**Title**

Deserving Abandonment: Governing Pain and Addiction across U.S. Opioid Landscapes

**Author**

Textor, Lauren M

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# Deserving Abandonment:
# Governing Pain and Addiction
# across U.S. Opioid Landscapes

A dissertation submitted in partial satisfaction of the
requirements for the degree Doctor of Philosophy
in Anthropology

by

Lauren Textor

2022

# ABSTRACT OF THE DISSERTATION

## Deserving Abandonment:
## Governing Pain and Addiction
## across U.S. Opioid Landscapes

by

Lauren Textor
Doctor of Philosophy in Anthropology
University of California, Los Angeles, 2022
Professor Philippe I. Bourgois, Co-Chair
Professor Laurie K. Hart, Co-Chair

Abstract: My dissertation focuses on mechanisms of abandonment, marginalization, and punishment produced in the name of care through biomedicalized responses to "opioid crisis." I examine exacerbation of abandonment as an effect of new state-mandated oversight of opioid prescribing and dispensing on patients seeking opioid-related care for pain, addiction, or both. I draw on immersive ethnographic research in a public hospital system and a largescale encampment in California, as well as interviews of patients and addiction treatment providers in New York City. Building on prior research that documents two tiers of drug law enforcement in the U.S., I examine how two tiers are produced and maintained not only by segregating individuals *into* punishment through spatially structured enforcement and criminalization, but also by segregating people *out* of treatment. I examine how individuals and communities come to be segregated out of treatment and abandoned through *state and capital investments in science and health care*. In particular, describing the intersections of bureaucratic mandates, biomedical constructions of risk enacted through guidelines, policies, clinical decisions, the circulation of paperwork, the embodiment of moral reasoning, and the encroachment of drug law enforcement, I document the enactment and legitimization of patient discharges from public health care settings. Finally, I examine how people's historicized and embodied relationships to state power affect the efficacy of buprenorphine as a treatment for opioid dependence. I propose that targeted state support for pharmaceutical interventions in response to social suffering can be understood as a mechanism of organized abandonment through investment.

The dissertation of Lauren Textor is approved.

Helena Hansen

Christopher J. Throop

Salih Can Aciksoz

Philippe I. Bourgois, Committee Co-Chair

Laurie K. Hart, Committee Co-Chair

University of California, Los Angeles

2022

# Table of Contents

## List of Figures

## Glossary

CDC: Center for Disease Control
CURES: Controlled substance Utilization Review and Evaluation System (California PDMP)
MAT: Medications for Addiction Treatment
PCP: Primary care provider
PDMP: Prescription Drug Monitoring Program

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# Lauren M. Textor

## Education

Lauren Margaret Textor graduated from the University of Pennsylvania in 2010 with a Bachelor of Arts in Anthropology and Philosophy of Science, graduating Magna Cum Laude. In 2014, supported by the David Geffen Medical Scholarship, Lauren joined the UCLA Medical Scientist Training Program (MSTP) in the newly established Social Sciences Track as an MD/PhD candidate in anthropology.

## Grants, Fellowships and Awards

2021-2022 UCLA Dissertation Year Fellowship ($20,000)
2021 Honorable Mention, National Institute for Drug Abuse, "Mapping Patient Journeys in Drug Addiction Challenge" (Ventura County Medical Center Primary Care Addiction Fellowship)
2014-2021 Geffen Scholarship ($32,000 with 3% annual increase)
2011 Minnesota Statewide Health Improvement Program (SHIP) Grant
2010 Phi Beta Kappa
2009, 2010 University Scholar Summer Research Grant, University of Pennsylvania
2018-2010 University Scholar Award, University of Pennsylvania

## Publications

**Textor, Lauren**; Ventricelli, Daniel; Shoshana Aronowitz. 2022. "'Red Flags' and 'Red Tape': Telehealth and Pharmacy-Level Barriers to Buprenorphine in the United States," *International Journal of Drug Policy,* (105)1: https://doi.org/10.1016/j.drugpo.2022.103703.

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**Textor, Lauren**; Tiedje, Kristina; Yawn, Barbara. 2013. "Mexican and Somali Immigrant Breastfeeding Initiation and Counseling: A Qualitative Study of Practices," *Minnesota Medicine*, 96(12): 46-50.

## Research

**David Geffen School of Medicine and Department of Anthropology, UCLA** 2017 - 2022
Faculty Advisors: Philippe Bourgois, PhD; Laurie Kain Hart, PhD

- Ethnographic project on violence of medical logics and state bureaucracy in the opioid epidemic, documenting enforcement against opioid prescribing/ dispensing and effects on patient and physician subjectivities across clinical settings and in a largescale encampment in California

**NYU School of Medicine** 2019 - Present
PI: Jennifer McNeely, MD, MSc

- Interviewing patients and staff members of a pilot program initiating medication-assisted treatment (MAT) for opioid use disorder during inpatient hospitalization in public hospitals
- Examining frameworks of addiction and recovery amongst residents of the South Bronx in historical comparison to radical health movements initiated by the Young Lords

**David Geffen School of Medicine at UCLA, Department of Psychiatry** 2015- 2018
Research Mentors: Eraka Bath, MD; Roya Ijadi-Maghsoodi, MD

- Conducted focus groups and interviews with children who survived commercially sexual exploitation (CSEC) on health needs and barriers to health care

- Analyzed data, co-authored abstracts and manuscript

**Olmsted County Medical Center**, 2010-2013

Research Mentors: Barbara Yawn, MD; Kristina Tiedje, PhD

- Conducted focus groups, interviews with immigrants from Somalia and Mexico on breastfeeding education in clinical settings, analyzing institutional racism in a Midwestern county hospital
- Analyzed data, co-authored abstracts and manuscript
- Developed educational tool on breastfeeding responsive to Somali immigrant patient needs

**University Scholars Research Program, University of Pennsylvania** 2008- 2010

Research Mentor: Deborah Thomas, PhD

- Completed ethnographic research project on the political economy and racial formations of Ethiopian immigrants to Philadelphia and the prevalence of suicide in the immigrant community

## Teaching Experience

- Facilitator, Structural Racism and Health Equity Theme, "Antiracist Positionality in the Clinic," David Geffen School of Medicine, 15 medical students May 2022
- Guest Lecturer, Harm Reduction Los Angeles, 70 medical students Jan 2022
- Instructor and Facilitator, UCLA Integrated Substance Abuse Program Quarterly CME, "Structural Racism, the War on Drugs, and Health Equity in California" 2021
- Guest Lecturer, Medical Anthropology, course with 30 undergraduate students Oct 2018
- Instructor, Founder, Critical Bioethics Selective Course, 30 medical students 2015-2016
- Guest Lecturer, Undocumented Health, David Geffen School of Medicine, 200 students 2015

## Presentations, Invited Lectures, Conferences

**Textor, Lauren** "'They expect you to be both pharmacist and police detective': U.S. Drug Policy and Pharmacy-Level Barriers to Buprenorphine Access," presentation at 2021 UCLA-Caltech Medical Scientist Training Program Annual Research Conference, Sept 21, 2021.

**Textor, Lauren** "Addiction Clinic Telehealth Implementation during COVID-19: Effects of Telehealth on Total Visits and No-Show Rates," Ventura County Addiction Clinic, June 15, 2021.

**Textor, Lauren** "Intravenous Places: Addiction, Race and the Production of Safety and Risk in the U.S." in Panel: "Whiteness and its Fractures in the Opioid 'Crisis,'" podium presentation at the American Anthropological Association Annual Meeting, Vancouver, Nov 2019.

**Textor, Lauren** and Khan, Tipu "State Surveillance, Opioids, and Risk: Emerging Subjectivities in the United States 'Opioid Epidemic,'" podium presentation at the National Conference for Physician Scholars in the Social Sciences and Humanities, April 7, 2019.

Ijadi-Maghsoodi Roya, **Textor Lauren**, Barnert Elizabeth, Cook Mekeila, Gaboian S, Bath Eraka, "Understanding Commercially Sexually Exploited Youths' Mental Health Needs and Experiences with Accessing Mental Health Care," abstract presented at: American Public Health Association Annual Meeting, Denver, Colorado, October 2016.

## Community and Leadership Experience

**Ventura County Syringe Exchange Volunteer,** Ventura, CA 2018 – Present

- Volunteer at Ventura mobile syringe replacement program run by the Department of Public Health, distributing sterile syringes and supplies, naloxone kits, and overdose reversal education

**Backpack Medicine Outreach Team,** Ventura, CA 2019-Present

- Provide outreach medical services, addiction care in semi-permanent encampments

**UCLA Mobile Clinic Primary Care Liaison**, West Hollywood and Santa Monica, CA 2014-2016

**Organizer, National Clinician Scholars Conference,** "Practicing Care in Syndemic Times," 2019-2022

**Admissions Committee Member,** UCLA MSTP 2017-Present

**Co-Founder, UndocuMed, Students and Allies,** UCLA David Geffen School of Medicine 2014-2016

- Led student group on fundraising efforts for undocumented medical students and to educate medical community about undocumented health care needs

# Introduction

"*I don't want to sound mean*," the resident pediatrician confides to me one morning, "*but I think Andrea might like morphine*." The resident, thinking out loud, is offering to teach me something about how she evaluates her patients. I look at the pediatrician with what I hope is a demure look of curiosity and ask, "*Who wouldn't like morphine*?" I wonder: why does the resident think she might sound mean (or cruelly judgmental) in saying this? How does deriving pleasure from morphine signify, to this resident, a moral failure?

As a medical student rotating on a pediatric ward of a county hospital in Los Angeles, California, I helped to admit Andrea, a 19-year-old African American girl who had been shot twice in the back 10 days ago while attending the vigil of her recently murdered friend. Andrea was bright, outgoing, and funny, and suffering from shooting pains from gaping wounds after surgeries to remove the bullets as well as her spleen. I had helped her be admitted to the hospital for "poor pain control" and presented her case to my attending, aiming to impress. When I described her "social history," the place in the medical presentation that ostensibly makes room for patients' social context, I divulged Andrea's history of an unwarranted prior arrest and a short stint in foster care. At this point, my attending physician interrupted my presentation. I sat in dismay and flustered embarrassment as my attending immediately reacted to her story with suspicion. "*When someone says they were arrested but that they didn't do anything wrong, they are lying,*" the attending told me. She added that she had met Andrea's mother momentarily in the hallway just a moment ago, and she seemed like a "good, church-going woman," adding that Andrea must have done something bad to be placed in foster care. In that moment, my attending set the tone for Andrea's stay in the hospital. After that, the medical team treated Andrea with an aura of accusation and self-defensive reactiveness. My intern told me that after the attending weighed in, she felt like she had been "played" by Andrea: "*She was saying stuff that I believed*," she said. Overnight, Andrea's medical team stopped all opioid orders for management of her pain, and she was forced into severe opioid withdrawal, having developed an iatrogenic dependence on morphine. After she was rapidly discharged still dependent on opioids and with significant gaping wounds in her back, the attending physician was relieved to be rid of her, having satisfied the service utilization review assertion that the patient no longer needed inpatient hospitalization.

- Field Note, 2017

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In a South Bronx church, a community dialog meeting is held in October 2019. City Councilwoman Diana Ayala addresses about 75 people. Amongst the audience are community members, employees and volunteers from agencies providing services in the surrounding neighborhoods, along with eight NYPD officers. On my walk from the train station to the meeting, about four blocks, I pass dozens of people on the street injecting heroin. Many others sit or stand holding signs on the curb. Outside the church, I pass an NYPD squad car that has left its lights flashing.

Councilwoman Ayala says addresses the people in the room:

*"How do I represent a community and not know that this is happening? This has become our normal. But it isn't normal. We are in the middle of a very unique crisis. ...*

*"I have noticed in my community a lot of resentment… There has been a lot of resentment in the black and brown community. They felt like the opioid crisis has always been a part of us. 'Now it's affecting White America and all of a sudden you care?' And that was what I was hearing. And so. This is killing black and brown people. But we're not paying attention because*

*we're so focused on the… being appalled. By the fact that now all of a sudden people were not being incarcerated, they were being helped. While we had spent years incarcerated. And we were distracted by that and we didn't realize that… I'm sorry to inform you, but the South Bronx, has the highest number of opioid related deaths. In the last two years we've been kind of going up and down… meanwhile people are dying."*

*"What is the action plan here?..."* Councilwoman Ayala explains that a year ago the mayor released the Bronx Action Plan aimed at combatting the Opioid Crisis by: increasing innovative programs to connect people who use drugs to care and services; expanding community supports to increase connections with people who use drugs; expanding efforts to engage people who use drugs in parks and public areas; expanding ongoing syringe clean-up; and increasing awareness about the dangers of fentanyl and the availability of medications for addiction treatment. Councilwoman Ayala highlights the CATCH team as one of the innovative programs being implemented. CATCH is a new inpatient addiction consult team at Lincoln Hospital aimed at starting patients on medications for addiction treatment and connecting them to outpatient follow-up care. I am currently engaged in qualitative research on the implementation of this consult service and am surprised to hear it mentioned, because the lead physician on the team told me he had written Councilwoman Ayala an email to try to meet with her and inform her about the largely unaddressed problem of addiction and overdose in the district, and she had sent a dismissive reply stating that she did not have capacity to meet with him.

*"We did other things,"* she continues. *"We worked with the 46th precinct."* She describes a high concentration of drug users in an area affecting a specific housing development. She emphasizes that the police are doing great work. *"We in no way think that we should police our*

*way out of the Opioid Crisis. We don't believe that people who have drug addiction should be incarcerated, they need help. But having said that, I'm also a human being and I am in this community that's been impacted and I also understand that we have a responsibility to the community as well to ensure that while we're giving out clean needles so that we're preventing the spread of HIV and hepatitis C, that we are then not allowing another public health crisis to happen by allowing individuals who are using those needles to discard them improperly and then expose our children and expose any of us. So we started doing cleanup."*

Councilwoman Ayala explains that *"part of the reason our area is so bad is that we have resources that are not in other areas."* Services here draw people who use drugs from other areas, she explains. She then passes the microphone to an NYPD officer to describe recent policing efforts. *"We started with the Hub,"* he says, referencing the enforcement his team was doing at the 149th Grand Concourse. *"One of the side effects of that was displacement. People have moved to other areas."* In summary, he describes, we are in a *"tricky position of enforcement and treatment."* Users have moved down to the street right outside of the church where we are meeting.

- Field Note, October, 2019

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## Opioids and Crisis

How has biomedicine, as a locus of state intervention, shaped opioids in "crisis"?

This dissertation lays out field notes taken between 2016 and 2022 and offers preliminary thoughts on how they might be understood in relation to this question. How might health care responses to the opioid epidemic come to constitute a locus of drug law enforcement and of racial capitalism? I ask how these relations coalesce in clinical encounters to produce and exacerbate abandonment and punishment. Rather than focusing on the overprescribing of opioid pills, the dominant lens through which causes of 'opioid crisis' are often analyzed and portrayed in popular culture and news (c.f. (Case & Deaton, 2015; Jarecki, 2021; Vance, 2016), this ethnographic research documents the increasing restraints on licit opioid prescribing that were already the norm by the time I began fieldwork, along with some of the impacts of these restraints on both people who use opioids and on health care providers, in particular, physicians and pharmacists.

The application of theories of the state and racial capitalism can help to illuminate less visible effects of drug law enforcement and racialized ideologies in spaces such as clinics and hospitals. These theories suggest that the opioid epidemic is structured by health care, though not exactly (or exclusively) in the ways that prevailing narratives have proposed. In fact, two dominant assumptions in political and popular discourse concerning the opioid epidemic are unraveling: first, that opioid epidemic predominantly concerns White people, and second, that because White people are affected, opioid use is now treated with care and kindness rather than criminalization and incarceration.

By now it is well known that in the early years of opioid overdose epidemic, White populations showed higher increases in overdose rates compared to some Black and Latinx populations. These early years were accompanied by an explosion of discourse surrounding a "white opioid crisis" (Foucault, 1980; Netherland & Hansen, 2017). Yet overdose rates increased for nearly all races and ethnicities, and the fastest rising rates of overdose are now in Black and Brown neighborhoods such as in the South Bronx. Still, in popular and political discourses one hears, "*Now it's affecting White America, all of a sudden you care*?" This begs the question: care for whom? What kind of care?

The U.S. state's capacity to arrest, immobilize, enforce, and expel has expanded within spaces of health care, as drug law enforcement aims to curtail both licit and illicit opioid supplies. In this dissertation, I describe how targeted investments in treatment, such as the expansion of support for the pharmaceuticals buprenorphine and naloxone, are contextualized by large divestments from marginalized communities since the 1970s that have endangered people's ability to access meaningful care. As a result of such dispossession, some—but not others—are subjected to group-differentiated vulnerability to premature death—what Ruth Gilmore defines as racism (R. W. Gilmore, 2002). This dissertation asks why and how state investments and divestments in the opioid epidemic, allocated through determinations of deservingness, serve to reproduce and augment racial ideologies and social inequalities.

While Councilwoman Ayala stated, "*in no way do we believe we can police our way out of the opioid crisis*," at a meeting for "community dialog," the group most visibly and numerically represented was the New York Police Department, who reported on their recent drug law enforcement efforts within the neighborhood. Gilmore conceptualizes the anti-state state as a structure that, in crisis, "grows on the promise of shrinking" (R. G. Gilmore & Gilmore, 2007). In such a moment, both state institutions and social relations are reorganized toward a more punitive basis in the name of managing what is represented as an acute period of social disorder. This dissertation builds on this premise to ask how the "opioid crisis" legitimizes the expansion of punishment on the promise of expanding treatment, and to what effects.

Two tiers of drug policy and enforcement in the U.S. have been observed: one that recapacitates individuals and returns their claims to citizenship, and the other which disenfranchises through abandonment and punishment (Alexander, 2020; Herzberg, 2017). Bipartisan calls for treatment, decriminalization, and drug policy reform have coincided with well-documented disparities in both diagnosis of pain and in treatment of opioid addiction that persist across race, class, and gender. Given this climate, how does criminalization, punishment, and abandonment from treatment continue to persist for some? By taking an ethnographic approach to these questions, I ask how- through what technologies, practices, rationalities, ideologies –inequalities are produced, reproduced, and worsened, even after such disparities are identified, described, and resources are allocated to reduce them.

## Spatialization

The chapters of this dissertation are broadly organized around different spaces where care related to opioids is said to occur: primary care clinic, addiction clinic, pharmacy, and encampment. Many spaces haunt these ones: jails, prisons, homes, hotels, rehabs and recovery programs, as well as other health care spaces like emergency departments and hospital wards. Several vignettes are woven between chapters to signal to the importance of these other spaces in shaping the lives of my interlocutors. Deservingness of care in one setting often hinged not just on the present but on imagined, spatialized, pasts and futures: as the first vignette above showed, a prior night in jail due to being "in the wrong place, at the wrong time," was enough to seal Andrea's fate in being labeled undeserving and criminal, and ultimately led to her forced opioid withdrawal and discharge from the hospital. This dissertation inquires into how the meanings of opioids, and of pain and addiction, are shaped by space. Kinds of care opened or closed to my interlocutors were contingent on the spaces they were tracked into or out of, as well as the social location they occupied.

This dissertation attends to multiple axes of space: at the level of the body, the institution, the social body, and the body politic (Scheper-Hughes & Lock, 1987). Along the spatial axis of embodiment, I ask how binaries of inclusion and exclusion, licit and illicit, are produced and reproduced. The politics of the intravenous needle, for example, demonstrate the production of binaries of safety inside and danger outside. While intravenous ‘access’ in the form of a needle in a patient’s vein is considered reasonable and safe within a hospital, when a patient walks outside the hospital with an intravenous line still in place, the danger is considered paramount. Socially sanctioned rituals of bodily intrusion with hypodermic needles are spatialized primarily to the hospital, demonstrating the boundaries of biomedicine’s technological gifts. This dissertation explores how forms of opioid related discourse, knowledge, enforcement and care come to be spatialized and embodied. While the hospital is conceptualized as a space for care to occur, it is also a place where violence happens; similarly, although the encampment is a space conceived of as a dangerous place, not just for drug use, it is also often a space of safety and solace for people who use opioids. In this dissertation, I trace how spaces where opioids circulate are socially produced, conceived of as supervised or unsupervised, safe or dangerous, caring or harming, licit or illicit, while through experience such binaries often break down in each space.

A thorough examination of what happens to people in spaces where care is said to occur is helpful for several reasons. First, the study of health care settings can reveal the workings of state power. Attending to opioid-related care, in particular, touches upon the way the state intervenes on aspects of everyday citizenship, including the recognition of pain, deservingness for capacitation and relief from suffering, and abandonment or punishment. Second, it helps to identify what the lived experience of “care” looks like within and across space, revealing how boundaries of deservingness and mechanisms of abandonment and punishment are implemented through social and physical location and the construction of space. Finally, attending to embodied experiences can identify and offer potential avenues for providing meaningful, transformative care.

## Caring state: abandonment through investment?

Ethnography focused on the anti-state state can add nuance to anthropological theories of abandonment proposed by scholars such as Povinelli and Biehl. These scholars focus on forms of abandonment as key effects of neoliberalism that dismantle social welfare projects and increasingly download responsibility for the self onto the individual (or, for Biehl, the family, which then abandons the unproductive individual) (Biehl, 2005). To expand on this concept, I ask how we might conceptualize abandonment and disenfranchisement in a way that also contends with state *investments*. How do we hold both divestment from social welfare, and investment in punishment and in targeted forms of care together? While the term abandonment often conjures up a sense of passivity, lack of agency, and "dumping" (Biehl, 2005) leading to descriptions of abandonment as an effect or an aftermath, here I ask, through what effortful actions and processes is abandonment produced?

Exploring the various ways a 'spatial fix' works as a technology of abandonment, I examine the emergence of specific, targeted investments, mostly in state-mediated increases in access to biomedical pharmaceutical treatments for addiction occurring amidst simultaneous contraction of the biopolitic worthy of care. How do both abandonment and punishment constitute a 'spatial fix,' producing new, spatialized markets through exclusions?

At least peripherally, large investments are visible in the production of abandonment when it comes to opioids. This dissertation attempts to examine some of these investments at a granular level. Billions of federal dollars are annually poured into efforts to address the opioid epidemic, including into medications for addiction treatment, recovery programs, research, and law enforcement, while overdose deaths continue to climb. One report estimated that federal

Medicaid spending on buprenorphine alone in 2018 was over $917 million, compared to $380.9 million in 2011 (Herzberg, 2020). Chapters 3 and 4 focus on documenting some of the impacts of the state investment in buprenorphine. Outside of spaces explicitly designed for biomedical care, the medicalization of homelessness, which portrays the problem of housing as a problem primarily caused by drug addiction and mental illness, has coincided with the rise of public and private investments in the management of the "housing crisis." Chapter 5 begins to consider what these investments mean for people who use opioids in encampments.  Nonprofit organizations and government-run agencies have grown into a large enterprise funded to treat the addicted unhoused, provide outreach, and exert "tolerant containment" (Gong, 2019) over people within encampments, spaces that are neither eliminated nor fully criminalized (Herring, 2014). In the process, many jobs are produced within a sector attempting to 'care' for the unhoused and addicted, while the unhoused are nonetheless not housed, nor meaningfully cared for, nor do they ultimately gather more resources. Encampments, as a manifestation of abandonment, could be conceptualized as a site of capital and ideological investment that reproduces the idea of the state as caring.

## Methods and Positionality

This dissertation is based on five years of ethnographic fieldwork in public hospital systems in Ventura, California and New York City, and one year of fieldwork in a largescale encampment in Ventura.

In California, I began by observing patients and physicians in emergency departments, clinics, and on hospital wards. I also became a volunteer on an outreach medical team that provides medical care especially focused around addiction treatment within the encampment, and volunteered with a mobile syringe replacement program next to the encampment. I verbally consented patients and physicians to observe single encounters in health care settings. For those participants that I followed after a single visit, I obtained written consent. I then followed patients to each subsequent health care visit thereafter, and met them outside of health care settings for in-depth semi-structured interviews. For physicians that I observed for more than single encounters, I likewise obtained written consent and conducted in-depth semi-structured interviews.

I also observed meetings held by a Countywide task force consisting of law enforcement officers and parole officers, public and behavioral health representatives, methadone clinic and addiction clinic directors, physicians, educators, and representatives from the County's managed care team, that aims to address and prevent opioid misuse and overdose. I conducted interviews with many members of the task force.

In New York City, I conducted interviews with staff members from the CATCH team: Consult for Addiction Treatment and Care in Hospitals. Implemented in six public hospitals in the city, I observed the care they provided and interviewed patients who received addiction treatment while admitted to the hospital as well as after discharge as patients received follow-up services at the Lincoln Recovery Center. Semi-structured interviews with staff and patients were audio-recorded and transcribed. While more in-depth ethnographic participant observation research was planned, following patients long-term after involvement with the CATCH team, the onset of the COVID-19 pandemic prevented me from completing this portion of the research.

This research was approved by the UCLA Institutional Review Board, the Ventura County Medical Center IRB, as well as by the NYU IRB.

The events described in the first vignette above, from an inpatient pediatrics hospital ward in a public hospital, shaped my entry into this project. My sense was that my presentation of a patient's social history had backfired, leading to punitive care. The experience made me question my role in doing violence through medical care, and my experience of arguing with members of Andrea's care team made me want to explore how clinical deservingness is shaped and determined at a granular level. The experience also taught me about my multiple roles as medical professional, ethnographer, and advocate in health care spaces. Throughout my fieldwork, I was aware that physicians understood me primarily as a medical student, and occasionally had difficulty viewing me as a researcher. As a physician-in-training, I am invested in the "culture of power" (Nader, 1972) that biomedical knowledge produces and enacts, even while critiquing it. In researching both physicians and patients, one of my aims was to "study up" (Nader, 1972) and to access physicians' hidden transcripts (Scott, 1990) that reveal their reflections on, and internal struggles against, their professional roles.

## Outline of Chapters

My focus in the first two chapters is to highlight that the two tiers of drug war in the U.S. (Herzberg, 2020) are not only produced by segregating poor, Black and Brown people *into* punishment through spatially structured enforcement and criminalization (Alexander, 2020), but also by segregating people *out* of treatment. How individuals and communities come to be segregated out of treatment and abandoned through *state and capital investments in science and health care* is a key question driving these chapters.

The first two chapters come under the umbrella signifier, "Discharged," tracing patient discharges from primary care clinics. Chapter 1 is entitled, "Tracing the Backlash Against Opioid Prescribing in Primary Care Clinic: Constructions of Risk and Deservingness in Scientific Knowledge Production." This chapter explores how physicians and patients wrestle with affective entanglements, moral panic, and institutional and structural constraints shifting under the weight of the "opioid crisis." Despite the mainstream narrative that opioid addiction is no longer conceived of as a crime and should be treated as a disease, in clinical spaces, this narrative was not translating into the compassionate envelopment of poor patients into forms of care for opioid dependence. Instead, physicians are frustrated and frightened by state guidelines and policies surrounding opioids, and suspicious of patients presenting with pain or with opioid dependence. I trace the ways designations of patient "deservingness" are produced both discursively via the circulation of scientific guidelines and within clinical encounters.

The second chapter, entitled "Checking the Monitors, Wearing the Hats: Physicians Enacting the Discharge," continues to follow patient discharges. This chapter focuses in on physicians' embodiment of the repressive state apparatus in rationalizing and legitimizing the violence of patient abandonment. I trace objects and technologies of drug law enforcement that circulate within the clinic and the atmosphere of suspicion produced through these objects. The omnipresence of the prescription drug monitoring report is described as a key factor in physicians' subjectivity formation and decision-making as well as in the discursive and material production of "doctor shopper" patients. I describe the erasure of patients' recognizable pain as physicians recognize a clinical and epistemic bind requiring them to wear a specific "hat," choosing to treat either pain *or* opioid addiction but not both.

Chapter 3, "The Sacred Object of Buprenorphine: Addiction Clinic and the Embodiment of Deservingness," travels into addiction clinics where many patients who use opioids but were discharged from primary care landed. This chapter examines the embodied effects of buprenorphine, a newer medication prescribed for opioid use disorder, on differently positioned patients. Examining state and medical investments in buprenorphine and lived experiences of it, I ask how buprenorphine can be conceived of as a fetish through which to comprehend the meaning of state power. I suggest that a patient's embodied experience of buprenorphine is deeply influenced by their past, by their lived relationship to the specter of the state and to biopower, and to competing frameworks such as faith-based recovery programs. Finally, I inquire into the role of physicians in addiction clinics. Documenting their practices that "flip the script" of addiction diagnoses (Carr, 2010), I ask how harm reduction values are entering into clinical spaces, shifting meanings of both care and harm reduction.

Chapter 4, "'Red Flags' and 'Red Tape': Bureaucratic Holds on Buprenorphine at the Pharmacy," continues to track the opioid buprenorphine into the pharmacy. Disparities in access to the medication for addiction have persisted despite numerous policy changes aimed at addressing these disparities. Moving beyond a description of "barriers to medication access," I explore historically and politically contingent experiences of *waiting,* both by patients and by physicians, to examine *how* the pharmacy operates to produce possibilities for care or abandonment for particular people seeking relief through buprenorphine. Through these stories, I argue that waiting on pharmacists is constitutive of the situation of drug war. Criminalization of opioids is reproduced once again through discourses promoting decriminalization and treatment. Funding for the Drug Enforcement Administration expands, and new divisions form to investigate within health care settings. I suggest that the state here produces a 'spatial fix' by producing a new terrain in which to fund repressive interventions, including within pharmacies and primary care clinics.

Chapter 5, "Outside Care: Probing Outreach, Policing, and Belonging," shifts locations to a large encampment where many of my interlocutors in Ventura resided. This chapter serves as an epilogue to this dissertation. In the midst of an opioid pressure-cooker expelling people from spaces of health care, I follow interlocutors to better understand how people are surviving outside: out of institutionalized health care, without licit opioids, and literally outside. This chapter is an attempt to open the door to alternative possibilities for care. Following interlocutors to their residency in a largescale encampment where they care for one another as well as for outreach workers claiming to care for *them,* I describe ways that people are finding to survive the arrival of highly lethal fentanyl in the drug supply. I describe two older residents' observations related to opioids, law enforcement, and the privileges of living in this community. A ready, cheap, and accessible supply of illicit opioids that they use together often provides a reprieve from high-pressured demands of bureaucracy, institutions, poverty, and police harassment. Rather than argue for definitive conclusions here, this final chapter dwells on ethnographic field notes to ask what taken-for-granted assumptions related to opioids, housing, and intervention might be called into question by struggles for meaningful care.

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# Chapter 1

## Discharged, Part 1.

## Tracing the Backlash Against Opioid Prescribing in Primary Care Clinic: Constructions of Risk and Deservingness

"*You need to listen to your patients*," Carlos, a patient tells me several times. He has come to the emergency room for chronic pain that he has recently been unable to get treated through his primary care doctor. "*I know what I need. But the thing is, it's hard to get the point across without offending the doctor*," he says, whispering the last four words. He tells me the relationship between doctors and patients, when it comes to pain, has gotten worse and worse in the last few years. It is almost too exhausting to talk about, he tells me. I ask him what he thinks that will mean for people with pain. He replies, "*Do you want me to say it in one word? Death.*"

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## Introduction

In this chapter and the next, I document patient discharges amidst ongoing backlash against opioid prescribing in primary care clinics. These two chapters examine how patient abandonment and discharge is legitimized and implemented through the imbrication of scientific knowledge production and drug law enforcement.

I describe increased pressure and regulation placed on physicians to reduce licit opioid supplies alongside the production of new kinds of knowledge surrounding opioid use, including CDC guidelines on opioid prescribing for pain as well as studies on the treatment of opioid use disorder. This chapter traces the ways that designations of patient "deservingness" are produced both discursively via the circulation of scientific guidelines and within clinical encounters. A key premise here is that the study of biomedicine, clinical care and clinical research are key to understanding the meaning of the 'state.' Here, I complicate divisions between repressive and productive forms of state power, looking to clinical encounters to show how categorical imperatives in diagnosing, treating, and defining patients conjoin with repressive drug law enforcement technologies to produce abandonment. In doing so, I advocate for examining health care spaces as key sites where everyday functions of the state are rendered visible for analysis.

My focus here is on highlighting that the two tiers of drug war in the U.S. (Herzberg, 2020) are not only produced by segregating poor, black and brown people *into* punishment through spatially structured enforcement and criminalization (Alexander, 2020), but also by segregating people *out* of treatment. How individuals and communities come to be segregated out of treatment and abandoned through *state and capital investments in science and health care* is a key question driving these chapters.

Ethnographic data center on a primary care clinic in a public health care system serving low-income patients with Medicaid insurance, many of whom have chronic pain. I combine ethnographic vignettes in clinics with additional participant observation data from stakeholder meetings with county-level insurance providers and policymakers, and finally, a critical analysis of scientific guidelines and studies of opioid-related care.

In this chapter, I explore how *risk calculations* are key mechanisms through which patients are segregated out of care spaces. This chapter focuses on risk calculations constructed in the 2016 Center for Disease Control (CDC) guideline for prescribing opioids for chronic pain, as well as the construction of risk discussed in several studies on the treatment of opioid use disorder. I examine how clinical guidelines on the use of opioids for pain tend toward the *universalization* of risk in ways that lead to increasingly restrictive criteria for opioid deservingness. By examining the scientific discourse in the guideline alongside the implementation of the guideline in clinical spaces, I offer a critical analysis about the ways that scientific data are mobilized to produce and reinforce a racialized biopolitics of incapacitation.

Scientific evidence does not always serve to universalize. In the final section of this chapter, I examine how scientific studies of treatment for opioid use disorder do important work to divide opioid use into discernible ‘sub-types’ that implicitly reinscribe specific kinds of White opioid use as legitimate. These sub-divisions reinforce the drive to allocate health care resources to White, well-resourced patients without naming whiteness as a factor. Here, I argue that scientific studies create subsets of opioid use that can be used to shore up boundaries of white privilege. Moreover, scientific knowledge production mirrors clinical care in that it privileges categorical simplicity over patient complexity. This kind of epistemic bind drives the benefits of novel scientific advancements toward those “straightforward” or “uncomplicated” patients who are already recipients of societal privilege. By combining analysis of ethnographic data within clinics with an analysis of recent scientific studies on opioids, I examine how patients who use opioids are constructed to fit into diagnostic and treatment categories, as well as the political economic pressures to produce ‘good outcomes’ that impact treatment trajectories.

Throughout this chapter and the next, ethnographic vignettes reveal how patients come to be legible to physicians and to the medical system *either* as a ‘pain patient’ *or* as an ‘addiction patient,’ and such diagnostic categories shape how patients’ individual selves, feelings, and futures are read and understood by physicians. I describe how patients have often been conceptualized and treated as one or the other ‘kind’ of patient based primarily on which diagnosis is projected onto them first in time—a determination impacted by their social and physical locations and structured by their race, class, and gender. Thereafter, this categorization travels with them through space and time, focusing the biomedical gaze narrowly upon the category assigned and shaping their care and opioid trajectories.

Amidst the current backlash against opioid prescribing, access to treatment for chronic pain, and the insurance-covered options for opioid-based treatments of pain, have profoundly narrowed. In response, several patterns emerge. First, the clinic becomes visible as a key site for categorizing patients and determining deservingness. Second, clinics also become sites of rescue for physicians' moral credibility in the opioid epidemic. Self-reflexive primary care physicians acknowledge that they encounter epistemic binds and practical constraints when faced with simultaneous pain and addiction and cannot treat both from the same physical location. Practicing authorized forms of risk reduction within the clinical encounter helps physicians to claim moral accountability in the opioid epidemic and to exonerate themselves, and biomedicine writ large, by demonstrating a corrective course. Finally, physicians acknowledge that their self-defensive risk reduction practices and specialty-focused constraints are problematic for patients, but remain willfully ignorant to the consequences of their own practices for patients' lives, a privilege enforced by spatial segregation of 'kinds' of patients and through the documentation of broken 'pain contracts' to discharge patients deemed unruly or deviant. Clinicians rationalize the withdrawal of care as necessary and ethical because it fulfills their sworn oath not to do harm. But by following one patient through discharges from clinical care, we can see how the harms of care abandonment manifest just outside of spaces where the medical gaze is focused. These harms are traced to iatrogenic sources when patients return to emergency departments with bodies ravaged by attempts to survive medical abandonment. Such patients are then admitted for inpatient care, where they are subjected to expensive, state-of-the-art care that preserves their physical lives, but leaves them immediately unworthy of clinical care once again upon discharge.

## "Things Change": From 'chronic pain patient' to 'injection drug user'

*It started with collapse. A large armoire, a shove, and it toppled over, burying Susan underneath it, and crushing and fracturing her pelvic bones. She was in the hospital for months.*

*For many years now, Susan has lived with pain since the crush injury. Born and raised in Ventura County to White, working-class parents, she grew up exploring swimming holes and the local hot springs and married a local man who loved the same music she did, with whom she had three children, two sons and a daughter. All of her children still live in town and her eldest son, an electrician, helps her to pay for her small apartment in which she now lives alone. Her twin sister lives nearby and visits frequently. She has always had a keen sense of vintage fashion and after her divorce from her husband, she began working at one of the thrift stores that are a staple of the downtown commercial corridor in Ventura. It was while working there more than eight years ago that she suffered her initial crush injury. She spent several months in rehabilitative care re-learning to walk. After the injury, she could no longer work at the thrift store, unable to do the heavy lifting required. She qualified for disability benefits, and was prescribed opioid medications during her rehabilitation. She practiced physical therapy after going home from her rehab. By the end of her recovery, she was prescribed a regular dose of Opana, an opioid medication that she took in extended-release form, prescribed to her by her primary care physician, Dr. Thomas, a man she describes as kind and who practices about a 10-minute drive from where she lives. For many years, her treatment was the same dose of medicine, which consisted of 90 millequivalents of morphine, which she took at the same time in the day, and her pain was kept mostly at bay.*

*In 2017, however, things changed. Dr. Thomas told her he might not be able to prescribe her pain medicine anymore. He explained that he had "run into some trouble," and was currently under investigation by the Drug Enforcement Administration. A patient of his, for* *whom he had prescribed morphine and oxycodone, had also been receiving oxycodone from another physician simultaneously, and died of an accidental acute morphine overdose several months later. A subsequent investigation, per the record of the ensuing case brought by the Medical Board of California, showed that Dr. Thomas' record-keeping had been negligent. Per the record, Dr. Thomas had failed to order imaging on this patient, whom he was treating for chronic pain, nor had he referred her to specialty pain management, and he had not responded appropriately to the prescription monitoring information available, which showed that the patient had been prescribed opioids by another physician and filled them at several different pharmacies, "all indicators for abuse and/or diversion."*[1] *Dr. Thomas told Susan that pending the decision of the medical board, he might not be able to prescribe to her anymore, and she had better find a different doctor. He was open with her about what the investigation was about, and she thanked him for his kindness and his honesty.*

*Susan then found Dr. Anderson, who ran a pain management clinic closer to her apartment in Ventura. For a time, she managed her pain under Dr. Anderson's care. He prescribed her Oxycontin 30mg pills which she took every twelve hours, again an extended-release medication that helped her to function throughout the day. Having regularly prescribed medications to help manage her pain allowed her to help care for her two grandsons for part of the week, and she met them after school until her son and daughter-in-law came to pick them up. She took them to the ocean and on hikes in the foothills nearby. Under Dr. Anderson's care, she also tried some other pain treatments: epidural injections, which had no noticeable effect, a weaker opioid medication, Norcos, that gave her unwanted GI side effects without good pain*

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[1] To maintain confidentiality this case record will not be cited in the bibliography.

