

**The Role of Race in the Heroin Epidemic:
How racial disparities in healthcare have made addiction a white issue and the
implications for African American health**

Abigail Block

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Professor Howard Pickett

On my honor, I have neither given nor received any unauthorized aid on this paper.

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Abstract

Opioid-related addiction has been propelled by opioid treatment within the healthcare system. The addictive nature of these drugs was underestimated, leading to opioid and heroin addiction in many patients who were treated for chronic pain. The public has addressed the current heroin epidemic sympathetically, acknowledging addiction as a disease and offering healthcare treatment as a remedy. This has been a positive shift from the “tough on crime” agenda perpetuated by the War on Drugs. It also coincides with another shift in drug abuse—racial demographics. White Americans have been more affected by heroin than any other illicit drug. African Americans use heroin and prescription opioids less often because they’ve been left unexposed. Because African Americans receive disparate levels of treatment within the healthcare system, especially regarding pain treatment, they have not received prescription opioids and have thus been insulated from the epidemic. This newfound sympathy for Caucasian victims was non-existent when minority populations were disproportionately plagued with addiction. This issue stems from two healthcare failures that require action: first for equitable health generally, as provided by the U.S. healthcare system, and second, for non-preferential addiction responses.

I. Introduction

Chico Lewis and Roger Lowe run the Syringe Exchange Outreach (SEO) program supported by the Free Medical Clinic of Greater Cleveland. The two men are recovering addicts who met in treatment and continue to give back as a way of maintaining their recovery. Each day, they park their large van at two predetermined locations and slide open the doors, greeting the familiar faces of local heroin addicts who come to exchange used needles. The program exists as a response to rising popularity of injectable drugs, helping addicts avoid skin abscesses and infections like HIV and Hepatitis C. In the Tremont neighborhood on the west side of Cleveland, it is a weekly struggle to keep up with the steady stream of van patrons. On a given day, the SEO program provides about 3,000 needles in a three-hour period¹. Chico, who has been involved in the program for over twenty years, greets each customer kindly, asking about their families and gently reminding them of several local addiction treatment centers which might have an opening if they call. Syringe exchange in East Cleveland, the second site, is a different experience. Here, only a handful of heroin users approached the van, seeming ineffective compared to the demand experienced at the western Cleveland location. Chico explained they were in the process of changing locations—this one was formerly the busiest, but gradually the area patrons diminished. Though less than seven miles separate the two locations, Cuyahoga County, which contains both Tremont and East Cleveland, is one of the most

¹Mark Naymik, "Heroin Epidemic drives insatiable demand for Cleveland needles," *Cleveland.com*, December 17, 2015, http://www.cleveland.com/naymik/index.ssf/2015/12/heroin_epidemic_drives_insatia.html (accessed February 14, 2017).

segregated counties in Ohio, driving the neighborhoods further apart². Tremont has a population of about 54% white and 21% black³. It is also nestled west of downtown, closer to wealthier and whiter suburbs. East Cleveland's residents, on the other hand, are more than 93% black⁴. It wasn't until Chico described this that I noticed how homogeneously white the heroin users at the first site in Tremont had been. Given stereotypes about who does drugs, I am ashamed to admit I was surprised by this. Why were African Americans using heroin less than more privileged whites?

The growing heroin epidemic has received considerable attention in the news, marked by headlines like "Drug Deaths Reach White America" and "Heroin Deaths Surpass Gun Homicides for the First Time"^{5,6}. They tell stories about terrible loss of potential and plead for sympathetic policy. There are two potential explanations for this attention: racial bias in the media's covering of drug abuse and the culpability of healthcare in the epidemic. The subject of this paper is the latter. Politicians on both sides of the aisle are calling the epidemic a public health crisis, supporting bills for more comprehensive addiction treatment and strict opioid prescription guidelines. Programs like the Free Clinic's SEO (which had been the only one in Ohio for over fifteen years) are being recreated in other

²Brie Zeltner, "Segregation, inequality reflected in Ohio's poor county health rankings," *Cleveland.com*, March 16, 2016, http://www.cleveland.com/healthfit/index.ssf/2016/03/segregation_inequality_reflect.html (accessed February 15, 2017).

³Cleveland City Planning Committee http://planning.city.cleveland.oh.us/2010census/downloads/2010SPA_Data.pdf (accessed February 15, 2017).

⁴Community Facts: 2010 Census Summary (East Cleveland, OH), <https://factfinder.census.gov/faces/nav/jsf/pages/error.xhtml>, (accessed February 15, 2017).

⁵The Editorial Board, "Drug Deaths Reach White America," *New York Times*, January, 25, 2016, https://www.nytimes.com/2016/01/25/opinion/drug-deaths-reach-white-america.html?_r=0, (accessed March 22, 2017).

⁶ Christopher Ingraham, "Heroin Deaths Surpass Gun Homicides for the First Time, CDC data shows," *Washington Post*, December 8, 2016, https://www.washingtonpost.com/news/wonk/wp/2016/12/08/heroin-deaths-surpass-gun-homicides-for-the-first-time-cdc-data-show/?utm_term=.f00e5fea8306 (accessed March 22, 2017).

cities to meet expanding need⁷. The Comprehensive Addiction & Recovery Act (CARA) passed the Senate with a vote of 92-2⁸. This bipartisan shift towards a public health treatment of addiction is not the only shift under the epidemic's umbrella: in the past fifty years, heroin has gone from a drug plaguing mostly African American neighborhoods to devastating predominantly white communities. This is not unlike the racial shift in heroin users witnessed in Cleveland. One retrospective analysis found that of those who initiated heroin use in the last decade, 90% were white⁹. So while a health conscious approach to addiction is a positive shift in scientific knowledge and public opinion, it is also conveniently sympathetic to its new demographic: rural and suburban white families. The now extensive research on heroin abuse has faulted the healthcare system for introducing patients to prescription opioids without considering consequences of long-term use in chronic pain patients¹⁰. Most of these patients suffered legitimately from chronic pain, but their extended use caused chemical drug dependence. To respond to resulting dependence and abuse, physicians cracked down on opioid prescribing practices, which forced many who were already opioid-dependent to turn to a cheaper and more readily available, but far deadlier alternative: heroin¹¹. The visible effects of heroin have drawn a lot of attention to the issue, which is rooted in excessive opioid-prescribing trends. These irresponsible

⁷Emmanuel Romero, "Cleveland has Ohio's only legal syringe exchange program," *Cleveland.com*, September 20, 2010, http://www.cleveland.com/healthfit/index.ssf/2010/09/cleveland_has_ohios_only_legal.html (accessed February 15, 2017).

