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EDITORIAL

Pain and prejudice: Exploring the racist origins of US drug policy and its impact on the modern opioid epidemic

Over the past decade, America has found itself in a pivotal moment of self-reflection, answering a call to reflect upon our national history, and reckon with the grave impact that systemic racism, societal inequity, stigma, and bias have all had in shaping the foundation of our modern lives. As pharmacists, we are entrusted by the public to devote our professional lives to the service of all humankind; it is, therefore, our duty to heed this call for action and work to develop a more equitable and just future. To accomplish this, we not only need to self-reflect upon our history of inequity but also seek to understand and learn from it. This will require a willingness to have difficult conversations and recognize the lingering effects that stigma and bias continue to have on our patients. Albeit difficult, this process of reflection and understanding will allow us to develop key strategies that address the impact that stigma and inequity have on our patients.

As we reflect on the negative impact that stigma and inequity have on our patients across every facet of health care, we find one area deserving particular attention: pain management. In a recent survey, 15% of cancer patients reported that they felt awkward discussing pain with their providers; another 20% reported that they use less opioid medication than they need in order to avoid appearing "drug seeking."[1] Opioids, and all other controlled substances for that matter, carry a stigma within the medical community, a stigma that continues to serve as a barrier and actively prevents patients from receiving appropriate medical care. The consequences of this stigma are vast, and unfortunately, they extend far beyond the realm of uncontrolled pain. The FDA has recently reported a pattern in which chronic pain patients, who are (as one would expect) physically dependent on their long-term opioid treatment, are having their prescription opioids abruptly stopped.[2] This rapid discontinuation has been associated with increased pain, severe withdrawal symptoms, and even patient suicide.[2] This is occurring across the United States, even within patients who show no signs of an opioid use disorder.[2] This opioid stigma, however, does not solely impact pain patients, it has had devastating effects among patients with substance use disorder, especially opioid use disorder. Currently, only one in five patients who has been diagnosed with opioid use disorder receives first-line treatment with buprenorphine.[3] The prevalence of appropriate treatment is even lower among African American and Hispanic populations, and also fails to account for the large number of patients with opioid use disorder who never receive an official diagnosis.[3]

Our lack of treatment utilization has consequences; despite our increased attention on opioid prescribing, overdose rates have continued to rise.[3] As it stands, opioid overdoses are more prevalent than ever before, yet at the same time, pain patients have continued to report sub-par care, and the public need for effective opioid use disorder treatment far exceeds availability.[1-3] If pharmacists are going to fulfill our oath, it is imperative that we reflect upon how we arrived at this point, seek to understand our history with opioids, learn from our mistakes, and use this newfound knowledge to develop equitable solutions and key strategies to improve the quality of care for all.

1 | A BRIEF HISTORY OF OPIOIDS: ANCIENT CIVILIZATIONS—20TH CENTURY

The use of opioids is not a new or uniquely American phenomenon. Opium use dates back to the ancient Sumerians of 3400 BC.[4] Opium production and exportation erupted in Egypt under King Tutankhamen: this exportation brought opium across the Mediterranean Sea and into Greece where Hippocrates first noted its utility as an analgesic.[4] In 1803, a German pharmacist isolated the active ingredient from opium, which he later named "Morphine" after the Greek god of dreams.[4] Heinrich Merck, another German pharmacist would go on to commercially manufacture morphine and distribute the drug across the globe in the 19th century.[4] Around this same time, China, a nation where smoking opium was commonplace, was experiencing severe economic hardship.[5] Predictably, the discovery of gold in California in the late 1840s led to a surge of Chinese immigration: this immigration increased the local competition for gold. Unfortunately, this competition escalated racial tensions in the area and ultimately led to widespread discrimination against Asian immigrants.[5]

