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Power in Healthcare: Discussing Buprenorphine for Opioid Use Disorder Treatment

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Abstract

Die Pathologisierung von Sucht ist ein weithin anerkanntes medizinisches Phänomen, dennoch sind die Reaktionen auf Opioidkonsumstörungen (OUD) in den USA sehr unterschiedlich und reichen von Inhaftierung bis hin zu langfristiger medikamentöser Behandlung. Oftmals korreliert dies mit der ethnischen Zugehörigkeit und der sozialen Schicht des Patienten. Neben dieser Variabilität außerhalb des medizinischen Bereichs variieren auch die Reaktionen innerhalb des medizinischen Bereichs stark, da das Gesundheitswesen zunehmend als Markt fungiert. Medikamentöse Behandlungen wie Buprenorphin tragen nachweislich zur Überwindung der physiologischen Opioidabhängigkeit bei, werden aber weiterhin zu selten eingesetzt. Angehörige der Gesundheitsberufe sind Gegenstand qualitativer Studien geworden, da Forscher versuchen zu verstehen, warum Buprenorphin trotz seines Status als Goldstandard weiterhin zu selten angewendet wird. In einem ähnlichen Ansatz führe ich eine kritische Diskursanalyse (CDA) an fünf qualitativen wissenschaftlichen Artikeln durch und analysiere dabei Machtverhältnisse in den Beziehungen zwischen Angehörigen der Gesundheitsberufe. Neben der Untersuchung, wie sich diese Faktoren auf die Anwendungsraten von Buprenorphin auswirken, analysiere ich, wie sie die fortschreitende Kommerzialisierung der Sucht reproduzieren oder in Frage stellen. Ich untersuche den Diskurs der medizinischen Fachkräfte, die Forschungsartikel, in denen dieser Diskurs eingebettet ist, und den größeren sozialen Kontext eines gewinnorientierten Gesundheitssystems. Aus einer STS-Perspektive analysiere ich die Machtdynamiken, die sich im Zusammenhang mit der Anwendung von Buprenorphin entwickelt haben, und analysiere die Ideologien, Praktiken und Werte verschiedener ideologischer Ansätze in der Versorgung sowie deren Beteiligung an der Reproduktion eines Suchtmarktes. Dabei identifiziere ich drei unterschiedliche Machtansätze bei denjenigen, denen die soziale Verantwortung für die Gesundheitsversorgung anvertraut ist. Der autoritäre und der wohlwollende Anbieter reproduzieren hierarchische Machtstrukturen, wobei der autoritäre Anbieter diese Macht als Richter ausübt und der wohlwollende Anbieter sie als Elternteil ausübt. Der Unterschied liegt in der Fürsorge für den Patienten. Interventionen können an diese Machtansätze angepasst werden, um einen dritten Anbietertypus hervorzubringen. Ein Anbieter, der die Kompetenzen seiner Patienten in den Mittelpunkt stellt, hat seine professionelle Macht zurückgestellt und verfolgt einen menschenzentrierten Ansatz in der Behandlung von Opioidkonsumstörungen, wodurch Zusammenarbeit und Neugierde gefördert werden. Mit zunehmender Verbreitung dieses Ansatzes wird der Einsatz von Buprenorphin aufgrund der medizinisch begründeten Nachfrage naturgemäß zunehmen.

Abstract

The pathologization of addiction is a widely accepted medical phenomenon, yet responses to Opioid Use Disorder (OUD) are highly varied within the U.S. ranging from incarceration to long-term pharmaceutical treatment, often correlated to the race and class of the patient. In addition to variability outside of medical spaces, responses within medical spaces are highly varied as well, as healthcare has come to function as a market. Pharmaceutical treatments such as buprenorphine are proven to assist in the recovery of physiological dependence to opioids, but remain underutilized. Healthcare practitioners have become the subject of qualitative studies as researchers attempt to understand why the underuse of buprenorphine continues despite being considered the gold standard of care. In a similar approach, I conduct a Critical Discourse Analysis (CDA) on five qualitative academic articles, analyzing articulations of power in healthcare practitioner relationships. Beyond examining how these impact the rates of use in buprenorphine treatment, I examine how these reproduce or challenge the ongoing marketization of addiction. I examine the healthcare practitioners' discourse, the research articles the discourse is situated within, and the larger social context of a profit-first healthcare system. Using an STS perspective, I examine the power dynamics that have evolved around the use of buprenorphine, analyzing the ideologies, practices, and values of different ideological approaches to care and their participation in reproducing a market of addiction. In this process I identify three distinct approaches to power among those entrusted with the social responsibility of providing healthcare to society. The authoritarian provider and benevolent provider reproduce top-down power structures, but where the former practices this as a judge, the latter practices this as a parent, the difference being care for the patient. Interventions can be adjusted to accommodate these approaches to power in order to produce a third type of provider. A capabilities provider has de-centered their professional power and provides a people-first approach to OUD treatment, fostering practices of collaboration and curiosity. As more providers adjust to a capabilities approach, the use of buprenorphine will naturally grow to meet a medically informed demand.

