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# Introduction

## Prologue

THE PROBLEM IS PAIN. No one deserves to suffer—not people who face each day with debilitating pain nor people who use drugs to cope with trauma and other struggles. And yet U.S. drug policy pits people with chronic pain and people with substance use disorders against each other in a zero-sum battle over opioids. Too much opioid prescribing exacerbates addiction and overdose. Too little opioid prescribing leaves the pain unmitigated and sufferers with nowhere to turn. The U.S. overdose crisis[1] has taken more than 1 million lives, and overdose rates increase each year.[2] At the knotted center of this impossible situation, physicians, pharmacists, prosecutors, and investigators face few suitable choices for patient improvement. This book details America's misguided attempts to curb the overdose crisis and the professions hidden at the heart of the problem.

Chronic pain and addiction sit uncomfortably on the cusp of law, medicine, and morality. Pain is alternatively framed as a medical problem or insufficient moral fortitude while addiction is considered either an illness or a crime. Lacking an adequate social safety net, the powerful fields of medicine and criminal justice take control over social problems[3] they were never designed to address. People with chronic pain and addiction land in emergency departments and jails that have scant resources to help. As a result, these problems fall through the gap even as physicians, pharmacists, prosecutors, and investigators labor to resolve them. Ultimately, the tools at their disposal are ill-suited to the job. Do workers make things worse by using blunt tools on problems that require sharpened ones or is doing *something* better than doing nothing?

I began my inquiry into the overdose crisis with an overlooked set of professionals: pharmacists. Contrary to what many people think, pharmacists do not

just dispense drugs that physicians prescribe. They have their own professional licenses that give them discretion over whether or not to dispense medications, and, in most states, pharmacists can refuse to dispense drugs they consider inappropriate. Their position as the ultimate gatekeepers to prescription drugs has propelled pharmacists into the crux of a national battle. Pharmacists, long considered healthcare's underdogs, like to operate in the background, to help patients without calling too much attention to themselves. The overdose crisis pushed them into the spotlight, where they found themselves grappling with competing forces: pressure to dispense drugs from patients, physicians, and managers and pressure to exercise caution from law enforcement.

Not long ago, I knew little about pharmacists and even less about the opioid crisis. As a budding sociologist, my interests centered on reproductive justice. When I learned that pharmacists were refusing to dispense emergency contraception (aka Plan B or the "morning-after pill"), I was troubled. What right did pharmacists have to refuse to provide drugs? Pharmacies, at the time, were the hottest battleground in the abortion debate that centered on whether healthcare providers could "conscientiously object" to dispensing medication. Delving into this debate taught me a lot about pharmacists and, to my surprise, helped me discover what was really troubling pharmacists.

From 2009 to 2011, I traveled to four states and interviewed ninety-five pharmacists. It was there, among towering shelves of medication in the recesses of chain and independent pharmacies, that I first encountered the havoc opioids have unleashed, and not just on patients but also on the professionals charged with helping them. Every interview began with the same question: What would you say are the key ethical issues pharmacists face in daily practice? For an answer, I expected emergency contraception, since the drug had captivated the media. Stories of pharmacists withholding the drug filled the newspapers. But emergency contraception was a minor concern for pharmacists. Across the board, their biggest struggle was opioids. And they had a lot to say.[4]

Their insights changed my entire focus. I was fascinated by pharmacists' stories about opioids—how they figured out which patients were misusing or selling medications and which patients needed them to treat pain, how they spotted "pill mills" and kept a blacklist of physicians for whom they would not dispense, how they managed complicated relationships with law enforcement who could be both friend and foe. I was struck by the Kansas pharmacist who kept a rifle on his counter after being robbed three times at gunpoint, by the Mississippi pharmacist who was frantically seeking guidance from law

enforcement after he identified a suspected drug ring, and by the New Jersey pharmacist who told me that a federal agent waltzed into her pharmacy, gave her his card, and urged her to contact him.

These stories shed light on the complex relationships between pharmacists, physicians, law enforcement, and patients. And they revealed how the opioid crisis manifested in daily practice, on the frontlines of care. All of these elements fueled the perfect storm of law, medicine, and organizations. The pharmacist's dilemma promised to answer so many questions about professional might, about relationships between medicine and criminal justice, and about the cultural and organizational context surrounding frontline work. I was hooked.

My research expanded to include physicians and law enforcement. Initially, I envisioned a tussle between law enforcement and healthcare over who would control the opioid crisis, but the people I spoke with quickly dispelled that illusion. Far from a sought-after prize, one that healthcare or criminal justice leaders could use to make their mark on one of the country's biggest social problems, the opioid crisis in its infancy repelled all potential reformers, who tossed it quickly from one field to another. The battle for control would come once the crisis gained steam, but we weren't there yet.

I interviewed the head of a prominent enforcement agency in New York City in 2012 and floated the idea that healthcare and law enforcement were competing to stake their claims on the overdose crisis. She laughed. She insisted that she didn't want this problem but was forced to deal with an epidemic "created by doctors and by drug companies." Neither the Board of Health nor the medical board had acted quickly enough. By the time her agency caught wind of the problem, people were already dead. "Nobody has owned the problem," she told me. "Everyone else has dodged it because it is so complicated." She felt poorly equipped to intervene. "My tools are not well-crafted for dealing with this. It is like hitting a fly with a hammer." In her eyes, law enforcement should be the "call of last resort because we have the least tailored tools to fix it." She went so far as to note that if doctors were doing their jobs, law enforcement would not have to step in. "Doctors drop the ball and criminal justice has to clean up the mess." Hesitant, but compelled to intervene, law enforcement tackled the crisis early on using the tools at hand, those designed for identifying and punishing criminals.

One tool in particular caught my attention—a new surveillance technology designed to ensure appropriate opioid provision. Prescription drug monitoring programs (PDMPs) became popular in the mid-2000s. PDMPs are databases

that track information about controlled substances dispensed in a state. Originally designed for law enforcement, the federal government has nudged this technology into healthcare.[5] State leaders, desperate to curb overdose rates, adopted this surveillance technology to help restrict out-of-control opioid prescribing, which, they hoped, would reduce overdose deaths.