Widespread discrimination at this time was not solely aimed at Asian immigrants; shortly after the gold rush, the practice of slavery was escalating tensions between the north and south, tensions that would eventually lead to war. The Civil War would lead to historic levels of bloodshed and suffering. Due to the widespread use of opioids during the war, opium addiction came to be known as "The soldiers disease."[6] This phrase, however, was a misnomer, as nearly 60% of those addicted to opioids in the United States after the Civil War were women. Women in 19th century America (primarily White upper-class women) were frequently given opioids for a variety of conditions, ranging from minor headaches to menstrual cramps and the incredibly controversial "diagnosis" of female hysteria.[6] As addiction rates soared, the use of medical opioids for minor conditions was considerably reduced, which led many opioid-addicted patients to seek out alternative sources, such as the opium dens located within

Chinese immigrant communities.[6] The increasing popularity of opium dens among affluent White women escalated racial tensions even further.[6] In response, a campaign of racial fear mongering, now referred to as "The Yellow Peril" aimed to further anti-Asian discrimination, portraying these Chinese immigrants as savages.[6] As a result, the United States went on to ban the practice of smoking opium, other forms of opioid consumption, those less common in Chinese communities, however, were still permitted.[6] The ban, predictably, led many Chinese immigrants to seek out cheaper and more potent alternatives, thus igniting a new national discussion regarding the regulation of all opioids.

National opioid regulation, however, was opposed by the post-Civil War South, who felt it would be an infringement on "States Rights."[7] To gain favor within the post-Civil War South, stories of a new "Southern Menace" began to circulate.[7] An article in the 1914 NY Times reported on a new (and mythical) enemy, the "negro cocaine fiend," who supposedly did not feel pain, gained superhuman strength, and had no regard for human life.[7] Despite the report having no basis in reality, many southern police departments began purchasing higher caliber bullets, and this fear ultimately led southern states to agree to national opioid regulation as long as it included cocaine.[7] The legislation, commonly known as The Harrison Narcotics Act, would pass later that year: the act was designed to curtail the "non-medical use" of both opioids and cocaine.[7] It is important to note that during this time, addiction was not considered a disease, and maintenance treatment of addiction, a therapy that was commonplace in the 19th century, was no longer permitted.[8] This legislation, formed out of racist fear mongering, served as the foundation of US drug policy until the 1970s.[8]

2 | THE WAR ON DRUGS

In 1970, President Nixon declared a "war on drugs," the early years of this new "war" were marked by the passage of the controlled substance act, the creation of the five-tiered drug schedule, and the formation of the Drug Enforcement Administration.[9] John Ehrlichman, who served as the assistant to President Nixon for domestic affairs, later had this to say regarding the origin of the war on drugs "The Nixon campaign in 1968, and the Nixon White House after that, had two enemies: the antiwar left and black people. You understand what I'm saying? We knew we couldn't make it illegal to be either against the war or black, but by getting the public to associate the hippies with marijuana and blacks with heroin, and then criminalizing both heavily, we could disrupt those communities. We could arrest their leaders, raid their homes, break up their meetings, and vilify them night after night on the evening news. Did we know we were lying about the drugs? Of course, we did."[9]

At the time when the "War on Drugs" was declared, it is estimated that roughly 13.8% of White Americans and 8% of non-White Americans used cocaine.[10] As the criminal justice approach to controlling drug use expanded, the underground drug market once again responded by looking for cheaper and more potent alternatives. In the early 1980s, Crack, an alternative form of cocaine, gained popularity. Crack, a chemical mix of cocaine and baking powder, has a lower melting point (and cost) than cocaine, which allows it to be smoked for immediate effects.[9] The reduced cost increased the accessibility of cocaine and led to an expansion of the drug into many poorer communities, particularly communities of color.[9] In response to the rise in Crack cocaine, the Anti-Drug Abuse Act was passed in 1986, an act designed to punish high-level drug kingpins.[11] In part due to who was using the drugs, (Crack and cocaine both have the same active ingredient), the legal penalties for Crack = were set to be 100 times harsher than for cocaine under this new act. The punishment for 5 g of Crack was, therefore, the same as for 500 g of cocaine.[11] Not only was the law itself racially biased, but the enforcement of the law also disproportionately impacted people of color, despite similar rates of drug use.[12]