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Abbreviations

AA: Alcoholics Anonymous

AMA: American Medical Association

AMPAC: American Medical Association's Political Action Committee

CDA: Critical Discourse Analysis

CRADA: Cooperative Research and Development Agreement

DATA: Drug Addiction Treatment Act-2000

DEA: Drug Enforcement Agency

DSM-5: Diagnostic and Statistical Manual of Mental Disorders

DTAP: Drug Treatment Alternative to Prison

FDA: Food and Drug Administration

MAT: Medication-Assisted Treatment (used interchangeably with MOUD)

MAT Act: Mainstreaming Addiction Treatment Act

MOUD: Medications for Opioid Use Disorder (used interchangeably with MAT)

NA: Narcotics Anonymous

NIH: National Institute of Health

NME: New Molecular Entity

POUD: Prescription Opioid Use Disorder

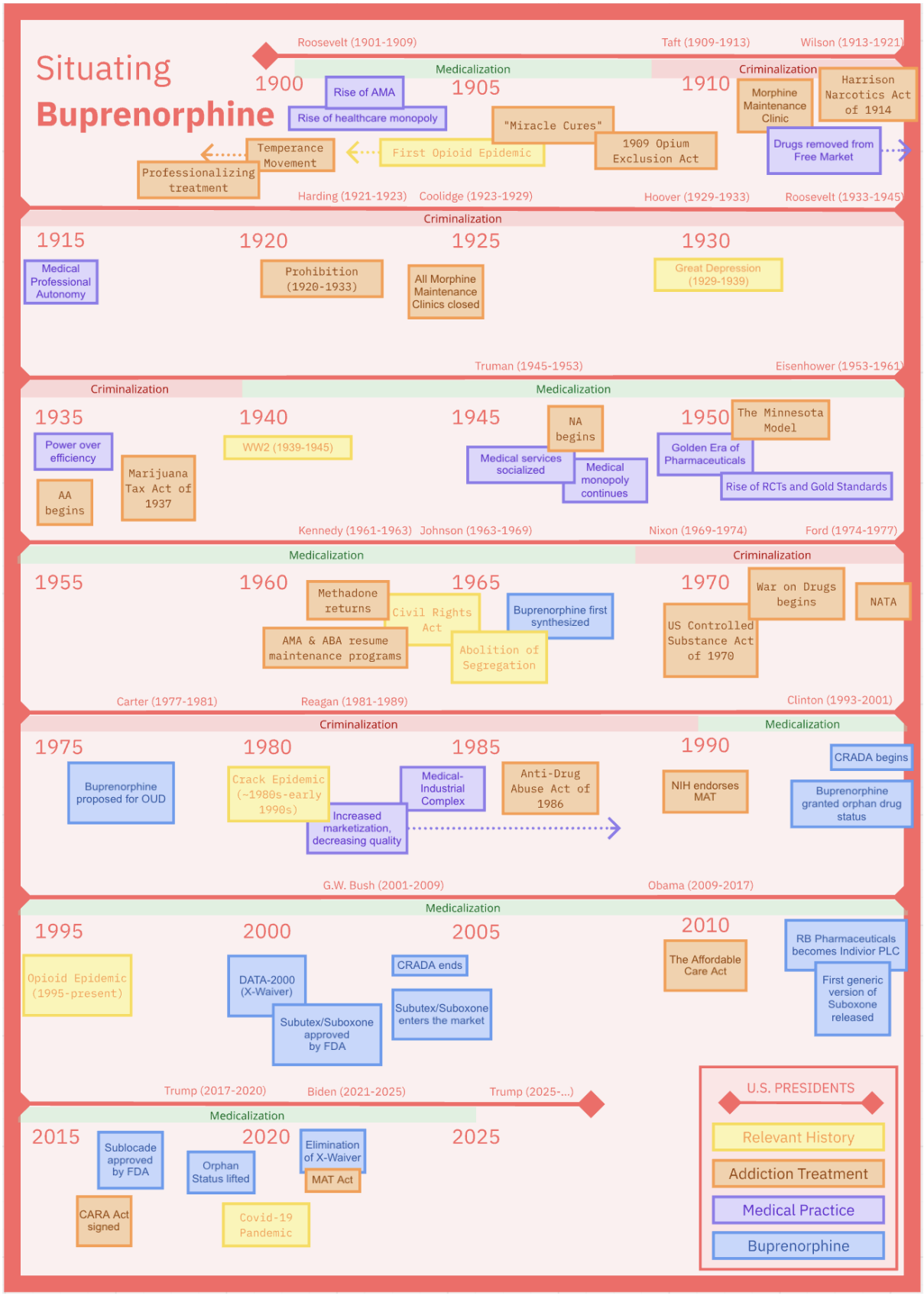
OUD: Opioid Use Disorder

RCT: Randomized Control Trial

SUD: Substance Use Disorder

WW2: World War 2

Timeline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Taft (1909-1913)
Wilson (1913-1921)
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Criminalization
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1905
1910
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1 Introduction