*relief, and acupuncture, which "did nothing" for her. She wasn't too concerned about these other interventions not working, because her regular opioid medication worked well for her.*

*But one day, Dr. Anderson told her that he could no longer accept public insurance and would have to switch to accepting only cash or private insurance. MediCal representatives had told him they would no longer cover his services as a pain specialty clinic. Since his office could no longer be reimbursed to see her as a MediCal patient, he told her that after her current visit, she would have 30 days to "figure it out."*

*Susan went to see yet another doctor nearby. But this doctor ran a urine toxicology on her which came back positive for marijuana. Despite marijuana use being legal in California, the doctor said he could not prescribe her pain medications because of this result.*

*Beginning to feel desperate, Susan asked her neighbor if she knew anyone from whom she could get pain medications. Her neighbor, who also suffers from chronic pain due to an injury from riding horses, gave Susan the number of a "famous friend" who could sell her opioid pills. Susan called him.*

*Sam, who drove to her apartment that day, offered Susan Oxycontin 30mg pills similar to those she had previously been prescribed, for $30 per pill. He offered other options: weaker Norco 10mg pills cost $5 a pill, fentanyl patches were $50 each, Oxycodone pills were $10 each. Even though Susan knew that Norcos didn't work well for her and bothered her stomach, she bought a few of them, unable to afford the expensive Oxycontin pills. With these, she was able to get by for a few days, uncomfortable, but without the worst symptoms of opioid withdrawal.*

*But the pills were only on offer temporarily. After a few days, Sam came by her apartment and told her that he didn't have any pills, but did have vials of morphine for $60 each. One vial, used via injection, he estimated, would last her about a week. While pills of the same* *kind prescribed by her doctor were her preference, the vials were the most cost-effective way offered to her to relieve her pain, and she reluctantly agreed. But she asked him to inject the morphine for her, because she didn't think she could do it herself. Before she would let him inject her, she gave him some extra money and asked him to go to CVS to buy clean needles for her, which he did. He came back a little while later with short needles that injected only under her skin and injected the morphine for her subcutaneously. Within 15 minutes, Susan felt the effects of the morphine, and the relief of her pain lasted about 12 hours. And she was able to avoid the throes of full opioid withdrawal. Once a day, Sam drove to Susan's apartment and helped inject into her lateral thigh with morphine. The next day, he injected into her opposite thigh.*

*After a few days, Susan noticed that Sam had brought, in addition to morphine, a browner substance, which he cooked on a spoon over a lighter. Knowing already, she asked what it was, and Sam replied, "Don't worry, it's just morphine mixed with a small amount of heroin." He explained to her that it was much cheaper than morphine alone. Two days after black tar heroin was added to the syringe, Susan's skin problems started.*

*The skin on Susan's thighs grew red, inflamed, and began oozing with abscesses. She endured the pain and inflammation for nearly a full month before she could no longer bear to try to manage it on her own. It was getting worse, and she began to have fevers and chills every day. Ashamed, she avoided seeking medical attention. But the entire thigh areas of both her legs swelled unevenly, with pockets of infection that were warm to the touch. Her legs spasmed painfully.*

*She called and made an urgent appointment with Dr. Thomas, her original primary care doctor. At his clinic, Susan told Dr. Thomas that she needed short-term help. She described her* *struggles to secure a physician who could treat her chronic pain. She didn't mention her recent injections of opioids, the abscesses in her thighs, or her fevers. Dr. Thomas sympathized with her difficulty finding a new physician. During his period of probation, Dr. Thomas had tried to have some colleagues take back their patients with chronic pain who had referred them to him in the first place, especially patients who were relatively straightforward to manage. Many had refused, telling him they had no intention of prescribing any opioids at all. So he wasn't surprised to hear about Susan's difficulties.*

*"Why didn't you contact me earlier?" Dr. Thomas asked Susan. He gave her three options for pain treatment: methadone, Norco, or Percocets. Susan's wasn't sure she would be able to feel like herself on methadone, and Norcos, she knew, still bothered her stomach. She accepted Percocets. The day that she got the prescription from him, she stopped injecting heroin.*

*But it proved too late. Her fevers worsened, and her legs only became more inflamed. She feared she would soon be unable to move, and, after avoiding it for as long as possible, she finally went to the emergency department.*

*Sitting with Susan in the emergency department, I watch as she winces each time her legs spasm, and frets over a spot of blood on her tie-dye skirt that comes from a draining abscess. "My skin is all scaly, like fish scales," Susan comments. It bleeds easily. The phlebotomist pokes her repeatedly trying to access a vein in her arm. To the emergency doctor who enters the room to take a history, she places her hands in front of her face, covering her eyes except for a small slit through which she looks out and says, "The first thing I want to say is that I am so ashamed to even be here."*

*As her work-up proceeds, she repeatedly considers leaving and returning home, worried that her children will find out what happened and won't allow her to be near her grandsons anymore.*

*A surgeon comes in to tell her they are going to take her in for surgery, and likely keep her in the hospital to get IV antibiotics until the redness clears. "Could I come back every day to get it?" she asks them. She does not want to sleep in the hospital, because she worries that her family will figure out what happened. They tell her that it will be hard to arrange optimal care for her that way. "I think we would be doing you a disservice," her surgeon tells her. After a discussion, she agrees to be admitted. "It's my fault, I have to own it," Susan tells me after they leave the room. "I hope they understand, my family cannot know."*

*"I just wish I could have found another pain management doctor," she tells me. "But you know, I understand the abuse of everything now." We talk about how many different treatments she has tried for her chronic pain: the epidural injections, massage, acupuncture. I ask her if anything worked, and she responds calmly, "No. But you just have to learn to live with certain things. One pill every 12 hours was the ideal regimen for me. But. Things change." – 2017*

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## Racialized Biopolitics of (In)capacitation

Here, I highlight the forms of structural violence that have shaped Susan's trajectory, focusing on the indeterminacy of structures by tracing how Susan's subject position was transformed rapidly, in part through state and biomedical interventions purporting to reduce opioid-related harms in the face of opioid epidemic.

Susan's trajectory arcs from having steady and privileged access to prescription opioids to increasing precarity as she is re-categorized from chronic pain patient to a high-risk opioid user who cannot find access to primary care treatment for pain. Several technologies contributed to this recategorization that I examine in detail below, including technologies of risk identification and mitigation through the production of clinical guidelines and prescription surveillance. Before delving into these mechanisms, I describe how Susan's positionality could be expected to shape her interaction with these technologies, clinicians' interactions with her, and by extension, impacted her opioid trajectory.

First, after her work injury, Susan was interpellated as an ideal candidate for opioid medications: a White woman and grandmother with access to health care, she represented the target market. White patients' pain is more often believed and treated than others' (Wailoo, 2014). White patients of lower socioeconomic status are more likely than patients of color to have health care access and clinically recognized pain (Anderson et al., 2009). They are also more likely than higher income patients to face occupational injuries (Poleshuck & Green, 2008). Lopsided opioid prescribing produced by racist (under)treatment of pain and racialized class disparities in health care access have contributed to a colloquially 'white opioid crisis' (Hansen & Netherland, 2016). Hansen et al (2023) have analyzed branded advertising materials to show that the "trustworthy" opioid patient was constructed through imagery of the White American grandparent, who was culturally considered highly unlikely to abuse drugs. Purdue Pharmaceuticals explicitly targeted older patients insured through Medicare, referred to as its "geriatric strategy" (Hansen et al., 2023; *Massachusetts Commonwealth vs Purdue Pharma*, 2019). Opioid manufacturers developed advertisements for medical journals featuring White grandparents whose pain was relieved enough to play with their grandchildren (Hansen et al., 2023). Susan fit the bill: she was injured, and she was believed and treated. She also had disability benefits and financial support from her son that helped to keep her housed in a county with one of the most unaffordable housing markets in the country.

Susan's public insurance likewise privileged opioids as a rapid intervention. During the height of the campaign to treat 'pain as the fifth vital sign,' insurance coverage for prescription opioids increased while access to more time-intensive treatments for pain was curtailed (Levy et al., 2018). For those like Susan with privileged access to the category of deserving pain patient, the temporality of opioid relief was fundamental to opioid distribution, as the efficiency-oriented market time of health care is structured to minimize the length of clinical visits while maximizing billable treatments (Satterwhite et al., 2019).

In contrast to Susan, Black and Latinx patients who had experienced traumatic injuries prior to and during the timecourse of the opioid epidemic— including work injuries, vehicle accidents, gunshot wounds, and major surgeries— had not received long-term opioids for their chronic pain, and most struggled to access disability benefits. Throughout my fieldwork, I observed physicians rationalize fast opioid tapers in hospital and clinical settings for poor, Black and Latinx patients, citing either patients' vulnerability and risk or asserting their criminality (or sometimes, referencing both simultaneously). "*When someone says they have been arrested but didn't do anything wrong, they are lying,*" a pediatrician told me, in the case of an African American girl who had been shot multiple times 10 days prior and was admitted to the pediatric ward for poor pain control. As described in the introduction, the assertion that this patient was a criminal dramatically shifted the tone of her treatment trajectory, leading to her doctors inducing a forcible withdrawal from opioids overnight.

Opioid prescribing disparities for pain by race/ethnicity are well-documented (Anderson et al., 2009; Mossey, 2011). These disparities are rooted in racist conceptualizations of who is believed to be truly experiencing pain and who is believed to deserve relief from pain (Whitmore, 2019). Such discrepancies in designations of deservingness for opioids track with what Jasbir Puar has described as a “biopolitics of debilitation” (Puar, 2017). Puar describes the normalization of commonplace debilitation and injury occurring to some deemed profitable under racial capitalism, while rendering other forms of injury to a privileged few exceptional and worthy of intervention through the category of disability. This complicates the notion of injury, by “understanding the statistical likelihood by which certain populations are expected to yield themselves to bodily debilitation, deterioration, and outright harm” (Puar 2017:3). In this landscape of disability, some are constructed as more “capacious,” while others are targeted for what Lauren Berlant has termed “slow death,” the “debilitating ongoingness” of structural suffering that consists of a “gradual decay” for those who are “both overworked and underresourced” (Berlant, 2011; Puar, 2017). I find Puar’s framing helpful for bringing together phenomena that are often considered as separate: namely, the ways that deserving suffering is constructed through the category of disability, funneling resources to capacitate some, while largescale debilitation under global capitalism is simultaneously naturalized. A critical analysis of disability in the context of widespread debility helps to highlight some of the contradictions of care deservingness under global capitalism.

Susan’s trajectory reveals a shift in the way that categories of deservingness are constructed through opioids. We see how poor White patients were initially included in privileged categories for capacitation as ideal targets for opioid pharmaceutical sales in the context of racial capitalism (Hansen et al., 2023). With access to disability benefits, public insurance and health care, and, crucially, constructions of pain deserving of relief, poor White patients rapidly became a site of enormous profit for opioid sellers such as Purdue Pharma, who benefited from constructions of the deserving White pain patient on which the deregulation of licit opioid supplies depended (ibid). With adequate pain control, Susan was able to provide free childcare for her son and daughter-in-law who were working parents.

Then, in a violent expulsion from the category of normative capacitation, Susan was abandoned to ongoing untreated pain. Her inability to access care was new and represents a new disposability of certain subject positions now expelled from a right to capacitation. Her recourse to heroin then left her further debilitated to the point of life-threatening infection. After arriving at the brink of death, she was admitted to the hospital for a lengthy and expensive hospital admission, once again worthy of (limited, temporary) biomedical recognition and care.

Susan's experience with pain, disability, and incapacitation challenges the newly dominant narrative that pain treated with opioids fails to treat the pain, while other modalities such as physical therapy, massage, or acupuncture better address the need to improve "function." Dominant critiques throughout the opioid epidemic place opioid use in binary opposition to healing from pain. For Susan, adequate pain control and capacitation can be understood to be operating on what Csordas calls a "margin of disability" (Csordas, 1997). Csordas describes how disability is constituted as a "habitual mode of engaging the world," such that someone living with a disability may be able to engage in more or fewer activities depending on whether the risk of pain feels worthwhile (1997:71). The process of healing, in this phenomenological schema, involves an existential process of "exploring the margin of disability," motivated by belief in a divine power of healing and by one's desire to demonstrate capacitation to oneself and to a supportive community (ibid). Those living with disability such as with chronic pain in a limb may technically be capable of moving the limb, but may refrain from moving it "for lack of sufficient motivation to make the risk of pain worthwhile" (ibid). Opioids can alter this calculus.

For Susan, opioids capacitated. They gave her enough confidence that the risk of pain was worthwhile, and helped her not to become isolated and alienated. Susan's experience raises the possibility that opioid prescriptions capacitate healing, rather than replacing healing. Adequate pain control may allow for patients and healers to come together and "challenge the sensory commitment to a habitual posture, [and] modulating the somatic mode of attention" (1997:72). Reconsidering opioids in the way that Susan describes both their physical effect and the helpful impact of a trusting therapeutic alliance with a physician places into stark contrast the devastating impact of ongoing racist under-treatment of pain and racialized incapacitation.

Susan's gender, class, and racial positioning likely helped her secure access to prescription opioids initially, on which she became dependent for daily functioning. However, her positioning rapidly shifted. I turn now to the ways that federal and biomedical institutional policies conceptualized and rationalized the interventions that transformed her from a 'chronic pain patient' into a 'high risk' prescription opioid user, despite her own opioid consumption and pain experience remaining consistent, to argue that *biomedical constructions of risk* play a key role in producing iatrogenic harms in a racialized biopolitics of opioids, complicating common sense meanings of care and abandonment.

### *Risky Guidelines*

*"The CDC guidelines say… above 50 milliequivalents of morphine, you start to get into potential danger territory. At 90, you have a much greater risk of dying of accidental overdose. Even if you're taking them as prescribed." – Primary care clinic doctor, 2018*

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*"In 2016, the CDC came up with their guidelines," the addiction specialist doctor explains with a hint of disdain. "This guy was sent over by his PCP to get off Percocets because the amount of opioids he takes daily is above the CDC guideline limit. He doesn't want to get off them. They work!" – Addiction Clinic, 2018*

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*"Our opioid risk management program is going into effect," the pharmacy manager for Medicaid managed care reports. "If a provider is outside of the CDC guidelines, we will reach out to the doctor to get them within the guidelines. We also make sure that they don't start patients on long-acting opioids, and make sure that they taper patients who are on them. If we find a member on high doses, we talk to the MD about what they need to do to lower their risks. It may result in a lock into a prescriber, to a pharmacy, or something else, to limit shopping. We are seeing positive trends but we're not coming down as much or as quickly as we would hope."*
*– County Stakeholder Workgroup Meeting, 2018*

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*"The number one bucket of grievances at [Medicaid managed care program] almost always has to do with, 'I came in for my prescription and I didn't get it.' 'I didn't like getting told to go to pain management because they're suggesting I have a problem.' In general, MediCal as a population doesn't grieve [file complaints]. It's remarkable. They go to the next person. Then they try their PCP. People are discharged from clinic. We did have one case where the woman had no physician that we could assign her. She had no provider. It's interesting, people are often impassioned in the presentation of their grievance."*
*[pause]*

*"But followed in the long run do they end up feeling better? Or how is their pain?" a doctor asks.*

*"Yeah, or has their addiction problem been addressed," another doctor offers.*

*"It's gentle," another doctor weighs in. "Take care and you don't slam anybody. We get plenty of grievances. They will not see themselves as someone with a drug problem."*

- *"Rx Opioid and Heroin Abuse Workgroup" Meeting, 2018*

## Constructions of Risk: Knowledge and Power

In the contemporary moment of U.S. opioid 'crisis', a plethora of tools and technologies for addressing overdose and opioid-related harms have emerged, many under the auspices of 'risk reduction.' Like many public health responses, the state public health approach to curbing opioid-related harms in the midst of overwhelmingly high and increasing overdose rates has been premised on defining and managing opioid risks. Tracking Susan's trajectory alongside these public health interventions clarifies how risks were defined, described and intervened on by overlapping arms of state regulatory authorities, along with the way these risk definitions play out on the ground and shape individuals' lives.

Risk reduction efforts were carried into the clinical encounters where Susan sought health care, including in primary care clinics and addiction clinics, as physicians had to make decisions about how, when, for whom and for what to prescribe opioids. Here, I suggest that clinicians' perceptions of risk are deeply structured by state policy as well as by their own moral conceptions-- which are often informed by, and inform, state policies. Medical anthropologists have demonstrated how individual perceptions of risk are structured by political contexts, technological developments, and quotidian experiences (Panter-Brick, 2014). Aronowitz (Aronowitz, 2015) has described how epidemiological measures of population health constructed the risk factor as an object of intervention, producing new markets for both risk evaluation and management within medicine and public health. A moral discourse of individual responsibility for health, which has long historical tendrils, has now developed a new center around the avoidance or minimization of risks. As scholars (Bourgois, 2000; Garcia, 2010; Zigon, 2010) have shown in the case of drug addiction, access to biomedical treatment is increasingly contingent on alignment with neoliberal ideologies of individualism and self-responsibility. According to this ethos, individuals are made responsible for managing their own risks, yet reliant on experts to define what constitutes a threat (Hanhardt, 2013), reinscribing the discursive dominance of medical and scientific authorities even while offloading their responsibility for outcomes.

## Guidelines: Evidence, Affect, and Pay-for-Performance

In 2016, the Center for Disease Control (CDC) released new guidelines focused on assessing and mitigating the risks of prescription opioids (Dowell et al., 2016). This publication was intended to provide a "systematic review of the best available evidence" on the use of opioids in the treatment of pain in outpatient primary care settings, and to provide guidelines for clinicians to "consider safer and more effective treatment, improve patient outcomes such as reduced pain and improved function, and reduce the number of persons who develop opioid use disorder, overdose, or experience other adverse events related to these drugs."

Nearly every physician I worked with explained to me that their understanding of what the guidelines boiled down to consisted of two points: opioids do not work for chronic pain, and prescribing more than 50 milliequivalents of morphine daily for a patient increases their risk of overdose. As in the first quote above, physicians applied the guidelines' logic that above this dose, prescription opioids were "dangerous territory."

These guidelines had major impacts on the way long-term opioid therapy is conceived of in public health and in clinical practice. Throughout my fieldwork, the guidelines were ubiquitous in primary care clinics. In the vignettes above, primary care physicians, addiction specialists, and county-level policymakers were all attuned to the guidelines, referenced them often, and saw their work impacted by them. Clinicians cited them either as scientific evidence, or, to explain why their judgment to prescribe opioids was structurally constrained.

But is this the definitive story of the guidelines? And how have these guidelines had such a large impact on practice? In my interpretation, clinical guidelines, together with the guideline researchers' framing of the questions, conceptualization of 'risks,' description of their findings, and their downstream implementation, produce a picture of 'universal knowledge' about opioids that overwhelms the possibility of decisions to be based in patients' relationships with their clinicians or based on their "functioning and life context." A far cry from the possibility of factoring in patients' own experience of pain, even clinicians' assessments of function, previously a legitimated form of knowledge necessary for making medical decisions, was ultimately undermined by the implementation of the guidelines. How did this happen?

The guidelines' tone of scientific neutrality has a marked affective register for prescribers attuned to the moral panic of the opioid epidemic, offering a pathway to practical action that feels defensible. Evidence and affect coalesce in the guidelines, shaping the clinical gaze then deployed by physicians in practice. Moreover, local implementation efforts incentivize following guidelines in a way that erases contextual circumstances and physicians' judgment. I turn now to a closer read of the guidelines and the way they were implemented to see how their effects were rendered common-sensical.

## Neutral Tone

The authors of the guidelines employ a measured, neutral tone and avoid statements that could be construed as either universally declarative or as overly determining of clinical decisions. “Clinical decision making should be based on a relationship between the clinician and patient, and an understanding of the patient’s clinical situation, functioning, and life context. The recommendations in the guideline are voluntary rather than prescriptive standards,” they state. They reiterate at the end of the introduction, “Clinicians should consider the circumstances and unique needs of each patient when providing care.”

Given the public blame that prescribers have faced about “their role” in producing the opioid epidemic, many physicians turned to the guidelines in an attempt to set an informed, corrective course within their practices, without attempting to rigorously analyze either the evidence or to verify whether or not their own practices had involved overprescribing opioids to patients. Physicians throughout my fieldwork referred to the “national opioid epidemic” as rationale for the changes they made within their own practices and pointed to the guidelines for support. Disclaimers and measured evaluations of evidence, in conjunction with time and resource constraints that prevented physicians from evaluating the evidence themselves, served to build trust in the guidelines themselves, shaping beliefs about the evidence that re-confirmed the conclusions drawn. Over and over in my field sites, primary care providers summarized the CDC guidelines as telling a definitive story: “There is *no* evidence supporting the use of opioids for chronic pain.” They then enforced rapid opioid tapers for patients who had been on regular opioid prescriptions for years, or simply discharged patients on high doses of opioids who expressed frustration about a reversal of clinical practice.

## The Paradox of “No Evidence”

The guideline researchers' first key question asked about the effectiveness of long-term (a year or greater) opioid therapy compared to placebo, no opioid therapy, or nonopioid therapy, for long term outcomes related to pain, function, and quality of life. They also wondered how effectiveness varies according to the type and cause of pain and patient demographics. To this question, the authors found no studies to cite for an answer. No study had evaluated such long-term efficacy. The fact that zero studies could contribute to an answer ought not to lead automatically to a conclusion that opioids are not effective for chronic pain. That studies had not been conducted evaluating patient outcomes long-term may in part be due to the fact that only recently have researchers felt the need to differentiate opioid efficacy according to such a time-scale. But the lack of scientific validation of effectiveness as conceived of by the researchers, when placed next to studies that had evaluated *risks* and *harms* from long-term opioid therapy, produces a kind of common sense for the reader. The construction of this common sense negates many patients' and clinicians' common experience, namely, that opioids often are effective, beneficial, and pose relatively low risk for many patients with chronic pain.

Their second key question was about the risks of opioids *versus no opioids* on abuse, addiction, overdose, and other harms. Likewise, they asked how harms vary according to the type and cause of pain, patient demographics, comorbidities, and dose. Here, they found that recent opioid use was associated with increased risk for overdose events compared to nonuse, and that the higher the prescribed opioid dose, the higher the risk. They found that those patients prescribed more than 50 milliequivalents of morphine daily were at increased risk of overdose and death. These results are important. I do not argue that opioids are harmless or risk-free. However, I want to unpack the way that opioid risk in these guidelines was constructed based on prescribed dosage, without consideration of other information.

One problem with the conceptualization of this question is that it imagines the world, and risk, as static. Risks of abuse, addiction, overdose, and other harms for a population are imagined to exist as discoverable truths of an unchanging nature. Many patients prescribed opioids for pain had high physiologic tolerance for opioids, and they required, and took, doses well above 50 milliequivalents of morphine to achieve the same effects that other patients felt at lower doses. Many of these patients have used such doses for years without harmful effects. Opioid-related risks are contingent upon dynamic factors, such as the way that individuals consume opioids: with or without good access to follow-up medical care, with others in settings of support or alone.

Moreover, the question compares the risk of a prescription medication to an imagined alternative: no opioids. In reality, risks of prescription medications would be more fruitfully compared to risks of their real-life alternatives: other types of substances that many people use in attempts to alleviate their suffering, including unregulated, cheaper, illicit opioids. The risks of licit opioids with a more predictable opioid dose can be directly compared to the risks of unregulated illicit opioids that are unpredictable. Susan's trajectory, which I have begun to describe, is a case in point of this problem.

The researchers summarize, "Evidence on long-term opioid therapy for chronic pain outside of end-of-life care remains limited, with insufficient evidence to determine long-term benefits versus no opioid therapy, though evidence suggests risk for serious harms that appears to be dose-dependent." Such a portrayal of value-neutral weighing of potential benefits and harms of opioids is repeated over and over in the guidelines. Although the authors are transparent about the limitations of the evidence used to realize the recommendation that long-term opioids should not be used as a first-line treatment for chronic pain, in fact repeating multiple times that studies had not been done to evaluate efficacy, the many repetitions of this limitation have the effect of increasing the perception that the guideline has a sound authority. In this repetition, an important transformation occurs. The statement, "the evidence of benefit is limited," is a negation: it is about what there is *not*. But, when used within a guideline meant to produce action, this negation, repeated over and over, transforms into a positive statement that could be summarized as: the evidence is that there is no benefit. Non-evidence is transformed into evidence. Here, the nature of a clinical guideline, necessitating intervention and practical action for clinicians who look for an efficient 'standard' for evaluating patients, necessarily produces knowledge in the form of a specific course of reasonable action: the recommendation to *not* prescribe opioids for chronic pain.

Through the description of recommendations, the guidelines tend to universalize the knowledge they produce. Again, the authors are careful to qualify that even for their strongest recommendations, only "most" patients "should receive the recommended course of action." They are detailed in potential scenarios. For patients found to be on high milliequivalent dosages of opioids, the guidelines recommend talking over concerns with the patient, considering a taper down to a safer dosage, and offering a naloxone prescription. They go on to state, "Experts agreed that clinicians should not dismiss patients from their practice on the basis of PDMP information." They add,

> "*Doing so can adversely affect patient safety, could represent patient abandonment, and could result in missed opportunities to provide potentially lifesaving information (e.g., about risks of opioids and overdose prevention) and interventions (e.g., safer prescriptions, nonopioid pain treatment [see Recommendation 1], naloxone [see Recommendation 8], and effective treatment for substance use disorder [see*

*Recommendation 12]).”*

In other words, the guidelines are carefully stated, considering of available evidence, and productive of knowledge that could not be portrayed as overly universalizing or prescriptive. They explicitly identify a potential pitfall that did in fact occur for Susan: patient abandonment that adversely affected her safety. Yet, through the conversion of context-specific, non-universal evidence into the basis for national guidelines making recommendations for clinical action, the guidelines tend toward the universalization of risk anyway. They construct prescription opioid risk via a theoretical framework that misses many lived risks of not prescribing opioids.

Yet, the guidelines are non-mandatory. It is therefore difficult to pinpoint the relationship between knowledge and power when it comes to clinical practice guidelines. I argue here that it is in fact critical that the guidelines are not mandatory to understand their role in shaping the subjectivity of prescribers. The guidelines may discipline prescriber behavior, not through coercion, but through affective manipulation.

## Comfort in Evidence-Based Guidelines

In the midst of widespread blaming of physician overprescribing for the opioid epidemic (Department of Justice, 2021; Gray et al., 2021; Hirsch, 2017; Joseph, 2022) which often constructs the physician as a “folk devil” in the moral panic of opioid crisis (Cohen, 1972; Stout, 2022), guidelines build prescriber trust and confidence in their practices (McCalmont et al., 2018). Although the guidelines make repetitive disclaimers and calls for individual judgment from clinicians, nonetheless, knowledge about the guidelines has been shown to have the effect of making clinicians more likely to carry out the standardized recommendations: McCalmont et al (2018) showed that knowledge of the CDC guidelines increased use of the recommendations and increased prescriber confidence.

Such beliefs and behaviors align with what Timmermans has termed a “librarian” style of “doing” evidence-based medicine, wherein the physician consults the literature quickly and without critically evaluating it (Timmermans & Angell, 2001). In my fieldwork, turning to the guidelines typically translated to parroting the conclusions and following the recommendations, rather than using individual judgment to manage uncertainty in each case. Timmermans has described how the increasing authority of evidence-based medicine, and the expectation of competent evaluation of epidemiological evidence, has produced new forms of uncertainty in clinicians who feel ill-equipped to evaluate evidence because of lack of training, time, and resources. For most physicians facing such uncertainty, Timmermans found that guidelines led to a feeling of “comfort within the chaos,” a feeling of authority and legal protection against liability (Timmermans & Angell, 2001).

As an example of such comfort and confidence, in the last vignette above, the Medicaid managed care pharmacy administrator, at a meeting with top County physicians and public health policymakers, marvels aloud at the fact that patients have complained and filed grievances about not getting their pain medications and getting discharged by their providers. Such is the confidence of the stakeholders in the meeting that they find such complaints “remarkable” and cannot fathom why such patients would be “impassioned” in their complaints. They even highlight the rarity of patients in poverty filing formal complaints to their insurer: “*As a population, MediCal does not grieve.*” But they rationalize that in the long run, these patients must be better off, reconciling their momentary uncertainty with the assertion that, in a disconnect between patient compliance and clinical guidelines, the patients must be wrong.

## Incentivizing the Guidelines

Some physicians in my field site were aware of problems and pitfalls of the evidence-based 2016 CDC guidelines. One primary care physician, for example, highlighted that many of the recommendations were based on evidence that the authors themselves conceded was of low quality. She protested, *"Like if you have to say, 'Low grade evidence based on expert opinion,' maybe don't put it in the guidelines?*" She observed that there are many clinical practice guidelines based on evidence that is "*flimsy at best. Then people go around 'dinging' providers until they follow them when no one actually knows the full information*." I asked her whether doctors want to feel confident and so follow the CDC guidelines precisely. She replied, *"Yes, and, even worse, they won't get their performance pay."*

Although the guidelines are non-mandatory, clinics can and do produce financial incentives to follow them, and many changes in the opioid policy landscape have supported efforts to curtail opioid prescribing. The 21st Century Cures Act provided states with financial resources to address opioid prescribing. At the state level, a toolkit produced by the California Quality Collaborative in collaboration with SmartCare California describes such incentives in their 2018 publication entitled, "Accelerating Opioid Safety: Ambulatory Care Toolkit" (Eubanks & California Quality Collaborative, 2018). Recommendations include extracting electronic health record data to "provide monthly provider feedback on performance, adherence to prescribing guidelines, and lists of patients at risk," and reviewing "pay-for-performance (P4P) measures of opioid safety for potential incentive-based revenue opportunities." As this physician alluded to, hegemonic common sense around opioid prescribing is produced not merely through the production of neutral scientific knowledge, but also through its deployment as an affective and financially incentivized tool.

Several studies have examined the effects of the CDC guidelines on opioid prescribing. Bohmert et al (2018) used retail pharmacy data on prescription dispensing and found that decreases in opioid prescribing overall and high-dose prescribing accelerated after the guidelines came out (Bohnert et al., 2018). Fenton et al (2019) found an increase in tapering and rates of rapid tapering for patients using long-term prescription opioids in 2016 and 2017, coinciding with the guideline release (Fenton et al., 2019).

These changes in clinical practice actually went beyond the guidelines' recommendations. As word spread of the prevalence of "pain refugees," and pain advocacy groups organized in protest of the guidelines, experts eventually weighed in (Bennett, 2021; Goldstone, 2018). In December 2017, a panel of "physician experts" convened by the American Academy of Pain Medicine Foundation, evaluated the guidelines. They wrote, "Challenges caused by guideline misapplication identified by the panel include inflexible application of recommended ceiling doses or prescription durations as hard limits; abrupt opioid taper or cessation without regard for CDC emphasis on empathically reviewing benefits and risks of continued high-dosage therapy and working collaboratively with patients on a plan" (Dowell et al., 2019). The CDC has since publicly promised to re-write the guidelines, stressing community engagement and a willingness to hear public comment during the rewrite process (CDC.gov, 2022). The new guidelines will be released in 2022, as will new guidelines for the California Medical Board, which stipulate how to judge physician license review cases conducted at the state level. Ultimately, the authors acknowledged that the guidelines were misapplied. They clarified that patients ought not to be forcibly discharged if they are on long-acting opioids or long-term opioid therapy. Dr. Abel is hopeful that the forthcoming California Medical Board guidelines may help to set a course corrective against the tide of discharges that have been occurring. "*The gist of the new guidelines is, 'Keep your door open, don't be punitive, prescribe MAT*,'" he explains.

There is hope to be found in new guidelines. However, I have argued above that the original guidelines themselves cannot be assigned full blame for the problem of serial discharging of patients. Rather, the way guidelines and self-protective policies get interpreted and implemented by insurers, care systems, individual clinics and practitioners, suggests that ideologies of risk and drug law enforcement, intrinsic to the implementation of guidelines, cannot be easily dismantled.

## Opioid "Populations": scientific studies of buprenorphine

In the final section, I expand out from clinical guidelines to examine recent developments in clinical trials examining treatments for opioid use disorder. As Susan and many others are recently being diagnosed with "opioid use disorder" rather than being treated for chronic pain, at a moment when it may appear as though all patients are being equally abandoned (even those White women formerly granted so much prescription opioid access), how are such patients newly constructed and understood within biomedical frameworks? Focused on narrative analysis of research related to the treatment of opioid use disorder with buprenorphine, I trace how recent clinical trials come to define, characterize, and imagine a new kind of patient who uses opioids: the prescription pill (mis)user. These research studies on opioid use can be read for the ways in which they both signal, and shape, the boundaries of whiteness, without naming whiteness explicitly. I suggest that, in the context of the medicalization of opioid addiction that is producing many more patients with the diagnosis, research studies creating subpopulations of opioid users may shore up the boundaries of white privilege— tracking patients into separate diagnostic and treatment trajectories and reproducing or exacerbating disparities.

In tracing the carving out of a special subpopulation of opioid users as defined by prescription pill use, versus heroin use, my argument is that this kind of sub-dividing through clinical research is both reflective of historical power dynamics and may act to reproduce them. Subdividing opioid users by type of opioid used can be understood as a sort of mirror image of the subpopulation carved out legislatively for crack cocaine use compared to powder cocaine. That subdivision had enormous downstream consequences in racializing crack and then criminalizing and incarcerating Black people through this racialization. Crack was quickly subjected to racist legislation, such that possession of 1/100th the amount of crack led to strict mandatory sentencing when compared to powder forms. In the case of opioids, I suggest, the inverse occurs to racialize opioid pills as White: clinical trials that subdivide opioid use disguise the clinical reasoning that first racialized opioid pills in the first place and disproportionately allocated prescription pills to privileged White patients. Such subdivisions then further carve out a separate epistemological space for understanding opioid pill users' addiction as distinct from others'. This subpopulation is imagined to have a special kind of addiction that will respond better to biomedical intervention and treatment. The historically two-tiered approach to drug policy is, in these ways, reproduced and perpetuated by this construction. Finally, the political economic need for outcomes of significance in clinical trial research, to fund future studies and fuel researchers' careers, incentivizes the subdividing of opioid users into categories as well as the focusing of interventions onto well-resourced patients most likely to benefit from a narrow biopharmaceutical intervention.

In this analysis, I invoke Hansen et al's theorization of technologies of whiteness at work in the contemporary opioid epidemic (Netherland & Hansen, 2017). In their analytic approach, which seeks to render visible the social and institutional techniques used for sorting people by race, they identify four technologies of whiteness at play in the opioid epidemic: addiction neuroscience, new biotechnologies including the medication buprenorphine, regulations such as the Drug Addiction Treatment Act of 2000 which allowed buprenorphine to be prescribed in outpatient clinics, and ethnic marketing and media. As they illustrate, addiction neuroscience behaves as a technology of whiteness in three ways: it relies on brain imagery that creates a racially unmarked, yet implicitly White, subject; it erases environmental and social structural factors in defining addiction; and finally, it creates a medicalized tier of drug policy for White opioid users, leaving Black, Latinx, American Indian/Alaska Native, and poor patients with low levels of health care access and high exposure to law enforcement and punitive drug policy (Hansen et al., 2023). As a new biotechnology, buprenorphine has worked as a technology of whiteness since its initial unprecedented approval as an addiction treatment that could be provided in outpatient clinics marketed to and consumed by primarily middle class White patients with a college degree. Here, I extend this analytic framework to ask how interventional clinical trials for addiction treatment work in tandem with these technologies to enact whiteness. I suggest that recent clinical research trials have reinforced partial medicalization of addiction specifically geared toward prescription opioid users as a special population, and in doing so, they erase histories of privileged access to prescription opioids as a social structural factor in their addiction while simultaneously naturalizing this privilege as a population trait. By converting initial route of exposure to opioids into a naturalized trait of a subpopulation, researchers suggest that this subpopulation will be better able to benefit from addiction treatment interventions and should be treated differently from others.

In 2007, researchers Moore et al at Yale published a study, “Primary Care Office-based Buprenorphine Treatment: Comparison of Heroin and Prescription Opioid Dependent Patients,” in the Journal of General Internal Medicine (Moore et al., 2007). In this study, the researchers compared 200 patients who were recruited for a clinical trial of primary care-based buprenrophine/naloxone treatment.  They stratified those who reported only using heroin (n=124), those who only used prescription opioids (n=29), and those who used both (n=47), comparing their demographic, clinical and treatment outcomes. In the study, the researchers describe that the prescription-opioid-only patients were both more privileged, and more likely to be successful in treatment: 97% were White, and they earned more income and had fewer years of opioid use on average. They were more likely to complete treatment compared to heroin-only users (59% versus 30%), remain in treatment longer (21.0 vs 14.2 weeks), and they had a significantly higher percentage of opioid-negative urine samples (56.3% versus 39.8%). The researchers noted that their findings were only exploratory. There were only 29 patients in the prescription-only group, which limited the power of the study to detect differences. They also noted that they had not asked about individuals' previous opioid use throughout their lifetimes, and suggested that defining sub-types of opioid users may require a more rigorous approach.

This study was one of the first to characterize a new kind of opioid addiction subpopulation in clinical research: the prescription pill user, also known by descriptors such as the "pharmaceutical opioid dependent," someone with "iatrogenic dependence," or, an ill-defined term, "nonmedical use" (Cooper et al., 2018; Potter et al., 2010). Reminiscent of the ways that members of Congress imagined and described a "new type of heroin user," (Hansen et al., 2023; *Drug Addiction Treatment Act of 1999, Congressional Record- Senate (106th Congress)*, 1999) one who was White and suburban and ought to be treated differently from those before them who had been relegated to highly surveilled methadone clinics, we can observe a mindset oriented to newness and uniqueness in these recent clinical studies.

Researchers have continually asked the question, how might this sub-population be different from others? One group, Weiss et al, described their “desire to examine a new population of individuals,” those with primary prescription opioid dependence, and developed a novel method for defining this population by establishing opioid dependence while ruling out people whose dependence has ever been attributable to heroin use (Weiss et al., 2010a). Yet, in asking the question of difference through the clinical trial, and defining this subpopulation, contextualizing structures such as racism, income disparities, and presence or absence of meaningful social support, factors that profoundly shape opioid trajectories, are ironically rendered less visible in the discourse. Although the 2007 study by Moore et al stated that 97% (28 of 29 people) of the prescription opioid only users were White, most subsequent studies failed to mention race/ethnicity in their characterization of their study population (Moore et al., 2007; Weiss, et al., 2010a; Weiss, et al., 2010b). Studies contrasted patients who take more than their prescribed opioid dose or who take them for nonmedical use, described as use “simply for the experience or feeling caused by opioids” with patients using illicit opioids such as heroin or fentanyl. This comparison between groups of opioid consumers, which may look race-neutral on its face, conceals the fact that most prescribed opioids are provided to White patients, due to racialized and classed prescribing of opioids for pain described above-- due both to White patients having more access to care settings and due to biased prescribers (Anderson et al., 2009). Given a higher proximity and ready availability to opioid pills that were prescribed, the vast majority of patients who are labeled as “abusing prescription opioids” are also White (Pouget et al., 2018). Prescription opioid versus heroin dependence, and method of first introduction to opioids, come to be the comparable differences of note, which erases how these distinctions came to be in the first place.

We can observe how researchers' thinking becomes muddied when such differences become naturalized as individual patient 'traits' rather than structural phenomena shaping opioid trajectories. Researchers conducting trial studies on the treatment of OUD employing these distinctions have drawn a number of conclusions worth un-packing.

First, the trials emphasize different treatment outcomes amongst the two groups. As one research group states, "Recent evidence suggests that individuals dependent on prescription opioids may have differential treatment outcomes compared to persons dependent on heroin" (Potter et al., 2010). A recent systematic review and meta-analysis examined five subsequent clinical trials that compared prescription opioid users to illicit opioid users (Sanger et al., 2020). In their findings, they state that method of first exposure to opioids "influences prognosis and treatment outcomes" of opioid use disorder, as patients who were introduced to opioids through a prescription were "significantly less likely to have illicit use while on MAT." They speculate that these patients have "lower risk-taking behavior," which may explain their findings (ibid:13). And they conclude that these patients "have a different prognostic and clinical profile that requires a tailored approach to treatment" (ibid:1). In their discussion, they state, "This cohort of individual are most likely people that did not intend to engage in risk-taking behavior. They ended up dependent to opioids because of the associated addictive properties. They may benefit from being treated in different settings and with the use of different approaches to addiction philosophy" (ibid:14).

Second, some researchers highlight abuse of prescription opioids as a risk factor for heroin abuse, and state that this "[places] new populations at risk for heroin addiction" (Miotto et al., 2012). One study team suggested that as this problem continues to grow, "possible risk reduction practices may include separating users of different drugs into different treatment groups" (ibid: 7). Here, the anxieties of the researchers that 'new populations' are at risk are based on a single patient out of several hundred in their study who began using heroin after attending a group meeting with both patients who use heroin and those who use pills. Risk, a powerful framework in biomedical research and health care, is evoked, and it is a 'new population' considered to be at risk: the (White) patients who the researchers are concerned will now be 'exposed' to heroin, in a health care setting no less. While prior trials highlighted that patients who 'abuse prescription opioids' may have better outcomes in treatment compared to those who use heroin, (Moore et al., 2007) these researchers suggest that they might have even better outcomes if they are isolated in separate treatment sites, separate clinics, and separate therapy groups. Here, discursive segregation manifests in recommendations for physical segregation; without invoking race specifically, disparities are rationalized (Pouget et al., 2018).

Finally, one study with poor treatment outcomes studying this subpopulation suggests limiting access to treatment to optimize outcomes. The researchers suggest "leveraging treatment" by restricting access to medications unless patients participate in higher levels of care (Miotto et al., 2012). Choosing patients with low complexity and those "committed to abstinence with social and occupational resources can improve outcomes," they write (ibid: 10). Here we can see how political economic forces demanding positive study results in academic publishing drive researchers' desire to restrict patient access to innovative treatment modalities. A circular logic is deployed that advocates for providing health care resources to those with more resources to achieve a maximally beneficial effect of an intervention. First, social determinants of health are rendered invisible by the research group, and then they are reinstalled as potential eligibility criteria for selecting a population to treat. The problem here is that the priority of clinical trial research is to achieve good outcomes, *not* to reduce health disparities. When the desire for good outcomes is indulged, those who are constructed as less redeemable or irredeemable lose access.

Here we can see how a lynchpin of biomedical scientific advancement, the clinical trial, can work against the public health goal of health equity and population health.

## Risk Reconsidered: Risks of Not Prescribing Opioids

Intensified efforts to reduce illicit opioid supplies have made diverted pills less accessible (Dasgupta et al., 2018), a dynamic that fueled Susan's transition to cheap and readily available heroin. Although epidemiological studies have identified high opioid prescription rates as a risk factor for heroin use and overdose (Kolodny et al., 2015; Muhuri et al., 2015), ethnographic data here show that Susan's transition to heroin and the consequent harms she experienced resulted directly from medical abandonment. This reverses a common trope in addiction research on opioids: while it is considered common sense that people transition from opioid pills to heroin as a downstream effect of overprescribing, Susan's story shows rather how her transition to heroin was a consequence of opioid *under*-prescribing. Policy interventions implemented to reduce opioid over-prescribing shore up the legitimacy of biomedicine in managing risks to patients, while neglecting to consider the risks of medical abandonment and its iatrogenic consequences.

As political momentum has shifted against the prescription of licit opioids, scientific studies have shown close alignment with this shift; however, a few studies recently have signaled to some physicians' unease about simply stopping prescribing of opioids for patients who have been stable on them for many years. These researchers have pointed out that while guidelines recommend assessing potential risks and benefits of prescribing opioids, the risks of *not* prescribing opioids, and the risks of abrupt discontinuation of opioid therapy, have been left largely unconsidered and uncharacterized, making an appropriate risk/benefit calculus difficult or impossible during a clinical encounter. One study within a Veterans Administration system showed that discontinuation of opioid therapy led to suicidality in 12% of research participants, with 2.9% attempting suicide (Dasgupta et al., 2018). Another study showed that mortality risk *increases* for patients who have opioids discontinued when compared to patients who have their prescription continued— and, crucially, even risk of death from overdose increases (James et al., 2019).