Unlike other big data surveillance technologies that are generally used in a *single* field such as policing or social services, both healthcare *and* law enforcement use PDMPs. Physicians and pharmacists use PDMP data to assess signs of drug misuse or drug diversion before prescribing or dispensing opioids. Meanwhile, law enforcement uses PDMP data to root out patients who misuse or sell prescription drugs and to identify physicians and pharmacists who overprovide opioids.

When I first heard about PDMPs, I thought pharmacists would hate them. In my earlier interviews, pharmacists spoke with frustration about time constraints, managers who insisted they do more with less, working fourteen hours on their feet without a break, and dispensing prescriptions in four minutes or less. Surely, navigating a new technology would consume their time and detract from what they really cared about—treating patients. I was wrong. It turns out that what pharmacists hate more than time constraints is uncertainty. Pharmacists are exacting people. There is a reason they go into pharmacy, a precise science akin to chemistry, instead of medicine, which looks more like an art. Pharmacists like to do the right thing. The problem is knowing what the right thing is. The PDMP offers guidance.

Before the PDMP, pharmacists used gut feelings to make decisions about opioid care. If they felt like something was wrong with the patient or the prescription, they tried to gather more information, and often refused to dispense. They avoided confrontation by telling the patient that the drug was out of stock, a move that turned their unwillingness to dispense opioids into an inability to do so. This approach made them extremely uncomfortable, but they felt that it was all they had to go on. Some pharmacists lay awake at night wondering if they had made the right choice or if they had denied a pain patient medication they needed.[6]

Enter the PDMP. With this surveillance tool in hand, pharmacists can review patients' drug histories to see if they have gotten drugs elsewhere. Instead of resorting to the lie that it is out of stock, they have ammunition. They can tell the patient where and when they last received the medication and note that the patient should still have enough opioids to treat their condition. Doing so deters patients from trying to get drugs early and signals to patients

that they are being watched. Pharmacists find that sharing PDMP data impedes confrontation and reduces the number of patients seeking drugs at their pharmacies. In the pharmacist's eyes, far from being a nuisance, the PDMP is a lifeline.

Physicians also use PDMPs, but they have additional strategies to vet patients, many of which look suspiciously like those used by law enforcement. Drug screens, random pill counts, and pain contracts all bear the imprimatur of the criminal justice system. Enforcement agents, meanwhile, use PDMPs to decide which providers to target and which to leave alone and to make their investigations easier and more convincing. At the same time, prosecutors use PDMPs to build airtight cases in preparation for battle with the high-powered, well-paid defense attorneys that physicians hire to represent them.

PDMPs are a hallmark of the digital age, a time when technology promises to make our lives better by providing solutions to a wide array of social problems.[7] Just as the digital age has transformed welfare, education, and immigration, so PDMP use has transformed healthcare and law enforcement.

Although the PDMP was pitched as a law enforcement *and* healthcare tool, it is really a law enforcement tool implemented in healthcare spaces.[8] PDMPs are rarely integrated into electronic health systems.[9] They do not diagnose or treat disease. They do not offer ways to refer patients to treatment. They are surveillance tools above all. Today, state-wide PDMPs exist in all fifty states. Moreover, forty-eight states participate in PMP InterConnect, a system designed to share PDMP data across states.[10] PDMP use enables law enforcement to expand its reach into healthcare and to track healthcare providers with an ease and accuracy never before possible.

These technological advances come at a cost. Healthcare providers who use PDMPs police patients in daily practice and consider enforcement central to their work. Providers' ready acceptance of enforcement technology lays bare how enforcement logics infiltrate hospitals, clinics, and pharmacies. We can think of PDMPs as *Trojan horse technologies.*[11] In the myth, the Greeks used a horse-shaped gift to convince the Trojans to let them inside the walls, a move that led to the destruction of the Trojan civilization. The opioid case, though not as extreme, bears striking similarities. Law enforcement's gift to healthcare ends up changing how healthcare providers understand their work in ways that threaten healthcare as we know it. Effective tools to treat chronic pain and addiction are sparse and diffuse. Many lie beyond the bounds of traditional healthcare. Without the right tools to treat pain and addiction, providers thrust patients out of the system, which exposes them to higher risk of arrest,

overdose, and death. People who seek help face grave harm, and the human cost of the opioid crisis escalates unabated.

PDMPs changed the face of healthcare. Physicians and pharmacists police patients instead of treat them, actions that violate their professional oaths and that exacerbate instead of mitigate harm. But this policing is not entirely new and it does not result from cruelty alone. Healthcare has long been a site of surveillance and social control, where unruly bodies and behaviors are identified and treated to conform to society's norms.[12] Minoritized groups such as women and people of color along with people with moralized conditions such as addiction and mental illness have disproportionately felt the brunt of medical discipline.[13] They are all too familiar with the policing function of healthcare.

What has changed is that surveillance has grown wider and deeper—more people are being surveilled and the same person can be more easily followed across institutional boundaries.[14] Policing has also become easier, more systematic, and taken for granted. Healthcare providers can obtain information more easily and are more likely to trust the algorithms that produce it. They police more people and do so more efficiently than ever before. This shift speaks volumes about how social forces shape care and punishment. Policing by physicians and pharmacists is the predictable consequence of a healthcare system ill-equipped to handle pain and addiction, of a society saturated with myths about drugs and people who use them, of federal policy consumed by a half-century-long War on Drugs, of a society rife with race, class, and gender inequality. The first chapter of this book turns to this social context to explain why healthcare providers are policing patients and what we can do to stop it.