3 | THE OPIOID CRISIS

The late 1990s and early 2000s ushered in a new era of drug use across the United States, largely characterized by prescription opioids. The origins of this modern opioid epidemic have been written about extensively. In short summary, an increased focus on improving pain management, combined with a lack of comprehensive pain management education at US Medical schools, an insurance industry reluctant to cover any non-medication, or over-the-counter therapies, and a pharmaceutical industry undeterred by unethical business practices led to a widespread overreliance on opioid pain relievers.[13-15] During this same period, the US economy was undergoing a massive shift away from manufacturing: this shift left millions unemployed, anxious, and depressed, without a clear path forward. Many of those who were now unemployed were still hindered by injuries sustained from their heavy manufacturing jobs and in need of pain management.[14,15] The overreliance on opioid medications within the realm of pain management, mixed with a patient population that was at an increased risk of addiction, proved to be a major driver of the early 2000s opioid epidemic.[13-15]

The origins of the modern opioid epidemic are written about extensively; what is lacking, however, is an evaluation of how the crisis has evolved over time due, in part, to our response. Media coverage of the opioid epidemic stands in stark contrast to the framing of previous drug use epidemics, a barrage of headlines describing the "New face of heroin" as "Young, White, and Middle Class" dominated the national story. These headlines serve as a shockingly open and unintentional acknowledgment that the public had previously associated addiction and drug use with non-White individuals, despite similar rates of drug use across racial lines. Those suffering from opioid use disorder were now seen as innocent victims rather than criminals when the United States inevitably called upon the criminal justice system to handle a drug epidemic once again; the criminals who were to be punished were no longer the individual drug users, they were pharmaceutical companies and prescribers. As a result of this widespread

focus on opioid prescribing rates, annual opioid prescriptions have largely decreased since 2010 and were nearly cut in half by 2016.[16] Unfortunately, this sharp decline in prescribing does not mean that the epidemic is over; in fact, we may have made things worse. As a result of our crackdown on prescribing, many pain patients report inadequate analgesia, and some patients have even been forced to abruptly taper off their opioids altogether, resulting in severe consequences.[1-3] Treatment availability for OUD is still inadequate when compared with public need, and opioid overdoses are higher than ever before.[3,16]

4 | A NEW CHAPTER: THE OPIOID OVERDOSE EPIDEMIC

The main driver of this increase in opioid overdoses has been the presence of illicitly manufactured fentanyl within the US drug supply.[16] As seen previously in 19th century America and the Crack epidemic, a crackdown on the supply of drugs drives up the demand for a more potent alternative. Fentanyl, however, was not simply added to a list of available substances that drug users could buy, it was and is commonly found as a contaminate within other drugs on the illicit market, most commonly heroin. Overdoses from synthetic opioids (fentanyl, etc) have increased roughly 10-fold from 2014 to 2018: today, they are responsible for most opioid overdoses.[17] Despite the rise in opioid overdose being largely driven by illicit fentanyl, the focus of the national opioid response has largely remained on prescription opioids. In recent years, a variety of new laws have been passed that inappropriately interpret and misapply the recommendations of the 2016 CDC opioid prescribing guidelines.[18,19] The misapplication of these guidelines has been so egregious that the original authors of the 2016 guideline wrote an update, specifically calling out their misapplication.[19] Despite this clarification, the guidelines were not revoked, as such, they remain as the predominant opioid prescribing guidelines, they continue to influence most of our public drug policy development, and they continue to be misinterpreted and misapplied. Prescription opioids still carry with them many risks, as such their use should still be limited to instances where they are truly needed, but the evidence is clear, the main driver of opioid overdose is illicit fentanyl.

If we aim to end the opioid overdose epidemic and reverse this trend, the focus of our national attention must shift. Rather than continuing to police opioid prescribing with an iron fist, a strategy that has decreased prescribing but arguably worsened the human toll of the opioid epidemic, we must acknowledge the failure of our past drug policy and seek out evidence-based solutions, even if they appear counterintuitive to our previous understanding of drug use.