⁸"Senator Portman's CARA legislation receives widespread praise," Press Releases, July 20, 2016, <http://www.portman.senate.gov/public/index.cfm/press-releases?ID=E8D2238C-3BB5-4AC0-B9FE-84C2ED250822> (accessed February 14, 2017)

⁹Theodore J. Cicero, et al., "The Changing Face of Heroin Use in the United States: A Retrospective Analysis of the Past 50 Years" *Journal of the American Medical Association, Psychiatry* 71, no. 7 (May 2014): 821-826.

¹⁰ Sam Quinones, *Dreamland: The true tale of America's opiate epidemic*, (New York: Bloomsbury Press, 2015).

¹¹ Anne Case & Angus Deaton, "Rising morbidity and mortality in midlife among white non-Hispanic Americans in the 21st century," *Proceedings of the National Academy of Sciences*, 112, no. 49 (December 2015): 15078-15083.

healthcare practices did not affect minority patients in the same way, due to differential healthcare access.

As this paper will later demonstrate, not only do African Americans have disparate levels of healthcare access, but they also receive worse treatment for pain than their white counterparts. Given the link between opioids' use to treat pain and use of heroin, African Americans are less involved in the emergent heroin epidemic. Though this is a positive outcome for the group, it is produced by discriminatory structures within the healthcare field among so many other negative health outcomes. To be clear, the issue is *not* that African Americans need better healthcare access such that they have equal opportunity to develop opioid addictions. Instead, this establishes that while equal healthcare treatment is necessary to equalize outcomes, it is not sufficient. This results from two failures in the healthcare industry: first, that physicians' excessive prescribing behaviors facilitate addiction, and second, that physicians' racial bias contributes to worse health outcomes for African Americans. Ultimately, these prescribing behaviors have not affected African Americans in the same way, because differential treatment of black patients has ironically shielded them from the heroin epidemic, revealing racial injustice within the healthcare system.

II. The Current Heroin Epidemic: Racial makeup and healthcare's role

There is empirical support which reinforces my experience in Cleveland. This includes sufficient consensus among researchers that white Americans are most affected by the opioid crisis occurring today. According to a survey regarding heroin use, of those who first

used heroin in the last decade, 90% are white¹². Despite this, African Americans use illegal drugs at a rate higher than the national average¹³. Opioids, when compared to other drugs, are uniquely and most commonly used by white people. Of substance-related deaths, African Americans have three times greater incidence for cocaine-related deaths while white Americans have more than double the incidence of death related to pharmaceutical opioids¹⁴.

A 2015 study by Anne Case and Angus Deaton, Nobel Prize Winner in Economics, examined mortality rates across all U.S. demographics, finding an increase in mortality only for white men who were aged 45-54. For the same group, drug poisonings had the sharpest increase among leading causes of death causes from 2000-2015, surpassing the leading cause of lung cancer and driving the aggregate increase in mortality¹⁵. While both white men and white women are experiencing significantly increasing rates of drug overdoses, black and Hispanic rates have increased at slower rates or not at all from 1999-2014^{16,17}. Case and Deaton suggest this results from rising rates of opioid-related overdoses caused by excessive prescribing.

¹² Theodore J. Cicero, et al., "The Changing Face of Heroin Use in the United States: A Retrospective Analysis of the Past 50 Years" *Journal of the American Medical Association, Psychiatry* 71, no. 7 (May 2014): 821-826.

¹³ "Racial and Ethnic Minority Populations" Substance Abuse and Mental Health Services Administration. February 18, 2016. Accessed April 3, 2017. <https://www.samhsa.gov/specific-populations/racial-ethnic-minority>.

¹⁴ Susan Calcaterra, 2013

¹⁵ Case & Deaton, 15078-15083.

¹⁶ Gina Kolata & Sarah Cohen, "Drug overdoses propel rise in mortality rates of young whites," *New York Times*, January 16, 2016, <https://www.nytimes.com/2016/01/17/science/drug-overdoses-propel-rise-in-mortality-rates-of-young-whites.html?mtrref=undefined> (accessed February 1, 2017).

¹⁷ Susan Okie, "A flood of opioids, a rising tide of deaths," *New England Journal of Medicine*, 363, (November 2010): 1981-1985.

The same middle-aged white men from their 2015 study also reported higher rates of chronic pain from 2011-2013¹⁸. Assuming that there is an established link between chronic pain treatment in the healthcare system and opioid abuse and overdose (which I will further investigate later), these statistics are alarming. Though the authors provide evidence of reported chronic pain, there is not data to determine whether this demographic actually experiences pain at higher rates than other racial groups, or rather reports chronic pain more often, which could result from disparate access to healthcare.

The reach of opioids has since stretched beyond the bounds of healthcare. As prescribing guidelines have grown stricter in response to these issues, demand for heroin as a substitute has driven down its price¹⁹. Concern for this issue has grown with the climbing rates of heroin overdose. As heroin use has increased, overdose rates have followed, most commonly affecting addicts. Prolonged use of heroin proves more deadly than long-term cocaine or meth abuse²⁰. Medication-assisted opioid addiction treatments like buprenorphine have risen in popularity, especially for white heroin abusers, who make up 91% of the patients using it²¹. These treatments allow for chemical dependence to be maintained and gently diminished while eliminating the accompanying high.

The racialized nature of the heroin epidemic and the progressive response to it has been concerning to those who acknowledge the racial contrast. “When the face of addiction had dark skin, this nation’s police did not see sons and daughters, brothers and sisters, they

¹⁸ Case & Deaton, 15078-15083.

¹⁹ Case & Deaton, 15078-15083.

²⁰Jen Christensen, “How Heroin Kills You,” *CNN*, August 29, 2014. <http://www.cnn.com/2014/02/04/health/how-heroin-kills/> (accessed April 10, 2017).

²¹ Helena Hansen & Julie Netherland, “Is the prescription opioid epidemic a white problem?” *American Journal of Public Health*, 106, no. 12, (December 2016): 2127-2129.

saw 'brothas,' young thugs to be locked up, rather than people with a purpose in life"²².The opioid crisis as witnessed in the 1970s was presented to the public as a problem within minority populations and was met with criminalized policies rather than a public health approach. Even today, the discretion allowed in drug enforcement, as policies currently stand, have the potential to reinforce these racial inequalities²³. This difficult history forces some to question the sudden change in direction for public policy pertaining to drug use. Why has a sympathetic view of addiction emerged only now? Healthcare's influence in this particular drug epidemic appears to play a role in who uses it and how American society deals with it.

²² Ekow N. Yankah, "When addiction has a white face," *New York Times*, February 9, 2016, <https://www.nytimes.com/2016/02/09/opinion/when-addiction-has-a-white-face.html> (accessed March 19, 2017).