## The Crisis That Shook America

> After the surgeries, Quána never got better. . . . By early 2017, Quána was diagnosed with a number of chronic pain syndromes, including fibromyalgia and peripheral neuropathy,[15] as well as autoimmune diseases, depression, anxiety, and post-traumatic stress disorder. . . . Quána spent most of her days in bed crying, and she would vomit and feel dizzy. Pain often woke her screaming from her sleep. When she did go to the ER, nobody took her pain seriously: a nurse once accused her of being drug seeking and even called the police. Her white boyfriend, who was there with her, managed to talk them down and explain what had happened to her. But that trip to the ER left its mark: Quána is now afraid to seek treatment for pain. At its worst, Quána describes her pain as feeling like "hot pokers are stabbing through my hips."

> At other times her hips and knees burn, or she has shooting pains that spider from one part of her body to another. Her skin hurts so badly that she can only shower for a few seconds because the pressure is extremely painful. For a long time, she had extreme fatigue, and could barely walk up a flight of stairs. "Even though I have learned to cope creatively with my pain," Quána said, "my life has immeasurably changed. My pain is poorly managed. I often struggle with food insecurity and to make ends meet. No one should have to suffer like this."
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> —QUÁNA MADISON, "PAIN STORIES," NATIONAL PAIN ADVOCACY CENTER

> In 2005, I was living in Florida, directly in the path of Hurricane Katrina. News stations played nonstop warnings about staying inside. Normal people complied. By not *my* people. We were out in the storm. Because the thing is, drug addiction doesn't take a day off. A day before Katrina hit, I got a last-minute appointment at a pain clinic. The place was crammed with people, standing room only. I was rushed through a ten-minute "checkup" and given a prescription for the medication I desperately needed. Then it was on to the pharmacy. Clutching my script in my sweaty hand, I drove as fast as I could. My addiction gripped me so strongly that I didn't give a single thought to my own safety. The waiting area was crowded with people moaning, complaining, sighing, fighting, and just *waiting* for their number to be called. By the time it was my turn, I'd dissolved into a puddle of anxious sweat. *Hampton.* I couldn't get to the register fast enough. I dry-swallowed two pills on my way back to my car. I felt them stick in my throat. I swallowed hard again, willing my hands to stop shaking. I'd be fine now. In just one more minute, everything would be fine.
>
> —RYAN HAMPTON, *AMERICAN FIX*[16]

Quána and Ryan represent two types of people who suffer from the opioid crisis: people in chronic pain who need opioids to treat searing, near-constant pain and people with opioid use disorders who take opioids to alleviate psychological pain or to avoid the agony of withdrawals. People like Quána and Ryan come into contact with four kinds of professionals who are tasked with combatting the overdose crisis: the physician, the pharmacist, the prosecutor, and the investigator. These workers devise various strategies to keep people safe, but sometimes their help hurts.

Physicians and pharmacists are supposed to ensure that only legitimate pain patients gain access to care, but things could have gone very differently for Quána if her boyfriend had not been there when the nurse called the

police. Prosecutors and investigators are supposed to root out bad providers, but shutting down the pill mill where Ryan got his drugs could leave him and others suffering from opioid use disorder with nowhere to turn. Professionals face complicated questions on the frontlines of the opioid crisis: when to refuse to provide opioids, when to investigate physicians—and what will happen to patients if they do?

I traveled across the country to talk with these professionals in a quest to understand how they make difficult choices and how patients fare. These are the stories at the heart of this book. We begin with a snapshot of the U.S. opioid crisis, then learn a new story about what caused the crisis that is different from the one most Americans have heard. Next, we listen to stories from the four main professionals in this book, engage with a set of cultural touchstones that put their stories in context, and trace a roadmap of the book.

The opioid crisis changed everything, from how healthcare providers treat pain and addiction to how law enforcement conducts investigations, to how patients view painkillers, and so much more. The term "opioid crisis" is shorthand for the rapid rise in drug overdose deaths since 1999.[17] Opioid overdose destroys 136 lives per day.[18] This number is equivalent to a commercial airliner crashing, leaving no survivors, every day of the year. Many people mistakenly equate "opioid" with "prescription opioid" and believe that drugs like OxyContin, Vicodin, and prescription fentanyl are the leading causes of death. The truth is more complicated.

The opioid crisis has crested multiple waves over the past twenty years. Each wave has different drugs driving overdose death rates—first prescription opioids, then heroin, and now synthetic (not prescription) fentanyl.[19] Chapter 2 elaborates on the different iterations of the crisis, but for now it is important to know that the prescription opioids that once fueled the crisis pale in comparison to powerful, illicit drugs.

Prescription opioids entered the overdose scene with a bang and left with a whimper. In 2006, for the first time in U.S. history, prescription opioids accounted for more deaths than heroin, cocaine, and methamphetamine combined. Deaths from prescription opioids climbed steadily until they began to level off in 2010. That same year, heroin overdose rates began to rise until they surpassed prescription opioid overdose rates in 2018. In 2013, deaths involving synthetic opioids like fentanyl began to spike. By 2019, overdoses from fentanyl and other synthetics accounted for more than half of all overdose deaths and 1.5 times more deaths than either prescription opioids or heroin. Meanwhile, cocaine and methamphetamine deaths escalated until they each

contributed to more deaths than prescription opioids in 2019.[20] After a small dip in overall deaths in 2018, the COVID-19 pandemic struck, and overdose rates hit an all-time high with 92,000 deaths in 2020, which jumped to 107,000 in 2021.[21] The majority of these overdoses involved fentanyl or other synthetic drugs.[22] Physicians were complicit in flooding drug markets with prescription opioids. When prescribing rates peaked in 2012, physicians were issuing 81 opioid prescriptions per year for every 100 Americans. Rates diminished after that, but did not return to baseline. In 2017, physicians still prescribed three times more opioids than they did in 1999.[23] The picture is bleak. Overdose rates increase year after year and the drugs driving those deaths change too quickly for anyone to fully grasp. What brought all of this on?

