PART ONE

Technologies of Whiteness in the Clinic, the Statehouse, and the Archive

CHAPTER 1

Pharmakon of Racial Poisons and Cures

(as told by Helena Hansen, psychiatrist-anthropologist)

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

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

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

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

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

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

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

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

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

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

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

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

The buprenorphine clinic of this New York City hospital was a theater in which the contradictions and ironies of this system came into view. Like Charlie, the buprenorphine clinic patients were not only more likely than traditional public addiction clinic patients to be white but also more likely to be young and physically healthy. Many had never before needed health care and were not used to the routines of a large public hospital. Jennie, a thin blonde woman who arrived at monthly appointments in form-fitting gym clothes, commuted almost two hours from her house at the far end of Long Island. The staff chuckled when they saw her name on the appointment list. "Oh, it's Jennie. We can take the other patients first." She never arrived at her appointed time, but when she did arrive, she pulled her car into the taxi stand at the hospital entrance and called the clinic staff from her cell phone. "I'm right downstairs and there's nowhere to park. Could you just bring down my script?" None of the staff ever brought down her prescription. She always ended up parking at a meter on the crowded city streets nestled between high-rise buildings, but not before calling from downstairs. The clinic manager had her own theory as to why. "She thinks we are dealers. In Long Island, the dealer hand-delivers the goods to you in a strip mall lot."

Jennie took her prescribed Suboxone tablets in her own way. Monday through Thursday, before leaving for her office job, she took them at breakfast, as her doctor instructed. But on Friday she would sometimes skip her dose so that she could "feel something" when she celebrated Saturday and Sunday with OxyContin from a dealer. She was honest with her doctor about it. Her doctor kept prescribing Suboxone, reasoning that at least Monday through Thursday, Suboxone kept her safe from overdose and arrest. This fit the rationale behind Suboxone treatment: reduce the harms of illegal opioid use by prescribing safer, medical opioids to prevent opioid withdrawal symptoms and reduce the patient's use of dangerous street drugs.

Even those most committed to the logic of Suboxone treatment can have a hard time freeing themselves entirely from older conceptions of addiction. Jennie's doctor, for example, was still worried about her patients' decision-making. She carefully screened all of her patients for signs that they were getting pleasure from Suboxone, and she lowered the dose if they were. She reminded patients to take Suboxone every day at the same time, "like a vitamin," and lectured them on the difference between a medication—designed to prevent withdrawal symptoms—and a drug that was used for pleasure. Perhaps she worried about the most common critique of medications for opioid use disorder—that maintain-

ing patients on Suboxone, itself an opioid, was just substituting one addiction for another. Her worry revealed that, while more medicalized than the prior century of American responses to drug epidemics, buprenorphine and other medications for opioid use disorder had not completely displaced older ideas that narcotics users needed to be disciplined.

The Suboxone clinic was only two floors below the methadone clinic, in the same hospital, but it rarely got referrals from, or made referrals to, the methadone clinic. The methadone clinic ran as it had run for decades: serving primarily African American and Latinx people from the South Bronx and Lower East Side of Manhattan, along with a handful of middle-aged, homeless white patients. Patients lined up in one of two shifts—at 7 a.m. or at 3 p.m.—in front of a medication window where a nurse watched them drink methadone from a cup and checked their mouths to ensure that they were not "cheeking" the medication for resale on the streets. After the line thinned and the medication window closed, patients gathered in group therapy rooms. The methadone clinic ethos was communal; it lacked the trappings of patient privacy.

I knew that private-office buprenorphine represented an important new development as an alternative to methadone clinics. When I was in medical school, my professors had run an early clinical trial of buprenorphine for opioid addiction; this was in the late 1990s, before it was approved by the FDA for addiction treatment and received the commercial name of Suboxone. These professors were excited by buprenorphine's promise to "change the culture of medicine": to have addiction finally recognized as a chronic, physiological disease, similar to diabetes, asthma, or hypertension and treated in the same way—with long-term medications—and in the same places, primary care clinics. They were eager to find alternatives to methadone. Methadone clinics were so stigmatized that they were often located a bus or train ride away from their parent hospital, in run-down neighborhoods whose residents were not organized enough to protest them. Methadone clinics were regulated by the Drug Enforcement Administration (DEA), required daily observed dosing, and had such restrictive hours that at times patients had to choose between methadone and a job. Affluent white patients usually refused to be seen at a methadone clinic, and most poor, rural, white patients lived hundreds of miles from one.

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The golf resort's largest lecture hall was filled to capacity with addiction specialists attending the annual meeting of the College on Problems of