

December 2013

Do No Harm: Prescription Drug Abuse and the Paraprofessionalism of Pharmacists

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DO NO HARM: PRESCRIPTION DRUG ABUSE AND THE
PARAPROFESSIONALISM OF PHARMACISTS

by

Kathrine Barnes

A Thesis Submitted in
Partial Fulfillment of the
Requirements for the Degree of

Master of Science
in Anthropology

at

The University of Wisconsin-Milwaukee

December 2013

ABSTRACT
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PARAPROFESSIONALISM OF PHARMACISTS

by

Kathrine Barnes

The University of Wisconsin-Milwaukee, 2013
Under the Supervision of Professor Paul Brodwin

History reveals long, intertwining chronologies between licit and illicit drugs, and social change. Currently, rates of prescription drug abuse are increasing and medical professionals at every step must mediate the flow of pharmaceuticals. The effect of the epidemic on emerging social change relative to pharmacy remains unexplored. While pharmacists are trusted and have shown to be effective in smoking cessation, little research has explored the impact of prescription drug abuse on their work. Pharmacists have little official authority and autonomy on the job, relegating them to the level of paraprofessionals, but pharmacists find novel ways of gaining agency in their day-to-day work. In conceptualizing addiction as a patient who lacks awareness and whose mind is fragmented by the action of drugs on their body, pharmacists are able to hassle patients and attempt to bring awareness of their condition through an assemblage of patient records comingled notions of profit, care, biomedicine, a global pharmaceutical market, and morality. While relying heavily on physicians to do their work, pharmacists blame prescribers for the actions of their patients. In seeing patient's patterns of use, not the effects of the drug, at issue in creating addiction to prescription drugs, pharmacists insulate their position of low authority, effectively relegating the problem to doctor's turf,

and absorbing a dialogue of the global pharmaceutical industry while actively constructing the effect of prescription narcotics on the addicted body. Through pharmacists' work, those impacted by the prescription drug abuse problem can ascertain what happens when the drugs meant to heal the public become profound agents of harm. Pharmacists and the rest of the medical community are subordinated by a language and conceptualizations rooted in the pharmaceutical industry.

I would to thank the members of my committee, Dr. Paul Brodwin, Dr. Kalman Applbaum, and Dr. Michael Oldani, for their input and support throughout the process of completing this project.

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Chapter I: Introduction

The fallout began in 2006. That year, researchers at the Center for Disease Control authored a monumental study showing a significant increase in deaths among women who abuse prescription narcotics with a concurrent 500 percent increase in the prescribing of such drugs (Paulozzi, Budnitz, Xi 2006). Immediately, representatives of the University of Wisconsin Pain & Policy Studies Group, Aaron Gilson and David Joranson (2006), refuted these conclusions, cautioning against tightening regulation of the drugs: people are in pain; we have a duty to absolve them of pain. Their names litter other literature on the dangers of underprescribing—as a citation in a book published by the Human Rights Watch entitled *Please Do Not Make Us Suffer Anymore: Access to Pain Treatment as a Human Right* (2009:5), in the *Journal of Pain and Symptom Management* (2002), and in the *Indian Journal of Palliative Care* (2005). As a 2011 investigative report by the *Milwaukee Journal-Sentinel* found, hidden by this record is a generous and ongoing financial relationship with several pharmaceutical companies, the largest donation of which coming from Purdue Pharma (Fauber 2011a). Between 1999 and 2010, Purdue Pharma paid the UW Pain & Policy Studies Group over \$1.6 million according to the *Milwaukee Journal-Sentinel*. The group's total pocketed profit from pharmaceutical companies exceeds \$2.5 million. Purdue Pharma is the producer of OxyContin, an expensive, highly addictive narcotic. Users put a pill of Oxycodone onto a piece of foil, light it from underneath, and using a straw, inhale the fumes. The following year, in 2007, Purdue was brought up on charges by the United States Department of Justice for fraudulently misleading prescribers in saying OxyContin was less addictive than other pain medications (Meier 2007). The company and three of its executives plead

guilty to various charges and over \$635 million in fines were imposed on Purdue Pharma. Despite this, OxyContin continued to be prescribed at high rates, largely fueled by claims furthered by the palliative care movement and the UW Pain & Policy Studies Group. Gilson and Joranson had an unexpected path to the organization. While making prescribing recommendations to doctors in peer-reviewed journals, neither has an M.D.—according to the UW Pain & Policy Studies Group website, Gilson has a doctorate of social welfare and Joranson, his masters in social work.

A year after the UW Pain & Policy Studies Group story broke Daniel Lee had a problem. He probably was not aware of the controversy being played out about 90 miles away from Milwaukee where he lived and operated as a small time drug dealer. Nonetheless, he had customers clamoring for OxyContin. Text messages to his phone indicated several of his customers asking for Oxycodone 30s (USDOJ 2013). The problem was that Daniel had none. So, Daniel made a decision. He searched on his phone for local pharmacies, removed the license plate from his car, and on January 2nd, 2012 around 1pm, he donned a gray hooded sweatshirt along with a thick black winter coat, a knit cap, a scarf, two sets of handcuffs, and a gun and walked into Thompson Serv-U Drugs. He walked out shortly thereafter with cash and narcotics (Docter 2012). While news outlets reported on the incident, Lee was not immediately apprehended. So, he robbed three more pharmacies in a similar fashion over the next two months. In May of 2012, Lee had a new problem: he was arrested and charged with seven federal felonies. He was sentenced to 65 years in prison (USDOJ 2013).

While the professional and privileged role of Gilson and Joranson existed a world away from the life of small-time drug dealer Daniel Lee, their experiences are united by

the sale and distribution of prescription narcotics. It can be easy to cast these incidents off as the acts of three morally misguided individuals; however, their stories merely skim the surface of a multi-billion dollar industry in pharmaceuticals. These incidents demand a deeper analysis; an analysis to properly contextualize the distribution of prescription narcotics.

Research is quick to pin the blame on prescribers and the industry as a whole. While I do not dispute the legitimacy of these claims, pharmacists are embroiled in this conflict in ways both unexpected but illustrative of the wider problem. The proliferation of pharmaceutical products throughout society in a variety of licit and illicit contexts is indicative as much of liberal prescribing as consumer demand: both spheres are driven by deeper conceptualizations of the power of prescriptions to effect change, be it curative, therapeutic, or addictive. While doctors are the primary power-holders in the medical hierarchy, pharmacists immerse themselves through years of training and on the job practice in pharmaceuticals. They represent the link between the liberal prescribers targeted by Gilson and Jorenson, and the use of medications in the community, whether they are legitimately and “responsibly” taken or bought from the Daniel Lees of the streets. Yet, for all the research on prescription drug abuse, the pharmaceutical industry, and doctor-patient interactions, research takes for granted pharmacists’ work.

Pharmacists’ knowledge deals intimately with the therapeutic effects, side effects, and contraindications of pharmaceuticals. By definition, their job is to exchange a doctor’s script for the medication itself. Pharmacists are what is termed paraprofessionals, professionals without the full trappings of doctors and must rely on prescribers for their work (Freidson 1988). The field has undergone an expansion in recent times as pharmacy

has taken on additional duties, such as administering vaccinations, blood pressure consultation, and advising on prescribing in certain hospital settings. Additionally, research has shown pharmacists to be highly trusted by the public (Gallup 2013) and effective in smoking cessation (Maguire, McElnay, & Drummond 2001). Considering their unique positionality with regards to medications, as well as the demonstrated role pharmacists can have in patient health, pharmacists' encounters with prescription drug addiction including how they conceptualize drugs and patients are worth documenting.

Furthermore, prescription drug abuse warrants a deeper analysis of the literature. Epidemiological studies have shown this problem to be unique from the abuse of classically illicit drugs. Prescription drug abuse is increasing at both ends of the age spectrum, particularly among Caucasians, and is spreading to rural areas (Manubay, Muchow, & Sullivan 2011). The abuse of street drugs, in contrast, has generally been described as a problem of urban areas and more prevalent among minorities than has been observed with prescription drug abuse (Swendsen et al 2012). Additionally, prescription drugs of abuse construct a liminal space between the legal, non-abusable pharmaceuticals on the market, such as antibiotics, with a clear therapeutic value, and entirely illicit street drugs, such as marijuana, heroin, or cocaine. The fact that prescription narcotics need to first be acquired with the permission of a doctor and dispensed by a licensed pharmacist calls into question the professional roles of these actors—how are abusers able to acquire controlled prescriptions for illicit purposes? Additionally, prescription drug abuse provides a useful analytic ground in which to examine the role of drugs—therapeutic or otherwise—in creating and recreating both the self, as a body and addict, and the professional role of pharmacists.

In fact, the juncture of pharmacy and drug abuse is in-and-of-itself not a novel analysis—pharmacy and street drugs have shared a relatively long history. Drugs that today are readily categorized as illegal, such as cocaine, were once used to treat illness (Acker 2002:2-9). It was only when these substances began to spread into immigrant and minority populations that the morality of consuming these substances began to be questioned. Quickly, the tide of public opinion began to ebb in the direction of increasing legal penalties for the use and illicit sale of such drugs. Demand for substances now synonymous with the lower classes waned among upper-class, predominately white naturalized citizens and beginning in the early 1900's, drugs such as marijuana, heroin, and cocaine were slowly outlawed. By the time drugs were codified into the Controlled Substances Act of 1970 by President Nixon, regulating the prescribing or prohibition of all drugs, the pharmaceutical market had become firmly enmeshed into American society. Thirty years earlier, in the 1940s, Pfizer developed a large-scale fermentation technique able to produce record quantities of penicillin (Williams 1984:124). A decade later in 1957, the invention of the discreet, female-controlled administration of the birth control pill for contraception set the stage for the women's liberation movement of the 1960s (Gordon 2002). While previous forms of birth control were male-controlled, "the pill" put birth control firmly and nearly completely in the hands of women and harkening a reorientation towards women's decision-making. The ability of pharmaceuticals to not only direct sociocultural change, but generate record profits was clear, most of all to pharmaceutical companies now in a feeding frenzy for the drug of the future. The next revolution of drug development is generally described as the invention of drugs for psychiatric care, namely fluoxetine, or Prozac, by Eli Lilly and Company in 1977 for the

treatment of depression, but it was not formally launched until 1988 (Healy 2006). The range of drugs marketed to treat psychiatric conditions became a fruitful market for the pharmaceutical industry of rather epic proportions, their profits bolstered by increased allowance for direct to consumer marketing for pharmaceuticals in 1969 (Ventola 2011). As the deinstitutionalization movement of the psychiatric population in the 1960's and 1970's occurred, moving large numbers of the indigent population out of hospitals and mental health wards and into the community, these drugs offered a therapy administrable in an out-patient setting (Szasz 2007).

By 1978, Knoll Pharmaceuticals (now Abbott Laboratories) had introduced Vicodin, composed of five milligrams hydrocodone and 500 milligrams of acetaminophen, or ibuprofen (New York Magazine, 2009). While hydrocodone along with opium and morphine is a strictly-regulated Schedule II drug, when mixed with acetaminophen, it can be more loosely regulated as a Schedule III drug (United States Food and Drug Administration, 1970). While the Controlled Substances Act (1970) does not permit Schedule II drugs to be refilled, Schedule III drugs can be refilled up to five times in a six-month period. Then, patients have access to four times the drug without the inconvenience of having to return to their doctor. Thus, for pharmaceutical companies, the looser restrictions on Schedule III drugs equate to more profit. While Vicodin's patent expired in 1983, making the generic version available at a cheaper cost to consumers, a variety of other prescription narcotics were patented and sold (New York Magazine, 2009). In 1995, the FDA approved OxyContin produced by Purdue Pharma as a Schedule II drug (FDA, 1995). The product remains under patent as of this writing and not only a huge contributor of Purdue's profits, but a primary drug of abuse. In 2002, sale of these

drugs had increased 500 percent since 1990 and by 2006, 130 million prescriptions were being written for hydrocodone products (Paulozzi, Budnitz, Xi 2006). In a New York Magazine (2009) spotlight on the history of Vicodin, the Director of Pain Medicine at NYU, Dr. Chris Gharibo describes the “product loyalty—to physician practice patterns that are very Vicodin-based” (2009). Despite concerns regarding the effect of these drugs on the liver, Vicodin, hydrocodone, and OxyContin continue to be prescribed for and dispensed at record rates, driving rates of the illicit use of these drugs ever higher.

As this brief history illustrates, illicit as well as licit drugs, sociocultural change, pharmacy and the pharmaceutical industry have a long and intertwined story. Drug regulation both creates and re-creates social structures—stigmatization of immigrants, minorities, and the indigent—and the pervasiveness of these drugs throughout society fuel a diverse array of changes from women’s liberation to deinstitutionalization. Even today, cocaine, a drug largely associated with upper class white men, although chemically similar to crack, a smoke-able form more favored by African American populations, carries a lighter legal sentence (Sklansky 1994). African Americans, who make up the majority of drug convictions, are more likely both to be arrested and spend longer in jail for drug charges than Caucasian criminals. Such racial divides exist in the prescribing of prescription narcotics, with doctors prescribing narcotics at significantly higher rates to Caucasians than minorities (Pletcher 2008). Despite this, as I witnessed in the conduction of my fieldwork, prescription drug abuse is often colloquially viewed as a minority drug problem, despite epidemiological trends to the contrary. Drugs, regardless of their legal classification, not only constitute an important driving force to sociocultural change to which pharmacists are often actors in, but the production, dispensing, and

consumption of these drugs constitutes an historically-rooted moral act. Thus, a critical analysis of pharmacists, whose work most intimately involves the exchange of scripts and money for drugs, offers a useful, but underutilized, ground for exploring questions of drugs, the pharmaceutical industry, the self, and the impact of these elements on professional roles.

To explore these questions and in the midst of the Daniel Lee and UW Pain & Policy Studies Group dramas, in February 2012, I began a four-month field project on the training and practice of pharmacy in the context of prescription drug abuse. I attended several lectures at a school of pharmacy in the upper Midwest and interviewed several practicing pharmacists—some newly placed out of school in corporate settings, others well established in community pharmacies. Their struggles in combating prescription drug abuse both practically and ethically, as well as the training they receive on the proper dispensing of medications from antibiotics to OxyContin, reveal a group of individuals grappling with a problem that has no easy solution in sight. Their words and actions are a testament to the difficulty of attempting to deal with a long-standing, ingrained problem from a position of low authority and low autonomy. Pharmacists described the multitude of ways they psychologically and practically, always creatively, cope with having little on-the-job decision-making.