If you know anything about the opioid crisis, you probably think that Purdue Pharma is to blame. As the story goes, Purdue manipulated regulators and physicians to get patients hooked on their drug, OxyContin, a powerful opioid used to treat pain. When people started dying with OxyContin in their systems, Purdue ignored the warning signs, pushed their drug even harder, and made billions doing so. OxyContin devastated a nation and made the Sacklers, one of the richest families in America, even richer.[24]

But Purdue's reign would not last. In September 2019, while facing 2,600 state and federal lawsuits, Purdue declared bankruptcy.[25] For many families and activists, this was cause for celebration. The enemy had been vanquished, the dragon had been slain, and the people were finally liberated from twenty years of pain and loss.

Yet this victory over Purdue is only truly celebratory if we imagine that the driver of the contemporary U.S. opioid crisis can be reduced to a single causal factor—a bad drug company selling addictive wares to an unsuspecting public. A company that used shoddy science to convince physicians to carelessly prescribe its drugs, leaving a trail of destroyed lives in its wake. A company led by nefarious people who sold a drug so powerful and so addictive that people were helpless to escape its grasp.

This kind of fairy tale with easy-to-identify villains and victims resonates powerfully with Americans. After all, we have digested narratives about "good guys" and "bad guys" our entire lives. From stories read at our bedside, to religious texts, to blockbuster films, to an endless supply of legal dramas, we have been trained to spot good and evil.

But we are less prepared to deal with complexity, to recognize that the good guys do bad and the bad guys do good. We are woefully ill-equipped to critique bad systems, to unpack how an ecology of laws, norms, politics, economics,

organizations, and relationships affect the decisions people make. We fail to consider that people do bad things because the systems in which they operate invite bad behavior. If systems are failing us, we can't just eliminate the so-called bad actor; we have to look at the rules of the game.

Painting Purdue as the villain in the opioid story does more than put a face to the crisis that has harmed so many Americans. It lets other, less visible perpetrators off the hook. If Purdue is a monster that intentionally set out to harm the American public, then slaying Purdue allows life to return to normal. What the Purdue narrative doesn't do is invite us to interrogate our social systems and ask what they did to invite this harm, how they let this monster breach our castle walls, and why our gatekeepers were asleep on the job. The opioid crisis, or, more accurately, the overdose crisis, is both a devastating tragedy for people whose loved ones are caught in its grip *and* a constructed social problem shaped by institutional power dynamics that affect how we define, elaborate, and respond to this issue. In other words, the so-called opioid crisis and our approaches to confronting it are distinctly cultural phenomena.

The Purdue story obscures more than it reveals; the truth is a far cry from this simple fairy tale. The true story of opioids is the saga of a society in which lines between illness and criminality are blurred, where punishers do the treating and healers do the punishing. A story in which the color of a person's skin and the substance that they use affects whether they receive care, punishment, or punishment disguised as care. A story in which suffering people are denied relief under the auspices of protection and support. For many, this story is a living nightmare full of impossible choices, one in which heroes die and in which villains, who are all the more powerful for being nameless and faceless, prevail. A chilling story, yes, but one necessary to unravel the tidy image knitted together by simplistic threads of blame so that we can finally understand this modern social problem's complexities and arrive at policy solutions that honor its subtleties.

We cannot understand the overdose crisis without understanding the people responsible for stopping it. That is why this book spotlights enforcement and healthcare workers on the frontlines of the opioid crisis, to ask what choices they make about providing opioids, targeting providers, and why. It invites readers behind the pharmacy counter, into the treatment room, and within the recesses of government bureaucracies to witness gatekeepers to medical resources and the enforcement agents who investigate and prosecute them. By looking at the opioid crisis through the lens of frontline work, we can see how strategies to curb the crisis affect the daily lives of workers and patients in powerful, but unexpected, ways. Particularly central is the use of

shared surveillance technology called the prescription drug monitoring program (PDMP). This technology affects how workers interact with each other and how they treat patients. Broader cultural forces shape it all.

Drawing on a decade of research and 337 interviews in eight states (California, Florida, Kansas, Kentucky, Mississippi, Missouri, New Jersey, and New York), this book reveals how the overdose crisis and the surveillance technologies designed to combat it have fostered a punitive turn in medicine. I created a "nested maximum variation sampling strategy" (described more fully in the appendix) where I collected as many perspectives as possible across a wide variety of organizations. I also spoke to some of the same pharmacists before and after the PDMP was fully implemented to see how their work had changed. When it comes to punishment, the narrative isn't new, but the form is. Data-driven healthcare is the latest manifestation of the perpetual War on Drugs, a failed political experiment that has done more to fuel mass incarceration than to reduce drug use.[26] Criminal justice tools will not dismantle the opioid crisis. Placed in healthcare providers' hands, they are doing irreparable damage to patient care and public trust.

This book tells a story about the unprecedented surveillance capacity of the digital age. It is a story about how our society views social problems through a punitive lens. And it is a story about how shared surveillance technology has ushered criminal justice logics into healthcare and blurred boundaries between policing and treating. When policymakers ignore the complexity of the overdose crisis and instead view it through a singular punitive lens, they shut off the most promising avenue for addressing the crisis: healthcare.

## On the Frontlines of the Opioid Crisis

In the opioid crisis, there are four groups who interact with patients: the physicians who prescribe opioids, the pharmacists who dispense opioids, the prosecutors who prosecute opioid cases, and the investigators who gather evidence. They have all received blame for the crisis, they all exercise discretion, and they all use technology at work.

Physicians and pharmacists have been blamed for overproviding opioids,[27] while prosecutors and investigators have been blamed for scaring physicians by creating a "chilling effect" on opioid prescribing that makes providers shy away from providing the drugs.[28] Each set of workers gets to decide how they allocate resources and punishment. Physicians and pharmacists decide who deserves access to opioids and who deserves to be turned away, while prosecutors

and investigators decide which healthcare providers deserve to be investigated and prosecuted.

