for blacks and the cheap drug, it becomes a site for diverse articulations of racialized American biological citizenship. In the debates about the particular appropriateness of thiazide diuretics or of brand-name alternatives, African Americans are betwixt and between pharmaceutical grammars of basic care and consumerist freedom. Consideration of these drugs that are at once racialized, proven, old, and cheap, provides an opportunity to consider how debates over drugs can articulate debates over the nature of inclusion and difference in American ways of life.

Chapter 6 turns to the drug that has been a focus of renewed interest in race and medicine among science and technology studies scholars: BiDil. This chapter tracks the contingent development of this branded combination of two generic drugs at the intersection of race and heart failure. When it won the FDA’s approval in 2005, BiDil became the first drug ever approved for use in a specific race, bearing the indication for heart failure in “self-identified black

patients.” The blatancy of its racialization has attracted considerable scholarly critique, and yet much of the critique has leaned too heavily on old arguments about race and genetics on the one hand, or about blockbuster drugs on the other. Neither of these lines of critique is up to the task of deconstructing a drug that is simultaneously effective in treating symptoms and delaying death, supported by diverse epistemologically eclectic actors, and commercially unsuccessful. The chapter highlights the divergent goals of the various actors that aligned around BiDil’s approval. For the Association of Black Cardiologists, the FDA, and the pharmaceutical company NitroMed, BiDil was a means to address different problems, and these actors should not be analytically collapsed. The chapter foregrounds the specificity of heart failure as a disease category, and critiques assumptions that drugs inevitably reach their markets. It also argues that BiDil has undecidabilities: the drug is irredeemably *pharmakon* (remedy and poison), and it is material-semiotic. Attempts by some of those mobilized for and against the drug to purge either side of those undecidabilities are unsuccessful. Drugs, like race, are both material and semiotic, and there is an inescapable polyvalence of a “black drug” in this current historical moment.

The conclusion highlights the relevance of this book’s account for race and medicine and for medical ethics, as well as reviewing the continuities and discontinuities in the intersections of race, heart disease, and pharmaceuticals recounted in the book. It is organized around a close reading of a juncture at which a debate about race and medicine broke down, after positions on BiDil were framed as an opposition between those “down with the people” and those “up in the academy.” I argue that race and medicine is best characterized as plural noninnocent discourses, rather than as racists versus antiracists. Race is a topic about which neither activists nor academics should feel comfortable, and discussion would better proceed by acknowledging that all engagement with it is noninnocent. I frame the book’s relevance for broader questions in medical ethics by exploring the ways that BiDil fit into, and failed to fit into, traditional quandary ethics. I argue that our project should be to make medicine answerable to justice, not to provide answers to narrowly framed ethical quandaries. Attention to generative dissonance should be a resource for scholarly engagement, and I hope that race seems more difficult to come to terms with after reading the book than it had before. Closing with contemplation of the myth of the hydra, I argue that any decrease in the durability of race in medicine can only follow its decreased importance in broader preoccupations

with difference, and that if we ever leave an account of race and medicine feeling satisfied that we have understood it, debunked it, or even staked out an innocent position on it, we are in error. Inspired by prophetic pragmatism, and committed to ethical noninnocence, I suggest that although there is no place of engagement above the fray, there is, nevertheless, hope.