²³ Hansen & Netherland, 2127-2129.

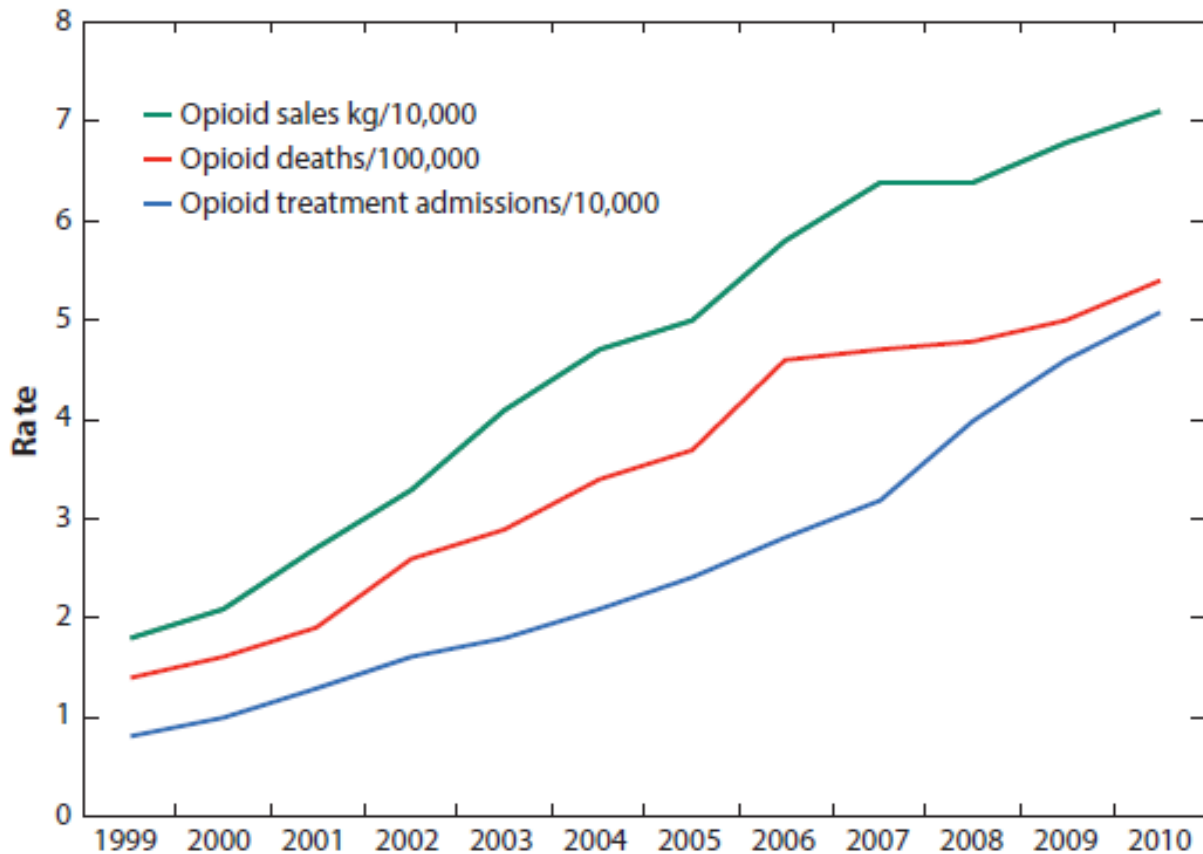


Figure 1: Rates of opioid-related death and opioid-related treatment admissions have risen steadily with the rising rate of opioid sales (Kolodny et al., 2015).

Today, the most agreed-upon contributor to heroin abuse is the high rate of opioid prescription by health professionals. Coinciding with increased rates of opioid prescribing is the 4-fold increase in opioid prescription overdose deaths and a 9-fold increase in those seeking opioid addiction treatment²⁴. This salient correlation is shown in **Figure 1** above. Opioid prescription rates seem to have increased following a failure in scientific communication. In 1979, Dr. Herschel Jick published a finding in the renowned *New England Journal of Medicine*, which stated, very briefly: “Of almost twelve thousand patients treated with opiates while in a hospital before 1979, and whose records were in the Boston

²⁴ Andrew Kolodny et al., “The prescription opioid and heroin crisis: A public health approach to an epidemic of addiction,” *Annual Review of Public Health*, 36, (January 2015): 559-574.

database, only four had grown addicted”²⁵. No other information about length or dose of treatment was reported. This “landmark study,” cited for decades since its publishing, did not clarify that these cases were for acute pain in a controlled hospital environment. Yet, this paragraph was used to justify long-term treatment of chronic pain patients with little concern of addiction²⁶. In the 1990s, the pharmaceutical industry propelled the study’s reach even further with a national campaign aimed at recognizing “pain as the fifth vital sign.”²⁷. While greater acknowledgement of pain for this initiative did not officially require opioid treatment, “the initiatives have coexisted with, and in some cases, been supported by, a pharmaceutical industry in which increasing sales of opioids have grossed billions of dollars”²⁸. As a result of unchecked opioid prescribing, from 2001-2012, heroin and prescription opioid overdose-related hospitalizations (not including fatal ODs) have increased 1.9 and 2.5-fold respectively²⁹. The U.S. healthcare system’s undeniable role in the crisis has inadvertently insulated most African Americans from its worst consequences.

III. African Americans Receive Disparate Levels of Healthcare

Differential access to healthcare

Because the healthcare system has played such a major role in facilitating opioid addiction and African Americans often receive lower levels of treatment than whites, it follows that African American rates of heroin addiction remain low as well. The racial

²⁵ Quinones, 2015

²⁶ Quinones 2015

²⁷ Richard A. Mularski, et al., “Measuring Pain as the 5th Vital Sign Does Not Improve Quality of Pain Management,” *Journal of General Internal Medicine*, 21, no. 6 (2006): 607-612.

²⁸ G. Caleb Alexander, et al., “Rethinking opioid prescribing to protect patient safety and public health” *Journal of American Medical Association*, 308, no. 18 (2012): 1865-1866.

²⁹ Douglas J. Hsu, et al., “Hospitalizations, costs and outcomes associated with heroin and prescription opioid overdoses in the United States 2001-2012,” *Addiction* (2017).

differential in healthcare treatment is well documented, most visibly by the poor health outcomes observed in African Americans. Mortality rates are higher in African Americans for breast cancer, prostate cancer, and lung cancer³⁰. Blacks also endure higher rates of death from heart disease and stroke³¹. African Americans are more likely to be diagnosed with diabetes and obesity³². Several factors contribute to these negative outcomes. African Americans receive lower-quality treatments and are less likely to receive diagnostic tests early. Of patients receiving treatment for stroke, black patients received imaging less often than whites for treatment monitoring. Even after controlling for income, blacks with heart disease received fewer angiography and bypass surgeries than whites³³. These advanced surgeries are often life-saving for patients, yet are not saving lives equitably. Surgeries that are not as beneficial, called “last resort” surgeries like limb amputation, are more often performed on black patients due to insufficient care for chronic disease³⁴.