Over the years, all four groups have been given access to PDMPs. These systems were originally designed for law enforcement. Healthcare leaders later began to implement PDMPs to help providers decide whether to prescribe or dispense opioids.[29] Physicians and pharmacists use them to size up patients, while prosecutors and investigators use them to assess the legality of providers' and patients' behavior. To put it simply, PDMPs are two-tiered surveillance technologies shared by healthcare and law enforcement that allow healthcare providers to monitor patients and allow prosecutors and investigators to monitor patients and providers. I wanted to know how this new technology affected workers' decisions and patient care.

My quest to understand how workers fared during the overdose crisis took me across the nation into chain and independent pharmacies; into clinics and hospitals; into courthouses, statehouses, and federal agencies; into conference centers, coffee shops, and restaurants; and even onto a ferry. I sat down with physicians, pharmacists, prosecutors, and investigators and listened to their stories, the stories at the heart of this book, the stories that will make you question what you think you know about the opioid crisis. Their voices echo throughout the following chapters, but allow me to introduce a few of them now.

## *The Physician*

Nobody in Florida wanted to talk to me. I spent hours cold-calling and cold-emailing physicians, pharmacists, and enforcement agents who, more often than not, ignored me or declined the interview. I chalked it up to exhaustion. Floridians had already had their share of research attention and media scrutiny. They were residents of one of the opioid hotspots, home to the "Oxy Express," a trip down I-75 that transported drugs from Florida pharmacies to small towns in Appalachia, a place where pill mills had popped up like weeds.[30] And here I was, late to the game, asking them to rehash old stories that they would prefer to let lie. But I was on a deadline and had only two weeks to gather data, so I decided to take matters into my own hands. Which is how I happened to meet Donna in an elevator.

Having had little luck with phone calls and email, I took a page out of the pharmaceutical rep playbook. I showed up at physicians' offices, left my card, and asked their staff to have the doctor contact me. On my way out of a medical office building, I found myself standing next to the very physician I had just

tried to recruit. I recognized her from the photo on her website. She had barely pushed the button for her floor when I introduced myself, described my project, and requested a meeting. To my surprise, she agreed to meet at her office later that afternoon.

When I arrived, Donna escorted me through the drab, gray-green interior and into a room with two gurneys and a microwave (staff took breaks there). She offered me a tall metal stool, sat down across from me, and started talking. Donna was no-nonsense tough, having spent much of her career in pain management and seen the opioid roller coaster go from free-flowing prescriptions to austere restrictions. To hear her describe it, she never got on the ride. She set strict limits around opioids and urged her patients to reject them. But she had seen other physicians prey on vulnerable patients, a common practice at the height of the opioid prescribing boom. She described doctors who sold prescriptions or traded sex for drugs, and her frustration was so palpable she began to cry. "Why the tears?" I asked. She replied, "I've been feeling like I'm fighting an uphill battle for 30 years. . . . I really feel bad for the patients . . . because some of them I know they're going to die." That is when it struck me—how much most physicians struggled to do the right thing.

Donna was an early adopter of policing techniques. She had begun policing patients as soon as she opened her practice. She drug tested patients, required them to sign pain contracts that limited them to a single physician and a single pharmacy, and did random pill counts that required patients to show up at her office and reveal how many pills remained in their bottle. E-Forsce, Florida's prescription drug monitoring program (PDMP), made policing patients easier. She can now use the state's database to assess whether a patient is telling her the truth. If they aren't, if the PDMP report looks fishy, she fires the patient. But she tries to give patients every opportunity to improve. She prescribes vitamins, offers procedures, and requires specific exercises. Her goal is to prescribe as few opioids as possible. But she notes that many patients have a long way to go. "I will tell you, the patients I have that are chronic pain patients, they're scared. They're scared that one day they're not going to have any medications to treat their problem."

### *The Pharmacist*

Halfway across the country in Kansas City, Missouri, Tracy faced similar challenges from a different perspective. As a pharmacist, she was the final gatekeeper to opioids, the person who ultimately handed over a small white bag

of pills or sent the patient away empty handed. Like Donna, Tracy struggled to figure out which patients should get access to opioids.

Tracy was what pharmacists call a "floater." She worked for a chain pharmacy, but was not tied to any one store. She filled in at pharmacies that were short-staffed or needed extra help. In this role, Tracy saw how different pharmacies in the city operated, how those located in wealthy, white areas compared to those located in poor, minority neighborhoods. She tried to keep her practice consistent regardless of race or class. She checked the PDMP as often as she could, but not all counties in Missouri were covered. She felt pressure from her managers to work as quickly as possible.

Work piled up before she even arrived. Phone messages, electronic prescriptions, and faxes awaited her, so she started her shift already behind. She routinely put in extra, unpaid hours just to keep up. And her chain was so committed to filling prescriptions quickly that they had installed a computer program that turned prescriptions red on the screen when pharmacist didn't fill them fast enough. Despite her commitment to fairness, the pressure to work quickly required Tracy to cut corners, to scrutinize some patients more closely than others. She couldn't check the PDMP for every patient every time. "Often," she told me, "you don't even have time to log on. . . . Every second counts."

Her chain's policy was to call the police on fraudulent prescriptions, but she didn't always think that was the right choice. In part, she feared patient retaliation: "I'm not going to risk my life. I mean, I don't know what they're going to do if I call the police on them." And in part, she was sympathetic toward patients who were struggling: "they're not bad people, they're just people that got addicted to drugs somehow." She thought that calling the police might be the wake-up call her patients needed, but she simply didn't have the time.

Both Donna and Tracy closely monitored their patients to avoid coming under law enforcement scrutiny themselves. At the time I spoke with them, physician arrests were a regular occurrence and pharmacist arrests, though less common, were frequent enough to raise concerns. But prosecutors insisted that these healthcare professionals had little to worry about.

## *The Prosecutor*

By the time I met Nick in the summer of 2016, he had already prosecuted a dozen physicians. He had only half an hour to spare, so he ushered me into a sun-filled conference room in downtown Los Angeles and began to share his war stories. It was a wild ride.