> *The Institute of Medicine has issued a stream of reports showing that the [American healthcare] system is deeply unjust; discriminates against the vulnerable and disadvantaged; causes planeloads of avoidable deaths, injuries, and treatment-induced illnesses; wastes far more than any other comparable [healthcare] system in administration, marketing, and other non-clinical costs; and has a weak public health foundation (Institute of Medicine as cited in Light, 2004, p. 2)*

A scathing critique of the U.S. healthcare system, although two decades old, still touches on numerous failures of the healthcare system today. These failures are in many respects intentional, a consequence of the profit-first values that macro-systems of governance and the pharmaceutical industry hold. In a profit-first healthcare system, population health is defined by standards of consumption, specifically the consumption of pharmaceuticals (Dumit, 2012). As such, the pharmaceutical industry and healthcare have become almost synonymous, measuring population health through quantitative standards such as rates of retention and use of pharmaceuticals (Datta Burton et al., 2022; Dumit, 2012). In framing health through consumption, there is an economic incentive for a population that considers themselves unhealthy and in need of treatment (Gaudilliere & Sunder Rajan, 2021; Mazzucato & Roy, 2019). A healthcare system that values profit before health relies on a population in a perpetual state of medical crisis to be successful, functioning first and foremost as a market (Dumit, 2012; Sunder Rajan, 2017).

Addiction, specifically in the case of this research opioid addiction, is one such market. Despite the perception that healthcare is pharmaceutical consumption, they are separate markets where healthcare practitioners act as gatekeepers between the patient and the pharmaceutical industry (Dumit, 2012). Access to prescription opioids have been the cause of countless opioid use disorders (OUD), acting as the catalyst of the Opioid Epidemic (1995-), and making up the majority of OUD diagnoses today (Hasin et al., 2022; Sharma et al., 2016). Much like access to prescription opioids is managed by the healthcare practitioners, access to the treatments for opioid addiction — buprenorphine, methadone, naltrexone — are as well, part of the same market of addiction responsible for an epidemic

(Henninger & Sung, 2014).

In my preliminary research, I found that healthcare practitioners' discourse around these treatments for a medically recognized disorder, OUD, depict power dynamics that are reflective of the monopolization of healthcare (Dollar, 2019; Lindsay & Vuolo, 2021). In order to explore these dynamics, I conducted a critical discourse analysis (CDA) asking the question: *How does academic research pertaining to the usage of buprenorphine in addiction treatment articulate power dynamics in healthcare?*

Using a Scientific-Technology-Society (STS) approach to this research, I chose to focus on the technosocial aspect of buprenorphine — one of four treatment options used to address physiological dependence — and the power dynamics that have evolved in healthcare spaces where this pharmaceutical treatment would be used. Taking a people-first approach to healthcare, I analyze its underuse as articulations of power in the patient-provider relationship, and the ways in which these reproduce or challenge the larger marketization of addiction. In order to inform this analysis, I begin with a social-historical understanding of the U.S. healthcare system, addiction treatment, and health in order to socially situate the healthcare practitioners. I follow this examination with a scientific and technosocial understanding of buprenorphine and OUD. Finally, I ground this research in a theoretical approach to value in the marketization of healthcare.

In what began as a celebration of science, practices of medical licensing and standardization quickly turned into efforts to legitimize the healthcare profession as a growing monopoly (Light, 2004). Prior to these efforts, early institutions of medical science were in close practice with the monotheistic religions of Europe, leaving a distinct mark on medical practice as the institution of healthcare evolved (Light, 2004; Szasz, 2006). Medical practice is not a science, but rather the culturally situated relationship between physician and patient (Szasz, 2006). While the church was still present in medical practice, monopolization moved healthcare away from charitable inclinations, shifting the attention onto paying patients (Light, 2004; Szasz, 2006). Despite medical standards, healthcare professionals developed a habit of unquestioned autonomy, allowing the practice of personal ideology

rather than medical science (Light, 2004). As of 2004, clinicians provide to their patients the medical recommendations of their professional body only about half the time (Light, 2004). Reproducing its religious roots, medical practice adopted the moral judgement and absolutism of addressing a sin in church (Szasz, 2006). This absolutism was termed medical monotheism, dictated not by science but by personal ideologies (Light, 2004). Practices of absolutism were reproduced when the pharmaceutical industry gained hegemony in healthcare, producing scientifically backed 'gold standard' treatments that often failed to test non-pharmaceutical options (Jones & Podolsky, 2015). One such example is that of the internationally renowned 12-Step Program. This remains the most popular method of addiction treatment, practicing abstinence, community, and faith; it is a freely available resource for recovery but is considered unscientific (Bedford, 2025; Grinspoon, 2024). These practices failed to standardize care, but rather left healthcare practitioners practicing their personal ideologies with the rigidity of religious devotion (Szasz, 2006).

Further, I found that modern conceptualizations of substance use and addiction were largely shaped by the formation of the pharmaceutical industry and the moral judgement of addressing vice (2.2.1 The Evolution of Medical Practice). In attempts to monopolize a growing industry, all psychotropic substances were removed from the free market (the exception being alcohol), before being returned as pharmaceuticals (Henninger & Sung, 2014; Light, 2004). Socially acceptable behaviors of substance use narrowed as the criminalization of those experiencing addiction and the substances they were addicted to grew (Dollar, 2019; Henninger & Sung, 2014; Light, 2004).

