

Pharmakon of Racial Poisons and Cures

*(as told by Helena Hansen, psychiatrist-
anthropologist)*

“Why did you stop working as a journalist?” I asked. Charlie* pulled his black T-shirt over his tattooed shoulder and ran his fingers through his buzz cut. “I got fired.” His eyes darkened. “I don’t blame them. Toward the end I got pretty outrageous. I showed up for work totally high, so high that one day I had a needle and syringe hanging from my neck with blood running from it. I didn’t even realize.”

Charlie was part of a crop of educated white patients who were beginning to appear at this large New York City hospital. It was the only public hospital in the region that, at that time, offered treatment with buprenorphine, commercially known as Suboxone. Ordinarily, the hospital’s clientele was Medicaid insured or uninsured, Latin American, African American, or recently migrated from China. The white patients we saw were undocumented immigrants from Poland or Russia, many of them day laborers living in Coney Island. If we saw American-born, white patients, they had been homeless for long periods of time before being sent to us for treatment by a shelter social worker or a drug court. But the patients in the new Suboxone clinic were different. The clinic was on the primary care unit, nestled in between diabetes and asthma

* All names of patients and opioid users in this book are pseudonyms, and key elements of their biographies are hybridized with those of other patients and opioid users in order to protect their identities, which was a condition of their consent to participation in my research. The same is true for Drs. Pine and Abrams.

specialists, and was open only one day per week. It was staffed by a vanguard crew of primary care doctors who had gotten certified to prescribe Suboxone because they were committed to bringing new technologies to indigent patients.

I first saw Charlie in 2009, but the clinic had been founded in 2005, three years after the US Food and Drug Administration (FDA) approved buprenorphine for treatment of opioid dependence, by Dr. Abrams, an internist who had made his name promoting harm reduction and HIV treatment for heroin-addicted people. Abrams had recruited Dr. Pine, a buzz-cut, muscular physician, to lead the Suboxone clinic. He looked like a Marine but spent his free time volunteering in homeless shelters. Pine gave his personal cell phone number to all patients who were starting Suboxone and encouraged them to call with questions about how to dose themselves in the first twenty-four hours of treatment. He welcomed everyone but did not expect to see so many patients come in from the suburbs. These new patients commuted to our clinic because they would not, or could not, pay the \$1,000 fee charged by private doctors near their homes for an initial Suboxone prescription.

None of the staff had predicted that their Suboxone clinic, the first of its kind in a public New York City hospital, would draw patients from affluent suburbs in Long Island, Staten Island, and New Jersey. Although many of these new patients were on Medicaid, and some were uninsured, a good number had attended college and had worked as professionals before their opioid use got in the way. Charlie was an example. His father paid the rent on his studio apartment in the fashionable East Village neighborhood of Manhattan, but he was on food stamps and on Medicaid, having exhausted his unemployment benefits.

Charlie's sojourn to our public clinic was one sign of a massive shift in American imagination surrounding addiction.[†] The ascendant "brain disease" model of addiction afforded opioid- and heroin-dependent middle-class white Americans an escape valve from the racialized moral blame that has historically been attached to narcotics in the US. The language used to describe addiction changed in accord with this shift to locating problem drug use in biological causes—in neuroreceptor dysregulation or genetics—and away from locating it in the character flaws

[†] Throughout the book we use the colloquial term *addiction* and the more neutral term *problem substance use* in order to distinguish everyday understandings from the clinically diagnostic terms *substance use disorder* and *opioid use disorder* in order to highlight how biomedical practitioners and pharmaceutical manufacturers use clinical language to shift the definition of problem drug use toward that of a biological disease.

of the individual, or in social influences on the person. Increasingly, clinical journals and later the popular press replaced the terms *addiction* and *substance abuse* with the diagnostic terms *substance use disorder* and more specifically *opioid use disorder*.

The logic of the brain disease model not only opened the door to biomedical treatment for addiction but also made the idea of technological fixes for the addictiveness of new formulations of opioids plausible; opioid manufacturers tapped into its ethos in their claims of safety and the aggressive marketing of technologically enhanced opioid pain relievers to insured, largely white Americans. Then, in response to the overdose crisis, the brain disease model led to pharmaceuticals as the primary response to problem drug use such as opioid use disorder. It led to federal promotion of buprenorphine maintenance as a rational, modern, science-based approach to addiction under the rubric of “medication-assisted treatment,” or MAT, increasingly referred to as “medication for opioid use disorder,” or MOUD. Buprenorphine’s advocates hailed it as a neuroscience-based, radical new policy innovation. But in fact, methadone maintenance for opioid addiction had been available, primarily for poorer Black and Brown people, since the late 1960s. What was new was the effort to, quite literally, whitewash addiction and addiction treatment—to replace the stigma and aggressive policing of methadone and replace it with the cleaner, medicalized empathy of buprenorphine. Yet even this effort was not new. It drew on a century-old system of narcotic segregation in the US, in which some drugs become illegal through association with nonwhite users, and other drugs are legal and are deemed “medicines” reserved for white and middle-class consumers: in short, a system in which the Whiteness[‡] of certain drugs medicalizes them.

In this book, we examine this unspoken but determinative Whiteness of opioids, to make the ways that Whiteness works in drug policy and treatment visible. Here, *whiteout* refers to the use of white imagery to hide or cover the inner workings of segregation in drug policies and health care industries. It also refers to the need to bring Whiteness out of the silence and shadows of drug policy and health care so that it can be seen—so that its harms to white people *and* people of color can be collectively addressed.

‡ Throughout this book, we capitalize *Whiteness* in order to bring attention to it as a system that undergirds the phenomena we describe, as opposed to racial identity as signaled by *white*, which we do not capitalize.