The risk of dying from opioid discontinuation— including from overdose— is crucially shaped by diverted and illicit opioid supplies. Still unconsidered in these studies is the fact that risk is continually reified: scientific studies treat risk as something concrete to be discovered, defined and quantified. Risk of overdose when opioid prescriptions are discontinued is profoundly shaped by the supply of non-prescription opioids— whether they are diverted prescription pills, or pressed and illicitly manufactured pills that contain fentanyl, for example. Such risks are dynamic, and produced *by* supply-side interdiction efforts and by the very thing being studied: discontinuation of prescriptions that disrupt the supply of diverted pills that could be more safely consumed than fentanyl. These risks are not waiting out there to be discovered, from which we could construct sound public health policy and good clinical decisions. Rather, they are risks that are constructed *through* our biomedical and drug law enforcement institutions, state policies, and through quotidien clinical decisions.

## Conclusion

In this chapter, I have attempted to pull together fieldwork from primary care sites and key stakeholder meetings to show some of the mechanisms by which the fault lines of deserving patienthood are being redrawn in response to opioid epidemic. Deployments of biomedical and public health policies, diagnostic categories, and specialty expertise shape both clinical spaces and the trajectories of patients who enter them. Here, clinical encounters for the publicly insured constitute everyday practices of state power, producing the meaning of opioids, pain and addiction for poor patients.

Whiteness has historically been crucial for licit access to opioids, made possible through the marshaling of sympathies for White patients' pain as deserving of relief, and via capacitation of White publics through the exclusive category of disability (Hansen et al., 2023; Puar, 2017). This access included poor White patients, who compared with wealthy White patients were especially likely to encounter injuries and chronic pain (Poleshuck & Green, 2008). But what we now see emerging for poor patients, including many White patients dependent on opioids, is a forceful abandonment and expulsion from spaces of care that they previously were allowed to occupy. Scientific evidence may be leveraged both to produce abandonment for patients with pain and to produce white racial rescue for those who are well-resourced.

Buprenorphine-focused clinical studies may continue to demarcate the boundaries of deserving suffering, reinscribing whiteness through models of scientific research that incentive good outcomes without deconstructing the reasons why marginalized patients may be positioned at a disadvantage in a buprenorphine trial. These studies blame patients for poor outcomes, and point to the urgent need for ethnographic research that seeks to understand how patients experience those biomedical interventions that fail them.

The next chapter continues to follow Susan and other patients who were discharged from primary care clinics, with a turn to examine state apparatuses such as drug law enforcement as they are implemented within the clinic.

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# Chapter 2

# Discharged, Part 2.

## Checking the Monitors, Wearing the Hats:

## Physicians Enacting the Discharge

This chapter continues to trace Susan's trajectory alongside surveillance and enforcement of physicians to examine how patient discharges are carried out, legitimized, and felt.

First, I zoom in on a single discharge to inquire into the weight of the words spoken, and technologies used, to enact and rationalize the discharge. I examine the breakdown of therapeutic possibility through analysis of clinical narratives. The professional authority of the physician is also enacted and reproduced through body posture, which expresses readiness to exit the conversation and abdication of responsibility toward a patient he considers dangerous.

Then, I explore how ambiguous encroachment by law enforcement into clinical spaces, through only partially visible technologies of prescription monitoring and surveillance, lead to atmospheres of suspicion and self-defensive practice by physicians. I trace the presence of the Controlled Substance Utilization Review and Evaluation System (CURES) report, the product of mandated use of prescription drug monitoring programs (PDMPs), throughout the physician's clinical practice. I also trace the use of the PDMP in County-level meetings with insurance providers, physicians, behavioral health administrators, and law enforcement personnel. In the previous chapter, I suggested that misapplications of CDC guidelines for opioid prescribing can be understood in part as inevitable as they were incentivized by productive forms of power, both affective and financial, while the guidelines themselves were shaped by constructions of risk that place the harms of not prescribing opioids out of view. In this chapter, I consider how these power dynamics work in tandem with what I describe as more coercive forms of power including state surveillance. I focus on the atmosphere of *paperwork* as a mechanism of abandonment to ask how the specter of drug law enforcement bears out through the shuffling of papers and the omnipresent computer monitor.

By continuing to trace Susan through clinical care, I show how the category of 'doctor shopper,' a term applied to those considered to be deviantly and illicitly seeking prescriptions from multiple clinics, can be applied to those who have simply been abandoned from health care and continue to seek health care resources. The category 'doctor shopper,' often constructed through prescription drug monitoring reports or insurance data reports and conjured in both policy and clinical care, carries moral and legal weight and informs downstream policy and care decisions in the opioid epidemic. I show how 'doctor shoppers' are *produced* by clinical abandonment, as patients are forced to seek care at multiple physicians' offices, with clinicians who may offer a single care visit but refuse to see a patient a second time.

In the final section of this chapter, I zoom back in to trace how physicians contend with these forces when they acknowledge that patients are in real pain.

## Prescription Drug Monitoring Programs

Large shifts on the side of state-run surveillance of prescribing and opioid related law enforcement have expanded into medical terrain. Prescription drug monitoring programs, or PDMPs, are now run by the Department of Justice in all 50 states. PDMPs track dispensing of controlled substances: when viewing a patient's PDMP record, one can view the name and dose, number of pills dispensed, prescriber, address of the dispensing pharmacy, form of payment, the date a controlled substance was prescribed and dispensed, along with other data. Increasingly, physicians and pharmacists are required to access and review a patient's PDMP prior to prescribing or dispensing controlled medicines for them (Haffajee et al., 2015). The PDMP has been widely embraced as a key technological tool to identify risky patients who may be 'doctor shopping' or acquiring medications that, when combined, can be dangerous (Holmgren et al., 2020). Audits of physicians' and pharmacists' practices by the Drug Enforcement Administration

(DEA) have increased (U.S. Department of Justice, 2019). The DEA developed a new branch exclusively focused on diversion of licit drugs, which has seen major increases in federal funding in recent years (U.S. Department of Justice, 2021). Below, I show some of the impacts of the PDMP on clinical practice to highlight the imbrication of scientific knowledge production with the repressive state apparatus of law enforcement.

The scaling up of these various licit opioid supply restricting efforts was rapid. It brought together numerous state institutions of public health, science, and drug law enforcement. Support for "doing something" to curb addiction and overdose rates— for a condition that "knows no boundaries" and can affect anyone, was vocal and bipartisan (S. Rep. No. 162-32, 2016). Many physicians throughout my fieldwork, including those who endorse values of "harm reduction," appreciated having access to the PDMP, and stated that it helped them to provide optimal care for patients with opioid use disorder. Rather than argue here that the PDMP is "all bad" or "all good," I focus on the effects of the PDMP's presence alongside other forces in the setting of a primary care clinic.

Having observed in the last chapter how Susan's trajectory was shaped by racialized biopolitics and clinical and scientific risk assessments that led to life-threatening infections and a long hospital stay, I turn now to Susan's attempt to re-establish care at Dr. Thomas' clinic as she hopes to return to him for treatment of her chronic pain.

### Discharged.

*Susan, currently staying in a post-acute care center to continue her recovery from multiple surgeries and a month-long hospital stay, needs to get reconnected to a doctor that can help her manage her pain. By now, I know her well, and I know her story well enough to be worried about the appointment we have set up with her former pain management doctor, Dr.*

*Thomas. Today, Susan is hoping to re-establish care with Dr. Thomas and get onto methadone or another opioid that will help her manage her pain and avoid opioid withdrawal after she leaves the post-acute care center.*

*I wheel her into the clinic in her wheelchair. We wait seated in the lobby, filling out her medication form, scratching out outdated information and writing down her current medicines. A few minutes later, her name is called, and a nurse comes to wheel her into a small room, where she and I wait seated next to one another. She is anxious, nervous that Dr. Thomas is going to refuse to see her as a patient anymore. If he has found out why she was admitted to the hospital, she feels certain he won't. I try to reassure her, reminding her that he does not have direct access to the county hospital inpatient medical records, so he likely does not know about that yet."The nurse didn't take my blood pressure," she comments, as a sure sign of the worst. "That's atypical." Her anxiety is making me nervous too. I sit up straighter in my chair, glad that I have worn my white coat today and hoping to engage as an advocate on top of my role as researcher.*

*Then we hear Dr. Thomas talking in the hall, saying something indiscernible with a tone of curt frustration. I think I hear him say something about a discharge paper, and my heart sinks. "Okay well do you want to see her?" we hear the nurse who roomed us ask him. A pregnant pause, and a few seconds later, the door opens, and Dr. Thomas and the nurse walk in.*

*"The thing is," he says to me immediately, "I can't see her anymore." He turns to Susan. "I can't see you anymore," he repeats to her. "I've found out that you were using things illegally," he says, waving a paper in front of us that we can't read. Susan tries to speak, but Dr. Thomas cuts her off. "It doesn't matter what the paper says, I haven't read it through completely but the bottom line is that I can't see you anymore."*

*Susan and I are still seated, but Dr. Thomas looks ready to walk out. "It's not true-" Susan begins, shaking her head, slouching over in her wheelchair, but, ignoring her, Dr. Thomas turns back to me. "See, the real story is that she was seeing me and I wanted to taper her down and she didn't want to do that. She didn't want to taper down when she had the chance."*

*He looks at her again. "Suboxone is really gonna be your answer," he tells her.*[1] *"You need Suboxone. But there's another doctor who can see you." Susan asks if he would help her to get on methadone, and he quickly responds that he can't do it, shaking his head. He hovers by the door with his hand on the doorknob, ready to leave.*

*I try intervening to advocate. Can he just take her as his patient for six weeks- temporarily- until I can set up an appointment with another doctor? I know doctors at the nearby addiction clinic well, but also know that the wait for new patients is currently six to eight weeks. But he has made up his mind that he cannot prescribe her anything. The only thing he agrees to, because he knows she is being followed by my attending physician throughout this research study, is that he may be able to see her again in several months, after she tapers off of opioids.*

*Then he abruptly adds, "For people like you- who are used to doing things the way you like to do them- with Suboxone, the thing is, you can't cheat. If you cheat, you go into withdrawal." He tells her that if she takes Suboxone and then takes any other pills, even Norcos, then they will take the spot of the Suboxone receptor and cause her to have opioid withdrawal. I don't argue with him in the moment, because it is clear that he is not going to provide any care for Susan today, but I know that the truth is more complicated.*[2]

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[1] Suboxone is the brand name of the combination buprenorphine and naloxone

[2] Experts I interviewed concurred that once stable on Suboxone or buprenorphine, the use of full-agonist prescription opioid pain medications such as Norcos would not be likely to precipitate opioid withdrawal.

*As I drive her back to the post-acute care center, Susan is distraught, crying quietly next to me and watching rain pour down out the window. "He didn't give me a chance to defend myself. So that hurt my feelings… It's a defeated feeling. I just want somewhat of a normal life," she says. "But I understand. If he believed everybody, then he probably couldn't be a doctor, because he'd be getting scammed all the time." - 2019*

How is clinical abandonment produced? In the clinical encounter above, Susan, an elderly, publicly insured, poor White woman with disability, who has in the past been well-versed in accessing health care and whom this doctor had previously treated dependably for several years, is unceremoniously discharged from care. In fact, a clinical "encounter" may not even have been allowed to occur. Here, I want to highlight several aspects of this encounter for what they reveal about the mechanics of expulsion from clinical care. I extend this to ask how a national-level, theoretically corrective course concerning prescription opioids constructs some patients as disposable by tying enforcement and clinical scientific reasoning to national political narratives.

Examining co-constructed narratives between patients and physicians within clinical encounters can help elucidate culturally specific meanings of suffering and healing and reveal ideologies, structural power relations, and material and symbolic consequences for the patient and physician and for the construction of scientific facts (Mattingly & Garro, 2001). However, opportunities for such narrative co-construction are sometimes foreclosed before the encounter even begins. Scholars have described such instances where narratives are "broken": doctor and patient interests conflict, their metaphors taken up by the other for different ends at cross purposes, tearing apart "the fragile world of shared experience" (Kirmayer, 2000). In Kirmayer's account of a patient who sees a psychotherapist about stomach pain, for example, "where what is at stake is the very definition of the clinical problem," narrative co-construction breaks down. The patient is not allowed to tell her own story of causation, while the clinician is also unable to advance his interpretation as the master narrative, evidenced by the fact that the patient declines to return for treatment. "To the extent that the master narratives of psychiatry claim healing efficacy, this failure to follow up on treatment and be cured constitutes a threat to its authority. This threat is neutralized by pathologizing the patient- she does not come for treatment because she is not psychologically minded or otherwise not yet ready to hear the truth" (ibid). The crux of the problem involves conflicting goals: where the doctor aims to settle the issue, seeking coherence, the patient aims to break through, seeking relief. The problem of efficacy then becomes: "Under what circumstances does one person's coherence become another person's relief?" (ibid).

Tuning in to clinical narratives, including in instances of rupture, can give voice to forces beyond those individuals within it that are manifesting there and shaping such encounters (Kirmayer, 2000). These forces include scientific reasoning, institutional and state constraints like laws, practice guidelines, insurance claims, forms of common sense and ideologies concerning opioids, pain, and addiction.

In the vignette above, from the beginning of the encounter, the patient has no power to ask for physician accountability for prior abandonment that led to multiple harms and necessitated months of hospital stay and post-acute care. Before the encounter begins, we find out, her pain management, and prescription fate, is not in her hands. Only a few years ago, the right performance of feeling pain, a demonstration of wariness about opioids, and the subject position of White grandmother had opened doors for her in the realm of pain treatment and a co-constructed narrative of chronic pain deserving of treatment for those patients with the right cultural health capital and racial privilege (Shim, 2010). But now, Susan was, as she said, not even given the chance to defend herself. What does the master narrative of primary care claim, if it no longer attempts to claim healing efficacy? Rather than wanting Susan to accept treatment on his terms, Dr. Thomas wanted her to leave the clinic.

Crowley-Matoka has described how biomedical approaches to chronic pain patients increasingly evoke images of infectious disease and models of 'universal precaution' (Crowley-Matoka & True, 2012). By this logic, the difficulty in predicting which patients may pose a threat to the clinician and because trying to do so produces unfair biases, leads to treating 'all patients as potentially dangerous.' Here, to Dr. Thomas, already put in a position of self-defense through the ramp-up of surveillance on his practice, even treating Susan with opioid maintenance therapy (such as methadone or buprenorphine) seems to risk a contamination. Even being in the room is observably uncomfortable for him. His hand, kept on the doorknob, reveals his desire to escape the room and the presence of the unruly patient. Such a posture, along with his declination to sit as he stood towering over us—so common in clinical encounters-- can be understood as a mode of performing a professional habitus described by Bourdieu's notion of *body hexis.* Body hexis denotes habit patterns specific to the body that are learned without moving through discourse or consciousness (Krais, 1993; Throop & Murphy, 2002). Body hexis is also the "root source of our intuitions, feelings and 'common sense'" (Bourdieu, 1977; Throop & Murphy, 2002). The doctor's posture here both represents, and reinforces, the danger the patient poses to the professional.

In this encounter, the patient is made responsible for pasts and futures. Past desires and exercises of individual will— such as not wanting to taper down "when she had the chance," and being "used to doing things the way you like to do them" — are invoked as forms of deviance that render her undeserving of care *today,* even if they did not make her unworthy before, and further blame her for her fate. The assertion that she had a single opportunity- “the chance”- to conform to abrupt changes in clinical practice, shows how shifting paradigms of deserving patienthood have been implemented on a singular “sink or swim” timescale, structuring the abandonment of poor patients in particular who cannot immediately marshall resources to buoy themselves. After we leave the clinic, Susan empathizes with Dr. Thomas’ positionality as a gatekeeper with the potential to get tricked by dishonest and opportunistic patients. Her statement resonates with Graeber’s theory of interpretive labor, the practice of doing imaginative work to understand the perspective of the powerful, who do not return the favor (Graeber, 2012). Graeber suggests that interpretive labor is increasingly ineffectual in contemporary bureaucracies, which manage social situations founded on structural violence and do significant work to obstruct people by means of inefficiency and opacity.

Her statement echoes sentiments frequently made by doctors themselves that patients often lie, and that part of the job of medicine is to distrust your patients, and that if you do trust what people say, you could kill someone, you could get exploited, you could lose your license. Relatively unexplored in these narratives are incentives for patients to present themselves as worthy of care and for physicians to act self-protectively that are structured into the encounter.

Reading this encounter as a problem of a “bad doctor” risks engaging in the same logics of individual responsibility that contributed to this patient’s abandonment. As Crowley-Matoka has observed, in pain and addiction treatment settings, “Both the self-destructiveness of addicted patients and the disgusted anger of frustrated clinicians are often mutually misread as matters of individual choice or moral failing” (Crowley-Matoka and True, 2012:692). I turn now to an interview with Dr. Thomas to illustrate the ways he experiences state surveillance over his practice, as well as his clinical and moral responses to it, to demonstrate the ways that increased surveillance and new constraints on opioid prescribing shape his stance of self-defensive moral certitude.

### “They Aren’t Around Anymore”

*Dr. Thomas feels “like a quarterback” for his pain patients. For over 20 years, he has focused his primary care practice on chronic pain management for his long-term patients, of whom he estimates 80-90% are insured through Medi-Cal. He coordinates various types of care for his patients from within his practice: myofascial release with osteopathic doctors, spinal/nerve interventions, physical therapy, acupuncture, in addition to prescribing opioids for them. For a publicly insured population, this is an atypically holistic set of care options. “All this stuff is not easily covered,” he sighs.*

*However, with recent policy changes and increases in oversight, he continues to run into more and more obstacles providing patient care for chronic pain. “The different rules I’m having to deal with are crazy,” he says. He is open about the recent DEA investigation into his practice, which was sparked by a patient’s accidental overdose on morphine, which she had been prescribed by both Dr. Thomas and another physician. He nearly lost his medical license.*

*Although still allowed to practice medicine, he is on a three-year long probation. This means that he has additional oversight. He was mandated to enroll in a prescribing practices course, a medical record keeping course, submit the names of licensed physicians who would agree to perform additional oversight and monitor of his practice, and consent to be available at the probation office or at his medical practice at any time with or without notice. He now sends every controlled substance medication that he prescribes through a new electronic code generator device that adds an additional assurance that he is the verified prescriber, which he* *believes may reassure some pharmacists wary of dispensing prescriptions written by him. He knows of at least one pharmacy that will not accept any prescriptions coming to them if his name is on them anymore.*

*Dr. Thomas is adamant that all the changes he has had to make to his practice amount to constant surveillance and oversight that has gone "overboard": With prescription drug monitoring and surveillance by the DEA, he says, "You're being constantly watched. I have to do all these things to keep my license." All of this has been humiliating for Dr. Thomas. Many of his colleagues know about the case and his probation. But probation is far better than the outcome of investigation for some other physicians (and pharmacists) across the country who have been criminally charged for prescribing opioids negligently.*

*Dr. Thomas has tapered down or discharged what he estimates to be 20% of his patients who were on high doses of opioids. He describes using "tough love" to get many of his patients to taper down from the high opioid doses to below the limit set by the CDC guidelines. "I smile, and I'm firm," he tells me. Mostly in response to increased surveillance of his practice, he has also tried to send some of his 'easy', straightforward patients back to other primary care physicians who had referred them to him for chronic pain management. "I went door to door," he says, but every physician he spoke to refused to accept these patients back. "'Absolutely not,' they told me. They don't want to prescribe* any *opioids."*

*In response to these changes, Dr. Thomas is fed up. "The people who were doing bad things aren't around anymore," he asserts. "People who were shopping around, and people with bad CURES reports, are not getting seen by me anymore."*

Dr. Thomas has experienced opioid prescribing as a risk to himself and his livelihood, after he nearly lost his medical license and was placed on probation. Rather than claim moral culpability for the opioid epidemic, as some other health care providers during my fieldwork did, Dr. Thomas believes that the overwhelming problem now is with surveillance gone ‘overboard.’ He situates himself as morally opposed to patients and physicians who have done ‘bad things.’ He sees constraints on his practice as state bureaucratic overreach that is no longer necessary, because these moral transgressors have been purged. Whether these patients and physicians have been purged from the health care system or from society generally— through overdose, incarceration, or death—is unclear; where they have gone now that they ‘aren’t around’ is left unanswered in his formulation. His statements, while indicting the state regulatory apparatus, nonetheless reinforce a moral discourse common in depictions of drug crisis, which advocates for containing and quarantining off the deviant individuals deemed threatening to ‘innocent’ society (Carr, 2019; Lassiter, 2015).

A pitfall of this framing is that Dr. Thomas knows that such purging has been widespread: he went “door to door” to speak with other physicians and found that they were even more frightened and practicing more self-defensively than he was, and they refused to see those patients who receive any opioid prescriptions. Here, Dr. Thomas demonstrates that forms of state surveillance that have emerged in response to the opioid epidemic place moral subjectivity at stake not only for patients, but also for physicians. Dr. Thomas participates in boundary making work to maintain his jurisdiction and that of other physicians in determining who is a deserving patient and how they should be treated. Although he expresses regret, he nonetheless discharges patients he fears might risk his practice. His abandonment of patients contributes to iatrogenic harms that are rendered invisible to him (the patients “aren’t around anymore”), but which shore up his own moral authority—and that of biomedicine-- and protect his prescribing privileges. Discharging patients from care is an act of self-preservation. His statement of engaging in “tough love" ("I smile, and I'm tough,") signals to his endorsement of the opioid guidelines themselves as a form of tough love left unchallenged. These clinical guidelines, enacted under duress by a cornered physician, are here disguised as a form of moral righteousness based on risk calculations ostensibly designed to protect patients.

As much as popular discourse and media narratives have suggested that "bad doctors" and greedy pharmaceutical companies are the sole guilty parties in the opioid epidemic, here we can see that constraints on opioid supplies have affected not just "bad doctors." Rather, the systemic workings of primary care medical practice, and the subjectivities of physicians and patients in primary care settings, have been substantively altered. This includes "regular" doctors, who shift the way they consider risks to their patients and, crucially, to themselves and their practices. The problem of clinical expulsion from care, similar to the problem of opioid overprescribing, is about more than simply "bad doctors."

So far, we have seen that biomedical constructions of opioid risk at the epidemiological level affect the clinical encounter, the practice of primary care medicine, and the subjectivities of patients and physicians. In turn, the possibility of narrative co-construction within such clinical encounters has profoundly narrowed. Although enforcement of physicians was rarely mentioned explicitly within the dialogue of a clinical encounter, its impact on practice was discernible in the broken narratives between patients and physicians. But how does the physician's narrative come to be justified, defensible, and practicable when it has clear negative impacts on the patient, and further threatens the authority of biomedicine over pain management, when patients are expelled from care settings? I turn now to highlight several mechanisms within this encounter that I argue play a key role in producing the structural violence of abandonment: documents and monitors.

## Documents and Monitors

A key mechanism through which Susan was discharged was through the enactment of paperwork. Dr. Thomas waved a piece of paper in the air, the contents of which we were unable to see. The form of the form— its presence in the physician's hand, waving in the air— mattered more in that instant than its content, as the physician said himself ("It doesn't matter what it says, I haven't read it- the bottom line is, I can't see you anymore"). Simply waving pieces of paper in the air, here, provided a sense of authorized officialdom in ejecting Susan from the clinic.

Across multiple clinical spaces in my fieldwork, partially visible forms of surveillance and monitoring, often embodied through documents and papers, read and un-read, were enacted, including prescription drug monitoring reports, patient pain contracts, electronic medical records, written patient instructions and referrals. I focus on the CURES report, the California-based prescription drug monitoring report, and on one term, 'doctor shopper,' to examine how physicians, nurses, front office staff, public insurance providers, and county level officials used this document in ways that were enormously consequential for patients' access to care.

Registering for CURES is now mandatory for physicians in California. Checking a patient's report is also mandatory for any opioid prescription lasting over five days. PDMP databases such as CURES are specific to each state and have slightly different rules regarding who can access the data. In some states, for example, court judges can directly access an individual's prescription record for controlled substances. Use of PDMPs is not limited to clinical settings. The data are also used in research and in policy making. Despite widespread positive support for PDMPs as a crucial tool to curtail opioid related harms, relatively little is known about their effects either clinically or in dictating policy (Zavodnick et al., 2022).

In my fieldwork within primary care clinics, while the content of a CURES report often did little to change the course of clinical care for an individual patient, occasionally, it had a large impact. In addition to its presence in Susan's encounter, I turn below to moments when I observed a CURES report to have a significant impact. The mere *presence* of the report was new and, I suggest, meaningful. I argue that PDMP databases, and their corresponding reports, are crucial to the way the category of 'doctor shopper' is constructed both for data-generating purposes guiding policy decisions and for clinical decision-making, both of which rely on these documents to contribute to the overall officialdom of patient discharges. Without reifying the distinction between the CURES report form and its content, here I emphasize the symbolic relations of the form to ask how the materiality of the CURES report provides a vessel that holds and transmits various emotions and interpretations, in the process capacitating administrative control and the construction of subjects and socialities (Hull, 2012).

### *"I'm not touching that"*

*A woman in her early 30s sees a primary care doctor new to her. She is now a law student but in the last year had multiple different jobs working as a community organizer, and takes several medications for anxiety and panic attacks. Her new doctor is pleasant and helpful but tells her, "Your CURES report makes you look like a doctor shopper. I understand you've changed doctors a few times because you moved, and got a new job so your insurance changed… But that makes your report look suspicious."*

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*Juan has diabetes, high blood pressure, emphysema, and he also has chronic pain. In 1995, while working as a plant specialist, he and seven other men were lifting a tree, and he felt a pain in his back. Imaging showed that four vertebrae in his cervical spine were fused, and he has severe arthritis impinging on the nerves in his cervical spine. He only takes 30 milliequivalents of morphine daily, well below the CDC guideline dose of 50 milliequivalents designating 'high risk.'*

*I ask Juan why he has come to emergency department. He has come because of his pain. He tells me he used to get his pain medications every month by the 1st of the month. Now for the last four months he's been having problems: refills haven't been sent over to the pharmacy on time by the clinic. Last month he didn't get them until the 9th, the month before that it was the 6th, and this month he hasn't gotten them yet and it's the 12th. He has seen the same doctor for years at a primary care clinic in Oxnard. "I love the guy but. Just tell me the truth. I can deal with it. If someone would just say 'Hey, we're not gonna give them to you anymore,' fine. But that not knowing- that makes me want to take it personal."*

*The only answer he's gotten when he calls the clinic is, 'Oh we got a lot more patients,' and essentially they say they've been busy and it will come soon. He doesn't believe it. He has friends who are on higher doses who have not had problems. "I feel like I'm being punished or singled out," he tells me.*

*When the nurse practitioner comes into the room, she silently hands me Juan's CURES report, which corroborates everything he has told me about his medications. In front of Juan, she say to me, "I'm not gonna be able to help him with his narcotics, so." Then she tells Juan, "I know you're being prescribed from Dr. Y, so. You'll have to call his office."*

*"I already did that-" Juan begins.*

*"So is there something new about the pain today?" she briskly continues.*

*Later, the NP tells me, "We don't give narcotics for chronic pain in the ED. That's why we have the CURES report. People like to come in with a convoluted story and try to distract you."*

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*In primary care clinic, a man's CURES report is longer than most. The physician doesn't look at the content of the report: what medications have been prescribed to the patient, how* *many, when, for how long. He glances at the length of it and feels immediately suspicious, and comments to me, "I don't want to get near that. I'm not touching that with a 10-foot pole."*

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*Dr. Glass is not treating the patient in the encounter I am observing; he is on a break between patients, being social by chatting with the treating doctor and me in the physicians' room. A primary care doctor, he has recently become trained in treating addiction, and is friends with the director of the clinic, Dr. A. He looks over our shoulders at the CURES report and the urine toxicology report that we are poring over in order to determine the care plan for the patient. At the patient's last visit to addiction clinic, he was prescribed Suboxone. But the last urine toxicology report, which resulted yesterday, shows no Suboxone in his system. "So he's using," Dr. Glass says. "And he's diverting it [the Suboxone]!" Dr. A nods slowly in agreement. After a moment, though, Dr. A says, "Hang on. Let's check the date of the report." He remembers from prior experience that in the chart, what is reported for urine toxicologies as the 'date resulted' is often wrong. When we look at the toxicology report itself and read through it, we see that sure enough, it was collected at his last clinic appointment several weeks ago, not yesterday. In fact, his urine was collected and tested before he even received his Suboxone prescription. And on closer inspection, the CURES report perfectly checks out. Nonetheless, the level of suspicion in the room has been raised, and is palpable. Dr. A suggests that we follow up closely with this patient and see him back in two weeks again, rather than the typical four. "Why not one week?" Dr. Glass says. "Sure, one week then," Dr. A says.*

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*I attend a meeting with leaders in the county who have organized for several years to collaborate and manage the county response to the opioid epidemic. The group includes behavioral health and public health administrators, public insurance managed care* *representatives, physicians, law enforcement and probation officers, and DEA agents. The group has led several inter-agency initiatives to try to make physicians prescribe fewer opioids, which they update each other about today. Non-law enforcement initiatives have included outreach presentations in clinics about safe prescribing, and putting out systemwide calendar alerts every Monday that read, "Have you checked CURES lately?" There has been a concerted effort to show prescribers how their prescribing patterns compare to others, by issuing report cards on controlled substance prescribing for themselves compared to others. "Providers don't seek out this information," a behavioral health official notes, "but they do respond to it." The managed care Medi-Cal administrators have begun tracking their patients' and prescribers' activities with prescribed controlled substances rigorously. If they decide that patient activity is suspicious, they "lock" a patient into a single prescriber, so that they cannot receive prescriptions from anyone else.*

*Today, the managed care administrator reports that opioid prescribing is way down from 2012 across the county for Medi-Cal members. "There is more to do," he emphasizes, but things are moving in the right direction. He then presents new data that the group has generated on "doctor shopping." He reports that doctor shopping has, likewise, significantly decreased. However, he comments that what he is calling "doctor shopping" may not in fact be "doctor shopping" at all. According to the way the insurance group collected the data, "doctor shopping" was defined as any patient receiving a controlled substance from three or more physicians within a given time period. The problem is, the presenter acknowledges, this may simply indicate a clinic with three or more physicians, all of whom prescribe to a given patient within their clinic. Or, the patient may receive pain treatment in one location, but other primary care at a different clinic, and this patient might also fit into the category of doctor shopper.*

*After the presentation, a law enforcement officer tells the story of an emergency room physician who tipped him off when a patient came in who, as it turned out on examining CURES, had seen "80 doctors in the past year. We arrested her. So the collaboration has been good. A lot more doctors have signed up for CURES. We need to get them to use it. And to call us more." The officer next to him, who recently did a research project on physician cultures and methods for getting physicians to collaborate with law enforcement, chimes in and says, "Reframing CURES data as a medical record has been helpful. It should be a standard of care."*

*- 2018*

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These field notes highlight the indeterminacy of meaning in both the CURES report itself and the data within it. Rather than cold, hard facts or a systematized direction to act, what the CURES report seemed to provide in these moments was a pervasive affect of generalized suspicion. Such suspicion often had a mood or atmospheric quality, floating without definite object and without adhering to the report itself, coloring how interactions unfolded.

In the case of the managed care group presentation, the presenter using large sets of prescription drug data understood that his description of "doctor shoppers" over-estimates the problem. The proxy lumps average patients receiving care from multiple physicians into the category of "doctor shopper," a category of patient thought of as purposively deviant. A physician notes a similar clinical dilemma: without knowing the context of a patient's shifting circumstances, a CURES report breeds suspicion of doctor shopping. In addiction clinic, a space where patients are accepted even while they are using substances not as prescribed, the CURES report worked in tandem with a misunderstood urine toxicology report and produced an atmosphere of suspicion along with a competitive desire to practice self-defensive medicine and increase surveillance of the patient in response. The mildly competitive performance between two physicians that I observed in a single clinic demonstrates the effect of providing physicians with their own data about their prescribing practices compared to their peers: it converts medical decision-making into a guideline-driven game that, rather than doing it well, one can *win.* Since the time of the field note above, registering for and checking CURES has become mandatory for physicians prescribing any controlled substance in California. Physicians, under pressure to perform many clinical tasks within mere minutes, only feel this time pressure increasing while they simultaneously have new responsibilities placed on them to document their own use of CURES reports (Harocopos et al., 2022). Gathering a 'feeling' from the CURES report, rather than poring over it in detail with full knowledge of contextualizing factors, was common as a tactic of efficiency in my field site. Such shorthands and "feelings" that physicians develop get folded into the meaning of clinical expertise and care.

The generative capacity of the prescription drug monitor to produce suspicion and to over-estimate doctor shopping is not due to the form alone, but is integrated with regimes of law enforcement that have heavily pursued and criminalized doctor shopping and have prosecuted both 'pill mill' doctors and 'doctor shopper patients' (Liptak, 2022; U.S. Department of Justice, 2019). Prescription drug monitoring databases are the source material for CURES reports on individuals, which are then perceived and interpreted by the clinician. With regard to databases, Bowker (2005) has argued, the "question is not what the state 'knows' about a particular individual, say, but what it can *should the need ever arise"* (p. 30, emphasis in original). Indefinitely suspended in a state of surveillance, individuals' futures are at stake. The state emerges here not only as drug regulation through bureaucracy, but also "as a spectral presence materialized in documents" (Das et al., 2004:250-251). The CURES report document plays a key role in mediating between such larger regimes of law enforcement, with stores of information, and particular individuals and places, constructing *this* patient or *that* physician as deviant. But importantly, the prescription data in the report itself was often not a crucial determining factor in clinical decisions. Rather, the report generated meaning through its presence, reminding physicians of the fact of state surveillance itself, and the possibility of enforcement against the physicians themselves that came with that. As a result, again, the desire to ward off a nonspecific danger was a pervasive effect of the CURES report, and physicians distanced themselves from their patients, not wanting to be observed "touching that" perceived danger—demonstrating the dehumanization of patients occurring through the CURES form, as people are converted into data objects to ward off.

Another point of indeterminacy lay outside of the clinic, where there were conflicting expectations over the use of CURES reports. Law enforcement officers in the county inter-agency workgroup wanted physicians to treat CURES reports as part of the medical record. Simultaneously, they also wanted them to call the police when they found an aberrancy in a report. These different desires reveal the contradictory framing of the CURES report as a medical record, which is confidential between health care providers and patients, and an external monitor used by law enforcement to surveil both parties. To add to these contradictions, law enforcement agencies have repeatedly stated that they do not tell physicians how to practice medicine, so they cannot and ought not give doctors direction about how to use CURES reports. In these discussions, the CURES report, now omnipresent and relevant across health care agencies and law enforcement agencies, signals to the difficulty in discerning boundaries between various disciplines and state-funded institutions. Mitchell (1999) argued that the "apparent boundary" between state and society is produced through "practices of spatial organization, temporal arrangement, functional specification, supervision and surveillance, and representation"

(Mitchell, 1999:185). Through these practices, he argues, the line between state and society is “a line drawn internally, within the network of institutional mechanisms through which a certain social and political order is maintained” (ibid:175). Discussions and lack of consensus surrounding what to *do* with the CURES report— to call the police, to simply have a conversation with a patient, or to discharge them— reveal that this social and political order with respect to licit opioids has been destabilized. Rather than reveal bureaucratic systematization, instead the presence of the report and its affective intensity reveals a widespread lack of consensus over the roles of law enforcement, public health, and biomedical institutions in regulating licit opioid supplies.

When Dr. Thomas discharged Susan, he justified it in part by citing a form, which he later told me he remembered to be her CURES report. But when I probed him about it, we looked at her CURES report together, and could not find anything that would confirm that she had been “taking things illegally.”

What is more, Dr. Thomas did not document in the medical record that he saw Susan on the day of this visit. When I interviewed him, he told me that because he simply told Susan that he could not see her as his patient, it did not count as a visit. It was not until later that I found out that this allowed Dr. Thomas to evade the responsibility of documenting the fact that he had discharged Susan from his care, an action that could have been challenged by her insurer based on its documentation. Ironically, the waving of a document in hand helped to justify expelling a patient from a clinic, and also helped a physician avoid another documentation practice: that of the medical record. The medical record does important work as both a scientific and a legal document. The discharging of a patient without documenting it rendered the entire encounter invisible to this medico-legal regime. The irony of this is that the increased surveillance on both

Susan and Dr. Thomas in the form of prescription monitoring ultimately led to the erasure of this contentious encounter, and the invisibility of its aftermath for Susan's pain and suffering, in the formal record.

The invisibility of pain in the clinic is here reinforced through the CURES report, which aids in the construction of opioid risks propelled both by biomedical guidelines and by state surveillance. Susan's pain was placed outside of the frame through the deployment of risk management and prescription surveillance. These techniques helped to construct Susan not as a chronic pain patient but as a high-risk opioid user with an addiction—and a scammer.

How do physicians feel out the boundaries drawn between opioid use for chronic pain and addiction? I turn now to observations within primary care clinics, where the majority of opioids have been and still are prescribed, to show how the diagnostic categories of chronic pain and addiction work on patients in pain. Primary care clinical encounters were shaped not only by the object of the CURES report, but by embodied interactions between patient and physician. In the next section, I focus in on physicians' sensory perceptions of themselves and their patients in clinical encounters. I explore how such perceptions affect how encounters unfold. Here, despite pain's presence, and the doctor's felt trust that a patient has "real pain," the doctor leads with a resigned sense of self-defense and a responsibility to approach the patient as addicted, and this clouds over any possibilities of treatment for pain.

### *"Real Pain, Poor Self-Care"*

*I am observing Dr. L today in primary care clinic. She is eager to have me along with most of her patients, until the very end of the day when she is preparing to see her final patient. Dr. L crinkles her nose and says, "My last patient- you can decide if you want to see him. But it's going to be a conversation with him, and it's not likely to be pleasant. He has a history of* *chronic pain and addiction." She tells me I may not learn anything interesting medically from this visit. I remind her that I am most interested in encounters such as these. She reviews a bit of his medical history with me: "He was just hospitalized with perforated diverticulitis and is her now with follow-up, and I'm going to have to sit down with him and tell him that he can't have any more pain medications."*

*We walk in together. John, the patient, is a White man in his 50s. He sits in a wheelchair, which he has used since multiple infections required amputations in his leg and pelvic bones. Tattoos cover his arms and chest, a colostomy bag sits on his lap, and a wound vac is visible on his exposed abdomen. "That was a long hospital stay!" Dr. Lyons says, "Really long!"*

*"Yep," he replies, slightly breathlessly, "The doctor came out and said, 'I didn't think you were gonna make it.' So. It was the man upstairs."*

*"He was looking out for you," she says. Then she gets down to business. Standing over him with her hands in the pockets of her white coat, she tells him that because he had a positive urine drug test when he was in the hospital, he can't go back to his pain management team.*

*"I did?" he says, unaware that he had even been tested.*

*"Yep," she says. "Cocaine."*

*"Well, I was lost for days, so, I guess I don't know," he replies quietly.*

*She tells him that she will talk to a pain specialist about what they should do next for pain management, and that while she can't prescribe him anything for pain at this point, at least he will have the Baclofen (a muscle relaxant) that he is already taking. He doesn't argue. He mentions that his pain doctor had given him something to hold him over until his next appointment but had said that this was the last time he would do that.*

*We complete a brief physical exam. She briefly taps his colostomy bag, and the edges of his wound vac. She listens to his heart through her stethoscope. Then we say goodbye.*

*Outside of the clinic room, the physician sighs, relieved that the encounter is over. "Any questions?" she asks. I struggle to come up with a more physiology-centered question than the ones I would like to ask, such as: What can we do to help this man who is clearly suffering and vulnerable to further harm? After he nearly died and was hospitalized, how do his outpatient medical doctors rationalize no longer caring for him? Finally, I ask her if the bowel obstruction he had was potentially related to chronic opioid use.*

*She tells me, "No- he had maggots in his colostomy bag. The obstruction was from poor care. Probably slow gut contributed but, the main thing he suffers from is poor self care. And now. His pain team fired him because of his positive tox screen. Maybe it wasn't cocaine, it might have been meth, actually. So now he has nowhere to go. I tried to help him, because I thought I could, but now he's tested positive with me too, so, I can't." I ask her what she means. The patient can't go to a pain management clinic if he tested positive for methamphetamines?*

*"Because it's a positive drug screen."*

*"Sorry- I just don't understand," I say. "You mean, the clinic won't see them at all if they have a positive screen?"*

*"No."*

*"Is it because of an interaction between methamphetamines with certain pain drugs, or because they assume that if you are using meth you are using opioids as well?" I ask.*

*"Both. So- opioid overdoses are going up a lot. Heroin overdoses especially. So we don't want to – you know, it's always a question of, can you safely prescribe these drugs. And a lot of*

*people who are using meth are using heroin as well. A positive tox screen is an indication that you can't trust the person."*

*As an afterthought, she adds, "I think he has real pain. I just can't help him with his addiction."*

*- Primary care clinic, 2018*

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Pain is, Ahmed suggests, a contingency: access to its categorical weight depends on one's ability to be read as a subject-in-pain to those that administer economies of intervention in the clinical realm (Ahmed, 2004). While pain has an interiority that creates crushing certainty in the sufferer (Scarry, 1987), it can also be understood as relational: it is social and political in the way that it necessarily "makes a claim asking for acknowledgement, which may be given or denied" (Das, 1996).

Clinical constructions of pain in the U.S. today articulate the boundaries of pain as a kind of belonging to nation, to self, and to futurity (Whitmore, 2019). To perceive the limits of this kind of belonging, it is necessary to read these constructions alongside the historical construction of sensation as racially differentiated (ibid). Pain felt by, and inflicted onto, marginalized people, especially enslaved African Americans and women, has historically been itself marginalized, ignored, viewed as a moral pathology of individual character, or as an important sign that should not be anesthetized away (Glucklich, 2003; Stanley, 2016). In the vignette above, we can see glimpses of the mechanisms— such as an addiction diagnosis— by which marginalized pain *comes* to be marginal within the clinic, even when it is declared to be "*real*."