My central thesis is: the conflicts that emerge regarding the (il)licit use of prescription drugs allows the professional role of pharmacists and the addicted body to become sites where micropolitics between dialogues of medicine and care compete with a pharmaceutical industry agenda centered on profit-generating work. Straddled between profit and care, pharmacy presents a workable metaphor for the development of medicine

and its increasing reliance on the products of the pharmaceutical industry. In how pharmacists describe addicts, I will show how their words resonate with the way they describe their own work. They describe individuals they suspect as abusing drugs as either a “true patient” in need of the medication-as-therapy, or an addict, as individuals unaware of their dependence. Nevertheless, as paraprofessionals, pharmacists are often forced to dispense to those they believe are addicts with no medical need for prescriptions. The resultant futility and ambivalence they feel towards their work and the products of this labor is ameliorated in part by blaming physicians who they feel misprescribe narcotics in the wrong amounts to the wrong people. Beholden to the idea that drugs are good and only one’s use of a medication can be bad, pharmacists rely on an “assemblage” of technologies, different iterations of patient records, to legitimize their work, attempt to bring awareness of addict’s problems to addicts, and portray their labor as more moral—i.e., the pharmacists’ drugs are good, but the doctor’s patient is bad. The definition of care they produce centered on this dictum reflects a larger theoretical tension surrounding pharmaceuticals: what are the pharmaceuticals that both treat disease and cause disease? The medicalization of addiction, casting it as a disease state, and “pharmaceuticalization”, which perpetuates drugs through society, demand a new definition of therapeutic care and of the work dedicated to delivering this care.

My analysis will begin with a review of the existing literature. As the brief history presented earlier introduced the historical derivation for my inquiry, these historical precedents will be built upon and contextualized through modern epidemiological studies, literature on the sociology of professions, analysis of the pharmaceutical industry—the manufacturing of its products as medicinal and social items—as well as framing my

argument through the lens of Latour's Actor Network Theory (2005). Next, I hope to address how my methods are uniquely situated to answer the questions that I pose. My primary data chapters will present support for the arguments introduced above. First, I will describe the unique tensions pharmacists feel as paraprofessionals equally situated between the worlds of care and profit. I will describe their two ethos centered on these worlds and how they collide when dispensing drug of abuse for profit to addicts whom they believe are harmed, not helped, by prescription narcotics. By conceptualizing addicts as unique from patients, pharmacists construct a new ground upon which to antagonize addicts and attempt to keep the medications from going into their hands. Yet, as rising prescription drug abuse rates attest to, their efforts often fail their objectives. For this, pharmacists place a great deal of blame on prescribers. Such blame serves both to set the boundaries of their profession, centered upon the medications, as distinct from prescriber's realm concerned with patient diagnoses and treatment outcomes. Yet, their reliance on doctors to write scripts that predicate pharmacist's labor creates an overall feeling of ambivalence on the part of pharmacists towards prescribers. Their small acts of defiance, blame, and patient hassling allows pharmacists the liberty granted them by their paraprofessional role; by readily working from such a constrained position, they avoid shouldering the blame for the problem their labor creates. Thus, their ambivalence legitimates their position as dependent upon, but unique from, prescribers. To further combat the futility of dispensing to those they suspect have no "legitimate" demand for the medication, pharmacists produce a collection of patient records, the only tangible product of their suspicions. These records are available to other locations within a corporate chain, or possibly to doctors, police officers, and others through Prescription

Drug Monitoring Programs (PDMPs). These records compose an assemblage, meant to bring awareness of the drugs' effects to addicts. A specific definition of care emerges. While decidedly centered on pharmaceuticals, pharmacists continually grapple with the juxtaposition of their training, which proffers pharmaceuticals as panaceas to any array of ills, with the reality that some of these pharmaceuticals produce an ill themselves, that is prescription drug abuse.

Ultimately, this tension is not unique to pharmacy, but representative of all domains of medicine. In a medicalized society that creates diagnoses for an increasing number of human states in an era of pharmaceuticalization that produces a never-ending stream of medicines to treat these ills, the bodies constructed through these processes of care, as well as the nature of care itself is radically transformed. Any answer to the prescription drug abuse epidemic will have to address these fundamental questions. Meanwhile, the hegemony of the pharmaceutical industry renders the medical community conceptually ill equipped, operating from a similarly constrained and futile position, to attempt to hedge the burgeoning abuse epidemic.

Chapter II: Literature Review

The supremacy with which physicians are afforded within the context of the medical field is intuitively known, so as to be nearly an a priori assumption. Researchers have adopted this stance as well, elucidating several nuances to doctor-patient and doctor-pharmacist interactions into a long history on the subject of doctors' role in delivering healthcare. The fact that physicians have a higher degree of professional autonomy in their jobs relative to other healthcare professionals, such as pharmacists, warrants this line of inquiry. Within the prescription drug abuse literature in anthropology, which is scant, doctor's authority and autonomy on the job provide the most obvious research interest, as they are the first gatekeeper (for lack of a better word) abusers encounter in gaining possession of prescriptions to abuse. Most research on prescription drug abuse seems predicated on the notion that altering doctors' decision making offers the best site of intervention to eradicate or at least slow down or understand the increasing rates of prescription drug abuse.

However, as I will argue herein, pharmacists who experience work characterized by multiple professional constraints offer another profitable site of inquiry. Not only are pharmacists the only healthcare professionals who handle the medications people abuse, but pharmacists also exist on the interstice between profit generating business and the realm of healthcare concerned with patient care. I proffer the reorientation of drug abuse and addiction literature to accommodate what I identify as the unique set of circumstances surrounding the acquisition of prescriptions for illicit use (in contrast to classically illicit drugs of abuse), the role of cultural notions of drugs, the body, and

cognitive experience, as well as the professional role of pharmacists can lead to an understanding of drugs, society, and professionalization in general.

Epidemiology. Prescription drug abuse is defined as the use of drugs targeting the central nervous system taken for nonmedical purposes. While rates of prescription drug innovation measured by spending and the emergence of new medications has declined since 2007 (Aitken, Berndt, & Cutler, 2009), rates of prescription drug abuse escalated during this time (NIDA, 2011) meaning increasing rates of prescription drug abuse are not driven by an increase in the number of abusable drugs available. 7 million adolescents reported abusing pharmaceuticals and 5.1 million of these cases involved painkillers. In fact, the use of prescription drugs such as Vicodin and Adderall are eclipsed only by marijuana. According to NIDA (2011), the rate of increase for prescription pill abuse (94 percent) between 1992-2003 exceeded the rate of increase for any other drug. Meanwhile, between 1991-2010, prescriptions for stimulants increased 9-fold (5 million to 45 million) and prescriptions for opioid analgesics increased 6-fold (30 million to 180 million). Specifically, pain relievers such as Vicodin and OxyContin constitute the pills of choice for most abusers. The use of oxycodone HCl with at least one other opioid was reported by 92 percent of users. Abuse is increasing at both ends of the age spectrum—young adults and those aged 65 or older report increasing use of non-medical prescription use between 2002-2007 (Pletcher 2008). Such users are 8 times more likely to concurrently abuse tranquilizers and 5 times more likely to concurrently abuse prescription opiates (Aitken, Berndt, & Culter, 2009). In contrast, rates of polydrug abuse in abusers of classically illicit drugs are comparatively lower, particularly when marijuana and alcohol are not considered, as these drugs have universally high rates of

abuse across most demographics. Additionally, classically illicit drug abuse is overwhelmingly limited to adolescents and young adults (Compton et al, 2005). Thus, the epidemiology of prescription drug abuse differs significantly from the abuse of classically illicit drugs.

Furthermore, prescription drug abuse is unique from other forms of drug abuse in that Caucasians use at a higher rate than Hispanics or African Americans across all classifications of prescription drugs—stimulants, anxiolytics, and opioid analgesics (Ford & Rivera, 2008; Gunter et al., 2012; Kroutil et al., 2006; McCabe, 2005; McCabe et al., 2006; Simoni-Wastila & Strickler, 2004; Sung et al., 2005). Additionally, conflicting reports exist as to whether education is a protective factor in prescription drug abuse as with use of other drugs (Gunter et al., 2012; Harrell & Broman, 2009; Huang et al., 2006; Merline et al., 2004).

Nonmedical use of prescription drugs also differs from abuse of classically illicit drugs in that individuals are often introduced to prescription drugs through legal channels as a result of organic maladies. When an individual develops tolerance and withdrawal, the hallmarks of addiction, as the result of the legal use of a medication to treat a medically diagnosed illness, what is termed “iatrogenic addiction” (Musto 1984). While it is not currently known how many individuals currently abusing prescription medications began in iatrogenic addiction, the number is potentially as high as the abuse rate of opioids, the most abused class of prescription drugs. Opioids also constitute one of the most prescribed classes of drugs on the market. Studies cataloguing the prescribing rates of opioids have found physicians are more likely to prescribe opioid analgesics to Caucasians. Additionally, the rate opioid analgesics are prescribed has increased with

rates of abuse of these drugs (Pletcher et al., 2008). While this association does not necessarily indicate causality, the correlating trends that suggest iatrogenic addiction are intriguing. These data add another dimension to prescription drug abuse not seen in other forms of abuse—that is, the potential that addicts previously, currently, or at some point in the future may have a medical need for medications with an abuse potential. The fact that drugs such as Adderall, Vicodin, or Valium shift between legality and illegality complicate the study of prescription drug abuse.

Different demographics in prescription drug abuse compared to classically illicit drugs and the different pharmacology of prescription drugs leads to new problems in combating the problem. Approximately 60 percent of those taking prescription drugs for non-medical purposes obtained the medications from a friend or family member (Aitken, Berndt, & Cutler, 2009). According to NIDA (2010), those friends or relatives largely report receiving the prescriptions for these medicines from only one doctor (81.7 percent). Acquisition from street dealers (4.3 percent) or the internet (0.4 percent) constitutes a small fraction of the pills abusers take. The issues arising from this fact are twofold. On one hand, current literature predominately discusses preventing prescription drug abuse through education to providers about the “warning signs” of addicts. However, this statistic indicates that prescribers are often not coming into contact with the abusers themselves. A knowledge gap exists in how information into how prescription drug abusers acquire drugs and conceptualize their use could inform prevention aimed at prescribers or pharmacists. Secondly, this statistic indicates that the acquisition of prescription drugs occurs through channels unmediated by formal control. Whether friends or family members knowingly provide drugs to abusers or if abusers steal the

medications without the knowledge and consent of those the medications are prescribed to is not known. Additionally, unlike illicit drugs acquired through drug dealers who are likely more or less strangers, exchanges of prescription drugs are occurring through established personal relationships. The different ways prescription drugs are acquired and motivations for the use of these drugs relative to classically illicit drugs in light of increasing rates in both older and younger Americans demands new ways of conceptualizing prescription drug abuse.

Thus, prescription drug abuse differs epidemiologically from the abuse of street drugs namely in the emergence of abuse of such drugs amongst Caucasians, across the age spectrum, and through legal and legitimate prescribing of drugs of abuse otherwise known as iatrogenic addiction. Opioid abuse constitutes the classification of drugs largely considered of most concern due to users switching to heroin when access to prescription opiates wanes (Wisconsin Department of Justice 2013). Heroin abuse, although similar in chemistry and effects to prescribed opiates, introduces concomitant risk of HIV/AIDS or hepatitis C transmission through the use of hypodermic needles along with increased risk of death from overdose as street heroin can vary greatly in potency.

Prescription Drug Monitoring Programs (PDMPs). These data have contributed to a swell of public attention both inside and outside the academic sphere towards prescription drug abuse. Research is only beginning to expand beyond description epidemiological work, including evaluations of prescription drug monitoring programs (PDMPs). Sometimes simply referred to as Prescription Monitoring Programs (PMPs), such programs track medications dispensed to patients across the state. Federal justice programs and the U.S. Department of Justice offer grants for states to implement PDMPs

in their states. Currently, 37 states have implemented a statewide monitoring program, and 11 states along with the U.S. territory of Guam have enacted legislation to establish PDMPs, but are not fully operational as of October 2011 according to the The Alliance of States with Prescription Monitoring Programs (ctd. in USDOJ 2011), which advises and informally oversees the implementation of such programs. A total of 48 states have operational or nearly operational PDMPs. Wisconsin, where the present study was conducted, during the duration of data collection did not have a functioning PDMP, but was one of the 11 states with legislation in place to support the formation of one.

Despite the success the organization has had in proliferating PDMPs across states, their implementation has received significant criticism. A recent article in the Journal of the American Medical Association asks, “Can Prescription Drug Monitoring Programs Help Limit Opioid Abuse?” Authors Gugelmann and Perrone note the lack of uniformity in the implementation and design of PDMPs as a major obstacle to their effectiveness in curbing opiate abuse trends. Some programs are available to clinicians, while others are limited to law enforcement. Some states enable real-time updates after a prescription is dispensed, while other programs update only periodically. Additionally, limited communication between states’ PDMPs do not protect against patients who may cross state boundaries to acquire prescriptions, which is of particular importance to Northeastern states and areas or cities located close to state borders such as Milwaukee and Northeastern Wisconsin.

Professionalization of Pharmacy. The field of pharmacy offers a productive site for generating new conceptualizations of prescription drugs. Research to date has predominately been focused on prescribers likely because physicians have greater

authority and professional autonomy in writing prescriptions relative to other medical professionals. However, research investigating the role of pharmacists in smoking cessation has long proven these paraprofessionals can be effective producers of change in the public's consumption patterns of addictive substances (Zillich, et al. 2012). In addition, pharmacists expansive training in pharmaceuticals both in the academic and praxis spheres makes them important conduits for the cultural significance and roles of such medications. Given the unique epidemiology of prescription drug abuse, knowledge of the deeper significance of pharmaceuticals in society may bear on the nature of this problem and perhaps few professionals are involved so wholly in the medications dispensed to the public than pharmacists. Thus, the notion that a study of pharmacy to uncover the significance of drugs and addiction in society is rooted in prior research and while it reasons pharmacists may be capable to positively impact the quickly increasing trends of pharmaceutical abuse, no studies to date have analyzed how pharmacists' operate under new constraints imposed by prescription drug abuse.

Pharmacists have become increasingly important, as the repertoire of drugs on the market has expanded exponentially over the course of the modern age. Accordingly, pharmacists have been subject to an expansion in training from a four-year degree to a six-year PharmD degree (American Association of Colleges of Pharmacy 2013). Despite these new requirements, the number of accredited pharmacy schools swelled from 72 in 1987 to 128 in 2012 (Brown 2013). While new practice settings emerge for pharmacists working alongside doctors to develop pharmacotherapeutic treatment regimens, research showing pharmacists' effectiveness in smoking cessation is encouraging for the professionalization of an oft-forgotten discipline (Zillich, et al. 2012). Furthermore,

according to Gallup polls dating back to 1981, pharmacists are consistently ranked the most or second most trusted professional and their rates of trustworthiness have steadily increased since the poll's inception; the percent of the public saying their trust in pharmacists is "high/very high" currently sits at 75 percent, second only to nurses with 85 percent and a healthy 5 percent above medical doctors (Gallup, 2012). Altogether, these data paint a promising picture for the capacity of pharmacists to positively impact healthcare.