At the time, Nick was one of only a handful of prosecutors willing to go toe-to-toe with physicians and their well-paid defense attorneys. And he emerged victorious each time. There was the doctor who dealt pills from his car, the doctor who kept prescribing even after his patient overdosed in his office, and the doctor who had stashed millions of dollars' worth of pills in his clinic ceiling and at an off-site storage unit. All of these doctors destroyed lives with the stroke of a pen. One physician had thirteen deaths to her name. Was that unusual? Nick, new to the world of healthcare, wasn't sure, so he started asking around. He asked physicians he knew how many of their patients had died. They looked at him quizzically and replied "none." That's when he knew he was onto something.

Nick wasn't interested in gray areas, the physician who had prescribed a little too much OxyContin or the pharmacist who had dispensed a few too many pills. He was after the "worst of the worst," those physicians whose patients ended up dead from the pills they had prescribed, "the people that are literally drug dealers in lab coats." He doesn't go looking for cases; they come to him. "[We] just don't have the resources to look at a PDMP and be like, 'Hmm, this doctor's prescribing seems really high, let's sniff this out.' It's more like, 'We've received nine consumer complaints about this doctor; we need to go see if something's going on.'" He told me that CURES, California's PDMP, is "the Bible of prescription medication" and he considers it "indispensable" to his work. The database provides "footprints of what this doctor is doing. . . . You can see if they're dispensing a particular kind of medication. To whom? How often? What quantities? . . . It provides so much information to you as a prosecutor just from seeing the patterns."

When I caught up with Nick the following year at a conference in Atlanta, he took a riveted audience through the anatomy of one of his cases. Nick showed undercover surveillance video of the defendant's office that looked like no doctor's office I had ever seen. Files were thrown everywhere instead of neatly put away. Boxes of drug samples were scattered on the floor of the office area and stored in the bathroom. And when the doctor spoke to the patient, she asked him what he wanted, told him "I probably shouldn't write this for you," and handed over the script anyway. This case was career-defining for Nick—it was the first time a California physician had been convicted of murder for overprescribing drugs to patients.

Nick took on physician harm and emerged victorious, but the cases that he prosecuted were only the tip of the iceberg. Most physicians who harm patients experience no consequences, partly because they are difficult to prosecute and partly because law enforcement lacks motivation to do so. Prosecutors can

complete several low-level drug cases in the time it takes to do a single physician case, so many of them choose the easy win over the gamble. Along the way, prosecutors frustrate investigators who devote time and energy to physician cases only to be told that there is not enough evidence to prosecute.

## *The Investigator*

For Caleb, catching bad doctors was personal. When we met in 2017, he had spent three years on a task force with workers from agencies in Southern California, investigating prescription drug diversion (the sale of prescription drugs through illicit markets) as well as illicit drugs and organized crime. Asked the first time to join the task force, Caleb refused. He had considerable experience investigating narcotics cases, but his brother had recently died of a drug overdose and the pain of that loss was still raw. Addiction ran in the family, but Caleb's brother had never touched drugs until he was prescribed Vicodin to treat injuries from a car accident. When that wasn't enough, he was prescribed OxyContin, and he began smoking and injecting. He then transitioned to the heroin that killed him.

The second time his commanding officer asked him to participate, Caleb accepted. Time had healed some of his wounds and he had specialized skills that made him valuable to the task force. He became the PDMP expert. Tips from the public or from other agencies motivated him to search the PDMP to see what volume of opioids the physician was prescribing. "If someone was causing death, we would absolutely initiate an investigation to go after that individual." However, once he began the job, he faced stubborn barriers to investigating and prosecuting physicians. Despite his team's best efforts, he says that "there are doctors that are still practicing in a criminal capacity, providing pharmaceuticals to our streets that I can name right off of the top of my head." The biggest barriers are lack of respect, lack of resources, and unwilling prosecutors.

Caleb says that doctor cases are incredibly challenging. He finds that other officers and superiors look down on his work. They call it "kiddie dope" because "it's just a doctor prescribing, it's medicine, it's not real opioids." Misunderstanding the harm that prescription opioids can cause keeps prosecutors away. Caleb concedes "they're not sexy cases. They aren't cartel guys that walk around with guns; they're doctors. You're going after white-collar people, regular citizens, and nobody wants to have a part in it."

Some prosecutors don't take cases seriously and end up flushing years of investigatory work down the drain. Or Caleb's task force can't get the resources

it needs. He described one physician who was still prescribing high volumes of pills because the task force couldn't get a confidential informant to work with it. In other cases, prosecutors lost cases that should have been slam-dunks. "It's disheartening to see that when you've put months and months and months of work into these cases and they're reduced to a ridiculous plea or the case is just not filed altogether. And we're talking cases that involved death, but the fear of taking on a doctor and a high-powered team of lawyers supersedes justice."

Donna, Tracy, Nick, and Caleb are just four of the workers trying to stay afloat in the wake of the opioid crisis. With different occupations and living in different parts of the country, these workers seem siloed, cordoned off from one another. But in reality, they are deeply interconnected in this crisis that threatens to drown them all. The choices they make affect their relationships with one another and have a profound impact on patient care.

Social scientists refer to workers like these as "frontline workers" or "street-level bureaucrats" because they do the client-facing jobs for the organizations in which they are embedded. Frontline workers exercise a great deal of discretion as they juggle heavy caseloads and reconcile conflicting laws and policies. However, they exercise far more power than one might expect. Even though they occupy the bottom rungs of the organizational ladder, their choices have such a great impact on clients that they are seen as bureaucrats in their own right, those who make law from the bottom up, hence the name "street-level bureaucrat."[31] Frontline workers in healthcare and law enforcement interact in spaces like hospitals and ambulances where norms of punishment and treatment jockey for position.[32]

It is tempting to hold frontline workers exclusively responsible for their decisions. When physicians or pharmacists deny opioids to a pain patient or when prosecutors and investigators scrutinize and charge an innocent physician, they make things worse instead of better. But frontline workers do not operate alone. They are embedded in cultural and organizational contexts that shape how they understand their legal and professional responsibilities and how they behave at work.