Rouse's work on sickle cell disease shows the importance of biomedical paradigms on dictating understandings of pain and its management. She describes a system in which specialist physicians can secure patients access to pain medications by focusing on the organic nature of the pain over and against the racist biases of general providers who suspect them of drug seeking-- but this paradigm also indirectly teaches patients that their pain and illness are uncontrollable except through medications such as opioids (Rouse, 2004). In contrast, the biopsychosocial model of pain requires patients to endorse the framework that medication alone is not sufficient treatment, emphasizing willing engagement in other treatment modalities (ibid). Clinical paradigms of chronic pain management in these cases negotiate a politics of self-efficacy versus dependency that reinforce the binary surrounding opioids described in Chapter 1. Such clinical paradigms contain and conceal structural racism and classism, such that even when a vulnerable patient secures access to opioids for pain, such access may come at high personal cost, a loss of a sense of agency over one's life, and a real loss of agency through dependence on precarious biomedical care access (Illich, 1975).

Chronic pain, anthropologists have argued, disrupts the usual relation between the self and the body, disrupts a person's affective and conceptual relation to the world, and unsettles relations with others (Geniusas, 2022; Good, 1994). In biomedical contexts, chronic pain has been constructed as a moral weakness, and pain patients depicted as dependent, malingering, and self-defeating (Aronoff, 1985; Buchbinder, 2011; Fordyce, 1977). In John's case, the physician is irritated by his case before even entering the room. Anticipation of a conversation that will be unwelcomed by the patient, wherein she will tell him she cannot prescribe him any more pain medications, leads her to dread encountering him. And the fact of his pain, simultaneous with his addiction, renders him untreatable in the clinic.

In the vignette above, a positive urine toxicology report is used as an "indication that you can't trust the person," and a justification for getting "fired" by the pain team. The physician assesses that the main thing the patient suffers from is "poor self-care." Many patients I followed spent their full days attempting to care for themselves: from morning to night, they spent enormous amounts of time and effort attempting to secure forms of identification, transportation, access to health care clinics, pharmacy prescriptions, disability benefits, food, housing, and basic necessities. Yet within each clinical space they entered, they were frequently, ironically, read as lacking in self-care. Here we see the deployment of a philosophy of behaviorism, in which behavior becomes a locus of knowledge and discipline (Fleming et al., 2021; Foucault, 1980; Harcourt, 2011). In this formulation, patients such as John with chronic illnesses are conceptualized as failures in the project of self-management, but rather than being subjected to intensified demand for improvement, they are rendered permanent failures of the pain project: fired. The formulation of getting “fired” by your pain management team suggests that pain treatment is a patient’s job: a patient must labor, and labor well, to manage their pain, adhering to the terms of their contract. Such a conceptualization shows the neoliberal practices of self-governance demanded of patients with pain, and the ways in which this conceptualization of pain management can ultimately serve to rationalize the withdrawal of opioid-related care.

While the physician above stated that she believes that John has “real pain,” she simultaneously uses the term “addiction” as a reason for her being unable to help him with either his pain or his substance use. In this case, the ascription of addiction renders biomedical care untenable and relieves the physician of an obligation to treat his pain. Addiction may seem an appropriate diagnosis for John. However, the diagnosis of addiction did not resolve his pain. The vast majority of patients I met suffering from both pain and a dependence on opioids could not easily be categorized as a clear-cut pain or addiction patient, and they were caught in the crosshairs of these diagnostic and treatment battles. Such constraints on care as those demonstrated above highlight the need to investigate how, and why, physicians decide where patients "fit" categorically, and how such categories impact patients' long-term trajectories.

Primary care physicians face an epistemic bind when they attempt to treat patients who would fit both the category of 'opioid use disorder' (the medical term for addiction) and the category of chronic pain for which a patient is prescribed regular opioid treatment. One physician likens such an epistemic bind to confusion about "which hat to wear," signaling to the way that these binds are forcibly resolved through the donning of one or the other professionalized role, rather than a fully internalized form of self-knowledge:

### Which Hat to Wear?

*"If you're gonna treat a pain patient with Tylenol, and Motrin, that's well within the scope of primary care. But if you're gonna start giving them opiates for a long period of time, you're gonna be held to the same standard of care that a pain clinic or a pain doc would be. Part of that is, you want to make sure that they're not using other substances along with their opiates. Because opiates are part of a prescriptive plan for treatment of their pain. So, you don't want them using other opiates. Even sometimes any other drug. And that's why pain clinics sometimes will kick you out of the clinic if you have meth in your urine. Yes, you might be taking your opiates as prescribed. But you're testing positive for meth, so that's a violation of your pain contract.*

*However, in the addiction world, we treat each substance use disorder separately. So. If we've got you on buprenorphine for [opioid use disorder], and you have meth in your urine, or you have even fentanyl in your urine, whatever, another opioid- that doesn't mean you're violating your pain contract. It means your opioid use disorder is not well controlled, or your substance use disorder is not well controlled. So let's focus in on that a little bit more. But if you* *come to see me in pain clinic, and you're on buprenorphine for pain, and I find that you're taking a bunch of Oxys on top of it, you know then that means we reassess, okay, your opioid regimen is not working. We should take you off of an opiate. Cuz it's not working cuz you're still using a bunch of other stuff on top of it.*

*In a primary care clinic it's tricky, because patients come in with both pain and addiction issues. You know, am I supposed to treat this patient as a pain doctor or an addiction doctor? How do I know which hat to wear?" - Physician, 2019*

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This physician points to the epistemic bind that primary care physicians face when attempting to manage a patient who has both pain and meets criteria for opioid use disorder. He acknowledges that he must decide which problem is primary. If the patient is a "pain patient," the treatment trajectory includes pain contracts, careful surveillance of urine toxicology and, if there are aberrant results, either discharging the patient or withdrawing their access to licit pain medications. In contrast, if the patient is perceived as an "addiction patient," illicit substance use does not foreclose treatment with licit opioids, but it does constrain which medications are available in the first place— for example, full agonist opioids that may be more effective against pain than buprenorphine, or Suboxone.

How *do* physicians decide "which hat to wear?" In the public primary care clinics where I did fieldwork, no physician ever asked the patient which problem was more important to *them*, neither did physicians attune to family member experiences or perceptions which might either corroborate or challenge the patient's point of view and could likely have given clarity about the questions at hand. The questions of import to the physician were, as described in the vignette above, whether the patient's pain was real and whether they could be trusted. As evidenced, such discernments have long been racialized and gendered. But in these public clinics, even if patients *were* conceptualized as pain patients, a positive urine toxicology report produced a discharge or a reconceptualization of the patient as an addiction patient. This shows how those patients privileged enough to access the category of pain patient have only a tenuous toehold on this fragile subjectivity. Rather than taking on the addiction treatment role themselves, however, uncertainty or suspicion related to the patient's future behavior often pushed the physician toward referring the patient away to specialty addiction care treatment, or, in Susan's case, simply abandoning them.

In fact, administrators for the business providing managed care for all Medicaid patients in the county recently acknowledged in an interview that they are observing "serial discharging" of Medicaid members who may have both pain and addiction. As one administrator described:

*"If you're a doctor, you may not feel empowered in dealing with someone who has an addiction issue. There's the actual experience of dealing with somebody with an addiction issue that maybe is upset or aggressive, maybe scaring people in your clinic. Another big factor here is- it's very time consuming. So the response we see, coming from systems, is that those providers want to discharge that patient from their practice. Which they have the ability to do, right? And they'll - you know, what they rely on is that 'the therapeutic relationship is irreparably damaged.' And the evidence of that is that they'll make a contract with somebody. But you know if you have an addiction issue, you're going to break the contract. That's evidence that you have an addiction problem, right? [chuckling] And then we see serial discharging."*
*- 2020*

This insurance administrator refers again to the feelings of danger and fear that physicians have when faced with patients who use opioids, this time placing the source of feeling disempowered both in the potential aggressiveness of a patient and in the time-consuming nature of working with these patients. In response, the administrator acknowledges that physicians set up a double bind for patients: deploying a pain contract (Payne et al., 2010) as a record of behavioral deviance by the patient. Pain contracts are documents wherein patients sign on in agreement that they will only use substances prescribed (and as prescribed) by the contracted physician. As the administrator observes, such contracts are tests that patients with both pain and opioid use disorder will inevitably fail. An opioid use disorder diagnosis, in fact, requires that a person use substances other than, or differently than, how they are prescribed.

In response to this, the managed care group has attempted to constrain provider discharge activity. Discharging a patient is a formal process within the managed care network, wherein doctors have to obtain their approval. The need for approval is the reason for the physicians to rely on an argument "that the therapeutic relationship is irreparably damaged," and use a broken pain contract as formal evidence of this.

The administrator noted that at the insurance management level, they are attempting to push back against physician discharges recently by "*tightening up that approval process to say, 'Did you do this? We don't see that you've resourced addiction medicine.*'"

Although this approach may help to pressure physicians to retain their patients, we can see how it leaves an epistemic bind unresolved for both physicians and patients, as patients' pain is continually left out of the conversation in favor of discussing their addiction. To retain their physician, they would have to acquiesce to their deserving patienthood being reformulated around their addiction, and to their treatment trajectories being adjusted accordingly as well. In Susan's case, as well, her physician avoided formally documenting her discharge, leading to pain's erasure and the absence of a potential route to accountability.

## Conclusion

Despite a popular narrative that the U.S. has softened on opioid use now that White people are dying, suddenly willing to provide treatment rather than criminalization to people who use drugs, these two chapters show a much more complicated picture. Segregated tiers of drug war in the U.S. persist, wherein individuals receive forms of criminalization or treatment depending on their social location. I have argued here that so-called "treatment" spaces, through risk management, knowledge production, and surveillance by drug law enforcers, work to maintain criminalization. In spaces where care is assumed to occur, through boundary making distinctions of deservingness, individuals are systematically segregated out of treatment while their pain falls out of the scope of recognition.

In these two chapters, I have described how Susan's trajectory was dually marked by the scale-up of physician surveillance and enforcement to reduce licit opioid supplies and by the application of science demarcating, defining, and intervening upon opioid risks. Her physician's probation made Susan's access to care precarious, and she was simultaneously identified as a 'high-risk' opioid consumer through the marker of being prescribed 90 milliequivalents of morphine daily, well above the 50 milliequivalent specification in the CDC guidelines. Ultimately, she was left to manage her chronic pain along with her opioid dependence absent medical involvement.

The harms of this abandonment were structurally shaped by criminalization, her race and class position, and the illicit opioid supply landscape in the U.S.— categories left unaccounted for in state-led risk calculations pertaining to opioids. While her whiteness insulated her from the most pernicious effects of criminalization in the racially and geographically segregated War on Drugs, nonetheless, changing risk paradigms meant that poor patients, even White women like

Susan, fell out of the protections that came with the medicalization of opioid dependence (Netherland & Hansen, 2017). She was not referred for treatment for opioid dependence or addiction by any of her primary care providers, including the physician with whom she failed a urine test due to marijuana use, and her recourse to illicit supplies came with additional risks.

In the next chapter, I examine the addiction clinics where patients including Susan are increasingly forced if they want to remain under biomedical care, continuing to follow Susan and several other patients along with their physicians in negotiating the meanings of opioids in their lives.

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# Chapter 3.

# The Sacred Object of Buprenorphine:

## Addiction Clinic and the Embodiment of Deservingness

"It might even be possible that what constitutes the value of these good and revered things is precisely that they are insidiously related, tied to and involved with these wicked, seemingly opposite things—maybe even one with them in essence. Maybe!" – Nietzsche, *Beyond Good and Evil: Prelude to a Philosophy of the Future*

## Introduction

How does the addiction clinic define and manage people who use opioids? In this chapter, I attempt to place the addiction clinic, a relatively new space for addiction-related care, within its operating context in the U.S. amidst contradictory forms of governance of people who use opioids. Beginning with a history of addiction treatment and of state investments in buprenorphine, I ask, how does addiction clinic manifest as yet another space where state drug policy is made meaningful? Having seen in the last chapter how patients with chronic pain are being continuously funneled into addiction treatment and simultaneously siphoned off of patient rosters in primary care clinics, what role does the addiction clinic play in circumventing forms of painful abandonment, and how can we understand this space as part of the same "system" of health care? Does addiction clinic, despite its apparent mandate, itself engender new forms of abandonment?

Within a county hospital system, the addiction clinic emerges as a spatial fix for patients who would have nowhere to go and for administrators tasked with finding a place to send them that represents a solution to the opioid problem and is simultaneously cost-efficient and profit-generating. Buprenorphine was lauded as a safer medication to provide patients with opioid use disorder due to its "ceiling effect" and its relatively lower risk for overdose or abuse compared to methadone. The medication emerged in my fieldwork as a catch-all, magic bullet solution to pain and addiction ‘problems.’ However, many physicians acknowledge that this medication often does little for patients in pain.

Given the fundamental role that addiction clinics give to buprenorphine in addressing addiction, and the way in which prescribing buprenorphine provides a charter for addiction clinics, this chapter asks what buprenorphine does and does not do for both patients and clinicians and for how addiction and care are interpreted. Who benefits from buprenorphine, and who does not? Within a public addiction clinic steadfastly promoting the pharmaceutical as its main intervention for patients affected by the opioid epidemic, I ask how one’s relationship to buprenorphine is mediated by the space where one receives it, and to one’s relationship to public health care, to pharmaceuticals, and to competing epistemologies of addiction and recovery.

While most studies of addiction treatment focus on a single modality or intervention and its effects, a key intervention of this chapter is to consider how competing frameworks of treatment and recovery are embodied by those who navigate treatment spaces. I ask how the experience of buprenorphine is deeply impacted by past and present experiences with the state and with alternative ideologies of treatment. Few studies have attempted to understand at a granular level why many patients choose not to take buprenorphine, or choose not to stay on it if they do start taking it (but c.f. (Hansen & Roberts, 2012; Meyers, 2013). This chapter explores experiences of patients who could not or would not take buprenorphine, and some who opted to go off of it after starting it. Through vignettes of clinical encounters, I show how patients and physicians continually negotiate the meaning of buprenorphine, talking past and missing one another as they assert their embodied or posited expert knowledge. I trace how a patient’s embodied experience of buprenorphine is deeply influenced by their past, by their lived relationship to the specter of the state and to biopower, and to competing frameworks such as faith-based recovery programs.

In the second half of this chapter, I ask: how do addiction physicians understand their practice? Using ethnographic data from the clinic, I trace how addiction specialists' behaviors and attitudes toward patients are spatially and situationally framed and constructed, and ask what impact these attitudes have on the treatment of patients with both pain and addiction. I suggest that physicians' willingness to treat anyone referred to addiction clinic as an "addiction patient," whether they believe the patients have addiction or not, produces a care safety net in the midst of serial discharges from primary care clinics. I suggest that this recent turn in the medicalization of addiction offers potential avenues for care through the flexibility to identify, or not, with pathologization. Patients are required to adhere to the treatment of buprenorphine medication, rather than to identify with the 'addict' title.

Addiction physicians' beliefs and approaches are often influenced by principles developed originally by a harm reduction movement in response to a lack of public health care. Contradictory and ambiguous meanings of addiction and care, advocacy and institutional policy are negotiated in the addiction clinic. This chapter raises the question of what impact harm reduction has on clinical care, and conversely, what impact clinical spaces have on the practice and principles of harm reduction.

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## "Really Here For Addiction"

*Susan has been vomiting bile all morning, anxious about her upcoming clinic visit and beginning to go into opioid withdrawal. She took a long bath and dressed up, straightened her silver hair and applied makeup, eager to look her best at the addiction clinic appointment I* *helped to set up for her. She wants a prescription for outpatient methadone to treat her chronic pain while avoiding daily visits to the methadone clinic. If she can get this, she can also travel with her twin sister to visit their extended family out of state soon. I set this appointment up because I have observed a few of the physicians in addiction clinic prescribe methadone for chronic pain for patients before, albeit usually from their primary care clinic or within the hospital, and I am hoping she will be able to see one of these physicians and make her case in such a way that they will prescribe her methadone.*

*On the short walk from the parking lot to the clinic lobby, Susan and I move slowly, stopping multiple times so she can rest and recover from shooting pains in her legs, which have not yet healed since her hospitalization several months ago.*

*In the clinic, the physicians I was hoping for are not working today. Susan gets placed into a room and I follow her in behind her doctor, a primary care physician who is getting additional training in addiction this year. Susan tells her story openly. In the end, she makes it clear that she believes a prescription for methadone will be her best option. "I just want to feel safe and have my pain under control to the point where I can have my life back," Susan beseeches the doctor.*

*"That's a fair request," he responds. But he tells her that he is "not comfortable" prescribing her outpatient methadone given her recent opioid history. He emphasizes that it is "really rare for doctors to prescribe methadone for pain," saying that he has only done so maybe two times.*

*"You couldn't do it a third time?" she asks.*

*The doctor, leaning against the patient exam bed, his hands folded in front of his lap, adjusts his stance, crossing his arms over his chest and then uncrossing them again. Because she* *has used injection drugs in the past, he says, and clearly has a "physical dependence on opioids, I don't think it would be the best thing," he says.*

*They go back and forth for almost an hour. This is the longest amount of time I have seen a physician speak with a patient in this clinic. The doctor listens. He responds with sympathetic tones. Eventually, he summarizes his assessment:*

*"You're really here for addiction," he says.*

*"I know... I know I have a dependence. And I'll own that too," she says, nodding tearfully.*

*Instead of methadone, he suggests that she take sublingual Suboxone, or buprenorphine, describing the partial opioid agonist as a safe and effective medication for opioid addiction. But he concedes that it may not treat her pain well.*

*For the rest of the visit, he instructs her on how to initiate Suboxone at home: she would have to stop taking all opioids including methadone, because Suboxone blocks their effects and if she is still feeling their effects, Suboxone can cause her to withdraw from them. The next day, once she is experiencing withdrawal, she could safely place the medication under her tongue and it would significantly relieve her withdrawal symptoms and prevent future cravings.*

*I go with her to pick up the Suboxone from the pharmacy. Her monthly disability check will not arrive until Friday so she does not have any money in her bank account, and has to borrow from her sister in order to pay for her prescriptions. In the car outside of the pharmacy, I show her the Suboxone strips and walk her through the home induction one more time.*

*The next day, Susan goes into severe opioid withdrawal, marked by shooting leg pains at the sites of her surgeries, diarrhea, vomiting, anxiety, and insomnia. I talk to her on the phone late the next evening, trying to coach her to take the Suboxone. But she is increasingly anxious,* *afraid to take the Suboxone. In her mind, she continues to hear the voices of friends who have told her that Suboxone will block the effects of pain medications if she has an acute injury and has to go to the emergency department. She is worried that taking Suboxone will make her vulnerable to untreatable future pain. The only thing worse than resorting to illicit opioids, in her mind, is the specter of unmanageable pain while she is taking Suboxone. "What if I get in a car accident?" she wonders.*

*She can't bear to risk it. Instead, she buys methadone off the street.*

*– 2018*

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Susan's interpellation as an addiction patient here, after years of being a chronic pain patient, and the iatrogenic consequences that came from her discharge from primary care clinic, highlights the contradictions of discourses and policies responding to opioid epidemic that implicitly construct medicalized categories of addiction and pain as mutually exclusive. Addiction clinics, separate spaces of care increasingly set apart with the rise of addiction medicine as a clinical medical specialty, have a distinct scope of care that presumes that pain will be considered and managed elsewhere. Such frameworks reinforce the delegitimization of pain experienced by people labelled as 'addicts' and rationalize a catch-all treatment plan of buprenorphine.

Susan experiences her chronic pain in a way that ruptures the self. Pain, as she describes it, makes her both acutely aware of her body and alienated by it. Her hips, her legs, are objectified into things outside of her self, that take her away from herself. The pain disrupts her ability to function and move in her body and to fulfill the roles in her life that constitute her world: a grandmother who can care for her grandchildren, a sister who can care for her sister. She wants to avoid pain, not only because of the experience of it but because of the danger it puts her in of losing her life and her world.

In the vignette above, a medical epistemology of addiction and treatment fails to encompass the range of patients' experiences with pain and with opioids. Susan endeavors to articulate her goals of care, present herself well, and perform the required moral subjectivity when requesting prescription methadone. She is unsuccessful. In the addiction clinic, her physician prioritizes managing the risks of addiction, which are framed as ultimately best managed with Suboxone. Although Susan perceives methadone prescribed in an outpatient clinic to be the treatment that will make her feel 'safe,' her doctor deems this too risky given her history of addiction. Rather than 'safe,' Susan experiences buprenorphine as a gamble: risking potential pain that cannot be alleviated with medical intervention. In her calculus, she decides not to take the prescribed treatment, opting instead to manage her pain with street opioids.

Discourses of chronic pain and pain patients' rights intersect with and compete with discourses of addiction and the rights of drug users (Bell & Salmon, 2009). While much biomedical and social science research conceptualizes these 'problems' separately, this chapter explores the ways that both patients and physicians often navigate these frameworks simultaneously. The segregation of these experiences is troublesome for patients, who are abandoned from meaningful care, and for physicians attempting to provide care, who are constrained by spatially reinforced epistemic binds and by regulatory enforcement.

Susan's concerns about untreatable pain echo ongoing debates regarding buprenorphine's efficacy for chronic pain and recognized challenges of managing acute pain in buprenorphine patients (Anderson et al., 2017). Many patients attest that buprenorphine does not significantly relieve their pain. Within the hospital setting, this claim is less often questioned by physicians:

patients often receive buprenorphine for opioid use disorder and simultaneously receive full agonist opioids for their pain. This difference, between best practice within hospitals and within clinics, is likely best explained by a difference in the level of risk perceived by the prescribing physicians, and the difference in the way those risks are constructed. Within a hospital, surveillance of patients and the perception of total control over patients' "ins and outs," that is, what they ingest and expel from their bodies, coupled with the present absence of surveillance by the DEA within the hospital, alters the construction of risk to physicians doling out full agonist opioids. Prescription drug monitoring programs run by the DEA do not track medications that are administered on hospital wards; they only track prescriptions dispensed at the time of discharge or in outpatient settings by pharmacies. Addiction clinics have different standards and different risks than inpatient hospital settings, and physicians there are not in the practice of managing pain.

The partial, incomplete medicalization of opioid addiction has occurred in the context of the massive shift in the medical treatment of pain detailed in the previous two chapters. In contrast to the growth of addiction treatment and the rise of addiction clinics, in 2016 the American Medical Association petitioned to drop pain as a "vital sign" (Levy et al., 2018). This was a reversal of a statute implemented in the 1990s that made pain evaluation and treatment a professional standard of medical care that was institutionalized in most U.S. hospitals, through the implementation of patient pain treatment satisfaction surveys and pain scoring systems.

As addiction has become more legitimized as a disease, morally and legally deserving of medical intervention, institutional and moral imperatives to attend to and relieve pain pharmaceutically have receded. Within this shifting landscape have emerged new and contested models of deserving patienthood as well as modes of caring for and governing patients who use opioids (Bell and Salmon, 2009; Bourgois 2000).

Just as the addiction diagnosis, in the clinic, erases histories of pain, the framing of buprenorphine as a ‘magic bullet’ technological solution to opioid dependence renders invisible why many patients seek out opioids in the first place: the alleviation of present and future pain. The question of what would happen next was, for Susan, paramount, and her fears of buprenorphine were heavily influenced by her embodied experience both of pain and of abandonment by doctors. These embodied experiences, both of deservingness and of abandonment, are the focus of my analysis of buprenorphine and the meanings of clinical care for addiction.

## A brief history of U.S. addiction treatment

Addiction clinics are relatively new sites of care and treatment for people with addictions. Addiction hasn’t historically been considered as primarily a medical problem, although there were some advocating for alcoholism to be treated as a disease as early as 1784 (Mann et al., 2000). Rather, mutual aid societies, sobriety circles, faith-based programs, state-run inebriate homes and asylums, hospital wards, and private treatment centers for the affluent operated in tandem. Alcoholics Anonymous developed enormous popularity from the 1940s onward, and the 12-step model of recovery has dominated much of the addiction treatment landscape since, although recent demographic surveys have shown that 62% of participants are men and that 89% of participants are White (AA.org, 2015).

Throughout the 20th century, a question persisted about the legitimacy and utility of using medications for the treatment of drug addiction. The Harrison Act was passed in 1914 following an international conference on opioids at the Hague, out of which came the first international drug control treaty of 1912. The Harrison Act regulated the production, importation, and distribution of opium and coca products and restricted the availability and consumption of opium. A clause applying to doctors allowed distribution of opiates “in the course of his professional practice only.” In this way, federal legislation avoided the appearance of regulating physician practice, which was protected by states. However, the Treasury Department issued regulations that made prescriptions valid only for “normal” doses, presumably disallowing maintenance-level doses for people with high opioid tolerance (Baumohl, 2000). Still, morphine maintenance for people with opiate addictions continued to be provided by physicians resisting these regulations. Local courts often upheld that these doctors were acting out of necessity and in good faith, until the 1919 Supreme Court case Webb v. United States the court held that prescription of narcotics for maintenance treatment was not legally permissible or under physician discretion (Baumohl, 2000). The last resistant, locally-run morphine maintenance clinic in Shreveport, Louisiana was shut down by 1923 (ibid). With just a few notable exceptions including the incurably ill and a “gray market” of patients in private sanitaria, most others were swiftly forced into opioid withdrawal, as abstinence became the only legitimate goal of treatment for several decades, until 1965 (ibid). In this year, methadone maintenance clinics partially disrupted prohibition with their establishment beginning in New York City. This change allowed for the opioid agonist methadone to be used for opioid addiction under strict supervised dosing at daily methadone clinics segregated away from other types of clinical care, where patients were administered the medication on-site and monitored with urine drug testing.

In 1987, the American Medical Association named all drug addictions diseases of the brain (Robinson & Adinoff, 2016). This embrace of medicalizing addiction came at a time when health care was transforming into an increasingly market-oriented system that frames patients as “rational” economic actors, (Esposito & Perez, 2014; Gronfein, 1985) and the types and duration of services provided in formal health care settings was increasingly limited; care responsibilities shifted onto families and individuals (Kittay, 2013). For mental illnesses, this followed shortly after the end of the asylum through deinstitutionalization of mental health care in the U.S. The use of pharmaceuticals in clinics to treat mental disorders was framed as moral progress, superior to keeping patients in institutions set apart from the community. It was also cost-effective and much cheaper than intensive psychotherapeutic intervention (Harcourt, 2011). Coupled with this era of deinstitutionalization and the rise of the neuro-pharmacological era in mental health, the medicalization of addictions translated into making pharmaceuticals the focus of addiction treatment. The increasing focus and funding placed on addiction neuroscience has mirrored larger shifts in framework and in health care system structure more broadly (Hansen & Skinner, 2012; Vrecko, 2010).

In 2000, the Drug Addiction Treatment Act carved out an unprecedented exception to the Harrison Act prohibitions, for the treatment of opioid addiction with the medication Suboxone: a combination of buprenorphine and naloxone. The law allowed the controlled substance buprenorphine, itself a partial agonist opioid, to be used in outpatient clinics for the treatment of opioid addiction, provided that certain conditions were met: prescribers would be required to complete an educational course concerning the use of the medication and apply for a waiver with the Drug Enforcement Administration. Such a shift reversed decades of drug policy and demonstrated a large shift in the dominant narrative about people who use drugs. Hansen, Herzberg and Netherland have traced, through media and content analysis of congressional records that led to the passage of DATA, how addiction was re-imagined at this time (Hansen et al., 2023). Addiction was discursively constructed as something not only experienced by Black and Brown residents of inner cities, imagined to be deviant and criminal, but also a disease suffered by White residents in suburban locations imagined to be high functioning, employed, and family-oriented (ibid). Since DATA was implemented, a disproportionate percentage of buprenorphine prescriptions went to white, privately insured patients (Lagisetty, 2019). In this way, buprenorphine has acted as what Hansen and Netherland term ‘a technology of whiteness,’ functioning to imbue whiteness onto both the phenomenon of addiction and users of the medication.

## Investing in buprenorphine

Unprecedented public and private investments in the development and approval of buprenorphine as a medication for addiction led to its ultimately being granted special status, an approval that reversed nearly a century of drug policy (Campbell & Lovell, 2012; Netherland, 2011; Netherland & Hansen, 2017). As Netherland describes, there were no precedents for a highly profitable addiction medication; then Senator Joe Biden lamented the fact that regulation of addiction treatment restricted access to patients and therefore stifled pharmaceutical industry’s investments in the area (Netherland, 2011). The developer of buprenorphine, Reckitt-Bensinger, was unwilling to invest in the regulatory approval process for buprenorphine as an addiction medicine without a guarantee of market exclusivity outside of methadone clinics as well as the ability to reach the mainstream practice of medicine. Lack of market incentives and “societal stigma” surrounding addiction treatments were used to rationalize government investment on behalf of industry, although such stigmas were at least partly produced by government regulations over spaces such as methadone clinics (ibid). Meanwhile, champions of buprenorphine, Campbell describes, developed a “fervor” due to the importance of buprenorphine for justifying continued federal investment in addiction research (Campbell & Lovell, 2012).

Buprenorphine has now become a major focus of public health and medical responses to the opioid overdose epidemic, and the medical specialty of addiction treatment has grown in tandem with the rise of buprenorphine. Public insurance coverage for buprenorphine has expanded while scientific studies have highlighted the efficacy of buprenorphine often independent of other interventions like psychotherapy and counseling, contributing to the idea of buprenorphine as a magic bullet intervention (Carroll & Weiss, 2017).

The addiction medicine specialty was formally founded in 2010, allowing physicians who are not psychiatrists to complete a one-year formal fellowship and practice addiction medicine (Smith, 2011). The Mental Health Parity and Addiction Equity Act of 2008 required insurance companies and group health plans to provide similar benefits for substance use treatment as other types of medical care, and the Affordable Care Act of 2010 expanded coverage for addiction treatment (Abraham et al., 2017). Since this time, the number of clinics offering specialty care for addiction has grown substantially. Buprenorphine has now been positioned as a crucial, if not the main, intervention on the treatment side of the state response to the opioid epidemic.

It is difficult to overstate the importance of buprenorphine for the functioning business of the addiction clinic. Although buprenorphine is also prescribed (typically in lower doses) in primary care and pain clinic settings, this chapter describes the increasing reliance on addiction clinic and its physicians in managing the dismay or resistance of patients who are either discharged from those settings or are forced onto rapid opioid tapers and offered only buprenorphine then after. In the main addiction clinic where I did fieldwork, most patients treated there use opioids, and in the course of their first visit, they obtain a diagnosis of opioid use disorder. Many simultaneously have a diagnosis of methamphetamine use disorder for which there is no FDA-approved pharmaceutical treatment. For these patients, buprenorphine is essentially the only medication on offer at the addiction clinic site. Methadone still must be obtained from a separate methadone clinic rather than through addiction clinics, reproducing logics of segregation that are rationalized at least in part by the pharmacological differences between methadone and buprenorphine: methadone is a full agonist opioid, is metabolized at notably different rates by different individuals, and does not have the “ceiling effect” or limit on respiratory depression  that buprenorphine has (Richardson & Raymond, 2018). Because of these differences, methadone is seen as carrying a higher risk of overdose and abuse compared to buprenorphine.

At the beginning of the COVID-19 pandemic, telehealth was permitted for initiating patients on buprenorphine, and many other public addiction and treatment services were cut back during the initial lockdown. The number of patients treated at the addiction clinic where I did fieldwork rose by over 50% and the clinic added more days when they were open in order to serve the increased demand. Today, there is a six week wait for an appointment to be seen for an initial evaluation.

## Competitive, and cooperative, frameworks for addiction treatment

Addiction clinics providing buprenorphine exist amongst, and in some ways compete against, other models of managing addiction that have dominated the treatment landscape historically. Such models range from state-funded and state-run efforts to non-state institutions and groups: on the state side, the most robust law enforcement and carceral system ever developed continues to track people who use or sell drugs into jails and prisons, most of which do not provide medications or other kinds of treatments for addiction (Vestal, 2020). Court-mandated addiction treatment governs individuals through medico-legal hybrids that highlight the importance of thinking through meanings of "care" when it is so often entangled with punishment and coercion. For example, "alternatives to incarceration" in the form of court-mandated rehab treatment, while perhaps well-intentioned, have been shown to extend the length of time individuals are under state surveillance and incarcerated, as clients who "fail" treatment are then mandated to serve the full length of their sentences without credit for any of the time they did under surveilled addiction treatment (Tiger, 2013).

Meanwhile, 12-step mutual aid groups and faith-based programs continue to proliferate, some of which receive clientele who are placed there through drug courts. Many such programs eschew medications for addiction treatment and describe such treatments as replacing one addiction with another. Even if these spaces allow medications such as buprenorphine, clientele must navigate relationships with diverse authority figures in these spaces including rabbis, pastors, captains, social workers, case managers, sponsors, and their insurance companies, each of whom has an orientation to various epistemologies of addiction treatment and many of which contradict one another.

### Medicalization and its discontents

Segregations that maintain a two-tiered drug law enforcement system are codified through law, the construction of space, and ideologies of common sense linking drug use with crime (Beckett & Sasson, 2000), drug use with dehumanization (Zigon, 2018), and drug use with a desire to self-destruct (Wise & Koob, 2014). Attempts to medicalize addiction both reveal and reproduce societal contradictions that rely on these ideologies. Netherland's (2011) important study of medicalization examines the social construction of Suboxone, the brand name of buprenorphine combined with naloxone, to argue that the pharmaceutical technology provides the conditions for neoliberal citizenship, increasing the responsibility and burden of blame placed on individuals, and reducing social problems to individual ones (Netherland, 2011). The simultaneous prosecution responses to addiction haunt discourses of medicalization and produce a continuum of care depending on one's social location, dually marking vulnerable individuals who use opioids as both patient and prisoner (Garcia, 2010). While medicalization is not necessarily synonymous with either pathologization or depathologization, it is imbued with morality (Fassin, 2011). Anthropologists of care have pointed to some of the consequences of medicalization and of regimes of care that imagine some deserving, apolitical suffering subjects separate from broader sociopolitical contexts, ultimately rendering others undeserving and simultaneously foreclosing possibilities of collective political responses to injustice (Ticktin, 2008, 2011). Scholars have illustrated cases in which medicalization is produced imperfectly and imbued with popular conceptions of history and race, which can exacerbate inequality and render certain subjects deserving of care and others deserving of punishment (Briggs, 2004).

How might medicalization distribute deservingness? One example of this is the role played by buprenorphine as a 'technology of whiteness,' as Netherland and Hansen describe it, conferring whiteness through its circulation. They argue that buprenorphine maintains racial boundaries around the biomedical uses of opioids, carving out "diagnoses, treatments, consumers, and boundaries between legal and illegal practices, and worthy and unworthy citizens" (Hansen et al., 2023). Such a social technology enables racial capitalism. They describe its creation of racially distinct subject positions: denoting a new subject distinct from the "unruly, noncompliant methadone patient," described as the "upwardly striving, pharmaceutically enhanced buprenorphine consumer." Other scholars have emphasized discourses of freedom and normalcy in both patient and prescriber narratives of buprenorphine

(Harris, 2015). Netherland and Hansen have likened buprenorphine to a prosthesis, one that bolsters the weakened self — "through an implicit Christian morality of grace through submission to a higher power" (Netherland & Hansen, 2017).

And yet buprenorphine is directly in contradiction with another, even more explicit, Christian morality: that of Narcotics Anonymous, or N.A. N.A. generally eschews medications for addiction. There are many people working in recovery programs who describe all medications for addiction treatment as "replacing one addiction for another."

Within the United States, the medical model of addiction treatment is a relative newcomer in the landscape of addiction treatments, in competition with older ideologies established by grassroots organizations, non-profits, and others who previously responded amidst a dearth of health care treatment options to provide models for recovery. As Bourgois and Hart have pointed out, the hegemony of the biomedical approach to addiction treatment is tenuous and uneven (Bourgois & Hart, 2010). They point out that science and religion are often understood as mutually exclusive, positioned in competitive binary opposition to one another that constitutes a waste of time in answering questions of how to best help vulnerable people struggling with addiction.

A tension in the literature on medicalization of addiction and the governance of opioids is how we can understand the ways that different discourses interact with one another in people's daily lives. While most research on addiction treatment has focused on one approach or another and its effects, I read these different frameworks and distinct discourses of addiction and recovery as key actors in an ongoing ideological struggle that plays out in individuals' bodies and psyches, who occupy a given habitus themselves. I argue here that interaction *between* different discourses and conflicting views produce real outcomes in people's lives.

Relatively little is understood about *how* epistemological competition between the medicalized model interacts with other models in the struggle for hegemonic control of addiction treatment. How does the N.A. model, for example, intersect with the biomedical model promoting buprenorphine, in patients' lived experience of seeking and receiving care?

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## Using Buprenorphine

Buprenorphine benefited many individuals whom I worked with throughout fieldwork. Especially in inpatient hospital settings, in both Ventura County and New York City, many people spoke positively of buprenorphine as it had helped them to stay off of illicit opioids and other illicit substances for some period of time, occasionally as long as three years. Buprenorphine also helped them avoid withdrawal in inpatient hospital settings when they found it more difficult to use illicit opioids, and in jail in New York City (it was not available to most individuals in California jails). Most people in my field sites had used buprenorphine at least occasionally to help them use heroin and fentanyl less often, and to help them stave off withdrawal when they didn't have enough money to score: *"Like, if I've got money, if I've got a couple of dollars, I'm like 'Damn, I don't need to take my Suboxones for like two or three days.' That means get high for those three days. Once my money runs out, then I can just kick back [and take the Suboxone]. Sometimes I do it like that."*

But most patients that I met throughout fieldwork were unable to get on, stay on, or benefit consistently from buprenorphine. What were their embodied experiences with the medication? What does it mean to want a medication to "hold" you? What social forces intersect and lead people both to acknowledge that buprenorphine works for them, but also believe wholeheartedly that they need to get off of it?

Despite harm-reducing and cost-saving benefits of buprenorphine, throughout my ethnographic fieldwork I only observed one person, Sandy, a young white woman who was 25 when we met, undergo a major transformation of her life with the help of buprenorphine. This transformation came in the shape of getting housed after living in an encampment for several years, re-establishing a relationship with her father, stepmother and brother, moving in with them and starting classes at the local community college. She was hospitalized for six weeks in order to receive intravenous antibiotics for infectious endocarditis, during which time she was stabilized on buprenorphine, along with receiving additional interventions including regular visitations by a drug counselor and a therapist. She then transitioned to a residential rehab program, at the end of which, in order to stay at the sober living, her insurance required her to taper off of buprenorphine. She immediately relapsed, contracted infectious endocarditis once again, and had to undergo multiple additional surgeries for the placement of a bioprosthetic valve in her heart. The second time, though, buprenorphine stuck. Because the COVID-19 pandemic had started, her dad invited her to come home to stay rather than trying to find placement in sober living. Her dad believed that his home was safer than the street or a crowded rehab from an infectious disease standpoint, as he understood that her bioprosthetic valve put her at higher risk of death from infection. Because she was able to be housed with her family, this time Sandy was not required to taper off of buprenorphine by her insurance in order to continue qualifying for coverage of a rehab program that doubled as her housing.

Sandy is one of the few people whom I met who felt unconflicted about going to N.A. meetings while simultaneously taking buprenorphine. She just didn’t bring it up to people in meetings. They knew that she had a “bad heart,” and that she was careful about COVID, and her sense of physical vulnerability made the issue uncomplicated in her mind. She was at N.A. for the community and support, not for the direction to get off of everything or to “get clean.” She felt like at some point she would like to get off of buprenorphine, but she wanted to give it a year or two before tapering down, which the addiction specialists she saw supported.

Most people who had benefited from buprenorphine in New York City likewise saw it as a temporary solution. Wanda, for instance, who was prescribed buprenorphine from the Lincoln Recovery Center (LRC) in the Bronx, barely used it for several months and continued using heroin but showed up to the LRC three times a week anyway for acupuncture and group. She loved it there, loved receiving acupuncture and benefited from the participation in the community. But she was always getting urine tested and there was no buprenorphine in her urine. Finally, after three months, the staff there had a conversation with her and told her that to remain in the program getting acupuncture and group support, she had to take the buprenorphine. She realized that for her, the LRC program made it worth it to take the medication, so she did. She got off of heroin completely. But she qualifies it: *“For me it's not to stay on it for too long, to get off it within a certain period of time. Don't make it a lifelong thing. I don't want to make this a lifelong thing, I don't. Because I know what it is to be in recovery. For me to be in recovery is to be clean. Abstinence of everything and working a program. Even though this is working for me.”*

For many, what Susan was afraid of was true: buprenorphine did not help with pain, and it might make things worse. Figuring out the right pain management scheme was harder with buprenorphine in the system blocking low doses of opioids from binding to receptors. The task of trying to achieve pharmacological relief from pain with buprenorphine in the system was never straightforward for physicians, and for patients with pain, the benefits of buprenorphine didn’t outweigh those risks. While physicians typically offered to split patients’ buprenorphine into thrice daily dosing rather than once a day, suggesting that this might make it more effective at managing pain, patients saw this as a feeble attempt to disguise a medicine for opioid withdrawal as a medicine that would treat their pain. A patient in New York City, who had gotten his leg caught in a train door, breaking 16 bones, put it simply: "*Here's the problem with buprenorphine: it's not a painkiller. And with all my injuries. I have to have something*."