The lack of attention paid to pharmacists in the literature is not surprising given their lower status as paraprofessionals relative to physicians. Eliot Freidson is perhaps the most well known chronicler of the sociology of health professions. In his seminal work, *Profession of Medicine* (1974), Freidson lays out the characteristics imputed to professionals including, "a formal standard curriculum of training, hopefully at a university. They create or find abstract theory to teach recruits. They write codes of ethics. They are prone to seek support for licensing or registration so as to be able to exercise some control over who is allowed to do their work" (76). While paraprofessionals, including pharmacists, may obtain all the trappings of full professionalization, as Freidson notes the defining factor of professionals is autonomy. Freidson states, "while it is legitimate for [paraprofessionals] to take orders from and be evaluated by physicians, it is not legitimate for them to give orders and to evaluate physicians. Without such reciprocity we can hardly consider them the equals of physicians" (76). It is, however, difficult to imagine individuals, particularly trained in a field, complicit in or entirely limited by this subordination. My research further illumines the ways in which pharmacists as paraprofessionals find agency in their role marked by low professional

autonomy. Specifically, I hope to further build on Freidson's exploration of the boundaries and qualities of paraprofessionals vis-à-vis prescription drug abuse.

Addiction and abuse: Connotations and history. The term "addict" emerged in the sixteenth century from the Latin words *addictus*, as the past participle of *addicere* (*dicere*= to say; to adjudge or allot; assigned by decree; Oxford English Dictionary 2013). Although now long defunct, this interpretation of the word survives in the colloquial way in which the word "addict" is moralizing and often socially prescribed. Awareness of the pejorative use of the term led professional organizations such as the American Psychiatric Association who composes the Diagnostic and Statistical Manual currently in its fifth iteration, to use the diagnostic term "substance dependence" (2013). Nonetheless, the phrase "substance dependence" preserves certain connotations of the word "addiction" in how denial is frequently utilized to describe this state, i.e., substance abuse and addiction are rarely self-assigned descriptors, rather they are assigned by friends, family or the public at large and an individual's protestations and failure to absorb the term are recast as denial.

Today, substance dependence in its many iterations is characterized as a disease state. However, this notion dates back to 1878 with the invention of the hypodermic needle making a form of opium and precursor to heroin prevalent at the time an injectable and potent medicinal (Parssinen & Kerner 1980). Concerns about new trends in the behavior of those prescribed the treatment culminated in a full disease model of addiction in 1910. The fact that increasingly the drug was spreading out of the formal, mainstream, medical sector and becoming comingled with other illegal and immoral behavior of the

time, the fringes of society, as well as to minorities and immigrants hastened a new era of drug policy and regulation (Acker 2002:2-9).

As suggested already, medicinals and illicit drugs have long shared a fluid and constantly shifting boundary. Heroin, cocaine, and amphetamines were once used to treat an array of health complaints, but are now strictly relegated to the black market. As the pharmaceutical industry gained traction in the world market and the emergence of new drugs quickened continually since the 1950's, it is hardly surprising the number of legally prescribed medications with an abuse potential continued to rise. The rate of prescription drug abuse first was reported on by the popular Monitoring the Future prevalence study administered by the NIDA in 2002. Since then, reported rates of Vicodin abuse have steadily increased from 2.5 percent to nearly 3 percent (2012). Although not initially impressive, declining rates of other illicit drugs suggest prescription drug abuse is increasing, while steadying national averages of all illicit drug use. Increasingly, individuals with problematic use of Vicodin or OxyContin are being introduced to a new line of pharmacotherapeutic treatments in the form of buprenorphine, naloxone, Suboxone (which combines the two), or Vivitrol. Such treatments have slightly different mechanisms of action but are promoted for their ability to supposedly decrease craving and/or inhibit the effect of opiates on the central nervous system. Criticisms abound regarding the safety of such medications and the irony of treating prescription drug abuse with prescription drugs of questionable safety and efficacy is not lost on a variety of researchers and practitioners (Bazazi 2011, Gwin Mitchell et al. 2009, Meyers, 2013).

Addiction-as-disease is understood by two main processes: tolerance and withdrawal (American Psychiatric Association 2013). Tolerance refers to an individual

needing more of the drug to achieve the same effect; while, withdrawal is the presence of adverse symptoms at the discontinuation of the drug. A proliferation of articles of the biomedical perspective explore the neurochemical and neurological mechanisms of these processes, but also serve to legitimize the diagnosis and the professionals that dispense these labels and the medications that both cause and presumptively treat this affliction. What is not captured in this simple yet complex, modern yet archaic concept of addiction is how such shifting definitions of what is and is not addicting impact the professional lives of those entrusted with the health and care of the public, particularly as the divide between legal and illicit drugs vis-à-vis prescription drug abuse ever blurs these boundaries.

Medicalization and pharmaceuticalization. Medicalization is widely researched phenomenon describing the process whereby human conditions become treated as medical conditions. Within the context of the history of addiction, medicalization is most obvious in the shift from addiction as a personal moral failing and the emergence of the disease model of addiction. The move has fueled a variety of medically-oriented treatment regimens, both psychotherapeutic as well as medicinal. Twelve-step programs, for instance, heavily rely on the notion of addiction as a disease. In the group reading entitled “Why Are We Here?” read at the beginning of each NA meeting, the organization explicitly states their stance on the status of addiction as a disease. “After coming to NA, we realized we were sick people. We suffered from a disease from which there is no known cure” (1986). Those intimately involved with addiction recovery adhere strictly to this thinking as it removes much of the blame inherent in the idea medicalization replaced—addiction as willfull deviancy resulting from deep, personal

failings. Although stigma predicated on this thinking continues in the collective consciousness as supported by decades of the “War on Drugs” and increasing minimum sentences for drug crimes, medicalization has nevertheless been a powerful counterforce.

While detractors of medicalization note its overuse (Kleinman in Bell & Figert, 2012), the concept of pharmaceuticalization, a related but distinct term, have emerged to describe the treatment of an aspect of the human condition by pharmacological agents (Bell and Figert 2012:776). The paradigm is useful in analyzing both the proliferation of treatments such as Suboxone to treat addiction to Vicodin or other prescription opiates, as well as the growth of the illicit market for prescription opiates for abuse. Complimentary to pharmaceuticalization from the perspective of consumers, is its effect on the move of pharmaceuticals from the prescriber to the pharmacy and into the increasingly eager hands of the public. Additionally, how the phenomenon actively shapes the definition of addiction within formal, professional spheres and influences decision-making among the only professionals to physically handle pharmaceuticals is a gap in the literature the current study hopes to address, at least in part.

Theoretical framework. Since legal actions, such as those taken against GlaxoSmithKline in New York by then Attorney General Eliot Spitzer in the spring of 2004 (*People of the State of New York v. GlaxoSmithKline* 2001), and the Vioxx controversy wherein Merck voluntarily withdrew the osteoarthritis drug from the market after evidence showed it significantly increased heart disease and stroke, increased public and academic attention has been paid to medical ethics as they pertain to the pharmaceutical industry. Several authors and researchers have uncovered the abuses of the medical industry by pharmaceutical companies.

One such work by Howard Brody (2007), professor and director at the Institute for the Medical Humanities at the University of Texas Medical Branch at Galveston, describes how medicine is “hooked” on the pharmaceutical industry in two ways. He says, “in one sense, medicine’s relation to the pharmaceutical industry, and the gifts and rewards that it dispenses, has been likened to an addiction. Addiction has been called the “disease of denial,” and we will see that denial characterizes many aspects of medicine’s assessment of this relationship” (5). Brody’s book gives a thorough analysis of medicine’s betrayal of public trust for the money and funding provided by pharmaceutical companies. Brody’s work focuses on what he calls the “industry-profession interface,” or the relation of the pharmaceutical industry to the physicians who often receive funds to garner research aligned with the pharmaceutical industry’s goals and prescribe these medications and the Food and Drug Administration (FDA) who is charged with regulating prescriptions. However, Brody explicitly shies away from speaking to the industry’s relation to society at large, or drawing specific parallels between the way addiction is characterized on an individual level to the medical system’s relation to drugs: namely, what logic predicates the role of such denial in addiction? The emergence of prescription medications away from therapeutic agents and towards drugs of addiction makes this question of particular import to studies of addiction, as well as the medical industry. Lastly, Brody’s work and other work critical of the pharmaceutical industry’s role in medicine makes it possible to ask: what parallels may exist between individual-level addiction and the flow of medications out of the pharmacy and into the public’s hands in a lived, real-world context?

From an economic perspective, Kalman Applbaum (2010) explores the perception of the side effects of Zyprexa in the drug's expansion to the Japanese market. He describes the "shadow science" used to downplay and recast the harmful side effects of the drug and manipulate prescriber's interpretation of these effects to facilitate such expansion. Applbaum makes clear how pharmaceutical marketing influences prescribers; however, an interesting question that arises from his work is: how expansive is this influence? Is it possible those that rarely come in direct contact with pharmaceutical company marketing and have limited decision-making power have similarly been subsumed by the "shadow culture" that insists on casting pharmaceuticals as universal forces of health? Michael Oldani (2004) similarly analyzes the implications of the pharmaceutical market from a global-economic perspective, but combines his analysis with a personal-psychological interpretation. He notes, "pharmaceutical companies are quick to promote to doctors (and to the general public) that the patient's best interest is always being served with the introduction of new medications" (338). Again, pharmaceuticals are pushed as unqualified agents of health, in this case, explicitly to prescribers and the public at large. While ostensibly extolling the value of pharmaceuticals with the patient's health in mind, the discourse of pharmaceutical marketing both on an international and interpersonal scale actually serves to further an inherent logic to meet the industry's (versus the patient's) needs. As Applbaum notes on the global distribution of pharmaceuticals, the reason for which he gives as "because their output is held to be the fruit of medical and pharmaceutical science, which operate on universal principles and whose importance is acknowledged everywhere. The global distribution of medicines carries the legitimating force both of science and ethics, insofar

as the speedy delivery of drugs to the sick is an unquestioned good. Good medicines should ‘sell themselves’ insofar as their utility need not be argued” (236). The same logic predicates the distribution of medicines in an interpersonal relationship, as between a doctor and patient, or pharmacist and patient, as the sphere of the global and local contexts of pharmaceuticals are difficult and possibly lack utility in being disentangled.

At another end of the chain from pharmaceuticals to consumption, Paul Brodwin (2010) analyzes front-line clinicians in community psychiatry who must actively negotiate compliance to pharmaceuticals with patients at the edges of society. Brodwin describes the “assemblage of compliance” composed of the competing interests of case managers and patients as mediated through an array of physical artifacts of great theoretical and practical import, including the container that separates patients daily medication allotments (termed a “med cassette”), paperwork, medical supplies, and treatment order. Compliance is then cast as micropolitics between the constrained position of both the caseworker bound by policy and law, and patients bound by their own low social status and as recipients of care. Taken together, Brodwin, Applbaum, and Oldani share a common theoretical root in Bruno Latour’s Actor-Network Theory (2005). Be it data on the side effects of a pharmaceutical product, a “gift exchange” that facilitates a multi-billion dollar global economy through personal exchanges, or a “med cassette” exchanged between a case worker and patient, the threads connecting and interweaving all the components of how medications are produced, sold, exchanged, and consumed often between two highly constrained positionalities actively construct a dialogue regarding the role of drugs in society.

To this dialogue, I hope to add a voice often so lost in the milieu it frequently goes unnoticed and arguably taken for granted—the participatory role of those that dispense a pill at the injunction of a doctor’s prescription pad. Pharmacists constitute a key role in the exchange of pharmaceuticals from their production and sale as part of a corporate structure, mediated through company representatives to prescribers, from those that have the authority to grant permission for patients to access these products, to the actual consumption of such medication by patients. Pharmacists also represent one of the most accessible components in the system. Frequently located outside clinics or hospitals, in hubs of business and economic activity within the community itself through employment in corporate pharmacies, pharmacists take no appointments and sometimes work third shifts in 24-hour pharmacies while other medical establishments are closed. While pharmacists swell in numbers (a 60 percent increase since 2000 according to Brown, 2013), are generally are not targeted by pharmaceutical company reps, and have little autonomous decision-making power, it is curious to ask: have pharmacists absorbed the dialogue that characterizes the wider exchange of pharmaceuticals? What would this dialogue and these negotiations and micropolitics as lived in a real-world, daily practice look like? These questions grow ever more pertinent as prescription drug abuse rates continue to soar, continuing to blur the line between licit and illicit and call into question the use and role of certain classes of abusable pharmaceuticals. Furthermore, prescription drug abuse becomes a site in which the patient-care centered dialogue of medicalization, which ultimately seeks to provide care for whatever comes to be defined as an ill, collides with the pervasiveness of pharmaceuticalization, a trend characterized by the profit-

generating work of multinational corporations whose products increasingly define medical care across the globe.

Conclusion. Prescription drug abuse constitutes a problem of growing concern for medical professionals and communities. The abuse of pharmaceuticals for non-medical purposes shares similarities with, but sharply diverges from the abuse of classically illicit drugs. While measures such as prescription drug monitoring programs (PDMPs) seek to more clearly define the boundary between licit and illicit use, a history of social theory predicates inquiry into the role of similar technologies, including the medicines themselves, as Latourian artifacts. Historical precedents establish “addiction” and its descendent term “substance dependence” as social designations and constructions as much as diagnoses. Pharmacists represent a under-researched but potentially fruitful site of inquiry into how a descriptor such as “addict” become encapsulated in a medicalized and pharmaceuticalized discourse, how these terms are absorbed by the fringes of medical society, as well as the iterative process by which these new but familiar micropolitics shape the paraprofessional role of pharmacists.

The way in which those medical professionals that deal most directly with the medications themselves in the script-for-pills exchange absorb the logic of pharmaceutical marketing has great import for the evolution of pharmacy as a profession, the prescription drug abuse epidemic, and wider sociological thought on the role of drugs in society. The logic underpinning the work of pharmaceutical corporations, prescribers, caregivers, and the healthcare system is becoming increasingly entangled as care becomes directly synonymous with medication. The consequences of these developments

and thinking, while buttressed by existing literature, are currently unanswered, yet constitute a useful and extremely pertinent investigation.

Chapter III: Methods

Anthropology is a science unique from other disciplines in that meaning is interpreted from human experience and the *a priori* assumption that an absolute truth exists is abandoned in favor of personal, relative truths. Clifford Geertz' famous quote proves quite apropos decades after its composition that "man is an animal suspended in webs of significance he himself has spun, I take culture to be those webs, and the analysis of it to be therefore not an experimental science in search of law but an interpretive one in search of meaning" (1973: 5). As an undergraduate student in anthropology and psychology, I did not fully appreciate the wisdom and perspective of this quote until I undertook my first truly anthropological research assignment my first semester in graduate school. While immersing myself through participant observation of Narcotics Anonymous groups and interviews with recovering addicts, I was able to fully embrace the utility of an interpretive approach to meaning. While biomedicine strictly adheres to the idea of addiction as a biological disease, I discovered those who struggled with addiction found strength and power in their personal psychological victories in overcoming substance abuse. While literature on addiction readily casts addicts as victims of a drug's power over their thinking and behaviour, in fact, the recovering addicts I came to know as a result of the project relayed their agency in both their drug use and recovery.