The inextricable link between minority race or ethnicity and lower socioeconomic status influences these disparities. Given the rising costs of healthcare, the ability to afford quality healthcare, especially primary care, is limited to lower income families. In 2005, almost one-fifth (19.6%) of African Americans did not have any form of health insurance, compared to 11.3% of uninsured non-Hispanic whites³⁵. Generally, uninsured patients

³⁰ Michael K. Brown et al., *White Washing Race: The Myth of a Color-Blind Society*, (Los Angeles: University of California Press, 2003): 44-48.

³¹ George Mensah et al., “State of Disparities in Cardiovascular Health in the United States,” *Circulation*, 111, (2005):1233-1241.

³² Ali Mokhad et al., “Prevalence of Obesity, Diabetes, and Obesity-Related Health Risk Factors, 2001,” *Journal of American Medical Association*, 289, no.1 (2003): 76-79.

³³ Brown, 44-48.

³⁴ Brown, 44-48.

³⁵ Carmen DeNavas-Walt, et al., *Income, Poverty, and Health Insurance Coverage in the United States*, (Washington D.C.: U.S. Government Printing Office, 2006): 60-231.

received fewer preventative treatments compared to those who are insured³⁶. These patients miss important physician guidance and health education that patients who can afford regular doctor visits are given³⁷.

African Americans' limited healthcare access can stem from negative environmental factors. Black neighborhoods have disproportionate exposure to toxins from the environment, a product of residential segregation³⁸. The differential rates of hypertension between blacks and whites, though assumed by some to be genetic, have been attributed to the stress that accompanies low socioeconomic status³⁹. Thus, lower income levels can impact health, outside of the ability to afford proper healthcare. Brown et al. describe these phenomena as "a perfect illustration of how disaccumulation works: small deficits in healthcare add up over time, leading to the disaccumulation of health and a perverse outcome"⁴⁰. Many of these disparities result from perpetuated disadvantage and discrimination against African Americans throughout U.S. history.

Historic disadvantage for African Americans

American history boasts of technological triumphs, and the field of medicine is no exception. J. Marion Sims, who has been called the "Father of Gynecology," developed a number of gynecological practices in the 19th century that are still widely used today⁴¹. To

³⁶ Selassie et al., "The Influence of Insurance, Race, and Gender on Emergency Department Disposition," *Academic Emergency Medicine*, 10, no. 11 (November 2003): 1260-1270.

³⁷ Becker et al., "Self-care among chronically ill African Americans: Culture, health disparities and health insurance status," *Public Health Matters*, 94, no. 12 (December 2004): 2066-2072.

³⁸ Brown, 44-48.

³⁹ Brown, 44-48.

⁴⁰ Brown, 44-48.

⁴¹ Jeffrey S. Sartin, "J. Marion Sims, the Father of Gynecology: Hero or Villain?" *Southern Medical Association*, (2003): 500-505.

do so required the bodily exploitation of three slave women. Anarcha, Lucy, and Betsey are three of these women who endured the most of his experiments. Anarcha underwent thirty surgeries for the repair of vesicovaginal fistula, a common complication of childbirth at the time⁴². Upon the final surgery's success, Sims relocated to New York, where his reputation grew and he operated on many wealthy white women. It was not until this relocation and his increased treatment of prominent white women that Sims began using anesthesia during these painful operations. Thus, successful medical procedures like this one used slave bodies to better the health and comfort of more privileged groups.

Historians like Victoria N. Gamble are outraged at this gap in clinical care⁴³. There is little doubt that racism was a factor in this era, as Sims was an avid defender of slavery and a slave owner. However, LL Wall defends Sims against these claims, citing the timeline of availability and acceptance of ether anesthesia. He quotes Sims', who said in 1857 that he did not use anesthesia for fistula operations, as "they are not painful enough to justify the trouble"⁴⁴. Yet, Gamble also uses Sims' own words in her argument, citing his notes from his late 1840s experiments on Lucy: "Lucy's agony was extreme. She was much prostrated, and I thought she was going to die"⁴⁵. However, unjust disparities in treatment like these were not limited to the era of chattel slavery.

In the 1930s, syphilis became a rising health concern. Treatments were limited and those available had risky side effects. Since this occurred during the Great Depression, little

⁴² LL Wall, "The medical ethics of Dr. J Marion Sims: A fresh look at the historical record," *Journal of Medical Ethics*, (2005): 346-350.

⁴³ Vanessa Northington Gamble, "Under the Shadow of Tuskegee: African Americans and Health Care," *American Journal of Public Health*, 87, no. 11 (Nov. 1997): 1773-1778.

⁴⁴ Wall, 246-350.

⁴⁵ Gamble, 1773-1778.

to no funds were available for drug development research. In response, the U.S. Public Health Service and the Tuskegee Institute organized a study to determine what effects the lack of syphilis treatment has on patients. They recruited 399 men infected with syphilis, all of them African Americans⁴⁶. These subjects were unable to give informed consent—they were not informed of their syphilis diagnosis and they were not offered treatment. The participants were solely informed that their “bad blood” was the study’s subject. Not only did the researchers withhold treatment, but they went to great lengths to prevent subjects’ treatment from other local physicians as well⁴⁷. Even after penicillin was widely used to treat the disease in 1945, the patients remained untreated. It was not until 1972, after a news story denounced the experiment, that the study ended its forty-year tenure of unethical research⁴⁸. The modernity of this case is particularly striking, as the study ended less than fifty years ago, after the Civil Rights Act was passed. Even more contemporary are current concerns of healthcare practices that disproportionately affect minority groups, as discussed previously by means of access to quality care, and in terms of physician discrimination once care is provided.

Gamble expresses concern that high-profile racist medical studies such as these examples contribute to some African Americans’ fear of government-planned genocide of their race. Some believed the AIDS epidemic to be another such case, as it disproportionately affected the African American community⁴⁹. Similarly, in the 1970s, increased screening for sickle cell disease in African American communities—genetically

⁴⁶ “U.S. Public Health Service Syphilis Study at Tuskegee” Center for Disease Control, accessed February 28, 2017. <https://www.cdc.gov/tuskegee/timeline.htm>

⁴⁷ Gamble, 1773-1778.