### "Buprenorphine doesn't hold me"

For others without pain due to identifiable injury or disease, buprenorphine was still missing something. "*Buprenorphine doesn't hold me*," Ariana, a 45-year-old Latinx woman from Oxnard told me. Ariana was first offered buprenorphine through a pilot program in jail—and although she was one of the "lucky ones" to receive MAT while incarcerated in California due to being pregnant, she also described being repeatedly harassed for her opioid dependence by multiple officers inside as she went to receive her supervised medication dose each day. When she was later admitted to the hospital for a fentanyl-related abscess, she received buprenorphine again. In this context, the term "hold" takes on multiple meanings. She expresses that the medication does not hold her in place, in the sense that it has not kept her from "backsliding"-- returning to using heroin and other opioids. It also does not hold her in the sense of offering a physical sense of comfort that adequately eases the anxiety and jitteriness of withdrawal symptoms. We can understand the idea of a medication "holding" a patient on multiple registers: as a biochemical embrace, and simultaneously, as a biochemical restraint. Neither does buprenorphine hold her in spaces of care, keeping her in the hospital and the wound clinic and away from her drug dealing boyfriend. Nor does it hold her in time, in the present, with the possibility of a future: she slips backwards. She describes going back to her boyfriend after she was released from the hospital and he was released from jail, and, when she said she needed to go to pick up her buprenorphine refill, he filled a syringe with heroin and fentanyl and told her, "I have your medicine right here. Stay."

On multiple registers, buprenorphine, for many patients, felt weak. Benjamin, a young African American man in the South Bronx, said,*"Sometimes I could wait, and take a Suboxone, and my body's still going through that withdrawal, it's like it needs something, so I'll be like, 'Damn, I'll go get a bag [of heroin], because the [buprenorphine] is not really doing nothing."*

For patients like Ariana and Benjamin, on the margins of buprenorphine's boundaries of deservingness as poor patients of color who had personally experienced contradictory valences of care within carceral settings, the insufficient "hold" that buprenorphine exudes raises crucial questions about how worthy and unworthy citizens are produced in ways that become embodied. Their stories highlight how strong the forces are that push individuals toward opioid addiction, and how relatively weak are particular social, economic, political, and embodied defenses. The 'weakness' of buprenorphine can be read in relation to the balance of these forces. What would it mean to be "held"?

Netherland and Hansen describe buprenorphine conferring whiteness through its circulation, continually producing boundaries of deservingness and enabling racial capitalism in the process. In the above examples, we see how the meaning of buprenorphine has become complicated by its increasing circulation. Rather than conferring whiteness here, it *connotes* whiteness and class privilege through its profile of moderation and of relative safety. But it does not confer whiteness structurally by reconstituting past or present resources. While biomedical discourses imagine the landscape of addiction as ahistorical, constructing a world wherein prior frameworks of addiction as criminal and as moral failure simply do not exist, these vignettes suggest that such historical framings continue to be felt within and through the very experience of taking buprenorphine.

The failed embrace of buprenorphine is bidirectional: those who have been left out of care and medicalization in the past do not hold on to buprenorphine as a meaningful solution to their disenfranchisement. And as Ariana and Benjamin describe, neither does buprenorphine hold on to them.

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*This morning I go visit Diane and Juan in the River Bottom encampment. I walk through a dusty path and pass by a number of neighbors' tents waving American flags, and a few with pirate flags up. There are mosquitoes everywhere in the tent and outside of it today. I hang out while Diane, Juan, and their friend Ernesto shoot their wake-up dose of heroin. I ask them about the COVID-19 vaccines. While the Johnson and Johnson vaccine for COVID-19 has been available at the street entrance to the encampment every Monday, Ernesto tells me, chuckling as he prepares to shoot heroin into his forearm, "We'll inject this stuff but we're scared to death of the vaccine!" A couple of months later, Ernesto will be arrested and receive the vaccine in jail.*

*Juan takes pride in his skills with a syringe, using a slice of a broken mirror to find and inject his external jugular vein, smiling unperturbed when I tell him my concerns about the dangers of injecting there. A little while later, we laugh about the kittens that keep coming back after Diane gives them away to other people in the camp. They know their home. Juan keeps asking for a donut, and Diane won't give him one, until finally she says, "Oh go ahead, have one," and he eats the donuts happily. Abruptly, Juan gets up and tells me he needs to get on Suboxone. I'm a little surprised, but I happily offer him a ride to the addiction clinic. I've told them both several times about the medication and offered to help them get on it. Diane has no* *interest. Juan tells me today that he needs a hernia repair and has to get on it before the doctors will do the surgical repair.*

*On the car ride over, Juan tells me about his childhood in Oxnard as the son of a single mother from Mexico, as the child that his mother's extended family always just seemed to dislike. He got in fights at school for looking more "hood" than his peers, and eventually got expelled from the public school system. He started using drugs at 12 years old and spent many of the adult years of his life in prison or in the encampment. Recently he was told by the cops that they will arrest him any time they see him in the encampment, so he has been "laying low" in Diane's tent and allowing others to bring him what he needs. Although he could stay with his mother just a mile or so away, he can't leave the encampment, he tells me, smiling broadly: "All my friends and family are here."*

*I bring him to the front door of addiction clinic at 1 p.m. at the start of clinic, but the nurse tells me he can't be seen today and that we "never do walk-ins." This surprises me because I've brought people there before without problem, but luckily a few seconds later, the case manager for the whole person care clinic walks up and tells me that he will see what he can do, and eventually brings him to the back door of the clinic and has him see the drug counselor. The case manager tells me to ask one of the doctors if they would see him. There is a 2 p.m. "no show" so I ask if the addiction fellow can see Juan. The fellow cheerfully agrees to see him. But listening in, the attending pushes back, asking if the patient is "with it" and if he could do the follow up and do an induction outside of the hospital. I tell him that I believe he can, I know him well and will be seeing him regularly as he completes the induction onto buprenorphine. The attending tells the fellow, shrugging, "It's up to you." The fellow agrees, so I go to the front office and sign him up for an add-on, registering him with his ID and doing the intake forms. The* *front office staff seem to barely tolerate him, exchanging glances with one another and wrinkling their noses as he approaches the window even through a plastic barrier. Juan then waits in the lobby for two hours. He gets seen at 3:30; the fellow does a brief history and prescribes his Suboxone, scheduling him for a follow-up next week. Juan is glad he took heroin right before getting in the car with me because it's been a long day. Before we leave, I get called back into the physicians' room by the attending. He tells me I am not to go above anyone's head again without making him aware that that's what I was doing. "We built these relationships very carefully," he points at the front office staff room, "and we don't want to jeopardize that." I apologize innocently and we leave, and I laugh sheepishly telling Juan I just got a "talking to." Juan and I stop at the pharmacy across the street and retrieve the filled prescription after a 30 minute wait. …*

*For a few days Juan took buprenorphine twice a day, and every time he saw me he smiled a huge grin, and told me quietly, "This is awesome. Not having to worry about the cops walking up right now… this is amazing." But after 4 days, he went back to heroin. He tells me that while he was on buprenorphine, he felt normal and didn't have any cravings for heroin. But he describes missing the ritual of injecting something. Without heroin, he was without his daily habit. "I missed the action of using," he said, looking down slightly rather than right at me like he usually does. "It was always on my mind to take a syringe." - Field Note, June 2021*

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*In the South Bronx, Carlos, a Puerto Rican man admitted to the hospital with sepsis and COPD—who tells me he dreams of making things better for the children and for the United States where there aren't enough jobs for people to do, who tells me that in jail he finds ways to sell and inject buprenorphine, who tells me his own son is in jail for 21 counts of home invasion,* *who tells me that he can communicate with me telepathically and asks if I am picking up the message he is sending, who tells me he grew up feeling like he was paying for his father's sins, who tells me his mother threw herself off a bike trying to abort him, who shows me a scar on his temple from being stabbed while staying in a shelter, who tells me he grew up feeling an emptiness inside, who still gets seizures that the doctors thought he would grow out of, which used to be fever induced but which he now thinks are drug induced, who tells me he has shot people, who during his last admission felt he was getting discharged too early and so took the television off the wall and took it with him to make a statement—was admitted to the hospital a week ago over the weekend when the addiction consult service was off duty, and his medical team did not allow him to have buprenorphine or methadone as he went through severe opioid withdrawal. Carlos tells me the doctors here punish him, and he has decided to go cold turkey off of heroin and never to take buprenorphine from a doctor again.*

- *Field Note, 2019*

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Time after time, I observed and participated in getting buprenorphine into the hands of patients, only to have the promise of health care fall woefully short. Not only was it hard to get for people in my field sites struggling against annoyed office staff, weekend service shortages, and many other infrastructural barriers to care. Buprenorphine also failed to treat the complexities of poverty, pain, and failed to meet the desires of the people I followed. It also wasn't typically the thing that made a difference for people, when a difference was made. Buprenorphine wasn't the "answer," as many physicians had said it would be for people. And while it was reducing harms, it was also clashing with a powerful notion of being "clean" in recovery.

Why, then, is the idea of a medication solution for addiction so powerful? And what kinds of effects result from the repeating notion that buprenorphine is *the* answer—the biomedical system's answer to the national crisis of opioid despair?

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> *"Man has, as it were, become a kind of prosthetic God. When he puts on all his auxiliary organs he is truly magnificent; but those organs have not grown on to him and they still give him much trouble at times. ... Future ages will bring with them new and possibly unimaginably great advances in this field of civilization and will increase man's likeness to God still more. But in the interests of our present investigation, we will not forget that present-day man does not feel happy in his God-like character."*
>
> *- Freud, Civilization and its Discontents*

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*"There's a war going on out there!" the captain at the rehab yells from the pulpit. "There is a battle for your soul! And when you continue to use drugs, you end up stuck in sin, out on the street, stuck in jail." You're a dead man walking, he says, a nod to the song that we all sang to a few minutes ago, the lyrics posted on television screens throughout the chapel. "The* only *way to live again is to seek God in your heart. Those who have not had a spiritual awakening are not seeking God truthfully enough." – Field Note, Rehab, 2022*

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*"Suboxone scares the shit out of me. I don't want it running my life… also, my AA sponsor told me it was time to get off everything."*

*John is telling us about how he relapsed. Dr. A and I are sitting in the office at New Rhythms, a private rehab center that treats people who seek help for addiction, offering detox* *and residential treatment. The center advocates for a "whole body, whole mind sobriety." Similar to the philosophy of Alcoholics Anonymous, with which John is involved, true sobriety at New Rhythms means taking no medications, long-term, to treat addiction. Nonetheless, medications are technically permitted, and Dr. A manages all of the patients' detoxification upon admission to the rehab and then can follow up with them at addiction clinic after their stay as often/frequently as they want. John has just arrived at New Tides, so Dr. A is completing an evaluation.*

*John is feeling "anxiety'd out." I notice his large bicep muscles flexing and relaxing periodically. He rests his hand on his right knee, which bounces as his right heel restlessly moves up and down. He stares at the desk, occasionally eyeing the doctor's hands, which are tapping at the laptop. Dr. A stops typing to tell John, "Detox sucks. It just does. I'm here to make the symptoms tolerable." John pulls his baseball cap up from his head then pulls it down again.*

*This is not John's first time in detox. In fact he has already been on Suboxone for months as maintenance therapy for opioid addiction. He was started on 16mg daily and had successfully tapered down to just 1 mg every 3 days- a miniscule dose, which, after John leaves, Dr. A assures me was "not doing anything for him physiologically." But a few weeks ago, he tried to stop taking Suboxone altogether, and then immediately relapsed: he started taking 10 Oxycontin 30mg pills a day (450 morphine milliequivalents daily – a large dose 10 times higher than what the CDC guidelines suggest as the upper limit of opioid prescriptions for pain to avoid increasing the risk of overdose).*

*After listening to his story, Dr. A wants to "plant a seed" in John's head: that it might be okay, in the long run, if John has to take a little Suboxone so that he can work his job as an* *electrician, have a family, and function. Addiction is a disease, and there's no shame in needing something to help the brain heal, long-term.*

*I watch John chew on this. When he responds, he says, "I would be feeling suicidal, and I would take like a half a pill of Suboxone and would feel normal again, and just go about my day."*

- *New Rhythms Rehab, 2018*

John, a White 39-year-old man and electrician, takes buprenorphine while also regularly attending Narcotics Anonymous meetings. He experiences a sub-therapeutic dose of Suboxone as beneficial, powerful, and simultaneously terrifying. Taking a Suboxone dose so low that physicians agree could not reach a therapeutic level, the effects are nonetheless significant: with *just a third of a tiny dose every three days,* his opioid cravings disappear. Moreover, he occasionally feels suicidal, but part of a strip of Suboxone makes him "want to live again."

How can such extreme effects for John—including a desire to keep living-- come to pass through a "non-therapeutic" dose of this medication? How does John negotiate definitions of 'recovery' through the embodiment of medication effects, incorporating disparate perspectives from biomedicine and N.A.?

The authority of habit, and the embodied effects of that authority of habit (Comaroff & Comaroff, 1991), might be better revealed through theories of hegemony, biopower, and sacred objects than by a theory of physiology or placebo. While the doctor told me afterward that perhaps John experienced his medication as a placebo, and that may well be true, this explanation doesn't account for *why* John experienced such powerful effects- *nor why others do not*. The habit of taking something provided by a biomedical authority provides structured limits to behavior and thought processes, and provides a substance that one can take somewhat unthinkingly, but also frequently. Habit reassures one that one's cravings and actions are part of a disease that there is a substantive treatment for: the habit is made meaningful through its embodiment and through the significance ascribed to it through its doing, and through beliefs about its properties. These effects of habit may be understood as unmeasured effects of biomedical hegemony, and buprenorphine understood as a symbol of this power. Could John's experience be mediated through his particular affective relationship with the symbolic power invested in buprenorphine? Of what does this symbolic power consist?

## Buprenorphine as sacred object

Buprenorphine is an opioid not unlike others. Despite its similarities to other opioids, it has a distinct life in the legal imaginary in the U.S. Here, I suggest that this imaginary has done political work to erase the similarities between buprenorphine and all other opioids, fetishizing it as a medication unlike other medications, as an opioid unlike other opioids, marking it as a sacred object and in its marking, erasing what is being marked. As described above, the state and capital investment in the sanctity of it has been unprecedented in the history of addiction treatment in the United States.

Michael Taussig theorizes the relationship of the fetishized sanctity of marked objects within the context of the modern state. Drawing on this theory, I ask what John's embodied experience, read alongside others' orientations to buprenorphine, reveals about buprenorphine as a sacred object that comes to be representative of state power and one's relationship to it.

Previous anthropological work on the state, as State, has labeled the State a fiction (Abrams, 1988), as a set of institutions working in the service of capital (Jessop, 1977), or as a mask that at every turn involves reification (Trouillot, 2001). In *Nervous System,* Taussig asked what it means to consider the State as fetish. He is referring to an "aura of might," or, following

Hegel, a "vision of the state as not merely the embodiment of reason, of the Idea, but also as an impressively organic unity, something much greater than the sum of its parts" (Taussig, 1992:112). Taussig argues that the notion of State fetishism helps to clarify the existence and reality of the *political power* of the *fiction* of the State: what he calls the State's "powerful insubstantiality" (ibid:113).

For Taussig, the modern State embodies both reason and violence while denying the conjuncture of the two:

> "There is something frightening merely in saying that this conjunction of reason and violence exists, not only because it makes violence scary, imbued with the greatest legitimating force there can be, reason itself, and not only because it makes reason scary by indicating how it's snuggled deep into the armpit of terror, but also because we so desperately need to cling to reason- as instituted- as the bulwark against the terrifying anomie and chaos pressing in on all sides." (*The Nervous System, p. 115*)

John is both terrified of the power of buprenorphine, not wanting it to be running his life, and he simultaneously acknowledges that he clings to it as an antidote to feelings of suicidality. His doctor responds by "planting a seed," further embedding in him the rationale of biomedicine that states that permanently staying on buprenorphine may be just what he needs to live a normal life. John does cling to biomedical reason, while simultaneously finding other forms of belonging in N.A. In contrast to N.A., buprenorphine is backed by the state-empowered capital of the biopharmaceutical industry. Addiction clinics, rather than fighting against the hegemony of what it means to be "clean" in recovery, are in many ways loving this idea to death by inviting N.A. and rehab models to co-exist with buprenorphine. All the while, buprenorphine proponents point to the superior logic behind the medicine as evidence-based, despite the fact that many (most) who start the medicine go back to using illicit opioids.

While state-supported efforts attempt to expand access to buprenorphine for poor patients in public clinics, John already has money to attend private rehab, and most buprenorphine prescriptions have historically gone to White privately insured patients with a college degree (Lagisetty, 2019). Here, I read the effects of buprenorphine as inextricable from the violent force of capital, which for vulnerable poor patients make the possibilities of attaining a "normal life," as John's doctor directs him toward, ever more narrow and difficult to reach.

What could be violent about buprenorphine? In my read, the specter of drug prohibition as the flip side of the buprenorphine coin imbues the medicine, and biomedical treatment of addiction, with the reasoning of violence. Buprenorphine, an opioid, has carved out a space of legality while the War on Drugs rages on, despite its chemical properties being so similar to other opioids that it replaces them on opioid receptors in the brain. The properties that make it pharmacologically distinct—a "ceiling effect" that limits the respiratory depression effect, making it harder to overdose, and a limited euphoric effect—also point to its similarity, as law enforcement authorities fret over the diversion of buprenorphine into street markets and the possibility of experiencing pleasure from it. The powerful narrative of its exceptionalism marks its status as a medicine in contradistinction to the marking of most other opioid consumption as criminal. Marking one kind of opioid consumption as reasonable medical treatment, and marking other opioid consumption as criminal behavior, is precisely what Taussig is referring to when he speaks of the modern state's conjuncture of reason and violence while denying such a conjuncture.

Taussig asks what attention to sacred objects can teach us about the nature of the State as fetish. He argues that sacred objects derive their power from the way these objects embody *and* erase the embodiment of the state. Sacred objects, per Durkheim in *Elementary Forms of Religious Life*, have healing properties, ensure the reproduction of life, and concentrate great power which "radiates to a distance and communicates itself to all the surroundings" (Durkheim, 2008). What is crucial is that the representation of the sacred, on and in the objects, is more important than that which is represented: "Totemic design itself is not only sacred and powerful, but more so than the totemic species or entity it represents, and more so than the clan it also represents, because it *in some way* represents the great and complex abstraction 'society'" (Durkheim, 2008). The materialization of the signifier, its ability to be *held and touched*, is key both to its importance and for its ability to represent this abstraction.

Access to sacred objects is typically restricted. In Durkheim's description of the Churinga, he emphasizes that access to sacred objects is limited to initiated males; they are not allowed to be seen or touched by women or uninitiated men (Durkheim, 2008). Any uninitiated who come into contact with sacred objects are severely and violently punished. Similarly, wrote E. Lucas Bridges, a sheep farmer and son of British missionaries in Tierra del Fuego among the Ona people, only men were initiated into the lodge there, and women and uninitiated men were periodically haunted by a spirit who, as it turned out, was an initiated man dressed up in disguise. Initiation for a young man involved an isolated journey at the end of which he would be forced to engage in combat with the angry spirit. The outcome was planned in advance so that the young man would always win, throwing off the mask of his attacker only to find that it was a fellow man in disguise, and in reaction, he attacked the one deceiving him with fury. From then on, “the duped becomes the duper, obligated to support the deception” of the uninitiated and of women (Bridges, 1947:425; quoted in Taussig, 1992).

Such restricted access to sacred objects raises two key questions for Taussig: first, whether the sacred force of these objects arises only with seeing, touching, and absorption into the initiated male body. And second, whether it is the object’s sacred force which impels powerful taboos, or whether it is the societal prohibition itself—the taboo—which sanctifies the object (Tausig, 1992:130).

While these descriptions of sacred objects seem distant from the contemporary landscape of addiction treatment, their insights can teach us about the embodiment of buprenorphine in the vignettes above. Buprenorphine is an opioid marked as sanctified by the state, converted into healing medicine, rather than demonic evil, as other opioids are marked. But buprenorphine’s approval as medicine doesn’t alone account for its power over John. His N.A. sponsor has also marked buprenorphine as unclean and as contrary to notions of recovery. These contradictions, I argue, imbue the medication with a quality and confused form of power beyond its physiological properties.

One takes the buprenorphine strip under one’s tongue, allowing it to dissolve from there to be absorbed into the bloodstream, the taste of metal disgusting but, as one is to understand, necessary. It rots the teeth (Commissioner, 2022). And yet law enforcement, and doctors too, from threat of law enforcement, are preoccupied with ensuring that it does not get diverted to those to whom it is not prescribed. Urban law enforcement institutions in Baltimore and Philadelphia in particular have obsessed over buprenorphine diversion and the possibility of allowing it to get into the hands of the uninitiated: the criminals, and the non-patients; diversion has been punished harshly (Buttram et al., 2021; Chilcoat et al., 2019; Pozo et al., 2020).

In the context of widespread disparities of access to buprenorphine since it was first made available, and in the midst of an unprecedentedly massive and racist War on Drugs, how might we interpret the power of buprenorphine arising from absorption into the bodies of the chosen who are granted privileged access—those who are initiated? To pose the question in Taussigian terms: *Is buprenorphine's sacred force—and the faith placed in biomedical interventions—what makes it taboo in N.A. communities, or is the prohibition of buprenorphine by N.A. groups what grants buprenorphine its sanctified nature?*

> "If it is restriction to a small group together with the prohibition that is decisive in sanctification, might it turn out that it is not just the sacred knowledge of myth and ritual of the *initiated* which constitutes the power of the sacred, but that instead such power derives from the *fantasies of the people prohibited* concerning the (supposed) nature of that sacred knowledge?" – Taussig, *Nervous System,* p. 130

The relationship of buprenorphine to racial and class privilege is integral to its meaning and has been since its development. It cannot be understood simply through its pharmacology or by asking those who prescribe it and those who are stable on it for years. It is important to understand buprenorphine, addiction, and the contemporary landscape of addiction treatment from the experiences of those who do not, cannot, or will not benefit from said treatments, and from those who use buprenorphine in ways other than those intended.

> "Might it turn out that not the basic truths, not the Being nor the ideologies of the center, but the fantasies of the marginated concerning the secret of the center are what is most politically important to the State idea and hence State fetishism? Here the secret takes on

> the burden of protecting not merely the deceit practiced by initiated men but of protecting a great epistemology, one that drives philosophers, scientists, social scientists, and policemen- the epistemology of appearance and reality in which appearance is thought to shroud a concealed truth- but not the truth that there is none." *Nervous System,* p. 132

What can those who are situated at the margins of the state teach anthropologists about the fetishization of the state? Taussig argues that those who are marginalized understand sacred objects differently from the way the initiated understand them. They may be speaking back to the state, defetishizing it, while simultaneously reenchanting it.

John's proximity to the center of the state is closer than most others in my field sites, and he may be more subjected to the biopower of buprenorphine and more incorporated by it as a fetishized object. We met while he was at a private rehab, he is White, is married, and is professionally employed making good money as an electrician. However, his orientation toward buprenorphine was clearly affected by his N.A. sponsor, a voice that could be conceived of as speaking back to the power of medical reason by defining "recovery" in mutually exclusive terms. This is one way that we may understand his embodied experience of buprenorphine and its placebo effects, which defetishized buprenorphine as pure medicine but reenchanted it as a container of magical properties. For John, buprenorphine is invested with such properties as to hold him *too tightly.* For those situated more marginally to the state, medicalization of an opioid such as buprenorphine may weaken its effects. What might this relative lack of fantasy indicate about the political and epistemological 'holds' of the U.S. state?

We might also read Susan's terror about starting buprenorphine as an indication of her fear of, and disenchantment with, biomedical reasoning. Her experiences taught her that the public hospital system no longer cares about her pain, and her doctors were willing to inflict more pain on her in the interest of providing what they imagined to be sound medical care. If buprenorphine was what is on offer with clinical rationale, she realized, it would be better to avoid it, and to risk the criminal life of street opioids.

Most people living in the Ventura River Bottom encampment were disenchanted by state biomedical care, and apprehensive of it, too, as they demonstrated with the COVID-19 vaccine: "*I don't want any shots from the government, thank you very much. It's just my belief*." And Ernesto, *"We'll shoot this [fentanyl] stuff, but we're terrified of the vaccine!"*

We could read the failure of buprenorphine to "hold" Ariana as an embodiment of her resistance to its sanctified nature and as another expression of disenchantment with state power. Similarly, Carlos both lifted a TV off the wall to make a statement of protest and refused buprenorphine, going "cold turkey" off heroin in the hospital because he felt punished by doctors who failed to offer him treatment for withdrawal over the weekend. While biomedicine constructs buprenorphine as an offramp from heroin, for Benjamin, buprenorphine enables him to "kick back," avoiding both withdrawal and worry when he doesn't have the money to buy it. Taking these responses seriously means reading them not as failures of individual compliance but as meaningful forms of embodied protest to the woefully inadequate magic bullet proposal behind buprenorphine.

So far, I have asked how patients experience medical treatment for addiction, mostly in addiction clinics, but always with buprenorphine. I have asked how their embodied experiences are affected by epistemological distinctions between biopharmaceuticalized care models and mutual aid-based recovery models. I turn now to the experiences of physicians in addiction clinic, to ask how their subjectivities are impacted by, and impact, the shifting landscape of addiction treatment.

### "I get people off stuff"

*When I walk into Dr. Hewey's clinic, he is running down the hallway. "Sorry I'm so manic right now!" he tells me, slightly out of breath, flitting into the room with the computers where he asks me to wait for a few minutes. He had a complicated case earlier in the morning, he explains rapidly, which has set him behind for the whole day. In an attempt to catch up, he is rushing around, carrying stacks of paper with him: prescriptions, referrals, and medical records to hand off to staff. A tall, thin, middle-aged white man wearing a Patagonia jacket, Dr. Hewey tells me that while he is trained in internal medicine, he is now an addiction specialist. Located in a relatively affluent part of Los Angeles, his clinic is filled with patients from all over the city, but only those with insurance.*

*Before we see any patients together, Dr. Hewey tells me about Stanley, a patient he saw earlier, who takes Percocets every day for pain and was referred to Dr. Hewey's clinic to taper off of them. The patient told Dr. Hewey, "I gotta say, I don't know why I was sent here. I don't want to get off them. They work." Dr. Hewey knows that the amount of opioids Stanley takes is technically above the CDC guideline limit designating high risk of overdose, which is why he was sent over by his primary care doctor. He prints off the guidelines for me to read. But Dr. Hewey doesn't see any contraindication for keeping him on the same dose of Percocets. "He's 69, and they work! But I don't* do *that. I get people* off *stuff," he says with some exasperation. Dr. Hewey wants me to understand the limits of his role as an addiction specialist. His job is not to maintain patients on high doses of prescription opioids indefinitely; in fact, his job is to do the opposite. Even though Dr. Hewey does not think Stanley meets 'addiction criteria,' he still feels* *that he is "supposed" to get him off opioids. So, he told Stanley, "You can stay on them for one more month. And see if your PCP will prescribe them again. Otherwise, I'll give you one more month worth of prescriptions and you'll have to find somebody else, because I don't really do primary care stuff."*

*Dr. Hewey tells me, "If I have to 'Uptodate' it, I feel like I shouldn't be doing it," meaning if he needs to look up medical best practices established annually by physician experts to help determine the best course of action for a patient, he does not feel comfortable practicing that line of care. He does not want to be anyone's primary care doctor because he fears he won't remember when to ask someone if they have had, for example, a colonoscopy, and doesn't keep current with the guidelines for such generalized health topics.*

*At the same time, he feels that a lot of people who are referred to him by primary care physicians don't need to be seeing him. A lot of people are simply referred because other physicians don't want to deal with the potential challenges or 'problems' these patients may bring. "I don't think [a lot of these patients] have addiction," he tells me. "They're just on a lot of addictive meds. Benzos, opioids. But they don't really meet DSM* [1]*criteria." Plenty of his patients have been forced to go to addiction clinic in order to maintain access to their primary care, he says.*

*In Dr. Hewey's view, though, the addiction clinic also offers patients an opportunity. They have a chance in this space to "try on" and mold together different frameworks about substance use and decide what will work for them. "People running treatment programs, like AA and NA, 12-step programs, are all in recovery themselves," he says. "It worked for them and they think*

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[1] Here, he is referring to the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (2013), which lists criteria for opioid use disorder. Crucially, the manual states, "These criteria are not considered to be met for those individuals taking opioids solely under appropriate medical supervision."

*this is the only way. I don't do that," he says. "What's nice here is that I think everyone can construct their own treatment regimen that works for them. For some people, a diagnosis, and saying 'I'm an addict,' really helps them. For others, they really* don't *want to be called an addict, even if they meet every single criterion in the DSM." And that's okay, he says, they can still get treatment here. – Field Note, 2018*

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### Doctors 'flipping the script'

What happens when a physician acknowledges that the diagnosis that he is tasked to identify and manage- addiction, or opioid use disorder- may not apply to the patients he is treating? While Dr. Hewey says that his job entails getting people "off stuff," he also recognizes that the current health care climate is recategorizing patients who use opioids and labeling them as "high risk" even when the opioids are working well and the patients are using them as they have been prescribed.

Within clinical spaces, people come to be understood in terms of diagnostic categories. Institutional discourses and structures heavily mediate this process. (Luhrmann, 2007) has described how psychiatric residents learn to see 'kinds of people' as characters and prototypes in order to differentiate disorders; this interpretive practice helps residents to manage some of the constraints of the clinical setting, including lack of time and resources (Buchbinder, 2011). Under such conditions, as Rosenberg notes, diagnosis "remains a ritual of disclosure: a curtain is pulled aside, and uncertainty is replaced- for better or worse- by a structured narrative" (Rosenberg, 2002:32). This clinical structured narrative, imbued with institutional logics that entail personal responsibility for care and recovery, "invite a transformation of moral personhood" (Buchbinder, 2011:460). And the politics of deservingness are paramount:

diagnostic judgments are “embedded in and constitutive of a moral economy of care in which certain types of people are seen as more deserving of treatment” (ibid:459).

Dr. Hewey is on the receiving end of the drive to “serial discharges” of patients who are seen as ‘high-risk’ opioid consumers described in the previous chapter. Although he can plainly see that many patients do not have addiction, he feels he must play the part of getting them off of full agonist opioids anyway. He does not turn them away, but neither does he treat the pain for which they sought care in the first place. The patients cannot in fact “construct their own treatment regimen that works for them,” but they are offered more flexibility and the diagnosis is acknowledged as relatively unimportant to treatment in addiction clinic. Here, the addiction category expands to incorporate not only those patients who do not identify with having an addiction, but also those whom addiction specialists *also* would not identify as addicts. This physician believes that patients may be able to benefit from coming to addiction clinic anyway- even to be allowed to retain their primary care physician and receive their opioid medications for pain, even.

Summerson Carr describes how clients of addiction treatment ‘flip the script’ of addiction to manage their institutional fate, “formally replicating prescribed ways of speaking about themselves and their problems without investing in the *content* of those scripts” (S. Carr, 2010:3, emphasis in original). By doing so, they leverage material and symbolic resources with their words. Carr argues that in addiction treatment programs, clients’ economic and therapeutic well-being hinge on the correct performance of speech, as therapists and others track and document clients’ progress through the way that they speak about their personalized narratives of recovery (ibid:11). Carr describes how “script flippers” consider their narratives to be “effectual, contextsensitive social actions, with histories and futures of their own," rather than transparent reports of the internal psyche of the speaker (ibid:18).

In the vignette above, we can understand Dr. Hewey to be using a similar kind of script flipping. Faced with constraining structural shifts on medical practice that he is both aware of and irritated by, and attempting to leverage medical resources for his patients, he chooses to speak to his patients and through the medical record as though his patients have addictions, even when he believes they do not. By documenting a diagnosis of opioid use disorder and maintaining patients in his clinic, he helps them to stay under the auspices of both his clinical care and the care of pain specialists or primary care physicians that require his supervision. And he provides them with as many resources and forms of care as he can under the constraints of his practice. This almost always means, in one form or another, buprenorphine, and sometimes includes referrals and streamlined access to pain specialists who can do procedures such as injections for pain. He does this in an attempt to provide an escape valve to patients caught in an opioid policy pressure cooker. Rather than resisting the use of a diagnosis of addiction, Dr. Hewey instrumentalizes it, strategically reproducing the ideology of language distilled in the category of 'opioid use disorder.'

Such a framing challenges expectations of self-pathologization and identification with the "addict." Across multiple models of addiction and recovery, an absence of self-pathologization has long been framed as "addicted denial," such that patients or clients who believe that they do not have addiction are understood to be lacking insight (Carr, 2010). These notions have been widely held by mutual aid recovery groups including A.A. and N.A. as well as more recently developed approaches to addiction treatment such as Motivational Interviewing (Carr & Smith, 2014).

## Harm reduction arrives in the clinic

The harm reduction movement has also challenged the framework of self-pathologization, by positing people who use drugs as experts of their own experience and by eschewing labels such as “addict” in favor of person-centered language. Dr. Hewey likes the idea of harm reduction. Many physicians have recently become educated about the evidence of life-prolonging effects of low-barrier service provision for people who use drugs. These services, such as the provision of sterile syringes to prevent infections through syringe sharing, were borne out of the harm reduction movement that formed in response to governmental and public health failure to provide them. In fact, needle exchange or syringe replacement programs were banned by most states for decades, and federal law prohibited the U.S. government from funding them until 2016, when the ban was lifted only for funding for operations such as personnel, while at the state and local level, the possession of drug paraphernalia is often still outlawed (Allen et al., 2016; Weinmeyer, 2016). A core principle promoted by the harm reduction movement is to “meet people where they are,” supporting individuals and communities based on their needs and desires and accepting that drug use is a social fact (Szalavitz, 2021). In recent years, the meaning of harm reduction has included working to ensure the provision of medications for addiction treatment without obstruction. Should we understand Dr. Hewey to be bringing core tenets of the harm reduction movement into the clinic?

Another addiction doctor told me he has received many patients in his clinic who were referred by their primary care doctors and have already been prescribed buprenorphine by their primary care doctors, but for pain-- and these patients are adamant that they do not have addictions. The problem for him in this is that from addiction clinic, he cannot prescribe buprenorphine for pain. He needs to be treating addiction, and believes that most of his patients probably would qualify for the diagnosis. If they would allow the diagnosis to be nominally put down, he could continue their prescribed medication. He believes that they resist the diagnosis because of stigma. In response, he attempts to convince them of the benefits of the diagnosis and to blur the lines in the medical chart around pain and addiction treatment: "*We do harm reduction as much as possible in our clinic, so. I fudge the line as much as I can,*" he told me. "*You just need three things for a diagnosis of OUD. Dependence, tolerance, and one other thing. Some patients won't go down that route, and they're not happy, and I have to tell them, we're practicing evidence-based medicine. I can't do another type of medicine, because it increases the risk for everybody*."

Dr. Hewey's *script flipping*, and the second doctor's strategies of *line-fudging*, could be understood as two of a set of social practices that I observed addiction physicians engage in to help their vulnerable patients work around existing barriers to care. For instance, one physician coached patients on where and when to show up to the emergency department and what to say upon arrival in order to get admitted for an insurance-covered inpatient induction onto buprenorphine. Another addiction specialist skillfully managed the derision of other physicians who were dismayed to receive yet another referral to see one of his "frequent flier" addiction patients by spending his social capital and advocating on his patients' behalf with lighthearted pushback: *"I apologized to you, man, before I even started the conversation!"*

When the COVID-19 pandemic started, one physician was briefly able to teach a class on Zoom for patients temporarily housed through Project Roomkey, delivering harm reduction messaging such as how, and in what veins, to inject drugs in order to be as safe as possible and to avoid skin abscesses.

This last, more radical practice aside, most of the practices that addiction physicians engaged were practices aimed at subverting existing barriers to getting their publicly insured patients access to, and onto, buprenorphine. This is the reason why Dr. Hewey documented addictions that he did not believe were there, and used the script of addiction medicine with patients he did not believe it suited.

Such experiments in patient advocacy, and the implementation of some practices developed by grassroots harm reduction organizations, conducted under-the-radar within formal, state-run county clinics, raise a number of questions. What kinds of politics are possible within state-run medical institutions? How has harm reduction, which began as a grassroots movement, changed the meaning of care in professionalized, medical addiction treatment settings? And how have professional institutions changed the meaning of harm reduction?

## Evolving meanings of harm reduction

Harm reduction has evolved since its beginnings as a grassroots movement in part inspired by radical health movements preceding it, which were based on a critique of structures of oppression that led to the poor health of marginalized people (Blanchard, 2018). The Young Lords, for example, occupied Lincoln Hospital in the Bronx in a historic indictment of the racism of health care workers there and society more broadly, and to demand addiction treatment, housing, and jobs (Fernández, 2020). They explicitly linked health care and addiction treatment to political education about local economic and racial inequality, and its relationship to U.S. imperialism more broadly. The Young Lords were against the use and sale of drugs, positing the influx of heroin into the community as a form of state-led terrorism aimed at killing and ruining the lives of the poor and people of color (Enck-Wanzer, 2010). Methadone was controversial: some believed it was a form of “liquid handcuffs” that kept one dependent on the state, while others believed in community-worker led drug treatment programs that could include methadone if they were oriented toward survival, political education, and empowerment of the local community (Enck-Wanzer, 2010; Schofield, 2020). Activists at Lincoln Hospital demanded funding for addiction treatment and advocated for the use of acupuncture in the treatment of addiction, which was implemented with high success rates through the newly formed Lincoln Recovery Center and was funded by the city (Fernández, 2020).

Organizers of these earlier movements sought to empower people in a broad political economic sense, and with more local contextual awareness, than what many organizations doing harm reduction aim for today. Today, harm reduction is heterogeneous, meaning many different things to different people and organizations, with a presence of some kind in many countries around the world (Zigon, 2018). In the midst of unprecedented deaths from drug overdose in the U.S., though, it is increasingly becoming common-sensical that the government ought to allow for the provision of services that prevent overdose, death, and preventable harms from the use of drugs. The government typically does not fund such programs, but at least, the common sense goes, they should be legal. Such political progress may continue to maintain a neoliberal order that downloads the financial burden of the preservation of life onto individuals and grassroots community organizations. The sole syringe service program operating in the county of my fieldsite is run by the department of public health (a rarity in the U.S): the department took over the program that had been started by a grassroots group, an instance of institutionalization of a set of practices previously seen as radical, and yet the program then narrowed the scope of services provided. There is only one employee operating the exchange for the entire county out of a single van, and he regularly struggles to get the department to secure him supplies that are supposed to be subsidized by California.

In a mixed methods study of Iranian drug policy, Ghiabi argues that grassroots 'crisis governance,' emerging as a 'rhizome,' acts as a form of power that ultimately reproduces state prerogatives on the management of social margins and public (dis)order. Asking what official drug policy and grassroots advocacy can reveal about the workings of state power in Iran, Ghiabi describes the initiation of harm reduction programs with the 'lights off,' wherein rhetoric of 'crisis' enables organizations and individuals to escape institutional and ideological obstacles to implementation, allowing them to push the boundaries of drug reform in practice before harm reduction is formally institutionalized (Ghiabi, 2019). Ghiabi argues that the seeming withdrawal of repressive state controls in the midst of 'crisis' often manifests as a form of government at a distance, whereby processes of privatization, delegation, outsourcing and devolution of state power actually *enhance* political control (ibid:2). In Ghiabi's case study, incoherent tactics and competing strategies co-produced by public and private agents signify more, not less, state interventionism and consolidation greater than that of direct state action (ibid:245).

Close attention to public and private investments in this 'crisis' moment of opioid epidemic in the United States is crucial for understanding the meanings of state power, care, and harm reduction. While radical health movements of the 1970s emphasized local context and focused heavily on political economic conditions of community oppression, clinical sites of harm reduction today appear mainstream and generalizable, oriented toward mutually supported survival but more disconnected from historical demands for a fundamental reorganization of the social political economic order. In the clinic, as the physician above recounted, harm reduction is imagined as a set of "best practices," not dissimilar to clinical expertise and evidence-based medicine that can be delivered in most places in the same ways.

In the U.S. today, often in the name of crisis, harm reduction service expansion has not been limited to addiction clinics, but is increasingly embraced by institutions including jails and prisons. Such a widespread embrace of "harm reduction" signals to a shift in its meaning, and, I suggest, a new form of politicization of the framework, rather than a depoliticization. What does it mean when a doctor indicates that because he practices harm reduction in his addiction clinic, he employs a flexible definition of the addiction diagnosis to get more people onto buprenorphine? Getting a patient onto buprenorphine may in fact be harm reductive, but context matters, as we have seen above, and buprenorphine is not always already necessarily a harm reductive technology; sometimes, it can represent a form of abandonment, especially for patients with co-morbid pain.

In terms of profit, addiction clinics stand to gain by embracing harm reduction and allowing patients to negotiate their relationship to the medical model of addiction treatment alongside competing frameworks. By telling patients to embrace buprenorphine while simultaneously attending N.A. meetings or faith-based recovery groups, addiction clinics only attract more potential consumers. Similarly, institutions of policing and prisons that embrace harm reduction do so by embracing a narrow definition that encompasses primarily buprenorphine and naloxone provision. Harm reduction, in this instance, becomes synonymous with pharmaceutical marketing, thinly veiled as morally righteous, evidence-based care. This raises important questions about how both patients and doctors are subservient to a consumer model of health care that affects the potentialities of a contextual and political approach of embedded harm reduction.

## Embracing buprenorphine

We have seen how buprenorphine has been lauded as a safer medication to provide patients with opioid use disorder than other medications due to its “ceiling effect” and its relatively lower risk for overdose or abuse compared to methadone and other opioids. It emerged in my fieldwork as a catch-all solution to both pain and addiction ‘problems,’ with highly variable results.

But buprenorphine was not always viewed positively. For several years of my fieldwork, primary care clinic directors would not allow buprenorphine to be prescribed within their clinics due to fear of the “kinds” of patients it would draw, and public hospital board members likewise fretted that buprenorphine provision would draw undesirable patients and make their spaces “like methadone clinics.” Being able to prescribe buprenorphine to patients in a new public addiction clinic was therefore a victory for harm reduction advocates in the county. In a rapid timeframe, buprenorphine has become a “go-to” solution for physicians struggling to develop a treatment plan for patients who use opioids. Referrals to the public addiction clinic have exponentially increased, and primary care physicians are more and more convinced that buprenorphine is “going to be the answer” for their patients, including for those with chronic pain. Returning to Dr. Hewey’s addiction clinic, the vignette below begins to illustrate some of the ways that clinical care with buprenorphine can come to constitute forms of tinkering. Tinkering here stands in for meaningful care while simultaneously erasing experiences of pain.