I remember quite clearly meeting with one interviewee and my experience cemented these personal views. I had known this individual for a few months and was grateful he had agreed to meet with me. We met to conduct the interview and before I could formally begin, he said he had some questions for me. He wanted to know my

opinions on addiction and Narcotics Anonymous as a recovery program. I explained to him I was not concerned with deciding whether NA was effective, but, accepting its efficacy, why it was effective from the perspective of those who had found success in the program. He was further comforted by my admission that while I was “the researcher”, I privileged his knowledge and experience with addiction and recovery over the professional literature; I was hoping he could educate me about his experience, not match the legitimacy of his words to the objective truths extant in the literature. He was candid in his interview and his candor throughout gleaned some of the most useful data for the project. I came to understand that allowing the voice of those with native knowledge of addiction to be heard in the “Ivory Tower” of professional literature was both an ethical and methodological imperative.

Anthropology is unique from other disciplines in yet another way. The positionality of the researcher as both a producer and reproducer of data comprises a central way anthropology recognizes and embraces bias, instead of attempting to reduce it in the pursuit of objective truth as is the case with positivistic science. Renato Rosaldo’s admission that his understanding of headhunting among the Ilongot was limited before the grief brought on by his own wife’s death allowed him to connect with the practice more deeply is a widely familiar example of this practice (1980). Similarly, my positionality growing up with prescription drug abuse has informed my research and perspectives and my story has intimately directed the undertaking of my research. One of the most poignant memories of my childhood was finding my father’s cache of prescription bottles and baggies of white powder under his bed. I was confused at the time why several of them were not in his name, but the memory stuck with me and as I

witnessed friends begin using drugs, I came to understand why my father would fall asleep at odd times of day juxtaposed with extreme bouts of energy. I became estranged from my father early in my adolescence as he slowly slipped out of my life. In first undertaking this research, I felt a profound connection with a side of his life that always remained remote from me.

After completing my fieldwork and in the midst of writing my research, I was informed of my father's death from a heart attack. Like Rosaldo, my struggles with experiencing the grief of my father's loss made my subject alternatively cathartic and emotionally raw and deepened my experience with the subject of prescription drug abuse and addiction. Although I spoke with and observed pharmacists, I was grateful for their constant sensitivity to patients who struggled with abuse. They did not see their labor as separate or even parallel from the experience of addicts themselves and it was important for me personally and for the integrity of my analysis to translate this same holistic perspective to my labor. While researching drug abuse history and modern trends, I undertook the personal project of researching my father's life and the years of life I had not been privy to. I was able to learn he kept the history of his use a secret from his family. I have similarly struggled with how to express being the daughter of a drug abuser—the fear of the halo of his drug abuse encompassing me and others' perception of me, my similar unwillingness to be seen in the light of the substances whose power and voice seem to echo louder than the people who use them. Thus, the stigmatization of drug abuse and the power of substances through their social construction to connect and tear apart familial and professional structures was not an experience-far topic, but rather a

process I was actively swept up in along with the pharmacists whose lifework had been similarly altered in response to prescription drug abuse.

I suspect for these reasons, my analysis differs from other research on the topic. The aspects of the problem my personal encounters illumined and alternatively, the nuances my biases left me blind to color my perspective in ways I anticipate and in other ways I cannot. Far from a limitation, I prefer to view this analysis and the problem of prescription drug abuse itself as a human construction, as living and evolving as those that shape the nature of this problem everyday. My primary aim as both a person affected by and researcher of addiction is to allow the evolution of this problem, the policies and countermeasures adopted, to be directed by the real-world lived experiences of all the actors involved through the research I view as most ethical and most sound. Thus, contributing the experience of pharmacists with regards to this problem became an essential undertaking. As can be expected, the ways I describe my personal experience as intertwining with my research subject is far from complete.

My four-month excursion in the field began in early 2012. Preliminary research into the literature on prescription drug abuse produced limited gains, as the body of literature then much as now is largely relegated to epidemiological description. My search for literature analyzing the profession of pharmacy produced an equally narrow range of literature. Thus, I decided to begin my experience the same way pharmacists do, in a pharmacy education program. I attended lectures and labs at a pharmacy school in the upper Midwest for approximately three months. I was immediately shocked by the difficulty in engaging a bureaucracy for fieldwork in comparison to an organization such as Narcotics Anonymous. Unfamiliar with the methods of anthropological research,

department heads were immediately suspicious of my presence. Despite my entreaties that my intentions were legitimate and going through the proper channels of Institutional Review Board Approvals for both my institution and theirs, they quickly limited my access. My initial entrée into the institution via a faculty member proved a constraint, as my observation took place in a different department. I became aware a professional competition existed between the faculty member I initially made contact with and the department chair in whose department I ended up conducting research. In no uncertain terms, the constraints of my fieldwork were tightened. I was strictly disallowed from communicating at all with students, but was allowed to attend lectures, audio record them, and attend labs under the supervision of another faculty member.

While I had originally intended to conduct interviews with students, this option was quickly tabled and I sought interviews with current practicing pharmacists. Through mutual friends, I connected with a number of pharmacists ranging in level of experience, setting, and background, including pharmacy students of a third institution. The experiences they shared constitute the majority of the data presented herein. Some pharmacists early in their career took special care in their presentation. One made it a point to tell me he wore a suit that day to work in order to look more professional for our interview. I noticed the older and more experienced pharmacists had no such pretences. They chose to meet in more informal settings, showed up in jeans and t-shirts, relaxed in their seats and were candid and quite frank about the limitations they operated within on the job and their frustration in dealing with patients and doctors. Regardless of the level of experience or setting a particular pharmacist practiced in, certain themes and contradictions regarding patients and prescribers emerged early and are presented herein.

Chapter IV: Pharmacists and the addicted body

Prescription drug abuse receives increasing attention from researchers, policymakers, as well as mass media. Entangled in these multiple discourses are larger beliefs about drugs, the medical system, and the body. While the role of doctors in patient's acquisition of controlled, abuse-able drugs is more frequently profiled, scant attention has been paid to the professional roles of pharmacists and how their conceptualization of drugs, the medical system, and the body can enlighten the debate concerning prescription drug abuse.

Pharmacists can be classified as paraprofessionals (Freidson 1974:71-84). Their work does not entitle them to an equitable amount of agency and autonomy as that which characterizes the work of more prestigious medical professionals. The expansion of available drugs on the market has coincided with an expansion on the degree requirements of pharmacists. Where a four-year degree once was sufficient to run a pharmacy, these jobs are relegated to holders of a six-year Doctorate of Pharmacy degree (PharmD). Pharmacists may elect to pursue an additional two-year residency requirement that enables them to practice in hospitals and other settings where they are involved in direct patient care (American Association of Colleges of Pharmacy 2013). Yet, the vast majority of pharmacists will be employed by corporate pharmacies where patient interaction is brief and they frequently describe succumbing to pressure from corporate superiors to increase profits. Thus, pharmacists' work is segmented into two discrete roles. On one hand, they share the care-oriented goals of other medical professionals aimed at patient care. On the other hand, however, pharmacists also experience a product-oriented ethos akin to business.

Traditionally, pharmacists dispense medications such as antibiotics that treat biomedical conditions. In dispensing these types of drugs, their business ethos are in harmony with the medical ethos of patient care. Dispensing the drug (profit) will improve the patient's health (care). However, the growth of pharmaceutical companies has introduced new classes of medications to treat a variety of newly defined illnesses. Among these new pharmaceuticals are a *mélange* of medications with abuse potential. According NIDA (2011), chief among these abusable medications are Vicodin, Oxycodone, and stimulants used in the treatment of ADD/ADHD such as Ritalin and Adderall. With the growing attention prescription drug abuse has received in recent years, pharmacists are acutely aware when dispensing these drugs of the possibility they are dispensing an illegitimate script. An illegitimate script¹ may include a fraudulently altered script, a script for medication the patient intends to use for the purpose of “getting high” or divert through selling the medication to addicts for the purpose of “getting high”. When the possibility for abuse exists, the situation brings into conflict several aspects of pharmacists' work and the ethos that direct such labor.

This chapter will focus on first describing the nuances of pharmacists' professional ethos and self-described professional roles and how pharmaceutical abuse brings several aspects of their work into conflict. While their business ethos stress dispensing a product in order to increase profits, pharmacists' care ethos dictate dispensing an addictive agent to an addict is not regarding the patient's well-being and health. Additionally pharmacists describe their role on one hand as “drug experts”

¹ For clarity, I will use the term *script* to refer to the physical paper patients receive from their doctor and bring to the pharmacy with indications for how the drug should be filled. I will only use the term *prescription* as synonymous with medication to refer to the bottle or pills patients consume.

conducive to a business ethos. Yet, they also describe their professional role as being patient advocates. The latter reflects their care ethos. Pharmaceutical abuse similarly brings into conflict these two professional roles. I will argue pharmacists partially ameliorate these role and ethical tensions by employing a particular understanding of drugs and addiction. This conceptualization sees drugs as agents of fragmentation where the addicted person is split into the addict on one hand, and the ‘true patient’ on the other. The process of addiction is seen in this conceptualization as enshrouding the ‘true patient’ beneath the cloak of addiction and enables pharmacists to navigate the uneven terrain of being paraprofessionals straddling business and medicine, profit and care.

Business versus care ethos. A pharmacist working in a corporate pharmacy in a small community somewhat notorious amongst medical professionals in the region for prescription drug abuse discussed with me the “business side” of pharmacy. “[Pharmacies] will be more successful the more scripts they sell, so pharmacies are trying to encourage more script volume...that means more revenue, better business.” Another pharmacist described how he has “to be more efficient. It used to be you could be profitable doing with one pharmacist and a tech, you’d only need to do about fifty scripts a day. Now, you need to do about 200 scripts a day in order to be profitable.” He went on to more specifically detail how his previous corporate pharmacy stopped filling for certain medications because “we are getting negative margins meaning we are losing money on certain scripts that we used to make money on...” Pharmacists experience the demand for increased script volume most acutely in their workflow. Pharmacists come under increasing pressure to work faster without sacrificing accuracy. However, “accuracy” is frequently couched in economic terms. “At one point, the average mark-up

on a script was about two percent meaning after we pay our people, after way pay the rent, all your overhead, it's two cents on the dollar. So, you make a mistake on a \$100 medication or a \$1,000 medication, you are taking a pretty big loss." Thus, the cost of poor accuracy and efficiency is lost revenue. Losing revenue is antithetical to the definition of "good business" proffered by pharmacists. One pharmacist described the workflow in retail as unstructured, "all of a sudden rush hour comes along and it's just book, book, book, you go as quick as you can and be as efficient as you can." Where the business of pharmacy dictates increased script volume, pharmacists experience unstructured workflow where their accuracy and job performance is judged by the effect on revenue. Pharmacists' "business ethos" is centered on the profit-generating aspect of their work and position the individual as a customer, not a patient.

Business ethos: Pharmacists as drug experts. I have described pharmacists as paraprofessionals equally engaged in a set of 'business ethos', which essentially product-centered, while also engaging in a set of 'care ethos', goals aimed at patient-care. These ethos are not discretely practiced by pharmacists on the job; rather, these two ethos are frequently conflated. Pharmacists express their aim of patient-centered care their self-identified role as "drug experts." The way in which this role helps to form pharmacists' "business ethos" must be developed here. Kim and Will are pharmacy interns I met in a bustling coffee shop in a mid-size Midwestern city. Both had been exposed to pharmacy for several years: Kim's cousin runs an independent pharmacy in Minnesota and Will began as a clerk in high school at his local pharmacy. When I asked them what role pharmacists have in healthcare, Kim responded immediately, "The drug experts. We may not know how to diagnose. I guess we're tested on it and we're exposed to it, but that's

not what we learn. You learn they got this; this is what you treat. This is their renal functions, this is what drug dose to use.” Will agreed and added, “not just necessarily treatment. It’s these deeper, more meticulous, more specific things like the drug lasts eight hours in the body, so we gotta dose it every eight hours not every twelve.”

Pharmacists’ role as drug experts supports the revenue-focused aspect of their work, as well as the patient- and care-oriented aspects of their labor. On one hand, their role as drug experts extends to patient counseling. The pharmacists I spoke with who practiced in independent pharmacies stressed how their role as drug experts was enacted to help patients find the cheapest, most effective medicine. One example an independent pharmacist I spoke with provided was encouraging patients prescribed Prevacid, an anti-reflux drug, to talk to their doctors about Tagamat or Zantec, which are significantly cheaper. Thus, pharmacists’ role as “drug experts” reinforces their goals of patient-centered care.

Yet, their knowledge of medications offers a way to legitimately participate in the hierarchy of medicine and intersects with the business-oriented nature of their work as well. In speaking with Will and Kim, the pharmacy interns, Will was careful to correct Kim when she cited the higher authority of doctors in prescribing medications. He retorted, “Well, sorry, they’re the ones prescribing [the medications] but we’re the ones verifying whether or not they’re appropriate.” Kim quickly tried to cut in, “I realize that, but...” before Will jumped in, saying “It still has to go through us.” Through pharmacists’ knowledge of drugs, they are able interact with doctors in a meaningful way by either allowing their scripts to be filled or questioning the doctor’s decision making. Thus, in

enacting their role as “drug experts” pharmacists can simultaneously be product-/business- and patient-/care-centered.

Care ethos. However, pharmacists as paraprofessionals also share characteristics in common with medical professions, not only with business. Pharmacists are invested in their patient’s health and well-being like other medical professionals. Pharmacists also couch their work in terms of patient care. When engaging in this script, the individual is treated as a patient. One pharmacist I spoke with described enacting his role as a medical professional: “we see the patient/customer the most frequent of any healthcare provider. I think considering the fact that people are trusting us, they are going to take something that we are giving them and putting it in their mouths and bodies to regulate a condition or to help try to maintain health.” In addition to how this pharmacist was acutely aware of his connection to patient health, he was also explicit of how the individuals he helps are both patients in the medical system and customers of a business. While community pharmacists were the only ones to couch their work in these terms, which will be expounded upon in a subsequent chapter, all the pharmacists I spoke with were motivated to enter pharmacy for patient care and relayed stories to me with pride about instances of patients approaching them with questions about their diagnosis or about complementary non-medication interventions. All pharmacists expressed a desire to develop relationships with patients. Pharmacists’ orientation toward patient care constitutes what I call their “care ethos” which simultaneously guide their on the job decision making along with their “business ethos” detailed above.

Care ethos: Pharmacists as “patient advocates”. Similar to their role as “drug experts”, pharmacists describe themselves as being “patient advocates”. Pharmacists experience

the care aspects of their work through the hierarchical nature of the medical field. The fact that prescribing physicians have more prestige, status, and professional autonomy is reinforced throughout pharmacy curriculum. In one of the labs I observed, students were evaluated on their ability to confront a professor acting as a prescribing physician who has made a mistake on a script. Students, acting as pharmacists, were given a patient description and the doctor's script and had to identify the mistakes on the script, which could range from a dosing error or an inappropriate drug for the "patient's" condition. Students who scored high marks on the lab were commended on their deference to the physician's authority and providing research gathered from textbooks or PubMed to support their suggestion. Once these students enter practice, they likely will have to respect the hierarchy in several ways as the practicing pharmacists I interviewed described.