Social and moral parameters of what are considered 'good' substance use behaviors, e.g. a glass of wine or a prescription, came to also dictate what are considered 'bad' substance use behaviors, e.g. smoking marijuana or injecting heroin (Dollar, 2019; Szasz, 2006). Politically, this was done by associating specific marginalized communities with different drugs, brought upon by the politically powerful white professionals in a time of legalized segregation (Dollar, 2019; Henninger & Sung, 2014; Lindsay & Vuolo, 2021). The criminalization of substances and their cultural association to marginalized populations

continues to create a disparity in the social response to addiction. For non-white people and poor white people the response remains one of moral badness and criminalization, while for white populations the response is to disease (2.2.2 A History of Addiction Treatment).

I then developed a scientific understanding of buprenorphine, and opioid addiction. Opioid Use Disorder (OUD), the medical term for opioid addiction, is classified today as a chronic disease in which the biggest risks are access to opiates (Hasin et al., 2022; Sharma et al., 2016). The majority of diagnosed cases of OUD today come not from heroin or fentanyl (two illicit opiates), but rather prescription opioids used as painkillers by medical facilities (Hasin et al., 2022; Sharma et al., 2016). OUD is particularly complex to recover from, possessing behavioral components, observable components (physiological dependence), and environmental components (correlations with adversity such as abuse or poverty) (Hasin et al., 2022; Sharma et al., 2016). While buprenorphine, methadone, and naltrexone manage physiological dependence, abstinence manages physiological dependence by stopping a socially bad behavior. None of these four options address environmental components. As prescription opiates were the leading cause of the Opioid Epidemic, and continue to factor into this ongoing public health crisis in the U.S. today, this has naturally led to growing distrust and delegitimization of both the pharmaceutical industry and healthcare practitioners (See 2.2.3 Paradigms of Health in Opioid Use Disorder) (Light, 2004).

Although healthcare remains far preferable to criminalization, the U.S. medical system carried into the medical treatment of OUD the stigma of treating morally bad criminals, a perception that the criminalization of substances contributes to. Today, despite OUD consisting of both behavioral and physiological factors, healthcare practitioners have the agency to respond to patients with OUD as optionally treated, morally bad, or criminals (See 3.1 Healthcare Practitioners' Discourse). Many healthcare practitioners only treat the behavioral component of OUD rather than the physiological dependence or environmental influence. This contributes to the stigmatization of buprenorphine and methadone in healthcare, two of the three Medications for OUD (MOUD) that are also classified as opiates.

Unlike the non-opiate MOUD, naltrexone, there is the common perception that taking buprenorphine or methadone still constitutes an addiction with the common adage of being 'just another drug' (Madden, 2019). This has resulted in three established but overlapping ideologies when responding to someone with opioid addiction: criminalization, pharmaceutical treatment, or abstinence.

I chose to center buprenorphine in my research for a few different reasons. Due to its bio-chemical makeup it is said to depict the best attributes of methadone and naltrexone when treating OUD (Hasin et al., 2022; Sharma et al., 2016). Unlike naltrexone, buprenorphine is an opiate and has attached to it some of the same stigmas that methadone has amongst those practicing abstinence. While methadone has come to be associated with Black populations, buprenorphine was marketed towards white populations (Smith et al., 2025). The intention was to provide white populations a less stigmatized treatment, with 90% of those who use buprenorphine being white (Madden, 2019; Smith et al., 2025). Examining discourse around buprenorphine specifically is more likely to depict dynamics of power that do not include racial bias, bringing attention to dynamics that might otherwise go overlooked (Datta Burton et al., 2022; Dollar, 2019; Gaudilliere, 2021; Light, 2004).

I began my CDA examining power dynamics in OUD treatment by finding five academic articles conducting a qualitative analysis on healthcare practitioners' perspectives of buprenorphine (2.4 Methodology). Using Mullet's (2018) analytical framework, I analyze this discourse at four different levels; the first two levels examine solely the healthcare practitioners' direct quotations (3 Empirical Analysis). The first level uses deductive coding to identify power dynamics, working with a framework based on section 2.2 State of the Art (3.1 Healthcare Practitioners' Discourse). The second uses abductive coding to identify morality in treatment practices and emerging paradigms of OUD treatment that challenge the marketization of addiction (3.2 Interdiscursivity). The third level of analysis contextualizes the healthcare practitioners' discourse into the immediate context of an academic journal, examining the ways in which researchers inadvertently reproduce a market of addiction (3.3. Immediate Social Context). The fourth level of analysis looks at the larger social context,

situating the source material into the values of a medical industrial complex, outlined in the theoretical framework (2.3 Theory, 3.4 Level 4 Analysis). I conclude this research by discussing my findings. I identify three types of providers in their approach to power, outlining their ideologies, practices, and values as well as preferred interventions when expanding access to MOUDs (4 Discussion). I conclude this research by reflecting on the structural value in delegitimizing the professional healthcare caste and the ways that decentralizing power in medical practice can ultimately challenge the marketization of health (5 Conclusion).