### “Pain almost doesn’t matter”

*The first three patients Dr. Hewey and I see together want to get off of buprenorphine, sooner than later. Each has chronic pain. One woman, Barbara, recently tried to switch from the buprenorphine film to a pill form but vomited for two days straight, and went back to the film. The Butrans patch, which she has tried before, gave her a bad reaction on her skin. She remarks, “Maybe my body just doesn’t want it.” Together, Dr. Hewey and Barbara decide to gradually* *cut down the film and see what happens. Dr. Hewey asks me if I have any questions. I ask Barbara to tell us about her pain. "What do you mean?" she asks, surprised. I ask her to tell us where her pain is, and what it is from. "My legs, my back, my neck… it's all over," she says. "I have fibromyalgia." Then she says, tearfully, "I've driven everyone in my life away because of my pain. That's why I'm here alone today." Dr. Hewey, typing on the computer, absentmindedly replies, "Well, don't do that either."*

*Walking out of the clinic room, Dr. Hewey tells me, "Sometimes I ask about patients' pain, but usually, in all honesty, it almost doesn't matter." Addiction clinic is not about pain, he reminds me. Generally, it's about getting people off of full agonist opioid medications used for pain, and onto some form of buprenorphine. He relies on pain clinics to do procedures, injections, acupuncture, and physical therapy for patients' pain in tandem with his buprenorphine care. He tells me that initially when he got into the business of treating addiction, he battled a lot with the pain doctors over prescribing too many opioids for his patients. "But now, they're my number one referral." He no longer feels like there is overprescribing, and he knows there is a broad overlap of patients facing opioid dependence or addiction who are also struggling with chronic, unremitting and complicated pain that he is not able to manage within the constraints of his addiction care focus.*

*- Addiction Clinic, 2018*

Within addiction clinic, buprenorphine is one of the few interventions available for patients specifically related to opioid use. Methadone must be taken under surveilled dosing at separate methadone clinics, or, to be prescribed in an outpatient setting, it must be prescribed for chronic pain rather than for opioid use disorder. As this physician noted, maintaining patients on full agonist opioids is not the norm in spaces like addiction clinics. Dr. Hewey acknowledges that pain, the primary reason that many of his patients have opioid dependence, has little presence or meaning within the confines of the addiction clinic. There simply are not resources for pain: not in time or in treatments on offer. Its significance, therefore, is minimal. When isolation through pain is brought up, Dr. Hewey, busy charting about the addiction care he is providing, absentmindedly issues the patient with a directive not to drive people away. And although many patients with chronic pain wanted to get off of buprenorphine, feeling, and saying, that their bodies were not benefiting from it, there was not much else he could offer them. He could only tinker with various forms of bodily delivery of buprenorphine, from patches to pills to injectable formulations. Here, harm reduction principles such as meeting patients where they are and delivering non-judgmental care led by patient priorities, can easily be reduced to prescription tinkering that takes for granted the erasure of pain as a meaningful experience. Even such tinkering was difficult and contingent on insurance authorizations that were often not forthcoming. Such limitations raise obvious questions about the evolving meanings of harm reduction to clinical providers.

Pain is acknowledged as most relevant to care in this clinic when the physician helps patients taper down their opioid milliequivalent dosage to get below the level indicated by the CDC guidelines. In order to regain entry into the category of deserving pain patient, patients must show adherence to opioids tapers in addiction clinic. But tapering down an opioid dose for the opioid-tolerant patient can lead to severe and intense pain. Dr. Hewey often refers to “opioid-induced hyperalgesia,” which is the medical term for the increase in pain sensitivity often experienced by patients who use opioids. According to this framework, when patients take opioids and blunt the sensation of their pain, pain receptors are upregulated, so that when opioids are not present, there is an increase in their sensation of pain (hence “hyper” algesia). In addiction clinic, opioid-induced hyperalgesia is often perceived as a “risk” in its own right, and one that should be avoided as much as possible through skillful tapering of opioids.

In an exception that proves the rule of pain not mattering, I turn to the story of a man with both recognized addiction and recognized pain attributed to terminal cancer.

### “Am I making the problem worse?”

*In a public addiction clinic, I work alongside a primary care physician who is gaining expertise in treating addiction as a fellow. We go in together to see a man in his fifties who has metastatic lung cancer. When I walk into the room, I introduce myself. He is friendly with me, but tells me he is in bad pain, mostly in his abdomen. He shifts slightly and I glance down and notice a large bulging mass on his right side, which he tells me is the cancerous tumor that has been growing. He is jaundiced, and just finished a course of chemotherapy before coming in. He looks exhausted. He tells me that he wants morphine or some kind of pain medication.*

*He tells me he is off heroin now, and that he last used it a few days ago. He does not feel that the buprenorphine prescribed to him from this clinic a month ago is helping him with his pain. He also doesn’t want to go back onto methadone because of the horrible withdrawals he has had in the past. He is sleeping on his friend’s couch. His two priorities in life, he tells me, are to stay off heroin, because he can get arrested for it and things will only get worse, and to get relief from his pain, which is why he came in today. He believes prescription opioids will address both of these priorities.*

*Nervous- because I have already learned that I am about to ask for something I am not ‘supposed’ to ask for- and because I know the patient does not want the standard treatment of buprenorphine, I present the patient’s case to the fellow, while Dr. A listens in. In my presentation, I try to emphasize that the patient has a poor quality of life, and expects to die soon* *from his cancer. I am aware that the desires of the patient matter less than the fact of his immanent death, as only the latter might make his desire for pain medications palatable within the biomedical logic of opioid risks. The fellow and I discuss the plan for the patient. I am immensely relieved when the fellow suggests doing exactly as the patient requested: to prescribe a full opioid agonist for pain.*

*Expectantly, I look at the attending."Yep, cancer pain is basically the exception to every rule about pain," he agrees. We tell him we are going to prescribe him Oxycodone, and instruct him not to use it at the same time as when he takes a benzodiazepine, Xanax, that he is also being prescribed. We prescribe Narcan as well in case he needs an opioid overdose reversal, as we do for all opioid prescriptions now.*[2]

*On the way out the door at the end of clinic, the fellow and I discuss the case, and he tells me that even as a primary care physician confident in providing basic pain management, he feels incredibly strange when he is put in a position to manage someone's pain from the addiction clinic. Something about being in the space of addiction clinic makes him feel that he shouldn't be doing that. I ask him to say more, and he raises the point that addiction clinics have become primary sites for addressing the opioid epidemic, and he asks himself a simple question— a calculus needed in the busy context of scarce clinic time- every time he writes a prescription for a full agonist opioid. "I always wonder, am I making the problem worse?" Both in the context of the opioid epidemic broadly, and also in the life of the individual patient in front of him, the fellow wonders, with each opioid he prescribes for pain, if he is harming or helping. "But whenever I write a prescription for buprenorphine," he adds, "I feel like I'm definitely not making anything worse." – 2019*

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Here, we see how in the addiction clinic, pain can override the drive to prescribe buprenorphine as a magic bullet, but only if the pain can be attributed to cancer. As the attending explains, cancer is the exception. In my fieldwork, it is the exception that helps to clarify the rule: that the burden of proof of pain in order to receive opioid-based pain management has become nearly insurmountable.

This vignette also shows how the space of the addiction clinic segregates both physicians and patients into types, reinforcing the notion that pain— the experience of it, the diagnosis of it, and attempts to control or limit it— ought not enter into this clinical encounter here. While Dr. Hewey stated that a primary reason why he does not manage pain is because he does not do primary care generally for patients, this provider is mainly a primary care physician. He has recently finished residency during which time he became competent and well trained at managing complex medical conditions, many in inpatient hospital settings, including those that involve severe pain. In the clinic, he knew what to prescribe this patient without needing to refer to treatment guidelines, and was confident that the patient would feel relief. So, it is clearly not *only* a disciplinary distinction between training in primary care and addiction medicine that produces this pattern. He attributes his lack of comfort in providing care to the strangeness of doing so from this space: the addiction clinic. He does not feel he ought to be prescribing opioids for pain from addiction clinic, of all places. Space here stands in the domain that indexes individual responsibility and blame: the primary care clinic becomes the domain of the primary care physician, the addiction clinic of the addiction doctor. When he steps into the domain of addiction doctor, he steps into the jurisdiction of addiction medicine. Here, prescribing opioids for pain feels awkward and wrong— and here, wrongness signifies a clinical approach that has morality baked into it. Here, the physician constructs the addiction clinic as a site for helping individuals to use fewer opioids, unless they are those few opioids that are approved for the treatment of addiction. Once again, that essentially means buprenorphine.

He engages in a simple calculus— needed in the busy context of scarce clinic time: Am I making it worse? For this doctor, 'it' is both the health of the patient and the health of the population, in the broader context of the opioid epidemic. This points to a broader discussion on the way that risks are managed both on the level of the individual body and population level or social body. Given the dominant narrative that 'bad doctors' made the opioid epidemic, here the ethical clinical decision entails correcting for these bad doctors. Here we see how the ascription of blame in the opioid crisis nails pharmaceutical companies (although not successfully in the case of the Sacklers) (Hoffman, 2022) while it simultaneously exaggerates the godlike power of the physician. Importantly, the doctor only asks, 'Am I making it worse?' about opioids used for pain. He feels he can draw a clear line from opioids prescribed for pain to future harms: addiction or overdose, which can foreclose possible futures and lead to premature death or disease. Only in the case of an imminently dying man do these potential harms become less crucial to consider.

The fellow feels at ease that buprenorphine will not make anything worse. Although his patient just told us, politely, how buprenorphine had left him in intractable pain for a month, and that he had turned to illicit use of heroin to serve as his palliative, end-of-life care, this outcome was not recognizable to the physician in the addiction clinic as problematic. Pain as a harmful presence, here, is again "almost" erased from addiction clinic, as its connection to buprenorphine hides in plain sight. But in many ways, such exceptions as terminal cancer only help to prove the rule that death is the acceptable setting for using full agonist opioids now.

## At every stage a contradiction

*Dr. Hewey pauses his typing for a moment, and then comments to me, “It’s interesting, people have almost like a PTSD about opioid withdrawal. They say, ‘It’s coming on! It’s gonna come!’ I say ‘No it’s not!’” He tries to comfort patients and emphasizes to them that they don’t need to worry about withdrawal, he says, because expectation plays a big role in how well tapering opioids down works for patients. “Our bodies are like an ocean liner,” he explains, “not a speedboat. When you taper, it's like hitting a beehive with a bat. The bees will all buzz up and get excited. If you don’t hit it again, they’ll calm down and be okay. If you keep hitting it, things get worse. So you have to pick a course and sail on it for a while, making a small change of a few degrees at a time.”*

*“At every stage, it’s a contradiction,” Dr. Hewey remarks to me. Addiction treatment in clinical spaces, he explains, entails both willful agency and passive surrender, in a mode not dissimilar to that asked by programs like Narcotics Anonymous. “You want the patient to be very active, but not make any decisions. We ask them to be very involved and active, not passive in recognizing addiction; you need them to be very* active in surrendering to it. *So they have to* do *things themselves, but at the same time not on their own. They need help,” he says. “They need* your *help.”*

Dr. Hewey likens opioid tapers to hitting a beehive with a bat and stirring up angry bees to stress the importance of slow and gradual opioid tapers. Mixing similes, he also likens our bodies to large ocean liners. Like beehives, in this description, ocean liners do best with slow change. Interestingly, he likens the opioid taper both to a boat’s course redirection of a few degrees, and to an assault of a beehive with a bat. The mixing of these similes is telling. The differences between the two images may be at the crux of the problem of shifting opioid policies in health care: how can we know if we are, in effect, correcting course, carefully adjusting patients toward a better direction, or if we are instead repeatedly assaulting patients with bats?

A notable pitfall of this framing question is that patients within addiction clinic are always already discredited from providing input on the direction their care should take. Dr. Hewey points this out by highlighting the contradictions inherent to our understandings of addiction: patient participation is required in order to receive care, but that participation requires *surrender* of control. Such a framing in the medical model of addiction ultimately constrains the co-construction of a therapeutic narrative. It is common to other models of addiction and recovery. Despite Dr. Hewey's "flipping the script" described above, he understands and operates within the constraints of medicalized addiction care models.

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## Conclusion

In this chapter, I have examined the rise of addiction clinics alongside the rise of buprenorphine in the U.S. as a biomedical "catch-all" intervention to stem the tide of opioid-related harms. As a pharmaceutical intervention representing significant political and capital investment, buprenorphine is always already more than just a medication that one places under the tongue. Yet its qualities as sacred object of state power are often hidden by the discourses and practices of biomedical care that recognize the effects of buprenorphine only in terms of individual compliance or willful surrender to its powers. While I take buprenorphine to be an important component of treatment for many people, I ask how its essence as valued and valuable is related to its insidious relation to those other opioids increasingly constructed as pure evil- even other licit opioids (Nietzsche, 2001). I asked how patients who do not feel "held" by buprenorphine offer insights into ongoing failures of the state to account for vulnerable patients' needs and demands for meaningful health care. Moreover, others who experience buprenorphine as terrifyingly powerful help to illustrate the ways that buprenorphine acts within the context of historical residues and structures of feeling (Williams, 1977), and takes part in ongoing ideological struggle over the meanings of addiction, care, and recovery.

Patients' experiences were juxtaposed with physicians' perspectives on what addiction clinic is *for,* and how buprenorphine fits into existing and emerging models of care for people who use opioids. Physicians in addiction clinics are transforming both the meaning of care, by implementing harm reduction in creative ways, and defining new meanings of harm reduction by centering the framework around universal best practices and medication induction.

The next chapter juxtaposes patient and physician experiences in addiction clinics with perspectives of pharmacists and DEA agents tease out in more detail the sites of both harm reduction and drug law enforcement manifesting in health care spaces.

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# Chapter 4.

# ‘Red Flags’ and ‘Red Tape’:

## Bureaucratic Holds on Buprenorphine at the Pharmacy

### *Wrong number*

*Dani, a nurse practitioner in Pennsylvania who provides medications for opioid addiction via telehealth, treats Cristina, a patient without a car in a rural town who walks to pick up her prescriptions from a chain pharmacy. After sending Cristina's first buprenorphine prescription, Dani receives a call from the pharmacist asking how she knows Cristina and why the patient lives so far away from her. Dani explains that she provides telehealth care. After she confirms that she would see Cristina for follow-up in one week, the pharmacist fills the prescription.*

*Pharmacists continue to call Dani for each refill for Cristina. They ask when the next follow-up appointment is and if she had done a urine drug screen. One day, Cristina is refused buprenorphine from the pharmacy. She messages Dani: the pharmacist stated that he could not get in touch with the prescriber, and so he refused her prescription. Dani does not have any missed calls from the pharmacy. When Dani calls the pharmacist, together they determine that he had dialed the wrong number. Dani confirms that Cristina has a follow-up appointment next week, and the pharmacist fills the prescription, although Cristina has already missed two days of medication and is suffering withdrawal.*

*After a month, Dani and Cristina agree that she would benefit from a small dose increase to treat ongoing cravings. Dani sends out the new prescription, but receives a call from a pharmacist asking why she increased the dose. Dani explains that this dose is medically standard, but the pharmacist responds that his supervisor "does not believe that higher doses of buprenorphine are necessary for long-term treatment." Dani would have to agree to taper Cristina down to the previous dose within weeks. Wanting to ensure that Cristina could pick up her prescription that day, Dani agrees. A month later, the pharmacist states that he will no* *longer fill the prescription unless Cristina's dose is tapered down, even though she was feeling better at the higher dose. Cristina ultimately switches to a different pharmacy farther away.*

*- 2020*

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*"They screwed me over"*

*"They screwed me over," Liza tells me as soon as I walk up to her in the encampment. We hug and I ask her what she means. "They wouldn't fill my suboxone prescription… they told me that the doctor did not put the diagnosis on the prescription, so they were trying to get a hold of the doctor. They told me I should even try on my end. I left empty-handed." A month ago, Liza had been prescribed buprenorphine after I connected her to a physician at the addiction clinic whom she had liked, and she had decided during their conversation that now was the right time to try an induction of the medication, which would allow her to qualify for housing programs and help her to save money too.*

*Liza recounts how difficult it had been for her to find a ride to the pharmacy from the encampment where she was staying: it took her most of the day to get there and back. But the pharmacist was unable to reach her prescribing physician right away, and refused to dispense her medication without speaking with him. Because she had been planning to take buprenorphine, she was in withdrawal from heroin and had no safe supply or sterile syringes available to her. "I should never have left myself open like that but it didn't even cross my mind that this would happen." Feeling upset and helpless, Liza scrambled to find a small amount of heroin that she worried may have fentanyl in it, and reused a syringe to inject it.*

*When I reach Liza's physician at the outpatient addiction clinic, he is noticeably frustrated at the pharmacist's response. "This is not standard of care," he says. "There is no* *requirement that a diagnosis code be attached to the prescription. This is a pharmacist with no idea what they're doing just giving the patient a hard time."*

*Although he writes a new prescription for Liza that day with a diagnostic code attached, she does not return to the pharmacy. A few months later, I see Liza again and find out that she has a warrant out for her arrest, for failure to show up to court for a new charge related to continued drug use.*

- *Field note, California, 2020*

## Introduction

Buprenorphine, approved in the U.S. in 2002 for the treatment of OUD, can be prescribed by primary care clinicians in outpatient settings, in contrast to methadone which in the U.S. can only be dispensed by certified treatment programs to patients who are under supervision for OUD treatment. The emergence of buprenorphine has already altered the landscape of OUD treatment in the U.S., shifting the spatial politics of addiction medication access from the surveillance requirements and quasi-punitive ethos of methadone clinics (Netherland & Hansen, 2017). However, buprenorphine access historically has been limited primarily to White, employed, privately insured patients; only recently has it started to make its way into OUD treatment settings serving low-income individuals (Hansen & Roberts, 2012; Lagisetty, 2019). Despite efforts to increase access, geographic, racial and class disparities in buprenorphine prescribing and dispensing have endured in the U.S. (Pashmineh Azar et al., 2020; Schuler et al., 2021). In fact, disparities in buprenorphine uptake have only worsened in recent years, resulting in a public health paradox: efforts to increase medication access to vulnerable groups have disproportionately benefited privately insured and White patients over others.

During the COVID-19 pandemic, U.S. federal lawmakers invoked an exemption to the 2008 Ryan Haight Act requiring in-person evaluation to prescribe buprenorphine for treatment of opioid use disorder (OUD) (Drug Enforcement Administration, 2020). For the first time, doctors and nurse practitioners could prescribe buprenorphine to patients over the phone and through telehealth visits. This policy change, celebrated by many prescribers in addiction clinics, could remove existing transportation and geographic barriers to accessing the medication  The use of telehealth for OUD treatment with buprenorphine provides a potential benefit of removing existing barriers to care for patients remote from clinics and those with limited transportation (Harris et al., 2020; Wang et al., 2021). This potential benefit comes at a time when the rates of drug overdose have been increasing steadily across both rural and urban counties (Hedegaard et al., 2019).

This chapter takes this policy change and its implementation as an ethnographic starting point to explore the role of the pharmacy as it affects buprenorphine access, opioid trajectories, and shapes common sense concerning ‘what is to be done’ in response to the ‘opioid crisis.’ How do efforts to increase medication access come to backfire, and instead exacerbate existing inequalities? How do fissures form between stated intentions of drug policy and lived effects of its implementation? How might these fissures reveal key assumptions and fallacies in our collective common sense about opioids and U.S. drug policy?

Throughout this chapter, I recount stories from participant observation and interviews with patients, addiction clinic staff, prescribers, pharmacists, and DEA agents to illustrate different orientations to and experiences of buprenorphine bureaucracy that often contradict one another. Moving beyond a description of “barriers to medication access,” I explore historically and politically contingent experiences of *waiting* to examine *how* the pharmacy operates to produce possibilities for care or abandonment for particular people seeking relief through buprenorphine. Through these stories, I argue that waiting on pharmacists is *constitutive* of the situation of drug war.

Although patients, prescribers, and pharmacists alike rhetorically support buprenorphine-- and the use of telehealth for buprenorphine as a welcome option-- "barriers to access" often manifest at the pharmacy as experiences in waiting. Patients, prescribers, and prescriptions are placed "on hold"—in a pattern of both waiting and wondering about the cause of the hold.

Unbeknownst to most prescribers and patients, who are experiencing the bureaucratic delays but are typically left unaware of their causes, pharmacists are laboring to identify 'red flags' for buprenorphine prescriptions. Such 'red flags' include geographical distance from patient to provider or pharmacist, desire to pay cash rather than use insurance, patients new to the pharmacy, the use of 'slang terms,' and seeking any type of controlled substance or combination of controlled substances from different prescribers (California Department of Consumer Affairs, 2014). Although a part of their everyday work life, identifying, sorting, and managing patients' and providers' 'red flags' constitutes a discomforting part of the pharmacist's job. Such sorting makes them feel that they are required to play dual roles of health care provider and of 'police detective.' Fears of surveillance, pharmacy audits, and punitive enforcement by the Drug Enforcement Administration (DEA) and the Board of Pharmacy coalesce into a "structure of feeling" that shapes pharmacists' orientations toward people seeking opioids at their pharmacies (including prescribers and patients) (Williams, 1977).

'Red flags' lead pharmacists to develop and implement 'red tape' measures that slow or stop medication dispensing. Such 'red tape,' conceived of as necessary to pharmacists, allows them to avoid direct confrontations and contributes to diffusion of accountability for buprenorphine access. Through the feeling of red flags and the use of bureaucratic red tape, I argue, pharmacists produce drug policy rather than simply enact it. Without explicitly naming who deserves the medication and who does not, arbitrary outcomes are produced. In this process, poor patients in particular are abandoned, leading to further downstream harms for these patients.

By playing a key gatekeeping role in buprenorphine access, pharmacists shape and reshape the ‘common sense’ of the War on Drugs and our collective response to ‘opioid crisis’ (Gramsci, 1992). Red tape at the pharmacy makes room for competing forms of common sense surrounding care provision and drug law enforcement to intersect and clash, while minimizing conflict for the pharmacist. While national public health experts and prescribers believe that the recent policy change should facilitate getting buprenorphine to patients geographically distant from pharmacies, pharmacists are in turn trained that geographic distance from their pharmacy is itself a ‘red flag’ to be warded off. Telehealth for buprenorphine therefore stirs up the tacit and common-sensical, deep-seated criminalization of drug use, throwing a light on intensified technologies of surveillance and criminalization that have been a key part of the state response to the ‘Opioid Crisis.’ While policy shifts incorporating telehealth seem to support decriminalization and treatment for drug users, in implementation, many are left waiting, and in the meantime, pharmaceutical companies, physicians, and pharmacists are paradoxically added to the list of criminals sought after in drug war. The bureaucratic entanglements in which prescribers, pharmacists and patients are embroiled are both constitutive of and disguise powerful social forces in competition over the meaning of buprenorphine in a neoliberal state and health care industry.

## Prescribers

### *“On a hold”*

### ***California***

*Raul, seated at a short table in the addiction clinic's physician room, is on hold with the pharmacy. Opus No. 1, a song from 1989 now known as the "addictively pleasant" and synthesizer heavy 'hold music' that transmits through the line of Cisco corporate phones, washes over us (Corbett, 2017). Raul is the attending physician on duty today, and is trying to figure out what went wrong for Mohammad, a patient without insurance who was prescribed buprenorphine a week ago. Last week, Mohammad went to the pharmacy in withdrawal from fentanyl to try to pick up his prescriptions, but he had only received two bottles of pills: one for nausea and one for anxiety that are often prescribed alongside buprenorphine—but no buprenorphine, which should have come in strips to put under the tongue. Mohammad had not realized something was missing and the pharmacist hadn't said anything about it. When the addiction clinic nurse called to see how his "home induction" of buprenorphine was going, he had told her he was not doing well: he was achy, nauseous, and shivering uncontrollably. He couldn't go to his job in this state. The nurse advised him to take more of the anti-nausea medicine, not realizing that the buprenorphine was missing from his regimen. Ultimately, he used fentanyl again in order to show his face at work, and returned to the addiction clinic for his follow-up appointment to ask for more help. When Raul realizes that the pharmacy had not filled his buprenorphine prescription, he explains to Mohammad that it is the most important medication to treat his withdrawal symptoms—it is the thing that is going to make the biggest difference to get through withdrawal from fentanyl.*

*For over an hour, I watch as Raul sits on hold with the pharmacy, occasionally checking his phone, typing notes in electronic medical records, and staffing a couple patients with fellows and medical residents under him. Opus No. 1 quietly starts and restarts. Raul raps his fingers on* *the table, looking at his phone, occasionally looking at me with an expression of half exasperation, half measured composure. Another attending might hang up, rolling their eyes, but Raul knows that sometimes this is how things go with pharmacies. While we wait, we chat, and looking online, he finds that uninsured patients have to pay $130 out of pocket for Narcan, which he needs to prescribe to Mohammad along with his buprenorphine prescription. He asks a nurse to get a sample of the overdose reversal medicine to give to Mohammad so he won't have to buy it.*

*Finally, Raul hears a voice on the other end of the phone line. He states that his patient had trouble picking up their suboxone. The voice interrupts to ask for the patient's date of birth and first and last name. "You're the doctor?" the voice asks. "The patient's prescription was put on a hold. I'm not sure why they're on a hold right now. I may need to talk to my manager who's not in right now. She's probably the one that put them on a hold." Raul then asks the pharmacist about the prices, asking if they accept Good Rx. "We do take Good Rx if he has coupons for the generic, not the brand." Raul tells the pharmacist to cancel the 4mg dose of Suboxone and he will write a prescription for the generic instead in that case. He tells the pharmacist that Mohammad does not have insurance. "Oh my god!" the pharmacist exclaims. "It's going to be really expensive."*

*Raul decides to cancel the ancillary medications for Mohammad's withdrawal treatment based on the cost, keeping only the buprenorphine itself in the generic formulation. Still, the buprenorphine is on a hold and the pharmacist says the manager will have to call him back. Mohammad has now been in the clinic for over three hours and has to leave to get to his job. Raul tells him that he hopes he will resolve the issue at the pharmacy before Mohammad goes* *there tonight to pick up his prescription, and helps him to schedule a follow-up appointment at the clinic.*

*After Mohammad leaves, Raul and I discuss the common problem of pharmacist holds on buprenorphine, and two other addiction doctors turn away from their computers to weigh in on the discussion. One complains, "I had to call 10 pharmacies to get my pregnant patient buprenorphine [Subutex]—they all said, 'Well we don't carry this.' It was like talking to a teenager… one woman essentially accused me of being a drug dealer. I said, 'I'm a doctor. I'm an addiction medicine doctor- I can explain to you how this works.'"*

*The other doctor says that top-down enforcement is constraining pharmacists*: *"From pharmacists I'm not sure if it is bias so much as a lack of interest and a systemic failure. In my experience the pushbacks are from big chain pharmacies that have faced lawsuits in the last few years."*

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The vignettes above, featuring the prescribers Raul and Dani and the patient Liza, highlight obstacles I observed in my fieldwork and that prescribers faced alongside patients to get buprenorphine dispensed. Prescribers, and prescriptions, were "on hold"-- in states of limbo that were difficult to understand the reason for, or to get "to the bottom of." Prescribers, and patients, were waiting. And bureaucratic 'red tape,' consisting of official or unofficial low-level pharmacy rules and obstacles that slowed or hindered the process of getting medications to patients, had recently become nearly or actually insurmountable: hours on hold to investigate canceled or delayed prescriptions; frequent phone calls required to maintain access; unmet promises of calls back. A wrong number dialed meant no medicine. Ironically, a pharmacist's distrust of both telehealth and the prescriber meant that the telehealth system produced a new transportation barrier rather than removing one, as Cristina was forced to rely on friends to drive her to a pharmacy that would dispense her medicine. These kinds of stories were told and retold by physicians, nurse practitioners, and clinic staff at many addiction clinics, both at my primary field site in Southern California and as far away as Pennsylvania.

Liza's embodied experience of "care" was a day full of painful, anxious, heroin withdrawal- an experience that she typically avoids at all costs, but which she willingly put herself into out of trust in a charismatic physician who had convinced her to start buprenorphine. I played a role in signing Liza up for voluntary torture: I knew the doctor well and connected him to Liza, and my rapport with both helped to build a bridge of trust between them. She followed instructions that she needed to be in moderate withdrawal before taking buprenorphine. Then, in the throes of withdrawal, she experienced the humiliation of being denied her prescription by a pharmacist, seemingly over a small bureaucratic detail. Red tape, a long wait, a refusal. Liza had been assured and reassured that she would be cared for only to be abandoned: "left empty-handed." While she had a modicum of trust in the care system prior ("It didn't even cross my mind that this could happen"), she retreated from institutionalized medicine after this incident. Heroin turned out to be a more reliable, accessible opioid to keep her out of the horrors of withdrawal compared to buprenorphine. Both Liza's interpolation *into* the medical care system and her immediate subsequent *abandonment* were links in a biomedical system that coalesced to punish her with a day of opioid withdrawal and humiliation. Through a complex labyrinth of attempted and missed communications, the pharmacist could not "get hold" of the doctor. Liza is left, as she says, "empty-handed."

In order to understand how care (and abandonment from care) comes to be experienced as punitive, I began to look more closely at this specific pharmacy-level break-down in the health care system with a focus on the fractures of biomedical care playing out on the ground.

In Liza's case, when telehealth allowed her to obtain a buprenorphine prescription from the encampment where she slept, she was grateful. But the unexpected disruption of access at the pharmacy multiplied existing vulnerabilities, as she went into withdrawal and lacked secure access to sterile syringes and a safe drug supply. Her physician conflated potential explanations that the pharmacist either lacked knowledge or was deliberately "giving the patient a hard time." But lacking knowledge is not the same as deliberately producing a barrier. To understand better what was happening at pharmacies, I accompanied patients through their clinic visits and pharmacy visits and interviewed prescribers and pharmacists around the county. I also collaborated with a researcher and nurse practitioner in Philadelphia to understand the scope of the problem across different locations in the U.S.

What social forces are at play shaping the 'holding pattern' in which both patients and prescribers are embroiled with pharmacies for buprenorphine access? While sitting 'on hold' over telephone hardly seems like a dramatic event, when repeated consistently over time, I came to understand the 'hold,' and other associated deferrals, delays and the time, effort, skill, and capital required to surmount them, as a key technology of pharmacy bureaucracies. Calling the pharmacy and waiting on hold became a common practice by prescribers, while the social forces contributing to the need for the wait on hold remained elusive. While managing to seem neutral and benign--perhaps containing misunderstandings or miscommunications that could be clarified away-- the hold nonetheless constituted the implementation of drug policy on the ground, slowing or stopping buprenorphine access to vulnerable patients. Combined with commentaries of prescribers and pharmacists alongside the downstream effects for patients that I witnessed, I came to understand the ‘hold’ as a mechanism of socially stratified abandonment from care that was fundamentally shaped by surveillance and regulatory apparatuses that are bearing down on the pharmacy.

## Waiting

Waits are political, existential, and situational (Hage, 2009). Waits signal as to who waits for whom and whose time is made to appear more valuable than others’, to power structures including scarce resources or curtailed capacity to provide services, which in turn may be rendered impersonal through mediating technologies such as telephone communications (ibid). Waiting is a disposition while it is also social, relational, and engaged: the search for meaning and desire for a future belonging can become constitutive of the subject, and “shameful waiting” or a rejection of the waiting game can become core dispositions (Hage, 2009; Pardy, 2009).

A physician made to wait on a pharmacist is a reversal in temporal politics that they resent with righteous indignation. Although it signals a shift in the historic power physicians have held over pharmacists, far from feeling newly empowered, pharmacists feel deeply afraid of enforcement and state surveillance, and they use waits to cope: making a patient or prescriber wait provides a temporal barrier that is self-defensive, providing them time and space to discern whether a person or prescription is legitimate. Although not formalized as such, participation in the wait itself comes to be key to *producing* legitimacy in patients and prescribers.

Liza, a poor patient who engages in anticipatory waiting at the pharmacy only to have her hopes dashed goes into florid opioid withdrawal. In response, she withdraws herself from biomedical institutions and refuses the waiting game, understanding it to be a form of organized punishment *and* abandonment. She returns to illicit heroin use with all the risks it entails- risks that were exacerbated by her mistaken belief that medical promises would be delivered. Although she tried, she could not wait for a licit form of relief. Neither could Mohammad, who had to go to work.

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## Prescribers

*"All these worrying negotiations, this endless going from place to place, and talking with pleasant and excellent people, who quite saw the unpleasantness of the petitioner's position, but were powerless to assist him--all these efforts that yielded no result, led to a feeling of misery in Levin akin to the mortifying helplessness one experiences in dreams when one tries to use physical force… What was particularly trying, was that Levin could not make out with whom he was struggling, to whose interest it was this business should not be done… With the hindrances that confronted him, no one could explain why they existed."   - Tolstoy, Anna Karenina (Tolstoy, 2004)*

Bureaucratic hurdles have existed for perhaps as long as bureaucracies have, the term 'red tape' attributed to the red-colored ribbon used to bind official papers as early as the 16th century (Dickson, 2014; Williams, 1985). Tolstoy observed a feeling of helplessness in the face of the impenetrability of such obstacles, which come with a decentered and inexplicable quality, often along with a pleasant face. In my fieldwork, local pharmacies often emerged as such insurmountable obstacles and permanent barriers to care for patients. For reasons that were not obvious at first, the pharmacy produced a kind of red tape that I, with all my health literacy, medical student ID and back-door access to physicians' cell phones, could not cut through for my interlocutors. Most patients that I followed had no car, and I often drove them to the pharmacy myself, either from clinic or from the encampment, and back. But even with rides and the implementation of telehealth for prescribing buprenorphine, many patients, along with their prescribers, discovered invisible barriers that emerged at the pharmacy. While waiting in bureaucracy is structured by poverty, it is not only the poor who are made to wait. The physicians in these vignettes, hoping and trying to medicalize harm reduction approaches to care, were left waiting. While they attempt to carry out a (popular, broadly supported) federal drug policy shift, possibilities for care are foreclosed on the telephone hold.

## “There’s no face, no name to that”

The partial newness, and the slippery seeming quality, of this mundane bureaucratic hurdle, highlighted it to prescribers. They could not seem to pin down the problem for pharmacists with their prescriptions. Some thought that it might be the need for a diagnostic code, so signs went up in the clinic reminding clinicians to *always* place a diagnostic code to correspond with buprenorphine prescriptions. Others called multiple pharmacies and another sign went up: “Do not write suboxone scripts to XX pharmacy, they do not carry suboxone.”

Prescribers in the addiction clinic cultivated a stance of righteous indignation and moral authority over pharmacists and on behalf of their patients. They described emotionally charged struggles over specific prescriptions with pharmacists whom they described as speaking “*like teenagers*” in obstinate resistance to dispensing buprenorphine without recourse to a rational explanation. Often strained interactions with pharmacists had been ongoing for years, but had become especially common and fraught now that telehealth was being used to prescribe buprenorphine to patients farther away. They described pharmacists deflecting their demands to dispense medications efficiently by citing ‘pharmacy policy,’ a frustrated prescriber explained, “*but there’s no face, no name to that… you can’t be like ‘Who wrote the policy?’*” Prescribers felt that pharmacists should work with them to help patients but often refuse.

In the absence of a discernible logic to pharmacy-level barriers and pharmacist resistance, physicians often resorted to the explanation that pharmacists were unable or unwilling to use logic. They categorized pharmacists as automatons who do not know medical best practice or their individual patients. "*Pharmacists are unwilling to go against anything that they feel is the pharmacy mandate. They are just a conduit of getting medication from shelf to patient and not thinking outside the box,"* one physician stated. Another felt that pharmacists do not have sufficient information to reject prescriptions: "*They are the dispensing arm and not integrated into care decisions."* In essence, many physicians' diagnosis of the problem was that pharmacists were not using their brains. Occasionally, they also hinted at a desire for pharmacists to remain this way, stating that they should simply obey physician orders rather than follow pharmacy mandates.

In addition to conceiving of pharmacists as mindless, some physicians simultaneously accused them of justifying refusals to dispense buprenorphine because of thinly veiled stigma and coded racism. Described one clinician treating a Black patient: "*The pharmacist did not take well to the patient's behavior in the pharmacy, which seemed fine. I remember the pharmacist stating clearly, 'You know how these people are, right?' trying to commiserate with me. I said, 'No, I don't know what you mean, but if we can get this medication dispensed, I can go about my day*."

While this clinician used confrontation to 'manage' the pharmacist in question, others attempted to appease and build rapport with pharmacists to resolve red tape surrounding buprenorphine. "*If the barrier is pharmacists questioning our legitimacy, we can have a conversation and bring them into the treatment loop and in on the patient journey*," a clinic staff member stated. Another prescriber described appealing to pharmacists' sense of duty in the face of public health crisis, telling them, “*This is an epidemic that you are aware of, and you can be part of the solution. This involves you.*”

## A Reversal in Waiting

People with significant or politicized health needs already know that pharmacies are sites of contestation and are often roadblocks in their care trajectories. Trans people have struggled for decades to get access to hormonal therapies, and have organized online to share crucial knowledge about which pharmacies will dispense what medicines, including across borders (Padilla et al., 2016). Not infrequently, U.S. citizens visit Mexican or Canadian pharmacies and purchase over-the-counter medicines that in the U.S. are much more restricted (and are also more expensive): pain-relieving Tramadol and Ketamine, anxiolytics like Xanax, and stimulants such as Adderall. Even those with relatively destigmatized health conditions cross the same borders to find more affordable versions of medications for diabetes or high blood pressure. Such journeys unite many people living with chronic pain or with chronic stress--including from pursuits like getting through medical school-- and their privileged ability to cross borders has enabled them to access substances they feel will help. The pharmacy, often presumed by others as an annoying but essentially apolitical errand, is a key site of regulatory enforcement over medication supply, distribution and dispensing.

Does the prescriber wait on the pharmacist, or does the pharmacist wait on the prescriber? Historically, physicians have treated pharmacists as often agreeable subservient colleagues (Higby, 2010). The physician desire and assertion that pharmacists should merely act as “dispensing arms” dates back to the professionalization of pharmacists in the early 1900s, coinciding with the rise of mass production of medications and the hardening of the division of labor between physicians and pharmacists (Urick & Meggs, 2019). Whereas previously pharmacists had mixed each medication individually and crafted local businesses as both care providers and chemists, William Procter Jr., the grandfather of professional pharmacy publicly worried that with industrialization and mass production of medicines imported from Europe, pharmacists would be denigrated to become “mere shopkeepers,” dispensers of medications—which, in some ways, they have (Swann, 2009). Many of the first drug laws and border-controlled regulations of the early 1900s were in part motivated by the poor quality of medicine precursors imported from Europe that had already had their medicinal properties extracted for European use, and were sold wholesale to unsuspecting American markets.

Battles for control over medication distribution and regulation have a historical and political economic basis for pharmacists, and physicians, pharmaceutical manufacturing companies, and pharmacists have long been embroiled in these struggles. In the 1850s, physicians tried to set norms and practices for pharmacists and pharmacies, only to see these attempts stymied by pharmacists themselves, who accelerated their own professionalization as a defensive tactic against control by physicians (Higby, 1986). Physicians’ current complaints about pharmacists, and their ongoing tensions, rather than representing a new struggle within a field of typically harmonious divisions of labor, in fact represent a continuation of a longstanding debate that hits at the core of what it means to be a pharmacist running private businesses or working within chain pharmacies, in either case licensed by the federal Drug Enforcement Administration to operate, trying to sustain a living in health care industry.

Prescribers’ tone of indignation over waiting on pharmacists, and their steadfast determination in waiting anyway, coalesced as claims to moral and intellectual leadership, a key asset in the struggle for hegemony concerning drug use. Such a position is aided by their biomedical specialization in addiction management, which grants them a privileged position in generating scientific knowledge within addiction medicine. They are situated as experts in the U.S. health care system that generates substantial profit from specialty care and the sale of pharmaceutical interventions, including buprenorphine. Addiction specialists are well positioned to cite ‘evidence-based’ studies on buprenorphine showing it to be efficacious in reducing the use of illicit opioids, safer than an alternative such as methadone (which cannot be prescribed in outpatient addiction clinics), with relatively low street value in comparison to other opioids. From an addiction provider’s standpoint, buprenorphine is attractive for having relatively low risk of overdose or diversion compared to other opioids, is effective for many patients undergoing opioid withdrawal, and is profitable (Netherland, 2011). Physicians’ role in funneling patients onto buprenorphine is explored in a separate chapter on addiction clinics. Here I want to highlight that prescribers’ moral authority over appropriate care, and their scientific authority over medical best practice, coalesces with their interests. When they spoke with pharmacists, however, they got the distinct sense that something was amiss, and that there must be some *reason* why getting them to dispense buprenorphine was *so* difficult, and required *so* much extra time out of their days.

How can these additional bureaucratic barriers that emerged seemingly from no specific place be understood? And how can the tense interactions between prescribers and pharmacists—two professional groups ostensibly collaborating in the health care industry-- be conceptualized? Were prescribers right that pharmacists were behaving as brainless automatons or stigmatizing cowards? Or was something else going on?