## Cultural Touchstones

To truly understand workers' choices, we must also consider the context that surrounds them. There are four main touchstones that offer insights into the contextual factors that shape workers' responses to the opioid crisis: (1) the shortcomings of the U.S. healthcare system, particularly when it comes

to treating addiction and pain; (2) the organization of society into social fields like healthcare and criminal justice that each have their own ways of understanding and responding to social problems; (3) the punitive turn that resulted in the criminalization of various social problems; and (4) the rise of the digital age that unleashed unprecedented surveillance capacity.

The U.S. healthcare system is notoriously inaccessible, expensive, and confusing. Compared to other Western, industrialized nations that treat healthcare as a right, 26 million Americans remain uninsured even after the Obama administration spearheaded the sweeping healthcare legislation that became the Affordable Care Act (ACA).[33] Insured Americans either get insurance from their employers or from government programs like Medicare and Medicaid. But having insurance does not necessarily result in access to care nor does it protect people from crushing medical debt. Waiting lists can be months long, particularly at Federally Qualified Health Centers (FQHCs) that treat the poor.[34] Insurance covers only specific facilities and specific providers and often requires authorization prior to a treatment or a procedure. For-profit corporations have a stranglehold on healthcare and the cost of procedures varies widely from place to place, resulting in what famed medical critic Dr. Arthur Relman called the "medical-industrial complex."[35]

At the same time, healthcare providers are typically siloed. They are experts in specific diseases or body parts, which makes it difficult to coordinate care for people with multiple conditions. There is a doctor for your skin, a different doctor for your feet, and yet another doctor for your bones, as if your skin, feet, and bones existed in isolation. And medicine has become heavily pharmaceuticalized, prioritizing drug-based treatment over hands-on treatment. With drugs available to treat all kinds of remedies, pharmaceuticals are globally a $1.5 trillion per year industry.[36]

This is the best-case scenario, what healthcare looks like for people who have insurance and who have diseases that are typically recognized as medical. Things look quite different for people with chronic pain and addiction, conditions that medicine keeps at arm's length. Chronic pain and addiction are heavily moralized and incompletely medicalized. Stereotypes of the "malingering pain patient" and the "manipulative addict" are used to justify refusing to provide adequate care to those who suffer. Not only that, but the healthcare system is ill-equipped to treat either condition. Most physicians receive little to no training on addiction or chronic pain. Chronic pain did not become a medical specialty until 1993,[37] and addiction medicine became a subspecialty in 2015.[38] Insurance companies are more likely to cover drug treatments like

opioids for pain than hands-on therapies like massage, physical therapy, or chiropractic adjustments. And insurance companies often deny treatments that physicians order until patients try another, cheaper course of treatment. As a result, when it comes to addiction and pain, the healthcare system is practically unnavigable for even the savviest patient and the most well-meaning provider.

Healthcare's inadequacies are only one set of barriers that affect how workers contend with the opioid crisis. Another barrier lies in debate over whether the opioid crisis is medical or criminal in nature. Choosing one interpretation over the other affects what kinds of resources are brought to bear on the problem and which workers are put in charge of solving it.

Sociologists envision society as broken down into a set of "organizational fields" or organizations that, in the aggregate, belong to a specific branch of society.[39] Criminal justice and medicine are fields as are religion, art, and education. The field includes not only focal organizations like prisons, hospitals, churches, museums, and schools, but also government agencies that regulate them, resource suppliers, consumers, clients, and competitors.[40] What holds fields together and distinguishes them from one another are their core principles, what sociologists call "institutional logics."[41] For example, criminal justice operates on a logic of punishment, while healthcare operates on a logic of treatment. When faced with social problems—issues like crime, illness, and poverty—each field brings its own perspective, offers its own solutions, and fights to have its solutions realized. Social problems like the opioid crisis stoke tensions between fields that subscribe to different institutional logics, though sometimes these fields find ways to cooperate.[42]

Take, for example, the problem of excessive alcohol use. Three fields—religion, criminal justice, and healthcare—have spent decades battling over whether alcoholism is a sin, a crime, or an illness. Today, we consider it a form of sickness that warrants medical treatment, but for many years it was considered a form of badness that required atonement or punishment.[43]

How we treat social problems, then, depends quite a bit on who gets to decide what kind of problem it is, what logics they use to frame it, and what solutions they think are best. Framing the overdose crisis as a problem of overprescribing and corporate greed suggests that solutions lie in the healthcare system. But framing the problem more broadly by pointing to the problems that arise from criminalizing drug use and the harms that result from a frayed social safety net requires new sets of logics and invites different types of solutions.

Not all fields are created equal. Some exert significantly more power than others. Today, one of the most powerful fields is criminal justice. Extremely well-resourced, especially compared to the associated fields of social services and public health, criminal justice enjoys not only financial power but rhetorical power as well. In a culture steeped in news of violent crime, often told from the perspective of the police, where investigators and lawyers play heroes on prime time, and a society whose impulse is to control minority groups and the poor, it is no surprise that so many behaviors from acting up in school to sleeping on a park bench are framed as crimes and the people who engage in them as criminals.[44] It was not always this way.

In the late 1970s, the United States began to experience a punitive turn.[45] Logics of crime and criminality ascended and overshadowed rehabilitative logics. This shift, especially pronounced in prisons,[46] occurred in a wide variety of fields, from social services to education to welfare.[47] Poor people and people of color disproportionately felt the brunt, entangled as they were in both carceral and social service arenas. Prisons and jails did away with rehabilitative programs in favor of punitive ones. Welfare offices prioritized rooting out welfare cheats over providing resources to needy families. These changes left poor, minority groups surveilled, disciplined, and punished, but they were not alone.