2 Research design

2.1 Research question

In developing this research question, I identified healthcare practitioners as one of the most interesting actors of addiction treatment. Healthcare practitioners have the power to act as gatekeepers between the pharmaceutical industry and the patient, determining the best course of treatment for their patient (Dumit, 2012; Light, 2004). They have long been able to act with a sense of autonomy and expertise, relying on the power and dominance of their professional caste (Light, 2004). However, the power of the medical professional caste has shrunk in the face of the global pharmaceutical industry (Dumit, 2012). In attempts to marginalize the power of the gatekeeper, pharmaceutical companies encourage the rise of the expert patient with direct-to-consumer advertising (Dumit, 2012).

While healthcare practitioners experience the delegitimization of their professional caste, patients seeking addiction treatment remain a particularly vulnerable population. They often experience social outcasting due to cultural correlations with the behavior of substance-use: immorality, socio-demographic disenfranchisement, and criminalization (Dollar, 2019; Lindsay & Vuolo, 2021; Sharma et al., 2016). Independent of how the health practitioner approaches power in their medical practice, they still work within the larger market of addiction. Their individual practices, although mundane, are powerful in their

reproduction or resistance to the marketability of an epidemic (Datta Burton et al., 2022; Dumit, 2012; Haskaj, 2018; Light, 2004). In order to more deeply understand their position as gatekeeper, I asked the question:

[RQ] How does academic research pertaining to the usage of Buprenorphine in addiction treatment articulate power dynamics in healthcare?

My initial intention with this research was to examine healthcare practitioners discourse and the power dynamics that take place within these spaces. However, in conducting a CDA, I was limited in sources that provided a variety of firsthand healthcare perspectives to analyze. I chose peer reviewed qualitative research as the source of my CDA as it consisted of numerous perspectives within direct quotations from healthcare providers. Instead of examining this discourse separately from the academic research, I instead chose a framework wherein the academic research the discourse is situated within becomes a part of the analysis.

Power dynamics, in this research, is defined through instances of unequal social power — e.g. class, race, gender, or education — but this does not necessarily appear in instances of abuse. Articulations of these power dynamics are identified as practices of reproduction or resistance to the status quo. Some of the ways in which these appear throughout the discourse is through the language used (pejorative vs medical), standards set (personal vs scientifically informed), and intention (managing behavior vs managing risks). I explore the ways in which practitioners assert their power as gatekeeper through their preferred methods of treatment and the ways researchers influence these dynamics in their approach to research.

2.2 State of the Art

In order to situate how power is articulated in healthcare I use an STS approach, with buprenorphine and healthcare practitioners working as the central actors of my analysis. I begin by developing a social-historical understanding of medical practice and addiction treatment within the U.S. in which to situate the modern day discourse that is part of the

empirical analysis. I identify three dominant OUD treatment ideologies that have established themselves over the last century: criminalization, pharmaceuticalization, and abstinence (medicalization without pharmaceuticalization). “Ideologies are the fundamental social cognitions that reflect the basic, aims, interests, and values of groups,” (van Dijk, 1993, p. 258). Ideologies inform practitioners’ approach to OUD treatment, depicting the values they hold, and the care they practice. Such “aims, interests, and values” do not exist in a vacuum, but rather come to be understood across space and time, situated in the evolution of cultural, economic, social, and political processes (Gaudilliere & Sunder Rajan, 2021).

Next, I develop a scientific understanding of OUD and buprenorphine, so as to approach the empirical research from a comprehensive conceptualization of the varying treatment modalities. I explore modern paradigms of health, and how they appear in the process of diagnosing and treating Opioid Use Disorder (OUD). Finally, as buprenorphine is my focus in OUD treatment, I outline its social, economic, and legal history from its synthesis as a molecule to the multi-billion dollar market it is today.

The foundation of this research rests on the technosocial premise that the analyzed discourse pertaining to buprenorphine is the product of over a century of political, social, and scientific coproductions. The technosocial informs how power dynamics within OUD treatment should be analyzed, their implications, and how to address them. The theoretical approach to this analysis expands on this premise, examining structural values within the pharmaceutical healthcare industry the U.S. has today. This theoretical approach highlights that more often than not structural value lies in monopoly, crisis, and death. The theoretical basis informs the healthcare environment in which OUD treatment is being addressed, depicting the power of mundane practices as instances of reproducing such an environment.

2.2.1 The Evolution of Medical Practice

In the development of Western medicine, early approaches to health and illness were closely co-constituted with religion, sin, faith, and treatment (Szasz, 2006). Western science evolved in relationship with the monotheism of Europe, creating a scientific culture that still

resembles religious sentiments of universal truths, and singular courses for best treatment (Jones & Podolsky, 2015, p. 1503). Medical practice evolved out of theologic practice, developing patterns of absolutisms in ideological preferences (Szasz, 2006). Early medicalization, or the expansion of medical jurisdiction into different aspects of life, merged into responsibilities of the church as behaviors considered sinful began to be pathologized (Szasz, 2006; Williams et al., 2008, p. 814). Processes of medicalization indicated the dominance of the medical profession, as they gained hegemony over defining what it means to be socially deviant, dysfunctional, and sick (Abraham, 2010, p. 604). Medicine today is a product of these processes; an integrated part of the economy, politics, law, and justice (Szasz, 2006).