The burden of doctors to increase their patient load and the decreasing amount of time doctors have to spend with each patient is well documented (Dugdale, Epstein, and Pantilat 1999, Baron 2010). However, how the demand for doctors' time intersects with the role of pharmacists in the day-to-day practice of pharmacy is not as well understood. As mid-level practitioners with little to no authority within the medical hierarchy, pharmacists rely on prescribers' authority heavily and in multiple capacities. The most pervasive demand for doctors' time from pharmacists is in checking suspicious scripts. However, pharmacists frequently bemoan the inaccessibility of doctors. One pharmacy intern described contacting physicians: "So, you call [doctors] and you know all of a sudden 'Oh, I'm with a patient.' So, they'll call you back. Well, what do you tell the patient that's standing right in front of you? 'No, you can't have your medication right

now?” Pharmacists must get physician approval for anything on a script that is not clear or to make any change to a script. They lack the professional autonomy to do so and also are encouraged by their companies to shift the onus of (legal) responsibility on physicians, including in instances of suspected fraud. One pharmacist who managed a corporate pharmacy in a small town told me she “[knows] for a fact that [Corporate Pharmacy X] doesn’t allow us to call the police or anything. We have to call the doctor and the doctor has to initiate that sort of thing.” Similarly, pharmacists avoided confronting patients and prefer to notify the doctor of a problem script to allow them to rescind the script. One pharmacist told me how “I try not to deal with the patient as much as I can just because ultimately the doctor needs to be involved.” If they cannot get a hold of the doctor, pharmacists will defer to other entities with professional autonomy in order to decline the patient’s script. One pharmacist described how she has run into “house fires...where patients said they had a house fire and they lost everything but they are only looking for their narcotic again even though they have diabetes medications, hypertension medication and depression medication.” In one such case, the pharmacist researched online to find a house three doors down from the patient had burned, leaving the patient’s house unscathed. “I called the insurance company and so I wasn’t technically lying to her and they said that they would give her diabetes medications and her hypertension medications...and the narcotic they said they wouldn’t really do much to help her get through.” The hierarchical nature of pharmacists’ work is another aspect of their orientation to care over business where they are beholden to the authority and autonomy of prescribing physicians or insurance companies in order to conduct business. Thus, pharmacists are highly constrained professionals through the medical hierarchy. These

constraints define in part their orientation to other medical professionals and to care on a broader scale.

Their second role as care-oriented patient advocates also treads the line between pharmacists' roles as businessmen and medical providers. A pharmacist who runs a small town independent pharmacy had been a pharmacist the National Guard for twenty years. She continued to live by the motto she learned in the military, "getting the right drug to the right patient at the right time." This slogan reinforces the simultaneous drug and patient centeredness of pharmacists' work. The first pharmacist I spoke with to identify her role as "patient advocate" described this as "I'd say we are patient advocates. So, try and help get patients the correct medications and also the best prices and ways they can afford it, that's everything. And also safety. *Protecting a patient from themselves sometimes whether they like it or not* [emphasis added]."

The significance of the prior quote should be properly contextualized. The notion that a patient needs protecting from himself or herself has great implications for understanding how pharmacists conceptualize prescription drug abuse. In dispensing an antibiotic, for example, pharmacist's business and care ethos are in line. Selling the medication simultaneously brings profit and health. However, prescription drug abuse problematizes and brings into conflict these two ethos, as the patient's acquisition of the drug enables addiction, a harmful and detrimental state. How pharmacists ameliorate this tension is what the remainder of this chapter will focus on.

Business and care ethos: Problematized by prescription drug abuse. A pharmacist told me his professors preached to him to "treat the patient, treat the patient and make sure that they are comfortable and happy and satisfied with the care that you give them

and make sure that you are helping them out the best way possible.” Yet, he observed a “big discrepancy” between the “idealism” propagated in pharmacy school and the realities of combating drug diversion. He soon found with regards to the patient dynamic promoted in school “working and having real life experiences teaches you that that’s a really bad philosophy.” He went on to describe how “you never want to turn someone away if they have a real reason for needing something early, but you got to be cautious. You got to realize that people are always going to lie.” Thus, pharmacists quickly approach their practice facing two fundamentally different kinds of patients: one who seeks to legitimately acquire medications for the treatment of a ‘true’ illness and another who seeks to illegitimately acquire medications for abuse. In order to incorporate these two patient/consumers and the ways in which they intersect and bring into conflict their two ethos, pharmacists must re-conceptualize the nature of drugs and how they interact with the patient’s identity. Then, pharmacists adopt the view that drugs fragment the individual into the ‘true patient’ and the ‘addict’ in order to accommodate both their business ethos and their care ethos.

How pharmacists conceptualize addiction. The way pharmacists discuss the process of addiction is indicative of the conceptualization of drugs as fragmenting agents. Pharmacists employed two terms to discuss the habituating effects of long-term maintenance on drugs: dependence and addiction. Pharmacists describe dependence as being both physical and psychological. Physical dependence refers to the processes of withdrawal and tolerance. Withdrawal is defined as the onset of symptoms upon discontinuation of the drug. The concept of tolerance refers to needing more of the drug to achieve the same high, or effect. Psychological dependence is described as a separate

but related process. Psychological dependence was described to me as a vague process where “your mind just becomes fixated on ‘I need this drug; I need this drug’...their body is fine but they’re just thinking, thinking, thinking about it.” The distinction between a drug’s physical and psychological effects and the notion that “their body is fine” but the addict’s mind is focused on the drug suggests a drug’s capability to create a mind/body dualism. Although “addiction” is now the preferred term in the literature, the term refers to the same constellation of phenomena as physical and psychological dependence. Thus, addiction and dependence are understood as processes by which a substance fragments the addict, separating mind from body as well as the autonomous control of the mind over the body.

However, pharmacists carefully delineated dependence from the pejorative connotations of the term ‘addiction’. One pharmacist pointed out how it is “hard to prove someone is addicted versus in actual dependence. I mean, we know that with any medication your body develops a kind of dependence over time. As far as drug abuse, that is more of the psychological, that is the craving, the drug-seeking behavior, the ‘I’ll do anything to get a fix,’ as opposed to the physical.” Thus, psychological dependence is the element that delineates the more general term of ‘dependence’ from ‘addiction’. Another pharmacist described “one guy, he gets Vicodin every Friday. We never allow him to get it early. So, I say ‘No, you’re due Friday; you can come in Friday’ and of course, he’s always there at 9 o’clock in the morning to get it, but he knows! We’re not going to fill it early for him and we’re up front with him...Now, that’s a guy that probably has a legitimate need for the pain medication but is very dependent on it. [He] doesn’t want to run out.” Again, dependence is employed as a general term, not

necessarily problematic, alternatively referring to a biomedical, physical process common to many medications and an independent psychological state. Thus, the presence of dependence does not necessarily make the prescription illegitimate. Dependence in the presence of a legitimate health concern is viewed as an expected occurrence of long-term maintenance on medication for a chronic condition. Addiction, then, can be defined as primarily psychological and pursuit of the drug when it does not serve therapeutic goals. A legitimate patient, the 'true patient', is one who "knows" they are dependent, as the patient in the prior example who attempted to get his Vicodin early. The addict is not aware of their dependence on the medication, meaning through the process of addiction, pharmacists see the drug as splintering the individual's biological processes from their psychological awareness. For example, one young pharmacist in a small-town branch of a corporate pharmacy told me about a patient he encountered early on in his career who was picking up a prescription for Suboxone.

One time when I was first starting out a guy was picking up a drug called Suboxone, which is a strip that dissolves under your tongue and it helps if you become addicted to a pain medication. It just helps to provide a lower amount of that feeling from the drug throughout the day it prevents you from really abusing that drug or other pain medications and I was just kind of asking him 'So, what did the doctor tell you about this so far?' Just trying to counsel him. It wasn't too busy, so I tried to have a good conversation. He seemed interested and everything. He really wanted to know all about it. He said, 'Well, it's kind of a necessary evil right now.' And I said 'Oh, okay I think I know what's going on here.' And he says 'Yeah, I was taking pain medications for my back and after awhile, I just

realized I shouldn't still be on these but it's really hard to stop.' So, that's why he was taking Suboxone. And then, we kind of went through what you can expect as a result of taking Suboxone, all the risks you know. You can still be *addicted* to this, but if you follow your doctor's directions carefully and follow up with him and gradually work your way off the Suboxone, hopefully you can get back to normal before you get *dependent* on the [Suboxone]. [emphasis added]

The pharmacist described dependence as the result of not carefully following doctor's orders, following up with the doctor, and weaning off Suboxone. As described earlier, dependence is referring to becoming physiologically habituated to the drug. Here, a patient's compliance and adherence is perceived to be indicative of the awareness and will to discontinue Suboxone and other addictive agents. If these behaviors are not followed, then the patient is deemed to be unaware of their addiction and not pursuant of getting clean. Thus, addiction occurs in the absence of compliance, adherence, and hence, awareness. Consequently, addiction is once again viewed as the result of a drug's ability to fragment an addict's biological processes (the 'true' patient) from their psychological awareness (the addict).

In review, as paraprofessionals, pharmacists are alternatively product- and care-centered. In order for these to not be in conflict, the product (prescription) has to be of therapeutic value (treat a legitimate diagnosis). The patient's awareness is what makes the illness legitimate because awareness is the distinguishing element between dependence, or becoming physiologically habituated on the drug, and addiction, where awareness of dependency is lost. By viewing the addict as essentially two individuals-- a biological customer and a psychological patient—the pharmacist can take their care ethos

out of conflict with their business ethos. I will now describe this conflict and how this understanding of addiction resolves the professional and ethical tensions that arise.

How ethos combine in pharmacists daily practice. Central to pharmacist's on the job decision-making is identifying the individual on the other side of the counter as a 'true patient' or an 'addict'. If the patient is 'legitimately' in need of the medication, pharmacists can pursue their business ethos in receiving the profit in line with their care ethos in helping the patient treat his or her ailment. However, the 'addict' may be physically dependent, but pharmacists view them as psychologically unaware of their dependency. This division is what specifically concerns pharmacists about dispensing drugs of abuse to addicts. While pharmacists are invested in increasing revenue for their pharmacies in line with their business ethos, their care-ethos is brought into conflict. Since the drug does not correspond to a 'legitimate' ailment, the drug is not seen as having therapeutic value although it would ameliorate withdrawal and tolerance.

Pharmacists describe the difficulties and frustration in handling prescription drug abuse from a highly constrained professional position. One pharmacist said it best when he stated, "the problem that pharmacists have is we're stuck in the middle. If it's a legitimate prescription... we're hard pressed to say 'No service.'" Another pharmacist echoed a similar sentiment in saying, "more often than not, we end up getting stuck doing things that we don't feel comfortable with." For the trained and well-intentioned pharmacist, having to dispense to someone whom they do not believe to have full awareness of the possible effects of the medication brings up issues of consent and causes them to question whether they are delivering care although generating revenue and profit. Thus, prescription drug abuse for pharmacists in a highly constrained position with low

professional autonomy who straddle the boundary between business and medicine, product and care, brings these two ethos and roles into conflict.

Pharmacists' frustration appears in how they often handle patients they suspect of abuse but who they are unable to take legal action against or refuse to dispense to. Pharmacists often have difficulty in substantiating suspicion of abuse or diversion, especially when overburdened doctors may take hours to return phone calls and corroborate a prescription. So, pharmacists find other means to hassle patients suspected of abusing or diverting medications as both an outlet for their frustration and an attempt to find agency in their highly constrained professional position. One pharmacist described his "poker face, the front of professionalism. 'Oh, so sorry that you are in pain right now but I need to make sure this leaves correctly, so please allow me a couple minutes to make sure I can contact your doctor, get everything accomplished the way he wanted it to.'" Pharmacists then will ask for supporting documentation, such as a driver's license that is not legally required. One pharmacist explained the utility of this approach because "once you ask for the driver's license, they're just like, 'Oh, it's in the car.' Then, they don't come back." Other times, pharmacists ask the patient for specifics on medications or medical equipment such as the volume and gauge of syringes, or simply insist on speaking to the doctor over the phone before dispensing. One pharmacist described a situation where he did exactly this.

"Sometimes, it's just professional fun to mess around with them...there's usually different specifications to a syringe. What volume is needed? What gauge and what needle length? They'll just make up absurd numbers...just stuff like that and you toy with them...I just try to ask them questions and just make them answer

me that they're not using them legitimately. What kind of syringes do you need? Oh, 300's? Well, I need you to be more specific than that in order to sell those to you."

These examples clearly highlight the presence of the professional and ethical conflicts and frustration that arise in attempting to combat prescription drug abuse from the perspective of pharmacists.

Conclusion. Pharmacists view the drug as fragmenting the addict into two individuals—a consumer composed of biological processes, what I call the ‘true patient’, and ‘the addict’ characterized by psychological unawareness of these processes—and doing so allows pharmacists to partially resolve their conflicts. While they more often than not end up dispensing the medication even though they suspect abuse or diversion, pharmacists can ameliorate some of the tension that arises. The subsequent chapter will expound upon another way pharmacists ease the tension pharmaceutical drug abuse creates by viewing the drug as overpowering the individual and challenging the authority of doctors by blaming them for abuse. However, first, I will argue for the view that pharmacists make a compromise in handling prescription drug abuse in the way described here. Merriam-Webster defines compromise as, “settlement of differences by arbitration or by consent reached by mutual concession; intermediate between or blending of qualities of two different things; a concession to something derogatory or prejudicial.” Hassling the patient allows the pharmacist to make their dissent known and they do not view this as poor care, but rather “the poker face, the front of professionalism.” Pharmacists are essentially able to make a compromise: they generate profit by dispensing the script in service of their business ethos as well as the consumer, while

hassling the addict to attempt to “make them answer me that they’re not using [the medications or medical equipment] legitimately.” While defining addiction as the process by which a drug fragments an individual and renders them unaware of their dependence is the very source of their immediate conflict in dispensing drugs of abuse, the view offers pharmacists a way to compromise between their business and care ethos. In the next chapter, I will expound on how this view of abuse also offers the logic to more fully ameliorate the ethical and role tensions prescription drug abuse arises. Thus, pharmacists’ view of drugs and addiction, as well as the effects of these on the human body creates the problem they struggle with but ultimately offers a net positive solution to the highly constrained nature of their paraprofession in handling prescription drug abuse.

In conclusion, I have introduced the nature of pharmacists’ daily work as they attempt to navigate two different roles, an employee of a corporate (or for some pharmacists, an independent) business and medical care provider. I have described how prescription drug abuse brings pharmacists’ roles as drug expert and patient advocate into conflict as pharmacists attempt to pursue profit while attending to patient care when the medications are no longer seen to provide therapeutic value. I also explicated how pharmacists’ decision making is predicated on the view that drugs have the capability to fragment the individual into a ‘true patient’ composed of biological processes naturally occurring in response to long-term maintenance on pharmaceuticals (dependence), and ‘the addict’ who is unaware of their dependence. In an analytic framework, pharmacists’ construction of the addict is rooted in the contradictions inherent in the problem and in pharmacists’ competing interests in generating profit and attending to patient care. While the addict’s unawareness is the very factor that problematizes prescription drug abuse for

pharmacists, adopting this view justifies pharmacists' attempts to themselves at creating agency through hassling addicts and the continued pursuit of corporate-defined profit-generating work.