The punitive turn reverberated throughout the social strata, resulting in what socio-legal scholar Jonathan Simon calls "governing through crime."[48] That is, efforts to combat crime have become so politicized that they often serve very different purposes from the ones they purport to address. At the same time, "technologies, discourses, and metaphors" associated with crime and the criminal justice system have infiltrated other institutions.[49] To put it succinctly, we now live in a society where talk about crime and efforts to fight crime far outpace the actual crime rates. This is at least partly explained by the fact that invasive criminal justice logics have creeped into nonenforcement fields. What we don't yet fully understand is how technology affects how criminal justice logics infiltrate other fields, a central question for this book given that legislators are attempting to stop the overdose crisis by implementing law enforcement technology into healthcare.

Times of crisis make strange bedfellows. Contemporary approaches to the opioid crisis are dominated by two fields—healthcare and criminal justice—that bring very different worldviews, tactics, and resources to bear and that are independently inadequate to address a problem of this magnitude. These fields' leaders may disagree about the best course of action, but they do agree on one

thing—the promise of technology. And they are in good company. Expansive computing power and the rise of the Internet have ushered in a digital age, one that makes it possible to gather, store, and analyze mountains of data and to deploy algorithms to make data analysis and decision-making easy and automatic.[50] Importantly, algorithms have become critical for allocating resources and punishment in social services, and policing and computers often take priority over individual workers for deciding who deserves resources or punishment.[51] Technology promises to solve social problems, even if it often fails to deliver. States have adopted big data algorithms to determine how they allot their shoestring social service budgets, which can perpetuate inequality.[52] With technology in the driver's seat, municipalities distribute resources in unfair or nonsensical ways.

Not only can new technology create and exacerbate social inequality,[53] but it also expands surveillance capacity of both law enforcement and of private businesses,[54] resulting in what Shoshana Zuboff calls "surveillance capitalism."[55] At a time when computing capacity is more powerful than ever before, we permit ourselves to be constantly surveilled by most of the technologies we use, even though some people are more heavily surveilled than others and surveillance is not always a choice. Most social science research on surveillance technology focuses on a single field like law enforcement[56] or compares surveillance technology across fields,[57] but we know little about how different fields use the same technology.

Technology built for use in one field often finds uses in other fields. Surveillance data, in particular, tends to creep across field boundaries.[58] This book addresses technology's migration by examining how surveillance technology shared across the fields of healthcare and criminal justice affects frontline work. It examines healthcare, rarely included in surveillance studies, and considers how shared surveillance technology links healthcare to criminal justice.

## Our Journey Together

As this book unfolds, you will begin to grasp how these four touchstones—healthcare's shortcomings, the logics of social fields, punishment, and technological surveillance—help contextualize the frontline work to fight the overdose crisis. You also will notice how understanding what workers do and why helps us see these cultural forces in a new light. Healthcare and criminal justice are major sites of inequality, places where punishment and resources get distributed in ways that help some and harm others. This book explores

how technology can intensify inequality by linking two unequal fields. How does giving law enforcement healthcare data affect the investigation and prosecution of healthcare providers? How does giving healthcare providers enforcement technology affect patient care? Most significantly, at the street level, how do patients with pain or addiction fare in this brave new healthcare world?

The answer to these questions lies in understanding how efforts to curb the opioid crisis have blurred boundaries between healthcare and law enforcement. Both healthcare providers and enforcement agents take professional oaths that commit them to helping others. Yet the ready embrace of PDMPs and other strategies to curb the opioid crisis threaten to undermine those commitments. People with pain and addiction need help, but providers lack the capacity to provide care. They have the wrong tools for the job. In short, the opioid story is far more complex and devastating than the story we have been told. An understanding of this complex ecosystem and a path forward begins here. I will show how PDMPs operate as Trojan horse technologies[59] as they usher enforcement logics into healthcare. Physicians and pharmacists who use them begin to accept policing patients as a core task, though they do not consider their actions policing. Instead, they embrace policing tasks while reframing them as treatment. This shift is possible because policing is already an aspect of healthcare work and because the technology that facilitates policing has become commonplace, easy to use, and, in some states, legally required.

PDMPs are widespread, but few people realize they exist. They have proliferated over the past decade, yet we know little about their social impact, particularly how they affect workers and patients. The book begins with a historical overview of the U.S. opioid crisis that explains how enforcement technology became a popular solution. Chapter 2 delves into specifics of PDMPs—where they came from and how they have evolved. In chapters 3–5, we see how PDMPs are used on the frontlines of three fields—law enforcement, medicine, and pharmacy—with a focus on how workers in each field use the same technology for different purposes and with different consequences. Changes in these fields raise questions about what happens to patients. Those questions are answered in chapter 6, which shows how efforts to curb overdose thrust patients out of the healthcare system, leaving them vulnerable to harm. Chapter 7 offers practical solutions for resolving the opioid crisis and zooms out to consider what this can tell us about frontline work, technology, and punishment. The methods used in this study can be found in the appendix.

Incomplete stories yield inadequate solutions. Current solutions that focus exclusively on doctors and drug companies won't curb the crisis and often do more harm than good. It is only by taking a systemic view of the healthcare and criminal justice systems and the social safety net that we might hope to disrupt the cycle of pain, addiction, and death that afflicts our nation. This book offers fresh policy interventions centered around treatment, harm reduction, and public health instead of surveillance, punishment, and incarceration. These approaches promise not only to stop the opioid crisis but also to prevent new crises from emerging in its wake.

From this point on, the story is ours. We decide whether we allow ourselves to be swept up in the rapids of moralizing and punishing that have claimed so many lives, or if we swim against the current and fight our way to a new river that offers a smoother and less treacherous journey. But before we can find solutions, we must reexamine the problem. We can only begin to understand how we got here, to a historically unprecedented moment where drugs claim over 100,000 lives each year, by venturing back to the turn of the twentieth century, when America's first drug law came into being.

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