5 | A WAY FORWARD: HOW PHARMACISTS CAN LEAD THE EFFORT TO END THE OPIOID EPIDEMIC

Pharmacists provide care, yet too often they have been called to act as DEA agents rather than health care providers. Time after time, the United States has responded to drug epidemics with a criminal justice approach; the war on drugs, a war in which the drugs appear to have won, has not been solved by the criminal justice system. Drug use and drug overdose, for that matter, is a public health issue and it demands to be treated as such. As one of the most versatile and diverse health care professions, pharmacists can lead the effort to end the opioid epidemic in a variety of ways. First, we must face the hard truth that successful drug policy does not result in complete elimination of drug use, but a reduction in the negative impact of drug use, on both a societal and individual level. People who use opioids, whether for pain or recreation, are patients, they are human beings, and like all other patients, they deserve the best possible care. Pharmacists can lead this effort to change practice and deliver equitable care for all by focusing on three key strategies.

Key strategies for pharmacists to improve equitable opioid practices

Key strategy	Specific aim	Actionable item(s)	Accountable entity
Reevaluate programs and policy	Ensure opioid stewardship programs exist with the primary goal of improving patient outcomes	• Require opioid prescribing metrics include markers of patient outcomes and pain control • Develop/utilize metrics focused on improving utilization of non-opioid medications for pain	• CMS, Health-Systems • CMS, Health-Systems
	Improve the patient retention within treatment programs	• Eliminate policies removing patients from treatment programs for relapse • Eliminate policies that disqualify patients with a + urine drug screen from pain management or substance use disorder programs	• Clinics • Clinics
	Improve the quality and accessibility of care for pain patients previously started on high MME opioid regimens	• Exempt patients from the opioid prescribing data for clinicians if they were accepted despite a high baseline MME regimen	• DEA, CMS, Health-Systems • CMS

Key strategy	Specific aim	Actionable item(s)	Accountable entity
		• Develop billing codes that incentivize providers to accept and manage patients previously prescribed high dose opioids • Develop pain contracts that restrict the practice of forced tapering • Reduce the utilization of arbitrary MME thresholds among opioid prescribing monitoring programs	• Clinics • DEA, CMS, Health-Systems
Expand education and support	Expand pain management services	• Expand clinical pharmacist services which help design effective multimodal regimens, tailored to pain etiology • Expand the availability of non-pharmacologic support services	• CMS, Health-Systems • Health-Systems, Clinics
	Improve pain management education for prescribers	• Require basic training regarding pain management and pharmacotherapy that is linked to a prescribers DEA license • Expand education programs to support prescribers regarding the principles of tailored multimodal therapy	• DEA • Health-Systems
	Improve the quality of technological support	• Creation of one national PDMP that is comprised of all medications (non-controls) • Restrict the use of unproven risk calculators that may increase stigma	• US Congress • US Congress
Increase the accessibility of treatment and harm reduction services	Increase the accessibility of products/services that reduce the risk of overdose	• Classify naloxone as an over-the-counter drug • Provide a CLIA Waiver for fentanyl test strips • Require insurance coverage of naloxone and develop billing codes to cover the cost of naloxone for the uninsured • Develop programs that incentivize naloxone dispensing • Pass legislation that creates and protects safe injection facilities	• DEA • FDA • CMS • CMS • US Congress
	Increase the accessibility of products that reduce pathogens	• Pass legislation allowing pharmacists to prescribe PrEP • Remove restrictive policies (paraphernalia laws) regarding syringe access	• US Congress • US Congress
	Increase the accessibility of SUD treatment	• Remove x-waiver requirements • Reduce regulations on buprenorphine prescribing, especially as related to provision via telehealth services	• US Congress • US Congress

5.1 | Final thoughts

The history of US drug policy is wrought with discriminatory policies, many designed for the purpose of enforcement rather than public health. Together, through continued self-reflection, pharmacists can begin to dismantle the discrimination that has been built into the fabric of our drug policy, leading the way to a safer and more equitable future for all.

CONFLICT OF INTEREST

The author declares no conflicts of interest.

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