Chapter V: Pharmacists and prescribers: Care and pharmaceuticals amidst prescription drug abuse

In the last chapter, I argued that pharmacists' work is partially governed by sets of business and care ethos. Their business ethos is comprised of the drive for profit imposed by the corporate structure in which pharmacists relative to other medical practitioners are employed. Additionally, this corporate structure also contributes to pharmacists' status as paraprofessionals making their work contingent upon the superior authority of doctors. The hierarchical nature of their work and pharmacists' place at the bottom of this hierarchy makes their position highly constrained with low agency, autonomy, and authority. Yet, pharmacists are still invested in the patient's health and well-being, which constitutes their care ethos. On the job, pharmacists similarly describe acting as drug experts as well as patient advocates. These roles are sites where their business and care ethos are co-existing, meaning these ethos are not discrete.

Prescription drug abuse brings these roles and ethos into conflict. Pharmacists define addiction as dependence without awareness, creating a fragmentation between the body and mind of the addict. Thus, in dispensing the medication without a "legitimate" diagnosis, pharmacists do not view this behavior in line with their care ethos. Yet, pharmacists must contend with more often than not having to dispense medications when they suspect abuse. To handle this and reduce the role and ethical tensions pharmacists feel, they fragment the individual into a 'true patient' and 'the addict'. Hassling addicts provides an avenue of agency, an attempt at bringing awareness of his or her addiction to the addict in line with their care ethos, while pursuing their profit-generating work.

Yet, the tension between these two roles exists largely with patients and constitutes only one tension pharmacists contend with in the course of their day-to-day work. Pharmacists' labor is also inextricably tied to the role of prescribers. While pharmacists overwhelmingly blame physicians for prescription drug abuse, in practice, they perceive their role as monitoring doctor's prescribing, seeing a managerial role for themselves over prescribers. In order to play this role despite being paraprofessionals with limited authority and autonomy, pharmacists disambiguate the medications they dispense from the patients receiving those medications. By conceptualizing their work in this way, pharmacists are able to establish a "turf" centered on medications and separate from prescribers' "turf" concerning patient care. Patient histories and records legitimize to a certain extent their labor both to themselves and physicians. However, pharmacists' orientation to medication catches them in the crosshairs of two competing dialogues: the medicalization of addiction, which argues addiction is a disease, not a personal failing, and pharmaceuticalization, which is the notion of medications as panaceas for numerous states of ill health on one hand, and the language of care and patient interests. Pharmacists strictly see the medications as their "turf", but prescription drug abuse has recast some medications as agents of harm, not agents of health. As a result, pharmacists regard their interaction with prescription drug abuse ambivalently. As the medical system has increasingly become predicated on pharmaceuticals, how professionals absorb these new definitions in their daily work has profound implications for the state of prescription drug abuse, the discipline of pharmacy and the self.

"You don't have a problem with him forging your signature?": Prescribers, customers, and patients. Tom Wilson was a good friend of the father of a friend of mine

and I met him for burgers one weekend afternoon. Tom's energy and enthusiasm belied his age suggested by his decades of experience in community pharmacy. "I can give you an example of something that will just crack you up," Tom told me.

"A patient who had never been to us before...came in to our pharmacy with a prescription from an emergency room from a hospital down the road from us, two blocks away. For Vicodin. Maybe 15 or 20 tablets, not a whole lot.

"Now, it's not signed by the doctor. The doctor forgot to sign it. So, the pharmacist said, "I'm sorry, but we can't fill this. You'll have to go down and get it signed," which is probably the wrong thing to do. The best thing would have been to call and verify and take it as a verbal order and be done with it. You know, this guy [is] probably a drug abuser; a guy coming in from the emergency room and he's needing meds, you know. That's why I mean sometimes we can be oh so cautious that it's wrong. And in this case, I think it might have been but anyway, the story gets funnier.

"So, he leaves, you know, kind of shakes his shoulders, shrugs his shoulders, and leaves and then he comes back and it's signed. Okay? This pharmacist already didn't trust this person, so she's going to call the hospital and make sure that he actually took it back there and got it signed. So, she calls and wants to talk to the ER doctor. The ER doctor gets on the phone. She asks him and he says, "No, I didn't sign anything." She goes, "Really?" He goes, "Don't worry. It doesn't matter. He really does need

the medication; just dispense it.” She says, “you don’t have a problem with him forging your signature?” He goes, “That doesn’t really matter, just go ahead and dispense it; it’s fine.” So then, she comes back and she talks to the two of us and I go, “Look, just fill it. You got a verbal order; just, you know, sign it off as a verbal [order]. Let’s not make an issue. It’s not a big deal.” Again, so we are trying to avoid a confrontation with the *customer* [emphasis added] to say, “So, we just called and you didn’t send it back there,” even though that’s the information we’ve received. Anyway, we dispense it. The *patient* [emphasis added] leaves. We pull up another signed prescription from this doctor, it’s his signature!”

Sitting in the restaurant, I wish I could say I was more surprised, but I have heard similar such stories for the weeks prior from other pharmacists. I respond, “So, the physician really did...” and I do not even need to finish my sentence. Tom jumps in, exclaiming with more exuberance and surprise than I can between bites of my hamburger, “sign it!”

Contained in this one story are several themes key to understanding the care pharmacists deliver and what tensions are intertwined with both physicians and patients. First, the physician in Tom’s story is portrayed as otherwise preoccupied. Tom concurrently introduced the previous story as a humorous one, as well as an example of “one of the reasons I get so irritated with physicians.” The tension Tom feels in this situation with physicians is both explicit and nearly palpable. Secondary to the fact the physician forgot he had signed the script, Tom is also frustrated by the physician’s laissez-faire attitude about the patient ostensibly forging his signature. From the perspective of Tom, the physician seems to think actually signing and filling the script is

a mere hurdle to getting the patient the medication to feel better. The physician's definition of care seems decidedly patient-centered that by extension is interpreted by the pharmacist as a sign of professional disrespect. Next and perhaps most obviously, parallel to the tension Tom feels with the physician, is the tension between the pharmacist and the patron. In sending the patient back to the hospital to get the script signed by the doctor in lieu of calling to verify and taking a verbal order in the first place, the pharmacists are challenging the patient's trust. They will call the hospital and verify the prescription regardless. Then, these actions by pharmacists are essentially moral. Thus, parallel to the tension between pharmacists and physicians, is that between pharmacists and patients. Third, Tom easily transitions into and out of referring to the patron as both a "customer" and a "patient". Before the financial transaction, he is a customer, but once money exchanges hands, the customer becomes a patient. This fact bears on the final theme of this story: pharmacists' care is essentially drug- (not patient-) centered.

"Why is it our problem?": Blame and ambivalence in the turf battles between prescribers and pharmacists. From the outside as often appears to patients, the roles of pharmacists and physicians appear intersecting and unidirectional; physicians write the scripts pharmacists must fill. Pharmacy training deals extensively with the side effects and interactions of the different classes of medications. As the number of pharmaceuticals on the market has increased over the decades along with off-label use of medications, this knowledge has become increasingly complex. However, this brings pharmacists with knowledge of the medication, into conflict with physicians who have knowledge of the patient and his or her diagnosis. Perhaps the most apposite example is one provided by a student pharmacist in her internship. She detailed a battle she was

currently undergoing with a physician about dosing with gabapentin. “[The attending physician] wants more and more research because he doesn’t believe me...[Gabapentin] is not doing anything above a certain dosage...it’s maybe not harmful to the patient; it’s just what’s the point of giving them 1200 milligrams extra that they don’t need?...[the pharmacist and I] have about five studies...we’re waiting to present it to [the prescribing physician].” She and the other pharmacist repeatedly provided the prescriber with research supporting their claim to no avail. As in this example, pharmacists’ knowledge of pharmaceuticals is the one crucial area on which to challenge doctors’ authority, particularly when doctors may be inclined to overprescribe medications.

As paraprofessionals, pharmacists often must mediate between patients and prescribers. In such mediations, pharmacists feel tension both with the addict and with the physician writing the script. Their futility is somewhat quelled towards patients due both to the fact pharmacists see them as much as customers as patients, as well as how they conceptualize addiction. However, pharmacists continue to feel tension with physicians, who pharmacists place primary blame on for the emergence of prescription drug abuse. Pharmacists are taught a language to engage with prescribers that reflects how they would like to be seen by prescribers and teaches pharmacists to handle the tension caused by their unequal authority. In the training program I observed, students were taught to make suggestions to doctors without questioning their authority. Pharmacy students were encouraged to say things such as, “I understand why you thought that way. I was thinking this drug might be better for the patient because...”. On one hand, this language reflects the real-life constraints of negotiating on the job, particularly with those of higher authority; however, this advice also teaches students how to wield their limited

authority and practice within the constraints set by their status as paraprofessionals.

Avoidance of words such as “but”, which change the tone of the sentence and referencing what “might be better for the patient” reinforce the common goal of patient health without referencing the power differential that exists between physicians and pharmacists.

The language training programs encourage their students to employ with doctors echoes the “spin selling” Oldani (2004: 328) describes between drug representatives and physicians. “Every *objection* (by physicians, patients, and the general public) can be turned around to become a *positive* selling point, something to be valued and sold for the patient’s benefit” [emphasis in original]. Oldani describes how the doctor’s initial objection may have been a “language game” to see if he, as a drug representative, would “be nasty towards the competition, usually not a good idea (the doctor and the competition may be golfing partners)” (2004: 328). Pharmacists were taught to elicit objections from prescribers and explain how another treatment regimen may better serve these ends without necessarily contradicting the doctor. Whether the adoption of this technique from the pharmaceutical industry was intentional or not on the part of faculty in a pharmacy training program is tertiary to the manner in which pharmaceuticals and their effects are actively shaped through language and social exchanges always couching these effects as in the patient’s, not the pharmacists’, industry’s or prescribers’, best interest.

Often belied by the non-accusatory language they are taught in school and when not engaging with prescribers, the pharmacists I spoke with unilaterally placed primary blame on physicians for the acceleration of prescription drug abuse. While their admonishments of society or patients were often vague and ill defined, pharmacists were

verbose with their blame of prescribers they see as abusing their authority. Tom, the pharmacist in an independent, community pharmacy for decades, wondered, “what’s going on in that office visit? What’s that person telling you [the doctor] and what are you believing? Sometimes, I think, ‘How naïve can you be, Doctor so-and-so? How can you think this is legitimate?’” Along these same lines, one pharmacist comically described what he calls “get-the-hell-out-of-my-office scripts, where they’ll write like five Hydrocodone just to get ‘em out. It’s like, ‘Oh, well it can’t hurt them because it’s not enough Tylenol for a daily dose. So, here’s five Vicodin. Go find another doctor.’ You see a lot of that.” Another pharmacist referred to scripts for small amounts of Vicodin as “calling-your-bluff scripts. ‘I don’t really believe that story you [the patient] are telling me but I’m just going to give you a couple to appease you.’” Pharmacists perceive such scripts for small amounts of abusable medications as irresponsible on the part of physicians and an affront to their professional duty.

Specifically, pharmacists regard such behavior on the part of prescribers to be an offense because they perceive such script-writing as an attempt by physicians to place the onus of responsibility on pharmacists for filtering out such patients who may be attempting to game the system. Because five Vicodin is not enough to be considered problematic prescribing and pharmacists have access to a kind of pan-record of patients’ medication history, pharmacists believed physicians to be pushing responsibility and thus, liability onto pharmacists for dispensing to a patient who may have a record of multiple fills of abusable medications. Whether prescribers have this intent is tertiary to the fact pharmacists conceptualize their role in healthcare as monitoring both prescribers and

patients. One pharmacist phrased this responsibility of managing physician's prescribing as "making sure that every doctor is prescribing within their practice limits".

While pharmacists bemoan this responsibility, their language implies a perceived "managerial" role above physicians. This claim is emboldened by what one pharmacist, Ben, described as the culture surrounding abusable prescriptions as one of apathy on the part of doctors. "Who carries the burden of responsibility?" I asked him. Without a moment's hesitation, he retorted, "Doctors. No doubt, it's the doctors...I definitely put a lot of the blame on doctors." While he conceded that doctors frequently lack the time to spend with patients, he thought doctors lacked "people skills" to give patients "insight" into their prescribing and recommendations "as opposed to when I tell a patient to do something, I say, 'this is why I want you to take this. This is why I want you to do this. It may seem unorthodox, but this is why I'm telling you to do this.'" Ben simultaneously and explicitly notes the blame pharmacists place on doctors for prescription drug abuse, as well as the closeness he feels he has with his patients. However, it is the paraprofessional role of pharmacists that allows such "closeness". Implied by such statements is the fact that the proliferation of prescription drug abuse problematizes the professional relationship between pharmacists and prescribers. Pharmacists couch the problem as an opportunity to have oversight over doctors, reorganizing the typical division of labor. While physicians would refute this perception, the trick of perception has limited functional utility, but is a psychological tool by which pharmacists cope with having low professional autonomy and authority.

While pharmacists profess they have a duty as part of their profession to monitor physician's prescribing, they do not perceive this duty as allowing them to shoulder any

blame for the problem. Instead, they are quite critical of prescribers. Their blame serves two ends. Blaming physicians aids pharmacists' moralization of patients. By constructing a dichotomy through blame—pharmacists versus physicians—pharmacists are able to imply their work is more moral and in better service to the “true patient,” even if physicians do not recognize, as pharmacists accuse, that they are actually prescribing to addicts. Physician blame also serves to set the boundaries of their profession. Such accusations bolster pharmacists' perception of a lack of education among physicians on medications. One pharmacist told me “doctors are really good at diagnosing, that's what they are really good at, working with the patient one-on-one to figure out what the problem is,” carefully talking around a perceived lack of knowledge pharmacists believe doctors have concerning medications. Another pharmacist went more in depth about the different “turfs” doctors and pharmacists occupy,

“I don't...no, I don't think, doctors have adequate training on medications.

I think though what you'll find is if you took the average, say internal medicine doctor. Internist, okay? And ask them routinely, how many meds do they prescribe? I bet it's less than 50. I mean, there's 10,000 drugs on the market; they don't prescribe 10,000 different products. Mostly, they'll have a very small group of medications that they prescribe. And you know, I could probably name most of them right now, the anti-hypertensives, drugs for cholesterol, drugs for diabetes... But most doctors...don't...prescribe outside of their comfort zone. So they do keep it close to the vest, I think. Cuz they...you know, they're trying to do a

good job, too. You know? So they don't want to start prescribing stuff that they're not too familiar with.”

As this pharmacist alludes to, pharmacists consider medications their domain and resent physicians they feel misprescribe certain classes of drugs. In blaming physicians for prescription drug abuse, pharmacists effectively disambiguate the medications from the patient. Pharmacists effectively maintain their claim to medications being in their domain, but leave responsibility for both the ‘true patient’ and the addict within the bounds of prescriber’s professional realm.