The scientific-materialist approach to medical healing is less than 200 years old (Szasz, 2006). Medical science is the empirical investigation of the human body, whereas medical practice (although based on science and scientific technology) is not a science, but a relationship (Szasz, 2006). Medical practice is dictated by culture and individual personalities; it is a service influenced by economic, ideological, religious, and political interests (Szasz, 2006, p. 326). The healthcare system the U.S. experiences today is an amalgamation of these interests, evolved over the last century (Light, 2004). As science began to be culturally celebrated, the twentieth century U.S. saw a rise in the legitimization of licensure (Light, 2004). The quality and value of health began to be recognized as a market (Light, 2004). The American Medical Association (AMA) rose to fill this role of regulator in the licensure of medical professionals (Light, 2004). The AMA took over the market: establishing state licensing, setting prerequisites (e.g. graduating from a certified medical school), and broadening legal definitions in order to further expand the jurisdiction of medical practice laws (Light, 2004). What was in every respect a monopoly avoided such charges under the guise of professionalism (Light, 2004).

Hospitals had previously been run as charitable institutions, where the poor could receive rest and care (Light, 2004). As the professionalization of medicine took place, hospitals shifted from charitable institutions to centers of surgery and cutting edge medicine

as a method of attracting higher class paying patients (Light, 2004). Rosner stated: “By 1915, doctors at many institutions had essentially wrested control from the trustees and had gained the power to make the decisions that were in their best interests,” (as cited in Light, 2004, p. 9). Other markets that were not led by the upper class, such as midwifery, came under attack from the AMA in waves of medicalization, skillsets that were eventually returned through professionalism (Light, 2004).

Freedom and choice were central values of this new medical professionalism created by the AMA (Light, 2004). Weller stated:

> It is *guild* free choice rather than *market* free choice, that is to say free choice within the profession’s terms of training, licensure, fees, and the structure of services. Market free choice would mean competing on price as well as different kinds of services offered by competing kinds of providers (as cited in Light, 2004, p. 11).

Not protected by “guild free choice” was the early pharmaceutical market, which worked in competition with turn of the century medicine (Light, 2004). Drugs were removed from the free market, instead becoming prescriptions, as a way to manage the unfettered competition between physician remedies, home remedies, druggists, and charlatans (Light, 2004). Freedom and choice rested on the power, autonomy, and control of the professional caste (Light, 2004). As they worked on trust building through the legitimization of medical licensure, professionals were regarded as a benevolent form of social control (Light, 2004, p. 11). Larson stated: “Professionals live within ideologies of their own creation, which they present to the outside as the most valid definitions of specific spheres of social reality” (as cited in Light, 2004, p. 11). As they passed laws and regulations that benefited themselves, benevolent social control took on instead the semblance of class control, led by the professional caste of the self-serving elite (Light, 2004).

In the years that led up to World War 2 (WW2), the U.S. healthcare system emphasized power rather than efficiency, providing the best clinical care and cutting edge medicine to paying patients (Light, 2004). Physician autonomy was valued as a method of legitimizing the dominance of professional medicalism, challenging peers risked

delegitimization, leaving medical practice to be driven by personal ideology (Light, 2004). Despite early efforts to standardize, there failed to be a widely practiced standard of care. Instead, individual ideology came to dictate treatment practices, always proclaimed to be the "one right way", this was termed as medical monotheism (Jones & Podolsky, 2015; Szasz, 2006). Following WW2, medical services were socialized, becoming normalized as part of the government's responsibility to provide to their citizens (Light, 2004). Even as responsibility became a matter of the state, the pre-war professional monopoly of healthcare continued (Light, 2004). Moves that would meet the needs of the masses, such as public insurance, were seen as a threat to the monopoly (Light, 2004). There was the separation of medicine from public health, and medicalization instead began to focus on the individual's personal habits (Light, 2004).

The rise of pharmaceutical companies took place at this time, taking part in a Golden Era of medicine, with an increase in molecular development and the rise of the Randomized Control Trials (RCT) (Abraham, 2010; Gaudilliere, 2021; Jones & Podolsky, 2015; Light, 2004). RCTs came to be recognized as the "gold standard" method in determining best courses of treatment (Dumit, 2012; Jones & Podolsky, 2015). Defined as the "exemplar of quality and reliability," pharmaceutical treatments were tested on large populations, allowing for research to identify the statistically best course of treatment, the gold standard (Jones & Podolsky, 2015, p. 1502).