⁴⁸ “Syphilis Study at Tuskegee”

⁴⁹ Gamble, 1773-1778.

discriminating against the race and severely limiting their freedom. Though there was no available treatment, and being genetically predisposed did not guarantee the manifestation of the disease, African Americans were subjected to genetic tests in the school, military, and prison systems⁵⁰. General healthcare practices indicate that when no action can be taken to treat or prevent a disease, testing for it is wasteful and unnecessary. Unfounded practices such as these instilled the idea that African American procreation was dangerous, which some saw as another attempt to confine or slowly eliminate the race⁵¹. The Black Panther Party led a campaign to address the fear behind the issue and President Nixon's apparent neglect to equitable medical care, as shown in **Figure 2**.



Figure 2: Above is a poster used by the Black Panther party to raise awareness about the oppressive nature of required sickle cell anemia testing in African Americans (Nelson, 2011).

Perpetuated racial stereotypes and opioid treatment

The discriminatory practices causing differential outcomes continue to exist today, drawing unfortunate parallels to historic patterns of disadvantage. The most obvious shift over time is from explicit bias to implicit bias. Racist or prejudiced attitudes have become

⁵⁰ Vernellia R. Randall, "Slavery, Segregation and Racism: Trusting the health care system ain't always easy! An African American Perspective on bioethics," *Saint Louis University Public Law Review*, 15, no. 2 (1996): 191-235.

⁵¹ Randall, 191-235.

increasingly taboo, but stereotypes have become internalized, and can still influence behavior. Implicit bias “refers to the attitudes or stereotypes that affect our understanding, actions, and decisions in an unconscious manner”⁵². Though these biases do not necessarily align with individual and conscious beliefs, they are generally understood to affect the perception of most individuals. It has been suggested that doctors especially, rely on their implicit biases when providing healthcare. Because their time is often limited, racial information about risk factors and genetic predispositions are often used to expedite diagnosis and treatment. These effects of implicit bias are measurable and significant, and could potentially influence the way physicians treat chronic pain in African Americans⁵³.

As heroin abuse and opioid-related overdoses have increased nationwide, hospitals have regulated opioid prescribing, as general fear of addiction has pervaded the treatment of pain. Some believe this fear is irrational, calling it “opiophobia,” citing the distinction between chemical dependence and psychological addiction⁵⁴. But as overdose rates climb, many healthcare providers have become increasingly wary, limiting who they prescribe opioids to and how much they prescribe. They are making it a personal responsibility to treat pain less vigorously. However, it is quite possible that the provider’s responsibility to society through the prevention of addiction is in direct conflict with the provider’s primary duty to the patient⁵⁵. This is a disservice to the health of patients, and may be

⁵²“Understanding Implicit Bias,” Kirwan Institute for the Study of Race and Ethnicity, accessed April 3, 2017, <http://kirwaninstitute.osu.edu/research/understanding-implicit-bias/>.

⁵³ Elizabeth N. Chapman et al. “Physicians and Implicit Bias: How Doctors May Unwittingly Perpetuate Health Care Disparities,” *Journal of General Internal Medicine*, 28, no. 11 (2013): 1504-1510.

⁵⁴ Timothy Rupp & Kathleen A. Delaney, “Inadequate Analgesia in Emergency Medicine,” *Annals of Emergency Medicine*, 43, no. 4 (April 2004): 494-503.

⁵⁵ Joyce S. Fontana, “The social and political forces affecting prescribing practices for chronic pain,” *Journal of Professional Nursing*, 24, no. 1 (2008): 30-35.

disproportionately affecting minority groups like African Americans. In hospital settings like the emergency department, African American patients presenting bone fractures were significantly less likely to receive pain relief treatment⁵⁶. Even for more chronic pain presentations, black patients in the emergency department with migraines and back pain were prescribed opioids less often⁵⁷. To provide insight regarding the depth of this disparity, a study conducted by Heins et al.⁵⁸ found that of 868 patients treated for pain in the emergency department, African Americans were 1.86 times less likely to be prescribed opioids, and nearly half as likely to receive any prescription analgesics (opioid or otherwise) to treat pain outside the context of the hospital. Similar trends follow for opioid prescriptions for post-appendectomy pain, for chronic pain, and for arthritis pain⁵⁹. It is unclear whether these disparate practices stem from the assumed greater risk of opioid abuse for the African American population or remnants of the belief that the group experiences less pain than other ethnic groups. However, either option wrongly relies on implicit bias to inform medical decisions.

African Americans who are treated with prescription opioids still face barriers to treatment for chronic pain, as they are met with more skepticism through the course of the prescription by healthcare providers. A comprehensive study by Hausmann and colleagues identified racial differences for nearly 1900 patients who were prescribed opioids for at

⁵⁶ KH Todd, "Ethnicity and analgesic practice," *Annals of Emergency Medicine*, 35, no. 1 (Jan 2000): 11-16.

⁵⁷ JH Tamayo-Sarver, "Racial and ethnic disparities in emergency department analgesic prescription," *American Journal of Public Health*, 93, no. 12 (Dec 2003): 2067-2073.

⁵⁸ Janet K. Heins, et al., "Disparities in analgesia and opioid prescribing practices for patients with musculoskeletal pain in the emergency department," *Journal of Emergency Nursing*, 32, no. 3 (June 2006): 219-224.

⁵⁹ Karen O. Anderson, et al., "Racial and ethnic disparities in pain: Causes and consequences of unequal care," *The Journal of Pain*, 10, no. 12 (Dec 2009): 1187-1204.

least 90 days for chronic pain⁶⁰. Not only is it more difficult for black patients to obtain these prescriptions, but those who do are less likely to report that this treatment was effective. African American chronic pain patients were also referred to pain specialists, pain clinics, or alternative pain treatments less often than their white counterparts⁶¹. Of those opioid-prescribed patients who were subjected to drug testing, black patients were asked more frequently to submit subsequent urine tests. Black patients were also more likely to be referred to substance abuse assessments than the evaluated white patients⁶². These heavy-handed and skewed monitoring techniques could result from cultural expectations that African Americans are more likely to commit crimes, specifically drug crimes. Regardless of the possible truth to these assumptions, it is important to note that using such assumptions to guide healthcare decisions is ill-informed and unjust, as expectations about a racial group's recreational behavior is prejudiced and cannot be confidently applied on an individual basis. Instead, these attitudes are formed from generations of discrimination and racial stereotypes. The distrust between patient and physician goes both ways, which has grave implications for patient health.