Yet, pharmacists alternately express reluctance at taking on a larger role in combating prescription drug abuse while bemoaning their lack of professional authority and autonomy to enact their will. Due to this, pharmacists conceptualize a key role for themselves in healthcare as monitoring patient’s consumption and use of medications. Part of enacting this role is monitoring doctor’s prescribing. Pharmacists exist, in one’s own words, to get “the right drug to the right patient at the right time.” Pharmacists must be capable of challenging doctors or patients when either contradicts this dictum. Yet, pharmacists must rely on doctors to write prescriptions and patients to patronize their business. One of the few avenues pharmacists have to autonomy on the job is deciding whom to appease and whom to antagonize. Their ambivalence allows them to alternately criticize and rely on physicians and patients as necessary. Ambivalence, along with blaming prescribers, then becomes a tool, unique to paraprofessionals, for pharmacists to create professional distance from patients or prescribers who may attempt to challenge their limited authority. The distance created through ambivalence and blame allows pharmacists to carve out their “turf” in the professional landscape. They see physicians’

realm as patient treatment outcomes and their “turf” as monitoring the flow and consumption of pharmaceuticals. By regarding both prescribers and patients ambivalently, as well as blaming prescribers, pharmacists attempt to set the bounds of their profession, legitimizing their position in the medical hierarchy, and constructing their own values system.

Pharmacists adopt a similarly ambivalent attitude towards prescription drug abuse and diversion. Every pharmacist I spoke with had at least one instance where they recounted an abuser they reported to a prescriber. Pharmacists recount these stories with a sense of pride and at times, their body language while retelling these stories would hint at feelings of superiority over doctors in their ability to detect these instances of abuse. First, pharmacists have the ability to work with insurance companies to see if a patient has received the same medication in the recent past. As I described earlier, pharmacists feel physicians rely on them to thwart patients who “doctor shop” for their medication, referring to the practice of visiting several prescribers seeking multiple prescriptions for the same medication. Of course, this strategy is limited to patients with insurance. For those without insurance or state aid, pharmacists still have exclusive access to all patient histories, a kind of pan-medical record of patient’s prescriptions. However, more often than not, pharmacists end up dispensing abusable medications and in this case, patient histories are the only record they have of their suspicions. Pharmacists I spoke with were adamant in their support for prescription drug monitoring programs, which would increase the control they have over whether to dispense medications or not by providing them with a complete record of each individual’s prescriptions, making it easier to catch “doctor shopping” and similar behaviors that flag abuse. Such monitoring programs

increase pharmacists' professional autonomy and control over their product, key factors in the development towards full professionalization.

While pharmacists enthusiastically supported prescription drug monitoring programs and expressed desire to achieve greater autonomy and control on the job, they quickly backtracked when discussing such drug monitoring programs in the context of prescription drug abuse. Overall, pharmacists' attitude towards intervening in prescription drug abuse could be described as ambivalent as well: they prized moments when they were able to challenge doctors' authority and call the prescriber's attention to a patient who was "doctor shopping" and welcomed the emergence of prescription drug monitoring programs, but were steadfastly resistant against taking on any role to formally intervene in the problem, saying it is the fault of doctors and doctors must resolve the problem. Their ambivalence allows pharmacists to challenge doctors by assigning them blame for prescription drug abuse in seeing it as a 'patient problem' (not a 'drug-problem'), but maintain their perceived role as monitoring both patient consumption and physician prescribing. Together, these views, although seemingly contradictory, allow pharmacists to insulate themselves from accepting the blame for prescription drug abuse. One of pharmacists' most fundamental doctrines is that addiction is created by a patient's use, not the chemical properties of a pharmaceutical. In seeing doctor's "turf" as patients and addiction the result of bad patients, pharmacists are able to maintain the sovereignty of doctors over their patients, insulating themselves and the pharmaceuticals from being viewed as the agents of addiction.

Pharmacy records in legitimating work and in coping with frustration.

Pharmacists currently have access to records within their chain of every person who has

filled a script at any location in the country. Pharmacists can also add subtle notes if they suspect a patient is abusing. One pharmacist described including these notes: “We try to keep comments on profiles. We have to be really professional about this. We can’t say something like ‘This patient will scream and yell if you don’t let their medication go early.’ You can’t write stuff like that. What we have to say is like ‘Watch for early refills. Watch Lorazepam [Ativan, a commonly abused anxiolytic] use.’ Stuff like that. That’s how we have to try to go about that.” Thus, such records contain not only a history of the patient’s business transactions, but also of communication with patients and whether the patient is suspected of abusing or diverting their prescriptions.

The role of pharmacists’ records and the kind of record prescription drug monitoring programs offer should not be understated for its role in legitimizing pharmacists’ knowledge and work. While their ambivalence legitimates their position in relation to physicians and patients, their records play an important role in legitimating their work, particularly when they suspect abuse but are unable to keep from dispensing the medications. Many times, pharmacists told me instances where they had to dispense potentially illegitimate prescriptions, “you document the heck out of it. Just document the snot out of it in case somebody comes back, in case there is a lawsuit, in case there is an audit.” First, such records provide a perceived unbiased perspective on which to challenge doctors and physicians when their professional position alone does not warrant such antagonism. Second, patient’s history also legitimizes pharmacists’ work by providing a record of their labor and patient interactions. Pharmacists come into contact with patients only briefly and are usually left unaware of patient health outcomes. Patient

records provide an inventory of their labor and a tangible artifact of their efforts at recognizing abusers.

In the milieu of Brodwin's description of an "assemblage of compliance", such records compose an "assemblage of awareness" (2010: 130-1). The definition of assemblage he provides is astute, "a whole constructed of heterogeneous parts that retain their distinctive identity...the notion of social assemblage insists that the various components do not really aggregate; they come together contingently at particular cultural and historical periods." (2010: 130). The patient records unique to a particular pharmacy chain and Prescription Drug Monitoring Programs (PDMPs), which at their most fundamental function collect these records from all pharmacy chains, are constituted by disparate components from different pharmacists and different settings detailing all aspects of pharmacists' exchange with patients. The medication(s) a patient receives, recommendations and instructions for their use (i.e., "take this food") and suspicions (i.e., "watch Lorazepam use"), as well as if contact with police and law enforcement are made can all be combined in this one data source. For such problem cases, pharmacists' hope is that this will facilitate prosecution should a patient demonstrate an ongoing pattern of behavior consistent with drug-seeking or at least absolve them of legal, if not ethical, responsibility for dispensing in such situations. The ultimate goal of these is for them to accumulate a tangible show of problematic behavior to encourage the patient to become aware of their irresponsible use perhaps in the pharmacy or in the courthouse. Since awareness is the key factor delineating problematic addiction from mundane dependence, this assemblage of awareness is the last vague hope pharmacists have of combating prescription drug abuse.

After all, even when pharmacists are able to positively identify an abuser and call the police, pharmacists make a costly time investment, which they see contradictory to both their care- and business-centered ethos. One pharmacist told me a story where he dispensed Ativan to a patient he suspected of abusing, just to have another customer come into the store and tell him he was trading the medication for cash in the parking lot.

“You go to all this work, you waste an hour like calling the police department “Alright, I need a case number.” You call the doctor and say “Hey, I have this case number where this patient’s medications were stolen and his son came into his house and beat him up is what the guy said.” And then you get doctor’s approval to let it go, state approval to let it go, police work...it takes a lot of time! And that holds you back from being able to help other people too. And, just to hear that it went out means...I mean, someone described the hat he was wearing, clothes and everything and yeah, he was just talking to another guy, handed him a bag, and took a bunch of cash and...that was frustrating.”

Despite pharmacists’ best intentions, they often have only a note in a patient’s profile of their time spent following up on the problem. As the quote implies, the work is frustrating both in its fruitlessness, as well as the fact it fails to serve either care- or business-centered goals. In documenting not just a financial transaction, but a record of what was dispensed or discussed, and sometimes their suspicions of a patient’s abuse in muted terms, pharmacists are at least able to align themselves with traditional care-oriented goals through these records enabling them to make appeals to doctors in the name of the patient’s interest to not dispense in cases where they believe a patient should

not receive medication. Additionally, such records are often the only outlet for pharmacists to express their frustration albeit in restrained terms at dispensing to those they believe have illegitimate intentions, helping to legitimize their work to themselves.

Prescription drug abuse: Shifting the definition of care. In summary, pharmacists' blame of prescribers for prescription drug abuse creates a schism between pharmacists with knowledge of pharmaceuticals, and prescribers trained in patient care. Pharmacists are able to establish a "turf" for themselves as managers and monitors of physician's prescribing and patient's consumption of medications. In adopting the dictum that there are no bad medicines, only bad patients, pharmacists are able to separate blame and responsibility for the problem from the medications and their challenges to doctors' authority. Adopting this ambivalence legitimizes their status as paraprofessionals, largely dependent upon the work of prescribers and seeking greater autonomy and authority, but not taking on blame or responsibility for a problem they define as a problem with patients and thus a doctor's concern. Patient histories and the notes pharmacists include provide a material link at their effort to boost their attempts at adopting more authority and autonomy through identifying abusers and stopping the flow of medications to these individuals; attempts that frequently prove futile to the great chagrin of pharmacists. Such records are an invaluable tool for pharmacists to legitimize their efforts, at least to themselves. Instead of making attempts to increase their professionalization *per se* through combating prescription drug abuse, pharmacists seem to be challenging the supremacy of prescribers and physician's definition of care in prescribing to addicts.

Amidst their attempts at combating prescription drug abuse, pharmacists must maintain healthy working relationships with doctors of higher authority because doctors

provide pharmacists with a potential powerful ally against a problematic patient. I have already described how pharmacists often have the knowledge of a patient's history used to identify "doctor shopping" and potential abusers to physicians. Yet, it is the relatively rare occasion when pharmacists are able to use this knowledge without referring to the authority of a physician or insurance company to deny dispensing medications. However, mostly, pharmacists dispense medications in such situations, feeding their alternating reliance and frustration towards prescribers, or their ambivalence. One pharmacist expressed the anger that results from such futility in saying "pharmacists get real frustrated like, why is it our problem? You know, why do we have to be the police?" While, it is certainly true this work falls to pharmacists as paraprofessionals to do the "dirty work", the futility pharmacists frequently experience on the job and their ambivalence towards prescribers suggests a fundamental disconnect worth exploring between pharmacists and prescribers: a disconnect between pharmaceuticals and patient care.

While pharmacists steadfastly see medications as benevolent and instead cast individual's use of medications as harmful, prescription drug abuse has nevertheless redefined medicines as not only agents of health, but also as agents of harm. In this way, pharmacists' work in dispensing such medications is often antithetical to patient care and treatment outcomes, aspects largely defining doctors' work. Then, pharmacists are brought into professional conflict with physicians and medications are brought into conflict with patient care. The tension between pharmacists and prescribers mirrors this tension emerging between medications and patient health.

For the purposes of this work, *care* is defined as an iterative, individualized, holistic and actionable (versus moral) process, which involves the patient as active subjects (Mol 2008). This idealized version of care can be contrasted with a “second logic of care” emphasizing patient choice and which views patients as consumers. While one logic of care involves the patient in defining the standard, “what follows is that for the logic of care gathering knowledge is not a matter of providing better maps *of* reality, but of crafting more bearable ways of living *with*, or *in* reality” (Mol 2008:46). The transaction of pharmaceuticals in exchange for a doctor’s script and money is inherently economic in nature and lends itself to the second logic of care Mol details. Yet, when the very product meant to deliver care in shifting contexts becomes an agent of harm, these two logics intertwine and often, strictly contradict each other and new facets to the definition of care emerge.

Unlike prescribers, pharmacists deal much more extensively with medications, especially with patients’ use of medications via side effects or contraindications. Pharmacists appreciate opportunities to educate patients on medications and feel they have a role regarding patient care as patient advocates. The way one pharmacist I spoke to described her role in the medical hierarchy reflected the potential for conflict in enacting this role with patients. “I’d say we’re patient advocates...protecting a patient from themselves sometimes whether they like it or not.” Implied in these words is the necessity of antagonizing patients. “We have the information to help people to try and take medication properly. Taking medication improperly can be as harmful as it can be beneficial,” one pharmacist extolled his skills. As these quotes suggest, pharmacists view pharmaceuticals as inherently health-promoting; an individual’s use of the medication

determines whether the substance is harmful or healthful. Put another way, there are no bad medicines, only bad patients.

In the same way pharmacists have adopted this dictum, the dialogue of prescription drug abuse has adopted an insular attitude towards the products of major pharmaceutical corporations. The medicalization of addiction created the notion of addiction as a disease, instead of the result of personal moral failings. Pharmacists absorbed this thinking in conceptualizing the ‘true patient’ as opposed to the addict. However, as the breadth of pharmaceuticals came to include ones capable of producing potent, addictive effects, pharmacists along with the rest of the medical community as well as society as a whole, continue to contend with the medications we have come to rely on being powerful agents of harm. Pharmacists grapple with the changing context of pharmaceuticals from curative agents to agents of harm in their daily work. On one hand, medications are viewed by pharmacists as inherently benevolent, addicts as victims of a disease, but a disease caused by medications they are believe to be wholly health-promoting. Thus, pharmacists’ ambivalence is the result of a wider ambivalence emerging around prescription drugs. To gain increasing control over the product and achieve more professional autonomy would accompany accepting responsibility for a tension yet to be resolved.

As in the story to introduce this chapter, pharmacists represent a medication-centered approach to care brought into conflict with physician’s patient care-centered paradigm. Similar to how Tom conveyed tension with the patient, pharmacists are unsure to a certain extent how to incorporate the prescription drug addict into their daily practice and thinking. While pharmacists desire more professional authority and autonomy, they

are constrained in how to combat the problem. They use language unique to their position as paraprofessionals to either couch their work as business by referring to individuals as “customers”, but once money has exchanged hands, they easily refer to the customer as a “patient”, switching their script. Since the only recourse of action they have to combat prescription drug abuse centers around how to keep medications out of the hands of suspicious patrons, once they dispense the medication, pharmacists are able to see the individual as a patient. Since pharmacists’ care is medication-centered, they have the opportunity to provide their version of care only after the medication has been dispensed. Tom’s story of the patient filling a script for Vicodin contains the tension he feels with prescribers, as well as patients/customers, and how they conceptualize care. Pharmacists’ ambiguity regarding prescription drug abuse reflects a deeper and wider tension existing between their conceptualizations of medication and care.

Conclusion. In instances of abuse, the patient becomes a site wherein pharmacists’ care and business ethos are brought into conflict. Despite the low professional authority or autonomy of pharmacists, they find ways to gain agency to enact their own moral code and in so doing, help ameliorate the tension between their two roles. Pharmacists can choose to detach from patient care by removing the label of “patient” entirely and categorizing patrons as addicts or portraying them merely as consumers or customers. Doctor blaming challenges the position of doctors and allows pharmacists to assert their authority, at least to themselves, in the face of the futility caused by having to dispense abusable medications to addicts—an act pharmacists see as contradictory to care. Physicians are regarded both by pharmacists and in the professional literature as full professionals, whose efforts are directed at patients towards offering care in the form of

better health. Pharmacists' position as paraprofessionals equally situated at the interstice between care and profit must redefine the meaning of care. How pharmacists define care in light of these competing ethics has implications for how they conceptualize and handle prescription drug abuse. In other words, pharmaceutical drug abuse requires pharmacists to re-imagine their definition of care.