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## Pharmacists

### “Call it a red flag, call it a gut feeling”

*“Call it a red flag, call it a gut feeling.” – Bob, pharmacist*

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*“Instantly my alarms are going off, all the red flags they teach you, and just being in the business for a while. These are all things that you need to look out for, people coming from far away areas to your pharmacy, never been there before.” – Jon, pharmacist*

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*“Sometimes a pharmacist can, just from sensing a situation, get something that seems unusual or suspect to them.” – Bob, pharmacist*

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*Jon, who owns and operates his own pharmacy in town, has a friendly but ‘no-nonsense’ demeanor. He is named by several addiction providers as one of the “good ones”: he regularly works with patients who have addictions, and is familiar with the routine of dispensing buprenorphine. He has a close working relationship with an addiction clinic a few miles away and with a nearby rehab center, so if he has a question or concern, he can reach a physician quickly and generally resolve it.*

*Jon does not fill prescriptions that come from outside of a five-mile radius from his pharmacy. This could be five miles to a patient’s house, or to a patient’s prescriber, it does not matter. When I ask him what would happen if he were to fill outside of this radius, Jon’s demeanor shifts. In consternation, his tone intensifies and he speaks rapidly, pressing his words together with emphasis. He describes the following scenario as a nightmare for any pharmacist:*

*“Let’s say you try to fill the medication but it’s outside your area. It flags the DEA. The DEA’s watching all this controlled stuff. You get the flag on the DEA and they say ‘Oh.’ A lot of times it’s not like they had any proof. It’s not like they called the patient and said, ‘Hey! Are you*

*trying to sell this drug? Do you get extra when you go to the doctor?' They just have a computer system that marks if I filled outside the area. And if I do, that gives them probable cause to come raid my pharmacy. And try to find something.*

*"Why would I put my pharmacy at risk? Like I don't care* what *your situation is. I can't do that to my whole establishment. My whole livelihood. All my patients that depend on me. I can't put my whole store at risk to get raided by the DEA because I filled your script because now they have probable cause.* Of course *I can't be courteous to that patient.* Of course *I can't be understanding. I have to do what's best for my store. That's why we have the policies we do, because of how strict things have become."*

- *Interview, 2020*

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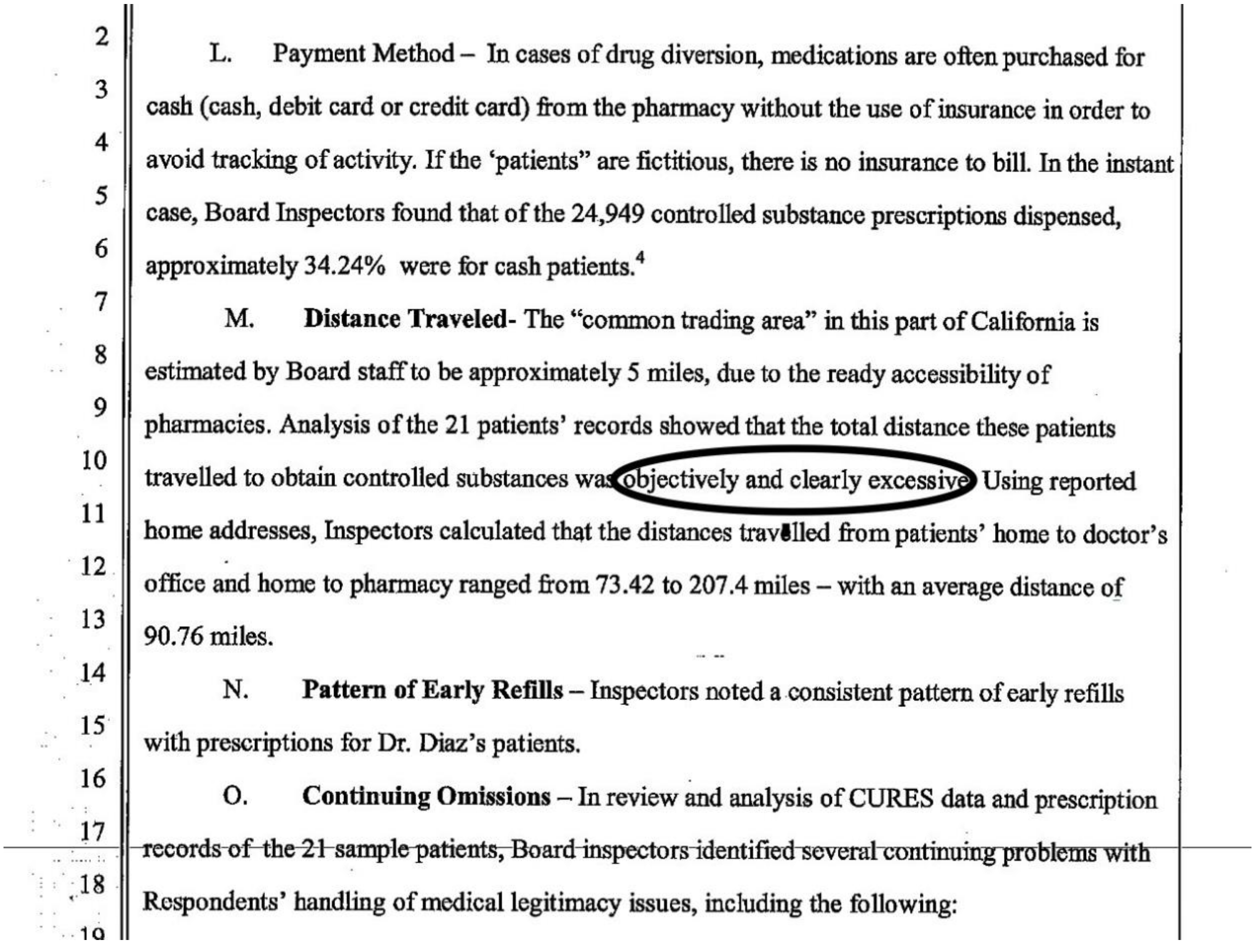
Jon, a pharmacist, shapes his pharmacy policies and practice around 'red flags.' He considers DEA enforcement to be a risk to his livelihood. Like Jon, a respected pharmacist amongst the addiction clinic prescribers I worked with, all 10 pharmacists I interviewed described red flags as key to identifying suspicious patients and prescribers within their practice.

Red flags incorporated both 'gut feelings' developed through experience, and formal instruction materials that pharmacists receive. For instance, a 2014 collaboration between the Anti-Diversion Industry Working Group, and the National Association of Boards of Pharmacy, produced a YouTube video entitled 'Red Flags,' which consists of multiple hypothetical scenarios that a pharmacist might encounter and instructs the pharmacist to identify each scenario as a "red flag" (California Department of Consumer Affairs, 2014). In the video as well as in pharmacist interviews, "red flags" included: patients or prescriptions from areas remote from the pharmacy; patients new to the pharmacy; requesting to pay cash rather than use insurance; seeking any type of controlled substance or combination of controlled substances from different prescribers; or using "slang terms" to describe medications. The industry working group includes McKesson, a drug distributor company. McKesson has been a frequent defendant in highly publicized lawsuits brought by states seeking justice from licit opioid suppliers for their role in supplying opioids to communities that were overwhelmed with opioid overdoses (Knauth, 2022). McKesson's role in producing a video in collaboration with the National Boards of Pharmacy could be seen as a tactic to demonstrate corporate responsibility in the midst of these lawsuits.

That geographic distance itself is a red flag for pharmacists contradicts both prescribers' understandings of buprenorphine access and the recent federal policy change that allows for the implementation of telehealth to start patients on buprenorphine in the midst of the COVID-19 pandemic. The implementation of telehealth ostensibly *removes* a geographic barrier to buprenorphine access. But pharmacists were operating under a different logic, one shaped by their perceptions of DEA surveillance and enforcement.

Why does the geographic distance between patients' homes and the prescribers, or home and the pharmacy, serve as a red flag for pharmacists? While multiple DEA agents told me that there is no specific set geographic distance outside of which pharmacists are not legally allowed to dispense medications, nonetheless, there were reasons why pharmacists often set an informal dispensing radius for their pharmacies. Through enforcement efforts aimed at curtailing the licit opioid supply, geographic distance has served as evidence to build a case against a "pill mill," and to show prescriber and pharmacist irresponsibility. In the Board of Pharmacy case against OMAC Pharmacy, for example (pictured below), based in Oxnard, California, "distance traveled" was used as evidence that the pharmacist in question was filling prescriptions for patients traveling distances for controlled substances that were “objectively and clearly excessive.” The investigators calculated the distances travelled from patients’ homes to doctors’ offices and from home to pharmacy and compared that distance to what they termed the “common trading area” as estimated by Board of Pharmacy staff:



L. Payment Method – In cases of drug diversion, medications are often purchased for cash (cash, debit card or credit card) from the pharmacy without the use of insurance in order to avoid tracking of activity. If the ‘patients” are fictitious, there is no insurance to bill. In the instant case, Board Inspectors found that of the 24,949 controlled substance prescriptions dispensed, approximately 34.24% were for cash patients.[4]

M. **Distance Traveled-** The “common trading area” in this part of California is estimated by Board staff to be approximately 5 miles, due to the ready accessibility of pharmacies. Analysis of the 21 patients’ records showed that the total distance these patients travelled to obtain controlled substances was objectively and clearly excessive Using reported home addresses, Inspectors calculated that the distances travelled from patients’ home to doctor’s office and home to pharmacy ranged from 73.42 to 207.4 miles – with an average distance of 90.76 miles.

N. **Pattern of Early Refills** – Inspectors noted a consistent pattern of early refills with prescriptions for Dr. Diaz’s patients.

O. **Continuing Omissions** – In review and analysis of CURES data and prescription records of the 21 sample patients, Board inspectors identified several continuing problems with Respondents’ handling of medical legitimacy issues, including the following:

Figure 1. OMAC vs Bd. of Pharmacy (*Accusation Against OMAC Pharmacy and Robert Valusek, Bd. Of Pharmacy Case No. 5371*, 2017)

One pharmacist noted that every month he receives an alert in his email inbox listing pharmacists in the state that have been penalized or shut down due to such forms of enforcement.

Pharmacists interviewed expressed fear and concerns about these enforcement strategies and stated that they kept within a strict geographic radius for dispensing buprenorphine, along with other prescriptions, as a result.

### “Not only a pharmacist but the police detective”

Asked whether a prescription for buprenorphine makes the pharmacist more or less concerned than prescriptions for other controlled substances, the pharmacist Jon responded in a way that reveals the logic and affect of drug war that permeates in pharmacies and applies indiscriminately to all prescriptions, not only to opioids considered to have been overprescribed:

> “Every *prescription I fill I’m concerned. Pharmacy has become very strict. It should be strict, right? We’re dealing with people’s safety. But the Board of Pharmacy and the DEA has come down really hard on a lot of pharmacists for things that in my opinion are real harsh. They expect them to be not only a pharmacist but the police detective. If I make the wrong choice, I get penalized. They will take my license. It is happening. They’ll ruin my livelihood. It’s terrifying. It puts the fear of God in you.” – Interview, 2021*

Here the specter of drug law enforcement triggers the “fear of God.” Such fears shape the subjectivity of this pharmacist, who describes being asked to take on dual roles as health care worker and police detective.

Pharmacists generally had little knowledge of how enforcement against them works. In interviews, they generally had no idea what information the DEA has access to and what it does not, and how this information may be used, but they imagined the DEA as a somewhat omniscient force, accounting for the “fear of God” that many felt. In interviews with pharmacists, there was a sense that such knowledge was so comprehensive, and enforcement so extreme and arbitrary, that if a pharmacist incorrectly checked a box on a form it may result in jail time.

### “Red Tape”

In response to red flags/suspicions, pharmacists described using strategies that increased the bureaucratic hurdles required to obtain buprenorphine. Across pharmacies, the common goal was to ascertain and document medico-legal legitimacy of prescriptions while avoiding direct conflict.

Such ‘red tape’ strategies included: requiring a diagnostic code be attached to each prescription; requiring verbal confirmation over the phone from the prescriber of the dose, quantity, or medication itself (often accompanied by a vetting of prescribers’ credentials); refusals of early refills; and requiring phone calls with prescribers to ascertain their location and qualifications. Pharmacists also sometimes avoided conflict by counterfactually telling prescribers and patients deemed suspicious that they did not stock buprenorphine: “If I have a patient come in and they ask for it and they’re a new patient, I just tell them I don’t carry it.” This produced many additional obstacles, as patients would have to return to clinic and prescribers would have to call different pharmacies to find one that was confirmed to stock buprenorphine.

Red tape typically took the form of informal policies. They were applied without fanfare and often-- at independently-owned pharmacies with a single pharmacist-- without written documentation. Chain pharmacies likely had more official policies that led to dispensing barriers but most pharmacists at chain pharmacies that I met refused to be interviewed, citing lack of time. One such pharmacist stated that the chain pharmacy where he worked did not stock buprenorphine, because all five pharmacists working there would have to go through a special internal training which they had not done.

Pharmacists were aware that additional ‘red tape’ could produce barriers for patients. As one explained, *“Sometimes the doctors will get on the phone and talk to me and explain the situation. Other times they say they’ll call but I never get a call back. And the patient never gets their stuff.”* Pharmacists stated that such measures were necessary to secure their livelihood. *“I’m not going to fill it until I hear from the doctor. [The patients] say ‘I don’t want to wait 45 minutes.’ Well, I don’t want to lose my license!”*

Bureaucratic policies at the pharmacy were introduced to reduce risk to pharmacists but were ultimately indifferent to patient outcomes. When this pharmacist described his policy of calling the prescriber for verification and explained that this sometimes left the patient without their medication, the patient outcome was not the chief concern; protecting his livelihood with bureaucratic procedure was the point.

### Abandoned through bureaucracy

Red tape produces arbitrary outcomes when success hinges on who answers a phone call and when. Such arbitrary outcomes have been identified as a key aspect of governance that produces unequal life chances for poor and marginalized communities, who are abandoned *through* bureaucracy (Gupta, 2012). Gupta has ethnographically documented how contradictory bureaucratic processes actually represent continuities between biopolitical care and the violence of poverty. Lives are cut short from the systematic production of arbitrariness throughout state systems. According to Gupta, bureaucratic red tape supports an *imagined* cohesiveness of state power, and such imagined cohesiveness accomplishes not only a representation of the state but is actually *constitutive* of state power. Red tape therefore enables violent exclusions and incites conflict. In pharmacies, discretionary bureaucratic procedures, based in pharmacists' logical fears of enforcement, made room to deliver care for some patients while rendering logics of abandonment less visible but intact.

Chiarello identifies three behavioral patterns of pharmacists when faced with a patient seeking controlled substance medications: 1. Treatment- providing or refusing the medication via medical gatekeeping; 2. Enforcement- refusing based on legal concerns and attempting to punish the patient via legal gatekeeping; and 3. Avoidance- sending the patient away without the medication, only partially engaging in medical and legal gatekeeping because the patient receives neither care nor punishment (Chiarello, 2015). Throughout my fieldwork, all three of these behaviors were observed. However, medical gatekeeping and avoidant behaviors, rather than being distinct from punishment, often were experienced by patients as just another form of punishment: patients such as Liza were left abandoned in crucial moments and exposed to additional health risks.

## DEA

### "They're legitimate professionals"

To contextualize and clarify the intense fears of enforcement by the DEA that pharmacists described, I interviewed three current and one former DEA agent about investigations into pharmacists and prescribers focused on licit opioid diversion. Rather than claiming responsibility for the effects of enforcement on pharmacists' behaviors, they emphasized a lack of specificity in the law and characterized pharmacist fears as hyperbolic, or firmly stated that pharmacists had nothing to fear if they simply follow the law.

One former DEA agent told me he recommends to pharmacists that they not fill prescriptions outside of their city or county, "*just as a risk mitigation move. Because in the past,* *a lot of pill mills would find mom and pop small pharmacies where they'll fill anything and they would be a magnet for all the patients*." However, he also emphasized that the DEA has no formal guidelines on geographic radius and no specific mile marker outside of which a pharmacist cannot fill a prescription, and said that pharmacists "*like blaming the DEA because of the enforcement actions the DEA takes*," while pharmacists ultimately have responsibility. "*DEA has no specific mile marker. It's not written anywhere… They have that sole authority as a pharmacist to determine how far out they will fill a prescription for a patient… There's a lot of gray in the whole arena. They're legitimate professionals.*"

This agent emphasized that while the DEA plays a role in enforcement, pharmacists need to both educate themselves about the risk of enforcement and practice strategies to limit risk to their own pharmacies, while also emphasizing that pharmacists make choices about dispensing over which that they have sole responsibility. By emphasizing that they are "legitimate professionals," he stresses pharmacists' autonomy and agency, while simultaneously owning that the DEA "*has the full authority to come in and do an unannounced audit into any pharmacy any time they want*." As another agent said firmly, "*The best way to not get in trouble is to not break the law.*"

Contradicting the pharmacist's scenario wherein dispensing a medication outside of his radius would trigger a DEA raid, an agent stated that geographic distance alone would be unlikely to trigger a DEA investigation. Patient information, including addresses, are not part of the data they routinely collect in DEA computer database, ARCOS, which tracks shipments of medications from manufacturer to end distributor. DEA investigators would not be able to track geographic radii, such as those cited in the Board of Pharmacy case above, without accessing state-run prescription drug monitoring program (PDMP) data, and different states have different rules about DEA access to the PDMP, with some requiring search warrants and others more openly integrated into law enforcement.

The order of operations for a DEA raid, an agent explained, is generally the following: someone near to a pharmacy notices unusual behavior, or a prescriber notices something odd about a pharmacy, and someone makes a tip to a local police department, who then contacts the DEA. This process highlights how the implementation and reproduction of drug war depends upon individuals embodying an ideology of catching troublemakers and criminals and calling on police. Investigations are not conjured out of thin air but depend on laypeople seeing something “suspicious” in their neighborhoods: red flags are for everybody. A DEA agent then conducts an “investigation of the facts.”

## Cultural Climate of Enforcement

DEA agents described that what they can do with information is in many ways not up to them but depends on a “cultural climate” regarding what types of cases federal and local prosecutors will decide to take on. If federal prosecutors decline a case built by a DEA office, the DEA office will then propose it to a lower level of court, down to local District Attorneys’ offices, which are prone to rapid cultural shifts after newly elected D.A.s come into office. DEA agents learn to discern what a given D.A. will be willing to pursue versus not, which affects their ‘outputs’: quantified measurements of their work such as number of successful prosecutions, or total settlement dollars paid. A DEA agent may determine that they will not be able to bring a criminal case and then may try to bring a civil case against a pharmacist or prescriber, only to find that the only viable avenue for their case is through a Board of Pharmacy or Board of Medicine. In that case, a key output measure is the number of physicians and pharmacists whose licenses were removed.

The number of DEA agents and funding dollars directed to investigations of diversion have ballooned significantly in the past ten years (U.S. Department of Justice, 2021). Although the agents I spoke with, along with local sheriffs, all corroborated that overprescribing of opioids is “not really a problem anymore,” nonetheless, there are whole divisions being funded to do enforcement against diversion of licit opioid supplies. As a somewhat smaller, relatively adaptable unit in Ventura County, the sheriffs have simply redirected their work to do online interdiction of illicit drug supplies as well as sent their officers to investigate every fatal and non-fatal overdose reported throughout the county (sometimes bumping up against Good Samaritan law). But the DEA office in Los Angeles recently expanded its diversion unit, representing a reinvestment in the status quo ethos of drug law enforcement.

## Diffuse Accountability

Throughout my fieldwork, bureaucratic discretion and geographic variability of enforcement cultures contributed to an overall sense of a diffusion of responsibility for drug law enforcement, and for access to buprenorphine, across multiple levels of state and bureaucratic authority, including individual pharmacists, Boards of Pharmacy, DEA agencies, local DA offices, and non-centralizing data tracking programs. Each individual encounter, gesture, and experience came to bear on a “structure of feeling” shaping affective atmospheres in pharmacies (Williams, 1977). Raymond Williams conceived the term “structure of feeling” to describe a potential interrelation between apparent fragmentations of contemporary values (ibid). Williams was concerned with “meanings and values as they are actively lived and felt” (ibid:132). He understood that, in practice, formalized, systematic beliefs are “variable, over a range from formal assent with private dissent to the more nuanced interaction between selected and interpreted beliefs and acted and justified experiences” (ibid:98). The feeling of red flags, the selective implementation of red tape, and the many interactions between interlocutors surrounding these pharmacy activities, can be understood in terms of such interactions between formal assent and private dissent. A structure of feeling denotes a distinctive quality of a “complex whole” which is “not present in its individual parts, or in their aggregate” (Middleton, 2020). I find the term helpful to comprehend the pervasive yet impossible-to-pin-down sense of suspicion, accusation, blame, amidst the simultaneous formal professionalism and barely-maintained decorum surrounding the bureaucracy of buprenorphine in pharmacies. Each interlocutor—prescriber, pharmacist, DEA agent-- had some other party to suspect or to blame for any conflict that arose, and yet suspicion and blame themselves were the main holistic effects on individual psyches.

In the final sections of this chapter, I ask how legacies of drug policy and historically sedimented ideologies of drug war come to bear on this structure of feeling.

## The “bureaucratic afterlife” of controlled substance law

While a direct line is often drawn from President Nixon’s declaration of the War on Drugs to the horrific consequences of the early drug laws passed during his administration, less often described is the large gap between the stated “good intention” of some of the policies and the way they were implemented. Revisiting these earlier laws is instructive to understand how federal policies relaxing restrictions for addiction treatment today are failing to take hold and are bureaucratically obstructed.

The 1970s saw the passing of the Comprehensive Drug Abuse Prevention and Control Act (CDAPC), out of which came the consolidation of drug law enforcement under the Drug Enforcement Administration as well as the Controlled Substances Act. Today, although buprenorphine is considered to carry a relatively low risk profile and has lower value on the illicit market compared to other opioids, as a federally controlled schedule II substance, buprenorphine is subjected to the same enforcement logics and bureaucracies as other opioids under this law, and in recent years, there have been major developments in state surveillance technologies and enforcement of all opioids along with other licit and illicit substances in the U.S. (Cicero et al., 2007; Pergolizzi et al., 2010). These enforcement logics have a complex history and political economy.

Legal scholar Lauren Ouziel has argued that while the initial stated goals of the CDAPC legislation included putting a greater percentage of budgetary allocation toward drug treatment and prevention as demand reduction strategies, the "bureaucratic afterlife" of the bill resulted in precisely the opposite effect: more funding and prioritization for supply reduction efforts of enforcement and punishment (Ouziel, 2020). Despite stated intentions to move away from prosecuting low level drug crimes and toward treatment for drug users, these intentions were stymied by bureaucratic reorganization and by misguided measurements of "success" during implementation.

Ouziel describes how the original aims of the legislation were organizational and strategic: it sought to coordinate federal drug control policy and replace a disjointed array of federal drug laws with a single regulatory regime, and to redirect resources toward demand reduction (treatment and prevention) from supply reduction (interdiction and criminal enforcement), and through penalty changes, it sought to redirect criminal enforcement away from lower-level dealers and users toward highest-level members of the drug trafficking trade.

However, Ouziel argues, its organizational success led to its strategic failure. Bureaucratic dynamics and competition for centralized resources that the CDAPC created ultimately favored single-mission agencies such as the DEA and the Bureau of Customs and

Border Protection over mixed-mission agencies that covered both treatment and prevention. Crucially, efforts to reduce drug *supply* since the passing of CDAPC have been judged by measures of *outputs*—drug seizures and arrests, successful operations run through enforcement efforts, or use of prescription drug monitors to reduce overall number of opioids prescribed—rather than *outcomes* (Beletsky, 2018; Ouziel, 2020). Beletsky and others have pointed out that for nearly every study of PDMPs, researchers have examined only outputs such as prescription reduction, failing to reckon with the problematic reality that large reductions in licit opioid prescription have coincided with exponential increases in opioid overdoses (Beletsky, 2018). In contrast, *demand* reduction success has reported the bulk of its measures as *outcomes,* such as the percentage of persons using illicit drugs or prescription drugs non-medically, or the average age of illicit drug use initiation. Agencies have much less control over outcomes when compared to outputs (Ouziel, 2020). Having different measures for doing one's job well across these two bureaucratic spheres may not seem like a problem, but when an attempt was made to legislatively fund comprehensive drug control efforts, the two spheres of supply and demand efforts were pitted against one another. In the process, the DEA, with its singular focus on drug supply reduction efforts, quickly won out against institutions doing more diversified efforts including drug treatment and education, and the DEA began receiving the bulk of governmental funding related to the drug policy (Ouziel, 2020). Incentives within the supply-reduction ecosystem that reward outputs such as seizures, arrests and convictions over outcomes such as actual reductions in drug use ultimately pushed federal drug enforcement toward lower rungs of the drug trafficking trade.

Examining the ways that these early policies were implemented as compared to their stated intentions is instructive in recognizing the ways the U.S. continues to repeat its history of failed drug policy reform. Despite a stated intent to increase access to buprenorphine treatment nationally, according to drug law enforcement logics, buprenorphine is read merely as a controlled opioid at a time when efforts to restrict the licit opioid supply have intensified. In this way, statements of intention toward treatment continue to be undermined by robust infrastructures of enforcement that are propped up by the same discourses of necessary timely responses to drug crisis.

## Ongoing ideological struggle

Since the passing of the Comprehensive Drug Abuse Prevention and Control Act, political and media narratives have strengthened ideologies of racialized criminalization of drug use fused to the notion of public order (Alexander, 2020). Social scientists have argued that state efforts combined with media coverage do not merely codify into law popular notions about drugs, but transform our collective ‘common sense’ and construct particular individuals as undeserving, deviant, and criminal (Hall et al., 1978). “From an ideological standpoint, the rhetoric and policies of the War on Drugs have transformed the symbolic meaning of poverty, thereby legitimating the replacement of the welfare state with the security state. Poor people were transformed, in contrast to New Deal anti-poverty initiatives, from those who are “in trouble” to those who “make trouble” (Beckett & Sasson, 2000).

From this vantage point, drug war-style regulations shape not only the subjectivities of those who use and sell drugs but also the subjectivities of those in positions of power over them, including pharmacists and prescribers in the health care industry. They are tasked with providing care while simultaneously rooting out ‘trouble-makers.’ In what Gramsci calls a ‘war of position,’ (Gramsci, 1992) the ongoing struggle between treatment/harm reduction frameworks and criminalization frameworks plays out in institutions like pharmacies and clinics, wherein employees negotiate, debate, and enact these frameworks on behalf of themselves and their patients.

Although recently the U.S. War on Drugs and corresponding mass incarceration and police violence have been challenged through mass mobilizations as unsuccessful, costly, and racist, the institutional apparatuses of the drug war remain intact. State-led efforts to catch ‘doctor shopper’ patients and ‘pill mill’ prescribers and pharmacists have expanded through highly publicized lawsuits and through surveillance and enforcement via drug reporting systems and prescription drug monitoring programs (Beletsky, 2018; Hoffman, 2022; Liptak, 2022). Despite efforts to expand access to low-income patients, drug war-style regulations pressure pharmacists to determine who is a ‘trouble-maker’ and who is ‘legitimate.’ Combined with income-stratified differences in ability to overcome bureaucratic hurdles such as waiting on the phone, finding transportation, or obtaining a private prescriber advocate, these regulations reinscribe class-based discriminations of deservingness. Thus, national regulatory relaxations in the COVID-19 era allowing for buprenorphine via telehealth have not fully taken hold as national policy has intended for many low-income patients.

Pharmacy policies, which grouped all opioids together with a logic based not in public health or pharmacology but in perceptions of drug law enforcement, negatively impacted buprenorphine access for marginalized patients. Pharmacists were ‘squeezed’ by prescribers to behave as an unquestioning ‘dispensing arm’, and by the DEA and Boards of Pharmacy to be the frontline ‘police detective’ doing drug law enforcement. Faced with competing pressures over their proper role, they felt that their livelihoods were at risk. Fears of legal and regulatory retribution were incorporated into pharmacists’ work practices: they developed discretionary policies, translated ‘gut feelings’ into a clinical grammar of ‘red flags,’ determined geographic boundaries outside of which they would not dispense buprenorphine, and introduced bureaucratic 'red tape' to block prescribers and patients they deemed suspicious.

Within this context, actors ostensibly collaborating to achieve the goal of care were pitted against one another and compelled to identify others as potential threats. The pharmacist who states, "*You know how these people can be, right?*" to commiserate with a prescriber at the expense of a patient, implicitly marks 'these people' (certain patients) as 'trouble-makers.' Another who emphasizes, "Of course *I can't be courteous,* of course *I can't be understanding,"* invokes a common sense that depends on and reinforces logics of danger and defensive abandonment: a prescription for a controlled substance from outside his town brings DEA surveillance that threatens his livelihood, so the prescription and the person bringing it become dangerous both to the pharmacist's job and to public safety, legitimizing the need to ward them off. Interpersonal dynamics of suspicion between pharmacists and patients intersect with, rationalize, and reinforce structural logics at the institutional and state policy levels; structures of enforcement likewise reinforce individual feelings of suspicion and practices of gatekeeping through the logic that some patients do not deserve care. Prescribers, pharmacists, and patients are pitted against one another, eroding relationships dependent on trust as individuals attempt to assign blame while a common goal of care goes unreached.

Akhil Gupta argues that such contradictory bureaucratic processes actually represent continuities between biopolitical care and the violence of poverty. According to Gupta, bureaucratic red tape supports an *imagined* cohesiveness of state power, and such imagined cohesiveness accomplishes not only a representation of the state but is actually *constitutive* of state power (Gupta, 2012). Red tape enables violent exclusions and incites conflict, and lives are cut short from the systematic production of arbitrariness throughout state systems.

Applying this understanding to the pharmacy, pharmacists introducing new bureaucratic barriers effectively disguised the contradictions between opposing forces: the power of buprenorphine manifested within biomedical models of health oriented toward pharmaceutical and care profits, and the threat of buprenorphine manifested through the repressive state apparatus of DEA surveillance. Such red tape disguises contradictions of state drug policy to patients and prescribers alike. Even pharmacists developing these strategies are not fully conscious of the forces and affective intensity behind the strategies they themselves are implementing, nor are they aware of the effects of this red tape on patients' lives.

Focusing on the processes of implementation of buprenorphine policies- within the space of the pharmacy, interactions between the clinic and pharmacy and between various professionals, along with bureaucratic objects such as forms, records, and databases- opens up possibilities of interpretation and avoids the problem of reification common to theories of the state and state power (Gupta, 2012). As Raymond Williams notes, hegemony can tend to be understood in abstract, static and totalizing terms, but "a lived hegemony is always a process… it does not just passively exist as a form of dominance. It has continually to be renewed, recreated, defended, and modified" (Williams 1977:112). Rather than treating the state as a concrete entity, or drug policy as a finished product upon its passing, in the case of pharmacy, we can see how the workings of state power are contingent, and the meaning of policies are co-constructed by everyday acts of discretionary decision-making, historically sedimented ideologies, and political economic conditions that entangle us in particular affective attunements of which we may not even be aware.

## Conclusion

In this chapter, the pharmacy emerges as a key site of ideological struggle over the meaning of drugs and their regulatory enforcement, a site of abandonment for poor patients, and a site of bureaucratic management in the War on Drugs. While common sense imagery and discourse may conjure the border, the prison, and the urban street corner, as the primary sites of drug war-- and the pharmacy as a kind of non-place (Auge, 2009)-- here, Zigon's description of the "nonlocalized complexity that is the drug war situation" fits to describe the pharmacy as a local manifestation of drug war (Zigon, 2015). The pharmacy is situated as a site of struggle and a place from which people are both punished and abandoned.

The places and temporalities to which individuals can re-orient are varied and dependent on social location. For well-resourced patients, expensive advocacy and large investments of time and social capital including private physicians' aid, or crossing borders to access alternatives, may serve to surmount pharmacy obstacles. For many poor patients, often the best and most economical source of relief comes through using illicit opioids intravenously, which come at huge personal cost and embodied risk, in the form of infection, injury, arrest, incarceration, and death. These are urgent, timely solutions to the trauma of withdrawal.

Just as methadone clinics were spatially segregated from clinics and subjected to their own regulatory enforcement regimes, becoming stigmatized spaces of discipline for marginalized patients, (Bourgois, 2000) pharmacies can be considered as a primary site of buprenorphine regulation and as a gatekeeping space that ultimately keeps buprenorphine out of the hands of many marginalized patients, segregating them out of health care. By doing this segregation mostly out of view of clinical settings, and above and beyond the stated policy of the pharmacy, health care systems claim to be providing state-of-the-art, destigmatized, medicalized care for addiction, while those deemed undeserving are excluded from access.

For communities harmed by the opioid epidemic, a downstream impact of self-defensive practices like those taught in McKesson and others' videos instructing pharmacists to identify red flags, is that patients in need of buprenorphine struggle to access it because they are labeled as "suspicious." In this case, a paradox of state lawsuits against private companies in attempting to dole out "justice" is that as private companies shore up their defenses against accusations, patients in desperate need of care are further abandoned in the fallout.

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# Chapter 5. Outside Care:

## Probing Outreach, Policing, and Belonging

*"PJ is brilliant," Mary says to me in a low voice. "He shouldn't be here. He could do so much."*

*Mary is a rehab nurse who has been in recovery from methamphetamine and alcohol use for the last several years. She organizes a church group to bring food and clothing into the Ventura River Bottom encampment every other weekend. I often go with her and her boyfriend James, visiting residents that I have gotten to know over the last year. She likes PJ, and she often recruits him to walk with us and carry some of the bags of food, introducing us to his neighbors, his friends and community, and talking with us. PJ, a 62-year-old White man, has been living in the encampment for the past three years, and on and off in various encampments for the past several decades. Mary thinks PJ is too high functioning to be living here.*

*PJ thanks Mary and James and says that it's great of them to do what they do, taking time out of their days to deliver food and clothing to people here. "It's so great that you haven't burned out on this yet," he says to them. Later, he privately tells me, "People come in here, because they want to feel like they're doing something about the homelessness problem. But the truth is people here are doing alright."*

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*One day when I visit PJ at his camp in the Ventura river bottom encampment where he has lived for several years, he shouts enthusiastically through the tarp covering a makeshift gate in front of his camp, "You caught me right when I was about to go pellet shooting!" Then he invites me into his place.*

*In his main living area, PJ has a drum kit, an electric guitar, and a generator. He has a large jug of water that he fills at the surfer shower area and bikes back with his bike trailer. He* *has a separate cooking area, having built out his camp from what he now calls his garage, which, when he first moved here three years ago, was his whole camp. He marvels that he lives right next to a narrow inlet from the ocean and has his own private dock, just about 30 feet from the back of his camp down a steep path to a quiet inlet from the ocean, where the dried up riverbed previously connected. There, he ties up kayaks and surfboards he has found and regularly paddles out to the shore break. In his living area, he has hung a painting he made of a woman injecting heroin that I think looks like a Basquiat; he tells me someone offered him $1,000 for it once. A California bear flag hangs next to it and he has used black tape to construct the words "I Can't Breathe" over the bear. Outside of his tent, on the dirt pathway leading up to it, he has constructed a makeshift fence with a gate entrance covered in tarp so that one cannot see into his shelter from the outside. There is a camera facing the visitors' entrance, although it's not powered.*

*PJ is in good shape. He has a slight swagger to his walk, turning his legs outward a little bit, almost a little bowlegged, and squats slightly as though sparring when people are joking with him or asking him a question. He gets a glimmer in his eye in these moments and to me has a youthful, boyish demeanor. Often when I visit him he takes me paddling, me in his kayak and him on what he calls his new invention, the 'dub sup' which entails him balancing one foot on one surfboard and the other on another, using a stand-up paddle board to paddle. We paddle about a mile to the open ocean. He explains that none of the shelters of the encampment are visible from the road and bridge that we paddle under. As soon as someone builds something visible from the road, someone complains and the police immediately tear it down. When he see police on ATVs on the beach, we turn around and paddle back.*

*PJ grew up in the San Fernando Valley, his dad commuting into Los Angeles to work for the city in public works. His parents kicked him out of the house when he was 18, and he joined the navy. He continued his education through the navy, studying photography, until eventually he got a job working for an industrial plastic fabrication company for 20 years. He was married and had two kids, but when he got divorced, he owed a lot of child support. He says he was able to pay the child support but not anything else. So he sold his belongings and bought a motor home which he lived out of until fees and fines added up and it was towed. After 17 years, his child support was paid but he had already been living in the streets and had gotten used to it and had started using drugs. He started with crack cocaine, and then moved into heroin and meth.*

*These days, PJ rarely uses heroin. His good friend and next-door neighbor in the camp, Charlie, died of an overdose in his arms a few years ago. He wasn't able to bring him back. Charlie's young adult daughter still lives in the camp and PJ watches out for her. PJ uses mostly meth now, and he excuses himself for a moment now to take his morning dose. While he had a hard time with it before, he says he came to understand that it's meant for certain times and certain purposes and not for others: "You can get carried away with anything, right? The number one cause of divorce in the U.S. used to be the Chevy Corvette. More men told women that the 'vette got more mileage than they did. It was me or the 'vette and they took the 'vette. So you can become addicted or obsessed or overindulge in anything. So once I came to terms with that, I learned to regulate my dosage much better. I was much more cognizant of the fact that you could just do a little bit. And not do it all at once."*

*PJ puts his pellet gun on his waist and he shows me a device used by golfers to estimate yardage, which he recently found on the golf course immediately adjacent to the encampment. I look through it to see the distance of the eucalyptus tree in the distance and the gradient on the* *ground as PJ gets his other pellet gun and adds it to his waist belt. He asks me if I've ever been out and down past the second eucalyptus tree, and I say no because people have told me not to go there. He says, "Well, they mean not to bother anybody down there but we can go on a walk, I'd be happy to take you on a walk there. Would you like to go? I'll show you." I say yes, and we start walking down a gravel path.*

*On the way, we run an errand by his friend's camp. I ask what he's carrying. It's a gift for his friend Terry, with whom he makes music a few days a week. In a serious, quiet tone, PJ discloses to me, "I have unemployment, Lauren." "Great!" I say. But he says he doesn't have an ID right now and is not getting his checks. He needs to go to the DMV. I offer to help in any way that I can. He received about $10,000 a few months ago initially from unemployment at the beginning of the COVID-19 pandemic, but he asked his neighbor to keep it in his bank account since he doesn't have a reliable account right now. Unfortunately, recently PJ had an argument with his neighbor's girlfriend, and as a result his neighbor is not speaking to him, so he lost access to his money. As a cost saving measure while he attempts to repair the relationship, PJ has returned to injecting meth rather than smoking it, to get more potency with each use. Before he lost access to the money, he used some of it to buy Terry a replacement part for a drum kit at the nearby pawn shop. Terry had not seen the gift coming. Upon seeing it, he starts to cry in gratitude. They hug. "If you make me cry again I'm gonna have to beat you up," he tells PJ.*

*We walk down into the woods, arundo growing tall and thick all around us. "We're really in it now," I say. Everyone used to live down here when they were more in hiding, he tells me. As recently as 3 years ago. A lot of people here used to live in "the old river bottom," he explains, a couple of miles away, but in 2010 everyone was evicted and many were thrown out of town: police arrested them or harassed them until they disappeared. He himself moved to San*

*Diego's river bottom at that time. When he came back to Ventura, he discovered a "private island" at the other river bottom, which stopped everyone stealing his stuff for a time. He had to build a raft to get to it. "Who has their own private island!" he says, marveling… "It's such a privilege and we're so lucky to be able to camp here and live here," he says.*

*- Field Note, 2020*

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## Introduction

In this final chapter, I make a departure from formal health care spaces to the place where several of my interlocutors along with a couple hundred others lived: a largescale, semi-permanent encampment in a dried river bottom in which people have made camp for nearly 100 years, since the Great Depression. While previous chapters briefly introduced this space through vignettes focused on Juan (Chapter 3), and Liza (chapter 4), as they sought out buprenorphine, this chapter dwells on the river bottom encampment.

I began to spend more time in the encampment when the COVID-19 pandemic lockdown began, and I could no longer do fieldwork in hospitals and clinics. I was already volunteering with the mobile syringe exchange program that operated at the edge of the encampment each week, an essential service. Wanting to know how participants in this fieldwork project were doing whom I already knew from clinical spaces-- either because they had received addiction treatment or had sought care for complications related to illicit opioid use-- I joined volunteers who were distributing supplies throughout the encampment daily.

Rather than attempt to make an argument or reach conclusions in this chapter, here I raise questions and offer openings. The four previous chapters followed patients through health care spaces where licit opioids and the possibilities of care and inclusion were increasingly restricted, pressured, and foreclosed, and I described how these spaces were sites of state investment and enforcement that led to expulsions, life-threatening infections, abandonment, and pain connected to these restrictions and pressures. Here in the encampment, away from buildings, outside of formal health care settings, and set largely out of public view, I probe the openings and possibilities found by residents to dwell, to care, to belong, and to exist outside of state imperatives. At the beginning of the lockdown there were several months when health care and housing outreach and law enforcement largely vanished from the encampment, but after this period, as I document below, residents experienced the return of both outreach and enforcement.

Anchored by vignettes centered around PJ and Diane, two older residents of the encampment, this chapter leans heavily on their thoughtful reflections alongside my observations of their friendships, activities of daily survival and joyful community, at the moment of the COVID-19 pandemic and the arrival of fentanyl in the drug scene. I probe the meanings of the frequent presence of outreach workers and police officers tasked with addressing the problems of homelessness and drug addiction in the county. While most of my interlocutors used illicit opioids daily, opioids were not typically at the forefront of our conversations or attention as they were in health care spaces. The illicit opioid supply during the course of my fieldwork was cheap, increasingly potent and readily available; the tortures of withdrawal were rare and overdoses became increasingly common. In this chapter, I describe forms of community, care, joy and adversity that shaped the days I spent visiting.

Who “belongs” in an encampment? What is the meaning of care “in crisis”? Throughout this chapter, I highlight PJ’s fraught relationship with the concept of belonging, or not belonging, within the encampment. How do PJ’s anxieties surrounding whether and where he belongs here shape his trajectory, along with the care he is able to give and receive? And what questions do such anxieties raise about mainstream drug and housing policies? While large investments are made in the name of care and in terms of time and human resources aimed at addressing the county's drug and "vagrancy problem," (Leung, 2019) I ask how those living in the encampment deal with and experience those who are said to be caring for them— including volunteers, outreach workers, and police working on the "homeless task force" (Rivers, 2021). Attuned to complex social relations within the encampment, PJ calls into question pre-existing notions of the directionality of care within hierarchies of power. I highlight the kinds of work asked of or demanded of people who are unhoused, in the process of legitimizing interventions aimed at *doing something,* or appearing to be doing something, about the "problem of homelessness." Who is doing care, and what are the potential possibilities, difficulties, and imaginings to be learned from care happening in non-normative spaces?