Generations of disadvantage foster distrust of physicians

“Our distrust is the direct result of our unique cultural birth in America [... and] is grounded in the knowledge that the health care system has been built on bodies of African Americans.”⁶³

⁶⁰ Leslie Hausmann, et al., “Racial disparities in the monitoring of patients on chronic opioid therapy,” *Pain*, 154 (2013): 46-52.

⁶¹ Hausmann, 46-52.

⁶² Hausmann, 46-52.

⁶³ Randall, 191-235.

In addition to the analogous disparities of past and present, our complex history of racial disadvantage has the power to increase the racial divide. The fear and distrust African Americans feel for healthcare providers has negative consequences for their health. Bias or discrimination by healthcare providers certainly contributes to distrust, but even the expectation of discrimination alone can break down doctor-patient trust. LaVeist et al. determined that 30% of African Americans believe racial discrimination is common in a physicians' office. When comparing the response of black patients to white patients, black patients were significantly less likely to agree that the two racial groups are treated the same way and that the two racial groups receive the same kind of care⁶⁴. A study by Jacobs et al.⁶⁵ found that African American patients in their sample expected to be mistreated by physicians due to both historical and modern examples of discrimination. On measures of trust, LaVeist and colleagues found that African Americans were significantly more likely to show distrust in healthcare providers than their white counterparts were⁶⁶. The existence of this distrust has serious implications for patients' health seeking behaviors⁶⁷.

There are practical consequences of this established distrust: patients are less likely to adhere to recommended treatments, less likely to inform their physicians fully, and less likely to report improved health⁶⁸. Patient trust is positively correlated to HIV

⁶⁴ Thomas A. LaVeist et al., "Attitudes about Racism, Medical Mistrust, and Satisfaction with Care among African American and White Cardiac Patients," *Medical Care and Research Review*, 57, no. 1 (2000): 146-161.

⁶⁵ Jacobs et al., 642-647.

⁶⁶ LaVeist et al., 146-161.

⁶⁷ Elizabeth A. Jacobs et al., "Understanding African Americans' Views of the Trustworthiness of Physicians," *Journal of General Internal Medicine*, 21 (2006): 642-647.

⁶⁸ Mark A. Hall, et al., "Trust in physicians and medical institutions: What is it, can it be measured, and does it matter?" *New England Research Institutes* (2001): 613-639.

antiretroviral medication adherence⁶⁹. Patients who lack trust in their doctors are more likely to refuse treatments, especially seemingly risky surgeries⁷⁰. African American patients are also less likely to participate in clinical research, which can limit their access to life-saving treatments⁷¹. While some could consider this the fault of patients, we must reconsider the historic and ongoing trends of mistreatment in the healthcare system. Not only were African Americans the subjects of risky medical experimentation, but they continue to receive negative consequences from physicians' biased assumptions.

While the seemingly extreme fears of genocide may be difficult for some to swallow, it is reasonable to understand that black patients may not have sufficient evidence that healthcare providers keep their best interest in mind. This 'choice' to limit or forego healthcare consumption is not necessarily ill-informed or intentional, but stems from legitimate fear based on generations of compounded racial disparities and distrust of health professions. Regardless of whether others consider this fear to be valid, it does exist, propagating sub-par care for African Americans. Billy Thomas suggests that by contributing to patients' fear and distrust, the healthcare industry is responsible for remedying the effects. "Part of the responsibility of the health care system is to identify those factors that negatively influence health within underserved communities and to educate the health care workforce, community, and policymakers about the direct, and in many cases very negative, impact these factors have on overall health, quality of life, and life expectancy"⁷².

⁶⁹ John Schneider et al., "Better physician-patient relationships are associated with higher reported adherence to antiretroviral therapy in patients with HIV infection," *Journal of General Internal Medicine*, 19 (2004): 1096-1103.

⁷⁰ Jacobs et al., 642-647.

⁷¹ Giselle Corbie-Smith, et al. "Attitudes and Beliefs of African Americans toward Participation in Medical Research," *Journal of General Internal Medicine*, 14, no.9 (1999): 537-546.

⁷² Thomas, 7492-7502.

The self-perpetuating cycle of distrust between doctors and their patients has heavily influenced the way African Americans receive healthcare. Physician practices—either conscious or unconscious discrimination—have shielded this population from the heroin epidemic by prescribing fewer opioids to African Americans. While this is not a directly negative consequence, it has serious implications for the health of African Americans. The healthcare disparities that have caused this differential rate of addiction are of serious concern. And while it is an issue that has received a lot of attention, equal access followed by equal levels of care within the healthcare system are required to *begin* to attain equitable health outcomes. However, healthcare treatment that is equal to that of white patients could potentially facilitate opioid addiction for minority populations in addition to the white population. In order to properly address this complex issue, adjustments must be made within the healthcare industry that addresses each of these failures.

IV. Why Should These Circumstances Be Addressed?

The implications for this conversation about African American disadvantage center around health. The healthcare system in the U.S. ought to be restructured in two ways: first so that it provides equal levels of care for all, despite an individual's racial group, and second, so that it does not compromise the health of patients, specifically by facilitating addiction to prescription opioids. Many would suggest that, first and foremost, health is the responsibility of each individual patient and their physician. What obligation could a society have for the health of its population or a specific group within it?

In John Rawls' *Theory of Justice*, he claims that a just society must be fair. This fairness is rooted in an unbiased democratic consensus, such that individuals who remove

their own self-interest can agree to some societal framework. Rawls then suggests that most people, detached from and unbiased by their individual preference and perspective, would call for principles like basic liberties and fair equality of opportunity for all⁷³. Equality of opportunity is not a foreign concept to most Americans, and tends to be viewed as a positive American value, central to the revered “American Dream”. Those who are less liberal-leaning might assert that this American value is instilled in the core of our government, and thus is already widely available to all U.S. citizens. Daniels, et al. would argue against this, expanding on Rawls’ theory of justice to define what is required to attain fair equality of opportunity (FEO).

Daniels might identify African Americans receiving differential levels of healthcare as relatively deprived, which “refers not to the lack of ‘goods’ that are basic to survival, but rather to the lack of sources of self-respect that are deemed essential for participation in society”⁷⁴. If black Americans are unable to participate fully in society as a consequence of poor health outcomes, it follows that they do not have fair equality of opportunity. Thus, a healthcare system that exacerbates racial disparities is unjust. Once it is acknowledged that African Americans are suffering injustice, Daniels and his colleagues suggest that justice requires action to alleviate these inequalities.

For the healthcare industry to most effectively attain equitable health, we can first address the social determinants of health that disadvantage African Americans. Social determinants can include healthcare access differences that negatively affect black

⁷³ John Rawls, “A Theory of Justice”, *Poverty and Economic Justice*, (New York: Paulist Press, 1981): 108-120.