Pharmacists' view of their work, and the ethics that guide it, allow them to antagonize patients and refuse to dispense and cast it as care, particularly when taken in light of their definition of addiction as splintering the mind from the body of the addict. Pharmacists often dispense medications when they do not believe they should. Patient histories legitimize this labor and allow them tangible proof to fight physicians' prescribing and combat the futility of operating with low professional autonomy. Pharmacists are rarely aware of patient treatment outcomes, although they feel invested in the impact of medications on patients' health, so pharmacists create a distance between their role in healthcare and the patient, disease, and treatment outcomes. Care is re-defined as knowledge of pharmaceuticals and the laws that govern the dispensing of these drugs.

In summary, pharmacists feel great tension with prescribers. By disambiguating the medications they dispense from patients, pharmacists can legitimize their blame of physicians by moralizing patients and viewing drugs as inherently health-promoting. Patient histories and records provide justification for challenging physicians on scripts and play a key role in allowing pharmacists to blame physicians, connecting physicians to patient care, and providing pharmacists an outlet to express their true suspicions when they dispense to people they suspect are abusing or diverting their prescriptions.

Pharmacists' care is medication-centered, but prescription drug abuse has recast medications as potential agents of harm. While medications have been heralded in modern medicine as the panacea for any array of health problems, trends of medicalization have promoted the view of addiction as a disease, not a personal moral failing as it was historically viewed. The ambiguity pharmacists have towards their work and the tension pharmacists as medication-centered paraprofessionals feel with physicians, as professionals in charge of patient care, reflect the tension existing between these two competing dialogues: pharmaceuticalization and prescription drug abuse, medicines and patient care.

Chapter VI: Conclusion

The presence of competing dialogues—between medicalization and prescription drug abuse, medicines and patient care—is replicated in other contexts. The University of Wisconsin Pain & Policy Studies Group continues research advocating for increased accessibility to prescription narcotics for non-terminal patients. While the group publicly announced in April 2011 they would no longer accept payouts from pharmaceutical companies (Fauber 2011b), life goes on for David Joranson and Aaron Gilson, still prominently employed by the group according to its website. Daniel Lee, the drug dealer who robbed several area pharmacies in the backyard of the UW Pain & Policy Studies Group, is still serving his sentence and will not be set for release until 2078, meaning Lee will have to survive to the unlikely age of 115 in order to live free again (USDOJ 2013). Yet, larger questions about the conflicts between patient care and the potential for prescription narcotics to produce addiction linger.

For pharmacists, these tensions become ingrained in their day-to-day work. In our discussions, discerning legitimate scripts from illegitimate scripts is a regular process and these categories have no clear-cut boundaries. Instead, levels of legitimacy exist depending on the patient/customer and the script itself. Pharmacists must strategically infer these clues from a set of everyday knowledge garnered through years of formal and informal training to make such decisions and in order to hypothesize the fate of the medications once they leave the pharmacy and enter the community. Based upon the regard for pharmaceuticals gleaned from both their formal academic training and society-wide beliefs, pharmacists regard their job in producing a bottle of pills for a script and money more than merely “pill counting” but a moral act. When all medications are good,

pharmacists see it as their fundamental duty to keep the good medicines out of bad hands. Yet, their actions so often fail their objectives.

It may seem easy to simply cast the actions of pharmacists as unique and their inability to keep prescriptions out of the hands of abusers simply a professional failure. However, increasing trends of prescription drug abuse demand a more thorough analysis. Perhaps in some part either large or small, this trend is fueled by direct to consumer marketing creating substantial demand for prescriptions among the public. From this perspective, the medical system, not only pharmacists, is constrained by pharmaceuticalization. Pharmaceuticalization refers to “the process by which social, behavioral, or bodily conditions are treated, or deemed to be in need of treatment/intervention with pharmaceuticals by doctors, patients, or both” (Abraham 2010: 290). Patients expect prescriptions because medicines are equated with care and the absence of pain or inconvenience. Doctors who prescribe, as well as pharmacists who dispense these medications are continually caught between good intentions rooted in patient care on one hand and economic and customer demands on the other. Pharmaceuticalization has made prescriptions, of which increasing numbers are patented each year, a social sign of care and concern. When medicalization produces diagnoses for any kind of pain or discomfort, the dispensing of pharmaceuticals becomes a primary tool to express care more generally.

The idea of pharmaceuticals as agents of care and concern that emerge from trends of medicalization and pharmaceuticalization is supported by epidemiological trends showing the vast majority of prescriptions individuals abuse are acquired through friends or family members who share their prescriptions. Pharmaceuticals as currency for

care extends beyond those with formal medical training, but are pervasive as a more general societal value.

Review of my argument. Pharmacy, drugs of abuse, and addiction share a long, intertwining history. Drugs such as heroin and cocaine were once medicinals used legitimately among the well to do to treat several illnesses. As these substances became associated with the world of leisure and particularly minority and immigrant populations, increasing legal penalties prohibiting their use reinforced the existing social order (Acker 2002:2-9). Addiction emerged as a medical diagnosis in the early 1900's amidst these increasing drug penalties. Such laws did little to slow the productivity of new drug development. A variety of drugs and methods to produce them in large scale developed in the first half of the 1900's. Certain drugs, such as the birth control pill, heralded eras of social change like women's liberation (Gordon 2002). In this case, the ability of a woman to control her fertility by a self-administered and discreet pill essentially constituted an act of social revolution. By 1959, over half a million American women were receiving the pill for contraceptive purposes producing large profits for G.D. Searle and Company. The notion that drugs could be symbols of social power was well embedded in the American psyche, and debates concerning birth control continue today. By the 1970's, the Controlled Substances Act was passed that attempted to establish set prescribing patterns. In allowing certain drugs to be automatically refilled without needing a doctor to write a new script and in combination with the deinstitutionalization movement heralded a new pharmaceutical era (Szasz 2007). Demand for these drugs fueled drug development by pharmaceutical companies. The emergence of Prozac in 1977 for the treatment of depression ushered record profits for the pharmaceutical industry and other companies

worked on developing their own version of Eli Lilly and Company's discovery (Healy 2006). Among these discoveries was hydrocodone that, when combined with acetaminophen, not only proved to be an effective analgesic, but a less tightly regulated Schedule III drug, bringing billions to Knoll Pharmaceuticals. While the drug was originally developed for use in terminal cases, in 1985, opinions began to emerge that such drugs had a therapeutic utilization among non-terminal patients. One such article described "opiophobia" among physicians that causes them to underprescribe opiates, or narcotic analgesics. "As a result of this practice, many patients undergo needless pain and suffering. Equally important, failure to use these drugs appropriately undermines the physician-patient relationship" (Stimmel, 1985). These words explicitly state the professional duty of those in medicine is to absolve pain and the value of drugs such as Vicodin to enhance the relationship between patients and their doctors. Ostensibly, the underutilization of opiates was tied to the illicit nature of related drugs such as heroin, heavily racialized and stigmatized dating back to its emergence among minorities and immigrants in the late 1800's. Like psychiatric diagnoses, pain is a state of suffering not readily translated to the atomized and materialistic terms of biomedicine. Pain can be a global complaint, not limited to one body part, and no swab or culture can prove its existence. A diagnosis of pain is based entirely on patient self-report and a doctor's recognition of this complaint and counteraction of writing a script for Vicodin to ameliorate this pain constitutes an act of care for which no other alternatives may exist. Drugs and particularly opioids are not value-neutral; instead, their prescribing, dispensing, and consumption constitute a social and moral act.

Pharmacists see these dramas play out in their daily work, as documented herein. They operate within constraints set by their paraprofessional role, as well as the demand for profit and general desire to provide care and ameliorate illness. However, when required to dispense drugs of abuse to those they suspect are abusing, the social and moral power they view drugs as having becomes ever more salient. While all patients habituated on a drug will develop dependence, tolerance, and withdrawal, they claim, addicts are in denial about these effects of the drug on their body. As part of this dialogue, the conceptualization of drugs as agents of health and prosperity remain intact; addiction is a disease of the brain, more specifically of a brain-body disconnect. Pharmacists are purveyors of the universal good: medications; however, they see prescribers as laying professional claim to patients. Then, pharmacists as not-full-professionals are able to fully lay the blame for prescription drug abuse at the feet of physicians. Pharmacists are able to attempt to pursue their care-oriented goals by hassling those individuals they see as not worthy or deserving of the medications. Meanwhile, they produce an assemblage of patient records, often compiled into a Prescription Drug Monitoring Program (PDMP)—a tangible record of their negotiations between the often-competing interests of doctor, patient, and pharmacist. Providing this semi-public show of their work and suspicions of abuse is useful in the face of the futility of attempting to fight the proliferation of pharmaceutical agents.

Although they place heavy blame on physicians for prescription drug abuse, pharmacists also must rely on physicians to predicate their work. Ambivalence emerges allowing pharmacists to effectively carve out their professional turf in the face of low authority or autonomy to formally do so. A decidedly medication-centered approach to

care emerges. Not only are medications the primary object of pharmacists' work, but they provide the means of profit and their therapeutic effects satisfy pharmacists' well-intentioned goals towards patient care—a key difference between full professionalization according to Freidson (1974:71-84). However, when dispensing to addicts, perceived as bad patients who lack awareness of the powerful effects of drugs, pharmacists face competing dialogues: medications they are heavily invested in as therapeutic agents become agents of disease. Yet, the receipt of these drugs constitutes a powerful and pervasive definition of care bolstered by a history of drug-driven social change and gross expansion of the market for pharmaceuticals.

Pharmacy becomes a key site for these dialogues to occur. Pharmacists' labor is more explicitly business-oriented; as paraprofessionals often physically located in business sectors outside of hospitals or clinics, they are without many of the trappings of physicians and their professional codes of patient care as a higher order value, and pharmacists are explicit in their pursuit of profit in the name of healthcare. Their training and labor is centered upon the drugs themselves, not their effect on patient outcomes. Pharmacists essentially exist betwixt-and-between business and healthcare and the fully professional world of prescribers and the community of patients and customers.

While the constraints pharmacists operate within are readily identifiable as part of their paraprofessional role, they are not unlike the constraints imposed on society at large from which an increasing demand for such drugs exists. If the pharmaceutical market is a zero sum game between medical professionals attempting to keep abusable prescriptions within a legitimate sphere and patients intent on using these drugs for illicit purposes, the estimated 7 million persons abusing prescriptions drugs annually are simply no match for

prescribers and pharmacists. Yet, the line demarcating licit from illicit use of such substances proves to be an incredibly thin one. Pharmacists described tolerance and withdrawal as properties of any drug a patient may become habituated on. They described the effects of suddenly discontinuing any medicinal regimen from blood pressure medication to antidepressants. Their claims are bolstered by professional organizations of prescribers, such as the American Academy of Pain Medicine. In a press release from 2003, they state “long term use of opioids results in physical dependence, which is different from addiction, but does not usually lead to addiction. *Physical dependence* [emphasis in original] is a normal adaptive state, the expected result of using pain medicine (as well as other medications) for a long time.” They define addiction as “characterized by impaired control over drug use, compulsive use, and continued use despite harm and decreased quality of life” echoing the DSM (2013) definition of substance dependence, i.e., a lack of awareness of the drug’s ability to direct behavior and influence the body.

While chronic abuse of illicit drugs are couched in terms such as tolerance and withdrawal outlined by the DSM, a special term exists to describe the effects a person will experience with suddenly stopping use of their antidepressants, discontinuation syndrome. This term emerged following a symposium hosted in 1996 by Eli Lilly and Company, the makers of Prozac, as well as an array of other psychiatric medications (McHenry 2006). The symposium was held in response to growing criticism that some patients experience difficulty in getting off their antidepressants. Eli Lilly had estimated “at most a few percent” of individuals would experience the onset of symptoms following discontinuation of antidepressants. However, research from Massachusetts General

Hospital found this initial estimate to be far too low. Researchers found as many as seventy-eight percent of individuals medicated on antidepressants will experience symptoms following their discontinuation of the drug (Fava et al. 1997). While some antidepressants are more prone to withdrawal symptoms than others (Zoloft and Paxil are cited as particularly problematic in this regard; Zajecka, Tracy, Mitchell 1997), these rates are significantly higher than the estimates provided by Eli Lilly. Following this symposium, however, Eli Lilly established the term “discontinuation syndrome” in an effort to distance their drugs from the terminology associated with abuse. Officially, such drugs are not classified as having an abuse potential based on animal studies showing rats provided free access to the drug do not seek it out. Yet, the commercials filling print and video ads urging the public to “ask your doctor about [a drug] to see if it’s right for you” along with increasing use of psychiatric and abusable medications attest to the fact that individuals do indeed seek these prescriptions out under the urging of pharmaceutical companies.

Conclusion. As these tensions make clear, the insistence of pharmaceuticals as agents of health and well-being and only a patient’s use and perception of the drug’s effects separate abuse from dependence more generally, are not perspectives unique to pharmacists. Rather, it is a carefully and intentionally constructed dialogue of the pharmaceutical industry that couches its products—be they ones more readily associated with abuse, such as Vicodin or OxyContin, or psychiatric medications, but not excluding other classes of medications—as the definition of care and a healthy relationship between patients and the medical establishment, physicians, and pharmacists. Pharmacists actively shape these dialogues as they educate patients about medication use and hassle patients

they suspect abuse their drugs. As part of this work, they create an assemblage of awareness; patient records, a tangible account of their reactions to patients/customers, an assemblage of profit, care, biomedicine, a global pharmaceutical market, and the morality that emerges to dictate how these disparate pieces coincide.

As a long history illustrates, boundaries ostensibly separating licit from illicit drugs, from pharmacy, sociocultural change, and the pharmaceutical industry are shifting and these components are continually being actively shaped to fit changing circumstances. Similarly, the global, local, interpersonal, and internal factors all contribute to how drugs and their use are conceptualized both in and out of the clinic or pharmacy. The body of the addict, as the ideal patient and consumer, becomes an active site for these discourses to play out as the persuasive techniques adopted by the pharmaceutical industry and medical professionals both attempt to bridge the divides that separate them by couching the drugs in the interest of patient health. Similarly, the discipline of pharmacy and the assemblage of awareness they compile from a litany of patient interactions, become a site where negotiations between the patient, the pharmaceutical industry, and the profession of medicine are negotiated. Essential questions—such as: who deserves medications? What ethics guide such decision-making? And what to do when the medicines stop becoming agents of therapy and become agents of harm?—are asked and answered over the pharmacist’s counter. Yet, the ability of the language with which those in the medical establishment to adequately answer these questions and slow the trickle of prescriptions onto the street for abuse is limited. The pharmaceutical industry has adopted ethos of care (e.g., “what is best for the patient?”) and subsumed this dialogue into a language of business and profit. It is no small action, as the change to the context with which such

pharmaceuticals are delivered and consumed is radically transformed. The addict, while the ultimate consumer, is the antithesis of the patient, cured or treated by the therapeutic power of pharmaceuticals. Instead, prescription drug abuse constructs addiction and business as opposed to patient care. The conflicts that emerge regarding the (il)licit use of prescription drugs allows the professional role of pharmacists and the addicted body to become sites where micropolitics between dialogues of medicine and care compete with a pharmaceutical industry agenda centered on profit-generating work.

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