Debates around the concept of a medical gold standard, the idea that there is one best way to receive treatment, took on the religious overtones and absolutism of medical monotheism (Jones & Podolsky, 2015; Szasz, 2006). Favaloro stated "Randomized trials have developed such high scientific stature and acceptance that they are accorded an almost religious sanctification...If relied on exclusively they may be dangerous." (as cited in Jones & Podolsky, 2015, p. 1503). Pharmaceutical companies have little economic incentive to test whether their treatments were best when compared to non-pharmaceutical options or for short term use, as both would result in less consumption of their product (Dumit, 2012). Day to day medical practice saw the impact of these medications on the individual rather

than as a statistic (Jones & Podolsky, 2015; Szasz, 2006). Decisions were made that varied from the predetermined “gold standard” due to physicians’ agency, biological reactions, or patient preferences (Dumit, 2012; Jones & Podolsky, 2015; Szasz, 2006). Where medical monotheism was absolutism practiced by the physician, gold standards were absolutism practiced by the pharmaceutical companies (Jones & Podolsky, 2015; Szasz, 2006). These absolutisms are not always in alignment (Dumit, 2012).

Pharmaceuticalization, the expansion of pharmaceutical treatments into different matters of life and health, has come to exist as an overlapping yet still distinct market with healthcare (Abraham, 2010; Light, 2004; Williams et al., 2008). The pathologization of social deviance has become today a target for the marketing, selling, and consumption of pharmaceuticals (Abraham, 2010; Szasz, 2006). Pharmaceuticalization can expand independent of medicalization; pharmaceuticals are developed to treat established medical conditions, e.g. buprenorphine for addiction, or as “magic bullets” for everyday life, e.g. viagra (Williams et al., 2008, p. 814). Pharmaceuticalization has come to have five main explanatory factors: biomedicalism, medicalization, industry drug promotion and marketing, consumerism, ideology or policy of the regulatory state (Abraham, 2010, p. 606).

Federal funds were directed towards the growth of academic research into pharmaceutical development, creating “academic healthcare empires” (Light, 2004, p. 14). As they continued to make great advancements in medical science, these advancements were rarely experienced by impoverished or disenfranchised populations that had pressing public health needs, as healthcare saw increased corporatization (Light, 2004). With lackluster attempts by Nixon to regulate socialized medicine, shortly followed by his impeachment and the delegitimization of his administration, discourse as it pertained to these monopolies was that regulation does not work (Light, 2004). In failing to regulate, the Reagan Era was able to enter with market based solutions; the continued privatization of healthcare services, cutting social programs, and increased policing (Dollar, 2019; Light, 2004). As the federal government became economically invested in the monopolization of healthcare, it created a medical industrial complex that saw variability in quality, rapidly rising

costs, and “greater efficiency”, meaning those experiencing extreme illness or disability were denied due to the added resources they required (Light, 2004).

Healthcare had effectively transformed into a government monopoly rather than a space of science (Light, 2004; Szasz, 2006). This monopoly was imposed by the state but naturalized by the people; only those licensed by the state could call themselves physicians, medical practice was conducted in accordance with state standards, and legal substances were only those approved by the state (Light, 2004). Deviations from this standard of care were considered criminal offences, delegitimized, or found threatening (Light, 2004; Szasz, 2006). Despite these strict standards, medical practice at this time was inefficient, impersonal, varying in quality and distribution, as the medical professional caste grappled with increased marketization (Light, 2004). A trend that continues today (Light, 2004).

What began as a theocracy, the alliance between religion and state, Western medicine has since transformed into a pharmacracy, the alliance between medicine and state (Szasz, 2006). A healthcare system designed in the name of professionalism has evolved to become the most “costly, inefficient, wasteful, and inequitable healthcare system in the industrialized world,” (Light, 2004, p. 19). These pitfalls in the modern healthcare system make for good markets as multi-billion dollar beneficiaries lobby to keep them in place (Light, 2004). Where provider driven ideology had led to a sacred trust in doctors, benevolent control, a shift to a buyer driven ideology sees increasing distrust of doctors’ values, decisions, and competence (Light, 2004, p. 19). Years of medical hubris wreaked havoc on the lives of trusting patients, one such instance being the Opioid Epidemic, where prescription opioids became a leading cause in an epidemic (Hasin et al., 2022; Light, 2004; Szasz, 2006). The conception of control has shifted as today the medical industry faces historic crises: a loss of legitimization, a loss of trust, attacks from insurance and pharmaceutical industries, and a patient body that is also in crisis (Dumit, 2012; Light, 2004).

2.2.2 A History of Addiction Treatment

While still closely related in practice and philosophy today, medicine and religion

began to diverge as medical science continued to evolve (Szasz, 2006). Actions that had previously been explained as “sinful” or “madness” began to be pathologized as a “bodily disease” (Szasz, 2006). Rush, the father of American psychiatry, stated, “Perhaps hereafter it may be as much the business of a physician as it is now of a divine to reclaim mankind from vice,” (as cited in Szasz, 2006, p. 331). Rush’s work focused on turning “badness” into a medical malady to be treated in the same way as an observable disease (Szasz, 2006). However, “badness” is a matter of culturally situated morality based on religion, society, and law (Szasz, 2006). It is not objective, scientific, or based on medical observations (Szasz, 2006). Any subjectively determined abnormal behavior, e.g. homosexuality or substance use, had the potential to be pathologized, as represented in the effort of Krafft-Ebing who worked to reframe sins into sicknesses (Szasz, 2006, p. 332).