⁷⁴ Norman Daniels et al., “Justice, Health, and Health Policy,” *Ethical Dimensions of Health Policy* (Oxford: University Press, 2002): 19-47.

Americans' health. But to refocus on the issue of the distrust that further divides the advantaged and the disadvantaged, these social determinants become more complicated.

V. How Should This Look in Political Practice?

Addressing addiction equitably

The healthcare industry has attempted to combat rising rates of opioid dependence by addressing opioid prescription rates. Because the drugs were so heavily relied upon in the treatment of chronic pain, many patients who had been using opioids for pain were severely limited in their treatments. Some had already developed a chemical dependence on the drugs, which constitutes a physical need for opioids⁷⁵. To suddenly limit opioid intake in this way made pain management *and* addiction very difficult, so the demand for heroin as a substitute rose quickly⁷⁶. Healthcare providers and policy makers ought to take some responsibility for this dangerous shift. It is the irresponsible behavior of medical professionals that enabled the epidemic. While less reliance on opioids could be a beneficial healthcare norm in the long run, there are more immediate issues that must be addressed.

The healthcare industry must act to attenuate the costs of opioid addiction. Benjamin Bowser and his colleagues recommend mirroring harm reduction strategies to address the health of heroin and prescription opioid users. As they claim, "The way to reduce any epidemic of illicit drugs is to remove as much as possible the social and

⁷⁵ Nora D. Volkow, "America's Addiction to Opioids: Heroin and Prescription Drug Abuse," *National Institute on Drug Abuse*, (2014), <https://www.drugabuse.gov/publications/research-reports/heroin/how-heroin-linked-to-prescription-drug-abuse> (accessed April 3, 2017).

⁷⁶ Volkow, 2014.

economic incentives for illicit drug use by medicalizing addiction”⁷⁷. Such a response would necessitate an expansion of the public health approach employed today.

As it stands in the U.S. today, initiatives for medical addiction treatments are spreading. Syringe exchange programs like the Free Clinic of Greater Cleveland’s are being implemented in growing problem areas nation-wide. Good Samaritan laws and access to naloxone prescriptions are spreading state-by-state⁷⁸. These laws permit drug users to seek medical help in the case of an overdose while avoiding legal action for drug possession. Naloxone prescription availability in pharmacies allows friends and family of addicts to reverse the effects of an overdose. Medically-assisted addiction treatment, via the regular use of non-addictive opioids like methadone and buprenorphine, provide options for regulated use and eventual weening from the drugs. Each of these solutions helps individual addicts to turn away from their prescription opioid or heroin dependence. However, none of these solutions address the epidemic at its cause by undermining the “social and economic incentives for illicit drug use”. Bowser et al. suggest that this would require adjusting the economic cost of treatment below the cost of heroin⁷⁹. This would include financial cost—making addiction treatment cheaper than maintaining heroin use, but also the social costs could be adjusted to lessen stigma surrounding addiction. Unfortunately, in the U.S., this means huge strides in healthcare access. To reduce the cost of opioid addiction treatment below that of heroin would mean a cost of near nothing to the

⁷⁷ Benjamin P. Bowser, et al., “Is the New Heroin Epidemic Really New? Racializing Heroin,” *Journal of the National Medical Association*, 109, no. 1, (2017): 28-32.

⁷⁸ “Overdose Prevention,” CDC, <https://www.cdc.gov/drugoverdose/opioids/odprevention.html> (accessed April 3, 2017).

⁷⁹ Bowser, 28-32.

patient. The state would take on this burden, meaning a single-payer healthcare system or something close to it would be necessary.

To expand this already enormous undertaking, we must still address the racial disparities that provide differential outcomes for African Americans. As many have noted, the current heroin epidemic, when compared to the numerous narcotics which plagued ‘urban’ or black communities in the 1960s and 1970s, has been treated progressively, with a positive approach guided by goals of health. This positive shift has grown from the HIV/AIDS epidemic, where harm reduction strategies have been successfully employed. Additionally, research about the chemical changes in the brain following addiction has helped many to understand the physical health changes addicts experience^{80,81}. However, criminalization of drug use and addiction in the past was a response to mostly racial minority users who were villainized as ‘super-predators’ in the media. As Seelye of the *New York Times* describes, “When the nation’s longest-running war against drugs was defined by the crack epidemic and based in poor, predominantly black urban areas, the public response was defined by zero tolerance and stiff prison sentences”⁸². Is it possible that this shift is solely driven by forward-thinking? The coincidence seems unlikely.

To avoid racial differences in addressing crises such as these, an approach that offers similar treatments for different types of addiction is needed. For example, cancer is a

⁸⁰ Rita Z. Goldstein & Nora D. Volkow, “Drug addiction and its underlying neurobiological basis: Neuroimaging evidence for the involvement of the frontal cortex,” *American Journal of Psychiatry*, 159, no. 10 (October 2002): 1642-1652.

⁸¹ Alan I. Leshner, “Addiction is a brain disease, and it matters,” *Science*, 278, no. 5335 (October 1997): 45-47.

⁸² Katharine Q. Seelye, “In Heroin Crisis, white families seek gentler war on drugs,” *New York Times*, October 30, 2015. <https://www.nytimes.com/2015/10/31/us/heroin-war-on-drugs-parents.html? r=0&module=ArrowsNav&contentCollection=U.S.&action=keypress®ion=FixedLeft&pgtype=article> (accessed March 19, 2017).

blanket term for a certain health malignancy. Though there are many different forms cancer takes, most people understand cancer as something that ought to be addressed aggressively by the healthcare system. Viewing addiction as an analogous over-arching term could eliminate the racial and socioeconomic factors that impact what types of addictions individuals develop. Each case of addiction, depending on severity but not on drug, would be met with the same sense of urgency. However, physicians would be trained specifically to determine which methods are most effective for different types of addiction. An approach like this would also require more resources, so that there is equitable division among illicit drug research. Medicine-assisted treatments that parallel methadone or buprenorphine, but treat addictions to cocaine, alcohol, or marijuana, could potentially be developed. Heavy investment treatments that address addiction more broadly would also be effective and efficient. Psychological therapeutics help addicts to understand the motivations behind drug-seeking behaviors as a way to prevent them. As cancer patients receiving chemotherapy for different types of cancer can often be treated together, addicts could offer shared experiences of addiction more broadly to supplement their individualized treatments. Costs of these treatments and research endeavors would need to be covered by the state as well. While costs of such programs may seem astronomical, Bowser et al., suggest that by diverting funds away from enforcing drug crimes, including police, the legal system, prison services, and drug monitoring, such a health approach is fiscally reasonable⁸³. Not only would financial costs be feasible, but costs to neighborhoods, such as violent crime, could be avoided.