In this chapter, I do not mean to romanticize the encampment or homelessness; neither do I make the claim that people who are unhoused wish to remain so, or that people who are chronically unhoused are refusing help or do not want help. By dwelling in the ambivalences and complexities of PJ's and Diane's daily lives, their comments to me, and their relationships to those in the encampment and those who work there, I mean to stall any foreclosure of analysis. Based on my interlocutors' perspectives, I problematize mainstreamed approaches to drug use, addiction, and homelessness. Challenging the premise that any situation would be better than sleeping outdoors in an encampment, I ask instead what kinds of social relations keep people there, in opposition to the stated desires of outreach workers and city officials. Similarly, I raise questions about the causes and consequences of the arrival of illicit fentanyl into the drug supply of the encampment. My intention is to sit with the possibilities and problematics these vignettes open up for thinking about ways of living and struggling, and ask what questions they raise for popular, academic, and political discourses surrounding homelessness and drugs, care and suffering, and the good life (Berlant, 2011).

## The river bottom encampment: landscape of geographic refuse, outreach, and enforcement

The Ventura river bottom encampment where PJ lives is one of several large-scale, relatively out-of-sight, semi-permanent encampments in the county. The river bottom is a place where individuals, mostly men, have made camp temporarily since the Great Depression (Swartz, 1990; Wakin, 2020) and today, several intergenerational families live there.[1]

The encampments are located on borderlands: on the border between Ventura and Oxnard jurisdictions, close to farms, to town, vital resources including a potable water source, and/or within a couple hours' walk of the public hospital and other institutions and resources organized around the governance of poverty (Fleming et al., 2021). In addition to being close to advantageous locations, the camps are also located *away:* they take form in spaces that Winston calls "geographic refuse" - space that has been refused incorporation into dominant geographies and developments and a site where the people, land uses, and material environment are cast as marginal to the workings of racial capitalism's ecologies (Winston, 2021).

In contrast, encampments in adjacent Los Angeles County such as one that grew up around Echo Park Lake in 2020 are highly visible and located on expensive real estate (Rosenthal, 2022). The Echo Park Lake encampment in particular has been highlighted in national news and the subject of devoted and skillful grassroots organizing pointing out woefully inadequate or nonexistent offers for permanent supportive housing in the county (Levin, 2022).

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[1] A city worker is quick to remind me that children under age 18 are "caught by the school system" and do not live in the river bottom, but young adults who grew up in the county often camp side by side next to their parents and, for a few, their grandparents.

The eventual police-led eviction of all residents of the encampment at the behest of a city councilman has become a focal point in political debates about the place of encampments and street sweeps as well as police budgets and public safety (Oreskes & Wick, 2021). Common in these debates is vivid imagery of drug paraphernalia deemed threatening in particular to women and children.

Although Ventura has many fewer unhoused people compared to adjacent Los Angeles County, the SOAR initiative, which stands for "Save Open Space and Agricultural Resources," passed between 1995 and 2000, locked in existing land-use policies with a priority of maintaining the historical pastoral aesthetic of the county (Wilson, 2016). Since then, voter approval is required for conversion of agricultural, open space, or rural land to urban use. new developments cannot be constructed unless the surrounding neighbors vote to approve them. As a result, affordable housing is extremely scarce and property values have risen precipitously. Point-in-time counts of unhoused residents in Ventura County have shown the unhoused population grew by more than 25% since the start of the COVID-19 pandemic (Varela, 2022).

As an example of the geographic refuse to which Ventura's encampments lay claim, one of the largest encampments in the county, on private land, sits on top of radioactive metal waste that was buried too shallowly. A county employee who works on homelessness informed me that living atop the waste is akin to receiving an X-ray every couple of months. While it was private property, the property owners had no intention of developing the land, and simply did not want to liable for the health or wellbeing of the many county residents building shelters on top of the waste. People have lived there for years, and some of the most ambitious construction I saw across the encampments has been attempted there, including digging holes and placing PVC pipes to construct makeshift plumbing, and the placing of metal roofing rather than tarps and tents alone.

Like many of the county's encampments, the one where PJ stays abuts (and/or overlaps with) environmentally protected land. One was designated a "bird sanctuary area of global significance." Another was on a "watershed protection district." A metal pole installed in the dirt with metal sign reads, "Trespassing and loitering forbidden by law. Violators will be prosecuted." Beneath it, a second metal sign reads, "Notice to Vacate: All persons and personal properties are required to relocate from these premises before December 24, 2017. For relocation assistance, call …" White spray paint letters cover most of the sign, and more people were staying on the premises between 2020 and 2021 than had been recorded in many years. Through initiatives aimed at clearing the area of invasive species of plants such as *arundo,* environmental conservationists and park rangers nonetheless lay claims to the encampment. These initiatives legitimize enforcement of evictions or displacements of residents in the name of environmental sustainability.

While the river bottom encampment is out of public view and has been allowed to remain an encampment, it is also a site of intervention by multiple publicly funded agencies. The Ventura City "Safe and Clean Initiative" consists of a partnership of various kinds of city employees, including police officers who implement a "patrol task force" to do what they term "restorative policing" or "street outreach." Seven police officers are on this force. There are also Ventura city employees tasked with finding shelters for individuals, and a partnership with the Turning Point Foundation, a non-profit organization that manages River Haven, which since 2009 has consisted of a set of "pods" that were developed to formalize the encampment into city-sanctioned affordable housing (National Coalition for the Homeless, 2010). However, these pods house many fewer people than the number that camp immediately adjacent to them. Many prefer to camp for free rather than stay in the tiny pods for a monthly rent of approximately $400, and they also object to the restrictive rules at the pods.

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*When I arrive to visit PJ, to my surprise, I find Sgt Z out front, with Carolina, a social worker, standing outside of their vehicle which they have driven up on recently bulldozed paths, talking to PJ. PJ is slightly bent over looking deferential. His usual boyish demeanor is gone and he is nodding agreeably to something. I feel slightly embarrassed to have come upon them. PJ greets me as I approach and I stand and listen.*

*There is a long pause as no one speaks. Then PJ says somberly to Sgt Z that John died last week. "Did you hear?" he asks.*

*"Yeah I heard," Sgt Z says. Another pause.*

*PJ says he hung out with John the night before he died.*

*"Did you give him the meth?" Sgt Z asks.*

*PJ responds calmly, "No, and you know actually what he had was he had a hole in his heart."*

*"I know," Sgt Z says coolly.*

*"He didn't tell anybody he was dying and I think that's understandable, if you're dying, that you wouldn't want anyone to know that," PJ says. He brings up Mark who recently died as well. Sgt Z apparently knows about Mark's death too, but doesn't express emotion, remaining stoic. There is another long, silent pause. Sgt Z looks expectantly at PJ.*

*Then abruptly, PJ says that this year he thinks he may be ready to go somewhere to stay for the winter. Finally, this gets a reaction from Sgt Z and the social worker. PJ says he has* *some sort of case worker through his veteran status but Carolina says that she happens to know that person is leaving his post in two weeks.*

*PJ asks, "Well then could you liaise, in the next week?"*

*She brightly responds yes. Sgt Z is excited about this idea. He seems to feel that he has accomplished something by facilitating this conversation. He encourages PJ and adds, "Well let's get this figured out in the next two weeks before he leaves his job and you have to start the whole process over with someone new."*

*"Okay, yeah!" PJ responds.*

*Sgt Z jokingly asks our group if his sound machine on his vehicle is working properly and is it loud enough. Everyone says Yes! except Jake, a volunteer, who jokes, "It could be louder!"*

*"Nah, he's just messing with you," PJ says quietly, but Sgt Z turns it up and it blares through the camp as they drive around, dropping off clear plastic garbage bags and announcing to everyone they need to put their garbage up at the main trail by next week for clean up by the city.*

*– Field Note, 2021*

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*In July 2020, when I first met PJ, a volunteer and journalist offered him all the furniture from her apartment, as she was going to go on a long writing assignment and would be giving up her apartment. She had been helping him to plan to move into an apartment for the past several months, visiting him daily since the beginning of the COVID-19 lockdown, bringing food into the encampment, and they had established a friendship. He expressed a great deal of gratitude for the offer and politely deferred it until later to decide, explaining that the timing may not work out for when he was going to be moving into his own place.*

*Weeks later, confiding to me, PJ tells me that he doesn't intend to leave the camp this year. But he likes to help the volunteers and the outreach workers feel good. I'm not sure how I've earned his confidence but I find myself feeling grateful that he doesn't view me as one of those people whom he needs to reassure that they're doing something good.*

*It can be scary to sleep here at night, he concedes, because sometimes people invade his shelter and other times he feels threatened by the scene especially by the newer younger residents. But the freedoms he has here, access to both solitude in nature and to a strong community and the freedom to use drugs when and how he feels he needs to, are worth it. He makes friends with nearly everyone, including the cops who regularly patrol the area, the outreach workers, the other residents, and me. – Field Note, 2020*

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*I am walking through the encampment as part of the Backpack Medicine Initiative, a team consisting of doctors, social work case workers, employees of a housing assistance nonprofit organization including case managers and peer counselors, and public health nurses. The team visits an encampment within the county once a week to deliver health care services, especially focused on providing buprenorphine for opioid dependence, as well as treating minor wounds and doing basic primary care for patients who cannot easily access a doctor. Doctors are equipped with ipads from which they can remotely access and enter into patients' medical records in the county's public health care system. They also carry several vaccines, non-opioid pain medications and first aid supplies, while case managers carry transportation vouchers for getting to appointments, along with housing applications.*

*The team is always accompanied by several police officers who work for the city's homeless task force. They "flank" the group at the front and back, going ahead and behind the* *outreach workers, typically shouting into tents, "Police! We've got a doctor for you to see! Anyone need to talk to a doctor?" Occasionally when people see a police officer in uniform approaching, they run. I watch as they are chased down and forced out of hiding to speak with us. "You need to show your face," the head sergeant says to those who respond from their tents that they do not need to talk to a doctor. "We're not doing any enforcement today," he often says by way of introduction. "We've got a doctor here."*

*When I ask a leader on the medical team about the presence of police, he explains that it was hard to get approval to start this outreach medicine initiative unless the police officers were escorting the team. In part, he reasoned, this was influenced by the fact that county physicians and other workers are independently contracted employees, so there is no worker's compensation coverage if they were to get injured while doing work in the encampment. He worried that an outreach worker might step on a syringe or trip on a hidden branch and that he could get sued for leading the team.*

*As we walk through the encampment, Sgt Z takes photos of every car license plate he sees. Cars are typically relatively hidden in bushes but still visible from the narrow, dusty walking paths. He will run the plates later to see if they were stolen or do not have vehicle registrations up to date. While he isn't supposed to be "doing enforcement" during the time that he is with the backpack medicine team, such as issuing citations or checking for and enforcing outstanding warrants, he also says that he can't let blatant violations go if he walks by them.*

*Midway through the morning, a peer counselor at a transitional housing program who is accompanying the outreach medical team today turns to me and says admiringly, "I love the way he talks to them," referring to Sgt Z talking to the residents of the camp. "He's so down to earth," she says, as Sgt. Z tears down recently-erected gates, doors with hinges, and other* *barriers that provide privacy to individual camps. A resident physician asks him about what he is doing. "Because of Boise vs Martin, we can't criminalize homelessness," he explains. "But we also can't let people build permanent structures out here and lay claim to land they don't own. So."*

*I've noticed that he leaves PJ's camp alone. Outside of his tent, on the dirt pathway leading up to it, PJ has constructed a makeshift fence with a gate entrance covered in tarp so that one cannot see into his shelter from the outside. And several other long-term residents, friends of PJ's, have more solid construction that the police have allowed to stand. Carlos, for instance, has built an elegant treehouse of wooden construction complete with two stories and a walking bridge with rope handrail to cross a swamp in front of the shelter.*

*Diane had a relatively well-hidden camp immediately adjacent to the golf course, although it was not durably constructed. I visited her often when her cat birthed a litter, and we played with the half dozen kittens for hours on end, watching them tumble around, and she found a cat tree for them to play on. Her camp was also well known to the residents who regularly used heroin and her living room often doubled as a shooting gallery. Eventually, though, the cops caught her burning her trash in a pit, and they bulldozed her camp, forcing her deeper into the encampment, all the way down past the second eucalyptus tree where I had been warned not to go.*

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*"Spare time. Extra money. Nice cop. Some words just don't go together."*

*– Diane, 2021*

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## Intimate Policing

The river bottom encampment exists in a state of semi-permanent impermanence and in a state of spatial legal ambiguity. Not formally sanctioned by the local government, neither are the notices to vacate fully enforced. The Supreme Court case Boise vs Martin ruled that individuals who are unsheltered cannot be charged with a crime for doing so if immediate shelter in the vicinity is unavailable (*Martin V. City of Boise*, 2019). In Ventura County, there are only 88 shelter beds for those who are unhoused, and they are typically at capacity, so those who are living in the encampment cannot be charged with a crime (Ventura.org, 2022).

Where possible, however, the city attempts to enforce other existing laws and ordinances directed at behaviors often engaged in by those who are unhoused. The city of Ventura's Safe and Clean website describes its "focused police presence with an emphasis on behaviors, which can include vandalism, drug dealing, drinking in public, urinating in public, physical violence, aggressive panhandling, and other types of harassment" (City of Ventura, 2022). They provide a phone number to call to report suspicious behavior, debris in public spaces, graffiti, potholes and code violations. The Safe and Clean approach "strive[s] to align city, private, business and non-profit resources" (ibid). There is a persistent tension between those volunteers attempting to help make life livable for those in the encampment and the city workers whose jobs it was to help relocate these residents: volunteers bringing in food and other supplies are frequently told by the city employees, "Don't enable them."

Much work concerning the medicalization of homelessness has documented how discourses and practices of "care" have become fundamental to the governance of poverty (Baiocchi & Argüello, 2019; Gowan, 2010). Anthropologists have also documented how initiatives aimed at addressing the unhoused often play an ambiguous role that both ameliorates suffering and coerces simultaneously (Bourgois & Schonberg, 2009; Fleming et al., 2021).

Examining an initiative to address a spatialized "hot spot" of ill health leading to repetitive hospital admission, designed in imitation of policing models that map areas of high crime rates to infuse the area with policing resources, Fleming (2021) has argued that hot spotting reveals shifting fault lines between criminalizing and medicalizing approaches to managing poverty. He writes, "When the state's primary purpose is to maximize the impact of financial investments, the lines between domains of state action become blurred. Punishment, care, and social services may be resolved into and made comparable with a singular register of economic calculation" (ibid:486).

This analysis bore out to some degree when I asked the former manager of the Ventura Safe and Clean program how she measured success. She answered frankly: "Measuring success in this field is really difficult. I measured success by the number of individuals in the shelter, by the point-in-time count numbers, by the numbers of engagement of the outreach team, the successful connection to services, successful connection to housing, bags of debris removed from the River Bottom, and the award of grant funding." Yet, the "point-in-time count numbers" have only risen in the county year after year. The fact that this count and the number of individuals successfully connected to permanent housing have been dismal may explain the addition of more indirect measures of success. But these indirect measures ultimately point toward incentivizing program permanency: the removal of trash, incidents of engagement by the outreach team, and the award of grant funding in particular actually construct an increase in the number of unhoused residents a success, as it would necessitate more (funded) outreach and trash removal.

In the vignette above, outreach tied to enforcement pervades the encampment. PJ is required to perform a desire to leave the encampment to be allowed to remain there today. In expressing such a desire, he satisfies the outreach worker's purpose of *doing something,* not simply making contact but, according to the director, gradually "building trust through continued engagement" over time. As evidence of the success of this kind of engagement, she described to me how residents in the encampment "no longer run" from the backpack medicine team, since they have learned to trust them. Observing these activities, though—painfully watching people being chased, apprehended, grabbed by the back of their clothing and pulled into the open to "talk to the doctor"— it was clear to me that little trust was built with our medical outreach team through such engagement, at least not in the way I understand trust. It did make consequences of running known to residents, and they did increasingly stay put upon our arrival.

Althusser describes precisely such a moment. Althusser was inquiring into working conditions to ask why it is that people continually submit to the rules of the established order (Althusser, 2006). His concrete example of this is a person who turns around when a police officer calls out to him: why does the hailed person recognize himself as the person hailed, and turn around? For Althusser, it is because of ideology. Ideology, Althusser explains, functions to recruit and transform individuals into subjects through the operation of interpellation, or hailing, "which can be imagined along the lines of the most commonplace everyday police hailing: 'Hey, you there!' The hailed individual will turn round. By this mere one-hundred-and-eighty-degree physical conversion, he becomes a subject" (2006:108). Ideology, here, is a "'representation' of the imaginary relationship of individuals to their real conditions of existence" (2006:100). Acting like the unconscious, ideology guarantees that so long as subjects "*recognize what they are and behave accordingly, everything will be all right*" (2006:108). As a result of ideology, Althusser argues, subjects work, and they work "by themselves," with the exception of "bad subjects" who occasionally provoke violent intervention by the repressive state apparatus.

By this formulation, residents in the encampment are called upon constantly to become subjects and to submit to the social order—not just by police officers, but by outreach workers, case managers, volunteers, and researchers. We might understand each of these instances, including moments when residents are required to express a desire to leave the encampment, as instances of "hailing," and each response as interpellation or resistance. Such a framing, placed next to the director's interpretation and to PJ's own concerns detailed below, raises questions about the relationship between ideological subjecthood and trust and between interpellation and belonging.

As PJ describes below, residents of the river bottom attempt to avoid police, and policing, by attempting to prevent occurrences that would bring police into the encampment. Nonetheless, many of the police officers have known residents of the encampment since growing up as they attended school together. Long-term relationships and continuity of police officers on the outreach team made for both forms of intimacy and forms of grudge-centered work. As PJ and many other residents described, getting on the bad side of the police meant repeated payback.

The river bottom has a loosely structured system for self-determining and delivering justice, which not infrequently involves violence. When a man not from the encampment assaulted a woman who was out running a nearby nature path, several men from the encampment came upon them and attacked the man. He later died at the county hospital. No one from the encampment would turn in the men who had committed the attack. If individuals are known to have committed violence deemed unacceptable, they may be expelled from the camp at least for a period of time. When police come searching for someone with a warrant out for their arrest, for at least a period of time the camp residents would deny having seen the person, until the police make life difficult enough for the other residents that someone might snitch.

Sonny, who had previously killed another man (as the police reminded me—and Sonny—every time we interacted), had been experiencing psychosis while using methamphetamines, and had run into Carlos' camp with a gun in his hand, waving it around and shouting paranoid thoughts about an intruder in the camp who was attacking the women. He wanted to know where Carlos' girlfriend was, to make sure she was safe. Carlos gathered several men to discuss what to do about Sonny having a gun and together they decided to jump him and take it away from him for the sake of the camp's overall safety. I never found out where Sonny had gotten the gun. The content of his psychosis was not entirely fantastical, though, as soon after this incident, a woman in the camp recounted to me how she was attacked and raped by a man she had invited there after meeting him on Facebook.

Enforcement as outreach within the encampment maintained a constant atmosphere of stable instability, producing a looming threat of destruction of property, displacement, or eviction that was nonetheless much less frequent compared to encampments on more valuable real estate such as in Los Angeles. Despite constant threats of evictions, tearing down of parts of structures and frequent bulldozing of individual camps, still, many people continue to make camps here for years at a time. Often, they can even hold on to some personal belongings. These kinds of stability depend on getting along well with cops and being perceived as non-threatening.

### "I am in a way, but not"

*Lots of people come into the camp including police officers, private investigators, bounty hunters, and "private people," who get rewards for finding and taking residents of the camp who owe money mostly to bail bondsmen. PJ never discloses information to the police or to the bounty hunters who occasionally offer him cash rewards for people's whereabouts. "I have to be able to sleep at night."*

*When PJ moved to the "old" river bottom encampment, one just adjacent to the one he currently stays in, "people had extensive camps, even more elaborate than this. Real structures, real rooms built. And I thought cool, you know, the price is right." At first, the river bottom just seemed like a no man's land. "I just tried to stick it out in the other river bottom but I kept getting caught. They would find me in the bush and cite me for unauthorized lodging." But then the cops "would play with my toys, and ride my bikes, and we'd have fun." Larry and Sam and Tim. "I know all the cops. They were actually really cool too, they cut me so much slack. Oh, so much slack. They pulled me over, 'cause they saw me, and they knew I had 5 warrants for unauthorized lodging. and I just had scored some dope. Like just seconds earlier. I turned around and there were the cops, I got it in my hand and there was nothing I could do. And I don't lie to the police 'cuz you don't want to get on their bad side. You start lying to them or being disrepectful, then now they're gonna hate you, now they're gonna jump you. Every time they're gonna jam you as they say right. So they go, what's in your hand PJ. And I go, here. And he goes [gestures with his arm] threw it off the bridge. He goes what's in the trailer. And what was in it was a big tank of propane and about 10 pounds of weed. This is when I found all that weed. He goes what's in the trailer oh miscellaneous items? Okay. So they- they were so cool to me, then they took me to the liquor store handcuffed and bought me a Redbull before they took me to jail. I was in violation of probation."*

*"[Violations are] the only thing I've ever been arrested for. That's one of the reasons the cops like me. When- there was Sgt F, he used to be the sergeant, he retired and they made Bob sergeant [Sgt Z], Bob would come down here and call Sgt F at home so I could talk to him and say 'hi.' We were really friends. We really were. Yeah. We were always on a first name basis.*

*"And they always said the same thing, 'PJ you don't belong down here, why are you*

*here.'"*

*"What does that mean to you?" I ask.*

*[long pause] "I'm not your average homeless guy. [pause] I am in a way, but not."*

*"Can you say more about that?"*

*[Long pause]*

*PJ begins crying quietly. "I can't."*

- *Field Note, 2021*

To my surprise, PJ was more affected by my question about belonging in the river bottom than any other question I had asked that day. Liked by pretty much everyone, and as someone who likes pretty much everyone, PJ takes belonging seriously. The question of where he ought to be strikes at the question of who he ought to be: he ties the question of belonging to the question of his identity as an "average homeless guy." The question of what it would mean for PJ to belong is an open one-- one he couldn't answer for me.

How does belonging operate in an encampment— a space that is constructed as doing ritualized excommunication from social belonging (Desjarlais, 1997)? Narratives about drug use, mental illness, vagrancy, and a culture of poverty have long constructed normative homeless subjects (Gowan, 2010). Mary's strong belief that Jack is an exception to the norm, quoted at the beginning of this chapter, implicitly reinforces the common sense logic that some people deserve to be unhoused because of some personal failure or a lack of ability to "do so much." But beyond the problematic logics that normalize homelessness for some undeserving subjects, I was surprised at PJ's response to these kinds of statements. He did not take particularly well to the fact that many outreach workers, police officers, and volunteers frequently told him that he doesn't belong there. Although I believe they meant these comments as a compliment to him, and I believe that he knew their intention, he did not experience them as simple praise. Instead, he felt tortured by these pronouncements, sometimes wincing when they were directed at him while thanking people for saying so. Rather than wanting to be accepted by these outsiders as yet another outsider within the encampment, what he expressed to me were complicated feelings about belonging in community and within the space of the river bottom.

One of PJ's anxieties around this topic was about whether or not he was certifiably "crazy." For instance, PJ expressed a desire to get service connected at the VA, but any time I attempted to help him talk to a VA psychiatrist for an evaluation, he expressed a concern about being labeled as 'crazy' in the medical record, and felt fearful of being stigmatized every time he sought health care thereafter. At one point he agreed to talk to someone with me, but on the day we planned for the phone appointment, PJ was nowhere to be found. In the moment of my disappointment, I realized, I had become another outreach worker that PJ had felt an obligation to agree with, conceding the logic of his expressed fears to the dominant logic of social service provision.

PJ handled outreach workers, and everyone else for that matter, with demonstrable graciousness. His friend and neighbor Diane, in contrast, had less patience. But she had a maternal affect that helped her get along in the river bottom. She and I quickly grew close after I met her at the weekly mobile syringe replacement program, and I began visiting her regularly at the camp she shared with her son. During a brief moment when I thought about using naloxone on Diane, fearing that she was overdosing on heroin, I learned that fentanyl had arrived to the drug scene in the river bottom.

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## Heroin and Fentanyl and Coffee and Kittens

*Diane had stopped breathing. Or had she? I watch her chest for signs of the rise and fall of breathing and search for a heartbeat in her neck arteries as she lies motionless on her back across from me, on a makeshift bed that sits on top of crates inside her tent.*

*I had watched as Diane searched for a vein in her legs for over an hour, trying here, trying there, poking herself with a short needle attached to a syringe with a small amount of black tar heroin in it. She calmly attempted various miniscule veins without success. I winced a couple times and tried to pass it off as a squint of concentration, but she didn't react to my facial expressions, seeming not to notice them. She was averse to tourniquets because she felt they caused severe bruising on her aging skin. At the age of 63, Diane had been using heroin for almost 40 years by now, but almost always lately by subcutaneous or muscular injections into her abdomen for a relatively weak daily dose of heroin that didn't deliver too much potent opioid into her bloodstream and the rest of her body. Now that she had recently gotten a large abscess in her abdominal area, which she hardly ever got with her careful skill and years of experience, she was trying to avoid injecting into the area. Her abdomen was red, swollen, inflamed, and hot, and showed the classic signs of badly infected abscess. She gently tapped at the small veins on her ankles and shins, trying to see if they were likely to roll away when she inserted the needle. Over and over, they rolled away as soon as the needle came close to puncturing the skin. Suddenly, and unexpectedly to me, Diane poked the short needle into an area of her mid-calf and finally hit a vein. She stopped moving, her facial expression frozen in time except for a softening of her eyebrows which had been turned down in effortful concentration a moment before. Her mouth was softly open and her body was still, her eyelids barely closed, the needle still stuck in the skin of her calf and the syringe still mostly full with dark liquid. This surprised me since she was clearly nodding out already. For someone like Diane, who has used heroin for 40 years, she* *had only injected a tiny amount to be having such a strong reaction to heroin. Over the next few minutes, I sat silently with her, watching as her body slowly leaned away from the bed she was sitting on and she nearly toppled over. I gently reached over and repeated her name several times. She woke up enough to inject the rest of the syringe and then take out the needle and lie on her back.*

*For several minutes, I watch her neck, and see a slow pulse faintly flicker in an artery. I watch her lips, which seem to have turned slightly blue. I wonder if I am imagining it. She is lying back on her bed, which is propped up on crates in the tent where she sleeps in the out-of-public-view wooded area that nonetheless directly butts up against the golf course. I eye my naloxone kit and am ready to treat her with naloxone if needed.*

*I eventually say Diane's name loudly and tap on her sternum, too nervous to let her be. Jimmy comes into our tent when he hears the pressured tone of concern in my voice, and, peeping in, sees what must be a fearful look on my face. Diaine opens her eyes then and looks around without expression. Jimmy chastises Diane half-jokingly, "Don't look like that!" He turns to me and smiles, "That's what she always says to me." Relieved, I tell him she had barely used any drug in the syringe. He calmly explains that all the heroin these days has fentanyl in it. "It's good huh!" he says to Diane, who continues to look dazed, finally sitting up slowly. Jimmy tells me that he only has to use about half of the dose he used to inject because of the potency of fentanyl in all of the drugs they get now, including heroin and meth.*

*For the rest of the day, I hang out with Diane. Having successfully taken her morning dose of heroin/fentanyl, she is now prepared to self-treat her abdominal abscesses. With opioids in her system, she feels comfortable making small incisions and draining the abscesses. She wants to draw out the pus, so she has Jimmy busy himself with making a fire and heating water* *in the kettle to make a warm, damp towel to hold to the abscesses before attempting to drain them.*

*Diane always knew she would use heroin. She wanted to use it. She felt it was what she needed to function in her life. When she was 13, she started using heroin. She wasn't the person who introduced it to her son, but now she and her son use together in the encampment where they both live. Her son brought her here after Diane's husband died and she could no longer afford the rent for the apartment they had shared together. Several women have young adult grandchildren in the encampment who brought them to live there with them after they were unable to pay for their housing—often after a spouse died.*

*Diane is referred to as "Mom" or "Moms" by the people who know her and are close to her in the River Bottom. Not only does her son sleep in a tent next to hers, but she makes it her job to provide maternal kinds of support to people in the camp, especially to those who also use heroin. I find her presence comforting myself. She isn't exactly a warm person on first meeting, but she offers me food—usually donuts— and coffee whenever I arrive for a visit, and gently nags everyone around her about something. She teaches people how to use heroin more safely, provides them with a safe place to inject in her camp, provides clean syringes and other materials that she dutifully gets from the syringe replacement program every week, and does first aid for those with minor wounds—either contracted from drug use or from simply living outside without access to clean water.*

*She raises kittens that her cat births, and gives several away to people in the camp that she believes will take care of them responsibly. We love watching and playing with the kittens. They are endlessly entertaining. I love watching her decide who in the encampment is worthy of a kitten: she grills people on their ability to be responsible, their skills in caring for helpless* *infants, their love of animals, their knowledge of kittens' needs. When one kitten showed back up to her tent, another interrogation began.*

*Diane and I bonded quickly, which I attribute in part to our gender and also to an overlap: her husband, who died several years ago, had been a sea urchin diver, around the same age as the father of my partner who had also been a sea urchin diver for several decades by the time I met him. For Diane's husband, the work was physically demanding and precarious, highly contingent on environmentally threatened kelp forest and volatile urchin prices set by distributors on a relatively small international market. While it meant that he was gone a lot, it also afforded him adventure and freedom to be in the ocean or on a boat all day and to be one's own boss. Diane described her marriage as the best thing that had ever happened to her, and her late husband as the love of her life.*

*Diane had been incarcerated for selling heroin in her early adulthood. When she got out and was on probation, she stayed with her mother briefly and it was through a family connection that she met her husband. After she got off probation, she got a minimum wage job doing pet grooming which she kept for many years. Despite the financial precarity they faced, they always enjoyed each other's company, and they often used heroin and cocaine together. After he died, she quickly became unhoused, unable to afford rent without his income. Recently, her son has gotten a job as a handyman on a boat in the nearby harbor, and occasionally he brings her to Las Vegas to gamble with the salary. Recently they won a weekend stay at an all-inclusive 5-star resort and were on their way out of the camp to make their way there, laughing that it is always "feast of famine" for them.*

*Diane regularly attends the syringe exchange that arrives in a mobile van to the parking lot just outside the encampment, and she stocks up beyond what she herself would need so that* *she can offer supplies to anyone who comes by to use drugs. She does pretty good first aid for people who come to visit her with minor wounds that are infected either from dirty drug injection or from living outside without access to clean water. She buys more heroin than she needs and sells small amounts of it to her neighbors. She keeps naloxone kits near her bed and has reversed several overdoses already this year.*

*What she is most adamant about during our visits is that heroin has little to do with the fact that she lives in the encampment. She has used heroin nearly all her life and has been in many different living situations. Heroin is as "regular as a morning cup of coffee," for her and many other residents. In fact, it is easier to fix than coffee, because firewood for heating water is scarce and fires are hard to make when the winter rains come and everything is wet and your hands are freezing. Fires can be harder to hide than drugs sometimes, too, and they can attract cops. If you get caught burning trash, as she did, your camp will get bulldozed. What keeps her here is that her community is here. She doesn't want to leave her son and she likes being a mother figure to others. Jimmy has become family to her too. She emphasizes that her health is better when she can be outdoors and active, as she can here. She is much stronger than most people in their 60s that I know. When she first arrived, she lost 60 pounds of excess weight from constantly walking, building camp, and hauling water. "And I eat whatever I want all day," she says.*

- *Field Note, 2021*

## Fentanyl's arrival in California

There were record amounts of methamphetamine seized in the U.S. in the year 2020, largely imported from Mexico, per a DEA agent on the County task force (described in previous chapters) made up of public health administrators, doctors, educators, and law enforcement officers and set up to prevent opioid misuse and overdose. The DEA agent offered that the reason for the increase was that the Mexican government was frustrated with President Trump and, as a result, they had been significantly less cooperative and less collaborative than usual with the U.S. DEA agents pursuing drug law enforcement on the Mexican side of the border. As a result, the drug supply in California flourished, and both methamphetamine and fentanyl was reported in record amounts in the state during the COVID-19 pandemic. While the illicit drug supply was cheap, readily available, and more potent than ever during the early months of pandemic, the human resources available to prevent and address harms from drug use were significantly curtailed due to lockdown. Many services shut down, including the outreach medicine team that I usually accompanied into the encampment. In-person addiction clinic counseling shut down as did methadone clinic counseling, as services went completely or almost completely remote via telehealth for a time. Policing also slowed down significantly during the initial lockdown months.

Fentanyl, along with the COVID-19 pandemic, reconfigured the intersectional 'risk environment' of drug use in the river bottom encampment (Rhodes, 2009). The risk environment framework highlights dynamic relations between individuals and their environments, including social, physical, political and economic contexts that shape the risks and harms of drug use (Collins et al., 2019). Many people in the River Bottom overdosed on fentanyl mixed into either heroin or methamphetamine during the year of my fieldwork. Week after week, I heard of new overdoses either within the encampment or nearby in the harbor, and in nearby houses and parks. Some were successfully reversed with naloxone; some were not. In the emergency department, stoic men who had been unhoused and dedicated heroin users for decades broke down in tears at the mention of fentanyl. They had never experienced anything so devastating as the arrival of fentanyl to their drug supply. It could be rapidly fatal, and many did not even have a taste or desire for it until they were dependent on its increased potency. Not realizing that it was mixed into the other drugs they were taking, fentanyl had already completely changed the landscape of drug related deaths in the region.

At the same time when fentanyl was dominating the illicit opioid drug market, the pandemic hit. In California, "Project Roomkey" was started, which was a state-funded initiative to temporarily allow "high-risk" individuals to stay in hotel rooms rather than outdoors (Donesky et al., 2021). Month after month, individuals staying in hotel rooms did not know if they would be allowed to stay and employees did not know if the program would be funded the next month. The program identified individuals who qualified rather than families or couples, which meant that many were separated from loved ones as well as pets in order to enter the program. This may have contributed to increased risks from using drugs in isolation, which many were unaccustomed to doing.

Many people switched to using pipes to smoke heroin mixed with fentanyl or straight fentanyl, rather than inject it, as a harm reducing measure to counteract its increased potency. At the syringe replacement program, we started passing out pipes for the first time. While most syringe replacement programs in urban settings have distributed pipes for years to facilitate safer consumption of crack cocaine, crack was rarely used in the River Bottom.

The risk environment was also reshaped by changes in policing and the presence of police as well as of service providers. In April 2020 at the beginning of the initial lockdown from the COVID-19 pandemic, a staff member at the mobile syringe exchange and I administered a brief survey to 86 participants attending the exchange at seven locations across Ventura County. We wanted to know more about what people who use drugs were experiencing as a result of the lockdown and the pandemic. We asked if there had been a change in police behavior toward the participants. Of the 86 respondents, 45 said that there had been a change in the way police treated them compared to before, while 41 said that there was no change. Of the 45 who said there was a change, 29 wrote responses indicating that police were interacting with them less. Answers included, "They don't come up to me for a usual shakedown," "They won't get out of their car," "They leave us alone a lot more. Priority calls only," "They stay away," and one person wrote, "Being more helpful as well as careful." We also asked participants whether the drug supply had changed, and if so how. 44 participants said that the drug supply had not significantly changed. Of the remainder, 16 indicated that the price had increased, with one person describing "price gouging," while two participants indicated a price decrease. One described a "strange batch" of methamphetamine, three described being ripped off or possibly being ripped off, and one stated that the "border closed down."

Shortly before the pandemic, I had already received reports from interlocutors that the drug supply had shifted toward synthetic fentanyl and away from black tar heroin. As one person said in August 2019, there was "a complete transition within the last six months. It's all synthetic now." As our survey did not ask about specific drugs or their supply compared to alternatives, this transition was not captured; only a general trend toward a price increase was indicated.

### Joy in Community

In the midst of such a devastating shift in the drug supply, Diane nonetheless had no plans to stop using opioids or to move out of the encampment. Like her naming the oxymorons of "spare time" and "nice cops," the idea of a "safe drug" would not really make sense and the danger inherent to using heroin was obvious to her. And she actually felt that she was, by a number of measures, healthier in the river bottom than other places she had lived.

Rather than needing to focus on accessing opioids, because the illicit supply was so steady and unemployment checks were coming in during the pandemic, the focus in the river bottom was often on other activities of daily living, making community, and having fun. I often left my visits to the encampment feeling like I had much more to learn about the art of staying present in a moment and playing within it. PJ and I did not always have to talk, although I often felt I was grilling him about his life history or that he was checking in on my educational progress. Sometimes, we simply enjoyed the day. For his part, PJ told me that he appreciated my calm demeanor. He also gently chastised me if I told him I related to his feeling depressed, telling me that at my age, I should just enjoy life and should "stuff those thoughts away." We went pellet shooting, paddling, watched videos on our phones, made music, played games, visited neighbors, and made food together. ATVs and bikes with motors attached were popular. Hair dye colors and art projects went in and out of fashion. Diane and I enjoyed food together, played with kittens, told stories about our families, looked at old photographs she had of her parents and extended family, gossiped about the goings-on in the river bottom, and talked all day about what is wrong with the world.

Stuff mattered. Many things were found or scavenged, collected, and traded, and setting up and improving camp according to one's desires for function and aesthetic was a regular pastime. Obtaining and storing clean drinking water could take several hours. A clandestine method for disposing of trash had to be found. Accessing mail, retrieving official identification or documentation, doing laundry, filing forms often took the bulk of a day, but having people to trade favors with was indispensable. A moral economy of sharing was well developed (Bourgois, 1998). Such reciprocity, the joy found in community, as well as the distinct (albeit short-term) reprieve from policing in the pandemic, made leaving for a government-supplied hotel room such as Project Roomkey, which provided no guarantees and no space for loved ones, seem close to absurd for many.

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### “It adds a teaspoon of humanity”

*PJ and I shoot pellets. I don’t shoot a single target. PJ teaches me how to reload, how to make sure the safety is on, how to aim. We enjoy the early afternoon sun. You look very nice today by the way, he says. I’m walking behind him through the jungle area and no one is around, and at one point I think briefly about how I get out of here if I need to. No one’s around. I mostly feel relaxed. He finds empty bottles in the brush and sets them atop reeds as targets. We have fun. It is a large woods, easy for me to enjoy, maybe because it reminds me of how I used to play as a kid in the woods behind my house that also bordered a golf course. My friend and I used to hide in a deer hunter’s lookout point and “spy” on golfers.*

*PJ tells me about how he was once briefly placed in temporary housing at the West LA VA called the “Domiciliary,” which provides housing along with mental health and rehab support for veterans. But he only lived there for two days. He says someone came in and let it be known that they could turn the TV off on him. He packed up and left immediately. He didn’t like all the people being around and those dominating interpersonal dynamics. “I had a temper then. I guess I still do. I learned to control it.” … “I don’t want to put my negativity onto anyone else,” he says. “It took me a long time to learn but now I separate myself from others when I’m feeling it, when I’m going through it,” he says. “I don’t want to put the burden on others anymore, so I self-isolate.”*

*I need to get back to help the volunteers bring food in so we start walking back. As we’re walking back he shows me a spot where people cut through the golf course to get to the grocery* *store. We walk up to the golf course path and I'm nervous, scared of someone telling us to get out. We calmly walk on the path a little ways and then suddenly two golf carts drive past us, one guy nodding at us as they drive past. We get off the path. PJ says of course they looked right at my piece, meaning the pellet gun on his waist. I laugh nervously. He says, "It's okay, but you know they say 80% of the golfers here are cops or retired cops. But they don't care, they just don't want their game interrupted."*

*We talk about how I feel pretty different from the church volunteers that we mutually know- they don't believe in the COVID vaccine for instance, and they supported Trump- and I tell him I refrain from talking about politics with them, and he says that's probably a good call. I can't remember how or why this comes up, but I end up telling him I have a problem where I have too high of expectations of myself and other people. This causes a reaction in him. "And, do you look down on me, Lauren?" he asks softly, "You can tell me." I stop in my tracks, "*No*," I say with emphasis, embarrassed that I have said the wrong thing, "And I'm sorry if I've said anything that would make you think that. I feel like I have a lot to learn from you," I say. He gives me a fist bump and we start walking again. He says "I meant what I said before, I'm a friend and if you ever need any help with moving or hauling stuff or anything, you let me know." He says "A lot of people think, you know, you shouldn't be here, like 'PJ why don't you get out, you could do so much- and… do you think that?' he asks. "I don't really think about things in that way," I say carefully, anxious to repair and understanding that he has experienced these comments as hurtful. "Instead of looking at individuals and thinking why are they doing this or that, I want to know what is going on in our society that so many people are left unsupported," I say. He nods at this, replying, "Yeah, like Jeff Bezos is famous because he took a gamble and came out big. A lot of other people take a gamble and it doesn't work out. But things are going to* *change," he says reassuringly. I tell him I hope so.*

*We are back at PJ's place. He walks inside his gate. I say that for example with Matt, who died in the hospital recently- I had high expectations of the health care workers and wanted him to receive good care, so I got upset when I saw that they weren't doing everything that I thought they should be doing for him. He responds, well, there seems to be a lot of disdain people have. I saw a paramedic taking care of someone out in the parking lot the other day and I could see the look of disgust on his face," he says. "I wanted to yell at him, you know, we're not asking for your opinion, just do your job," he says.*

*PJ tells me that when his picture was in the paper the caption of the photograph of him in the river bottom calls him a "resident." "Do you know the significance of that?" he asks me. "What it does is it adds a teaspoon of humanity. To be called a resident, not a homeless or a transient. It sets a precedent too. That I have a right to be here, that I have a claim to this place. That could maybe even hold up in court."*

*- Field Note, 2021*

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