⁸³ Bowser, 28-32.

A response to addiction generally prevents individualized responses to “epidemics” that affect powerful demographic groups while excluding less powerful minorities. By reason of financial cost or physical location, different communities face different challenges in similar ways. Thus, if crack cocaine is more available than heroin for African Americans to treat their under-treated chronic pain, their similar disease of addiction should not be treated differently than the white heroin addict. Legal classes for drug offenses differentiating between crack and powdered cocaine forms have been criticized for this reason. By diminishing criminalization and equitably treating health among addicts, those who fall into addiction, regardless of wealth or race, have the potential to regain their health.

Addressing broader racial disparities in healthcare

It proves more difficult to affect broad change in healthcare across all specialties in treating black patients. One way to address attitudes of healthcare providers is via cultural competence training, such that medical professionals are better equipped to meet the needs of minority patients⁸⁴. If physicians and their colleagues are more educated and more understanding of underlying distrust their patients may feel, then more time and energy can be spent to foster trusting relationships.

⁸⁴ Thomas, 7492-7507.

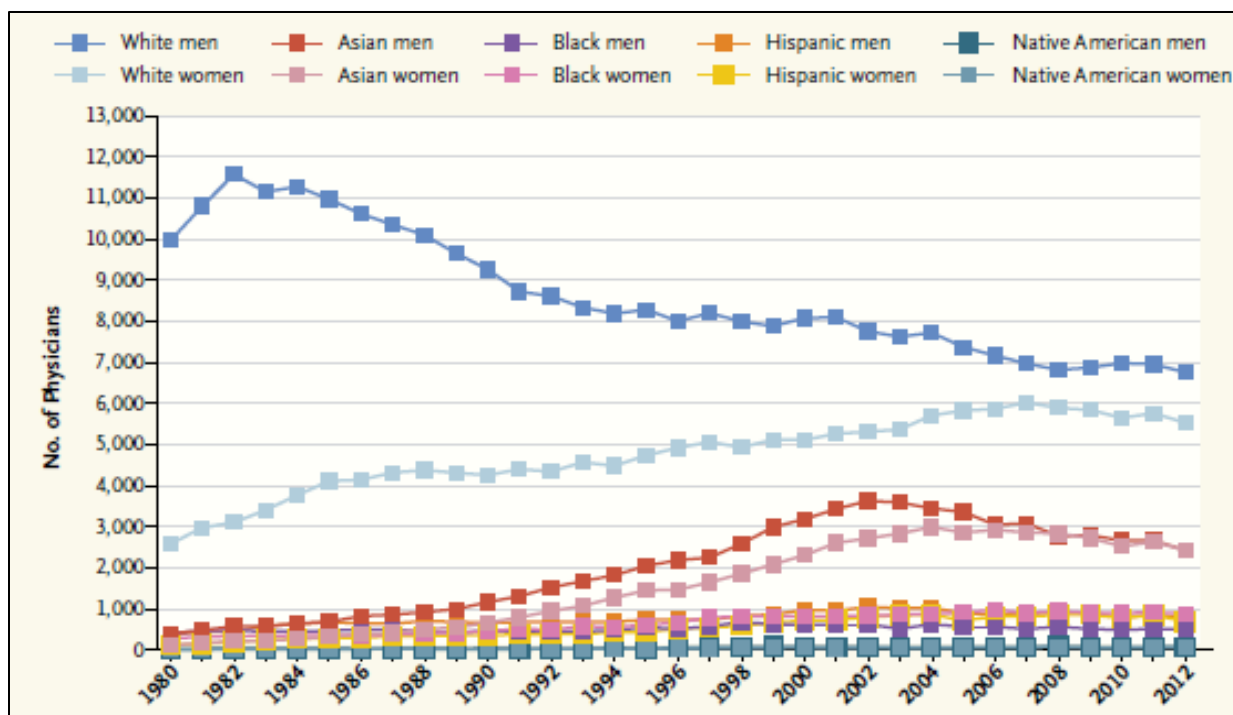


Figure 3: The number of physicians since 1980, broken down by race. African Americans have steadily maintained low representation in the profession.

Beyond cultural competency is the general whiteness of the healthcare field, which has not had significant change for African Americans in recent decades, as shown above, in **Figure 3**. If more resources were devoted to recruiting diverse medical school students who may have a better understanding of particular patients' disadvantage, the healthcare industry will be better equipped to address them. Increasing diversity of the healthcare providers could also facilitate cultural competence of white doctors, as working together could help to diminish the effects of implicit bias.

To encourage diversifying the field and fostering of cultural competence, state or federal programs could provide some sort of incentive to hospitals for improving the health outcomes of African American patients. This would motivate hospital administrators to adopt targeted initiatives that would help reaffirm trust between healthcare providers and African American patients. Hospitals would also have the autonomy to develop programs

that specifically and efficiently aid their patient population. To limit influence of implicit bias, hospitals could encourage longer appointments for minority patients. By spending more time to develop a relationship with their patients, they can make more informed recommendations, and hopefully black patients would be more comfortable trusting these recommendations. Additionally, many hospitals have moved toward the trend of interdisciplinary teams for more comprehensive treatment. By making these resources especially available for African American patients, those who may have limited healthcare access can receive more attention. Professional group discussions about a patient's health may limit the bias that affects decisions. This could include specialists like nutritionists, pharmacists, and social workers who are prepared to address the unique needs of underserved populations. Quantifiable improvements in health outcomes would then benefit both patients and hospitals.

VI. Conclusion

The duty of healthcare providers is not to profit or to the cultural norms, but is to the health of each patient. While what health requires can be ambiguous in numerous situations, looking at broad disparities and failures system-wide can inform those responsible on how to make individual adjustments. In most cases, changing an institution itself is not only daunting, but can be ineffective if healthcare providers working within the institution are not also improved. The healthcare field, for this reason, requires physicians and other providers to constantly re-evaluate health outcomes and their roles in producing them. Even though many disadvantaging systems cause disparities outside of the hospital, their duty is to aiding patient health, regardless

of cause, and often despite it. Healthcare has the potential to serve as an equalizer if those who provide it are better equipped to perform their required role. Thus, the opioid crisis and racial disparities are products of the same issue: losing sight of a patient's health. Looking forward, constant analysis of healthcare's successes and failures will help to maintain equitable health in a time of constant technological and societal advancement. This can include checks and balances on profit-driven health initiatives, especially those driven by the pharmaceutical industry. Healthcare systems are required not only to keep up with the pace of progress, but also to identify when progress occurs in the wrong direction or with questionable motive. Thinking of equality as a component of population health is of the utmost importance.