Known as the Virchowian standard, disease used to be tied to observable and fixed criteria (e.g. chickenpox), but in pathologizing culturally situated behaviors, disease no longer became tethered to the material world (Szasz, 2006). Science today is still synonymous with materialism, understood as objective and absolute, however the demarcation of disease has long since switched to a Fiat standard, one based in the nonmaterial of behavior and abnormalities (Szasz, 2006). Barondes argues that while the border between illness and normality is ill-defined, and the definition of normality is debated, there are instances of behaviors so maladaptive that they move past the social uncomfortability of abnormality where illness is the only reasonable designation (as cited in Szasz, 2006, p. 331). While behavior is real, it is not always material, and it is more often the social that determines what qualifies as bad, good, and abnormal (Szasz, 2006). Contemporary biologists and scientists dealing with matters of the mind and brain conflate the two as interchangeable, despite the brain being material and the mind being non-material (Szasz, 2006).

Nosology today works to understand and demarcate disease (Szasz, 2006). Disease has come to be used as a value-neutral term, describing observable aspects of the material world, i.e. Virchowian standard (Szasz, 2006). Disease is also used as a value-laden, ethical

term that is used to excuse, condemn, or justify human behaviors, i.e. Fiat standard (Szasz, 2006, p. 326). That the term “disease” is used in both these ways, is regularly overlooked (Szasz, 2006). The subjectivity of the Fiat standard allows for outside influence from political authorities, activists, and popular opinion in the creation of diagnostic labels for unwanted behavior (Szasz, 2006). It created a symbiotic relationship between medical experts and the public (Szasz, 2006). The flexible definition of disease allows for greater economic support and new markets, but impacts scientific credibility as the public gains a voice in determining what should be pathologized, but loses the security of clearly defined diseases (Szasz, 2006). Nosology is put in a place of crisis, torn between the desire for scientific precision and compassion for those seeking to explain abnormal behavior (Szasz, 2006).

The use of substances have long been understood as behavioral, non-material, a situated feature of life, only recently coming to be pathologized. In Western culture, some uses of substances such as a glass of wine or a prescription, are normative, even considered healthy (Dollar, 2019). Other uses that fall outside the boundary of normal are seen as pathological, an addiction, with acceptable responses being criminal punishment or medicalization (Dollar, 2019, p. 317). This has allowed the societal response to addiction over the last couple centuries to swing from moral failing to disease (Dollar, 2019; Henninger & Sung, 2014). Addiction has prompted three overarching responses from society: first criminalization, followed by medicalization (abstinence), and much more recently pharmaceuticalization (Lindsay & Vuolo, 2021; Madden, 2019). Where criminalization was originally used as a form of behavior management, medicalization has historically provided the opportunity for rehabilitation, but both have become political tools in managing specific populations (Dollar, 2019; Lindsay & Vuolo, 2021: Scarritt, 2022). The widespread use of substances functions as both a crime and a public health threat (Lindsay & Vuolo, 2021).

Early U.S. addiction rhetoric was concentrated primarily on alcohol use (Henninger & Sung, 2014). Alcohol was an integrated part of the culture, but public drunkenness was considered socially unacceptable (Henninger & Sung, 2014). Targeted interventions for alcoholism ranged from moderation to abstinence (Henninger & Sung, 2014). In the early

19th century, “drunkards” were typically incarcerated for short periods in order to sober-up, as hospitals, almshouses, and asylums were limited in number and none offered treatment (Henninger & Sung, 2014). The Temperance movement was formed, offering a communal space of recovery with abstinence but, led primarily by middle class white women, it eventually came to target the Irish (as economic and criminal threats), non-protestant white people, and “violent” African Americans (Dollar, 2019; Henninger & Sung, 2014; Lindsay & Vuolo, 2021).

As physicians began identifying the material and observable consequences of addiction, institutionalization came to be a common form of treatment (Henninger & Sung, 2014). In the late 19th century, the American Association for the Cure of Inebriation formed with the goal of professionalizing treatment, arguing addiction was a disease not a vice (Henninger & Sung, 2014). Inebriate asylums focused on medical treatment — isolation, inpatient, short, and long detoxification — receiving state sponsorship and making the first attempts at outpatient and continuum of care (Henninger & Sung, 2014). The focus was to return the body to a healthy state, prioritizing exercise, meals, and vitamins (Henninger & Sung, 2014). However, this period also saw early iterations of pharmaceutical therapies, using “miracle cures” that consisted of cocaine, morphine, opium, and cannabis; sold by both doctors and charlatans as treatments that could take place in the privacy of the home (Henninger & Sung, 2014).

With early processes of urbanization and immigration, substance use and the response to substance use diversified (Henninger & Sung, 2014). An increase in opioid and cocaine addiction created the first drug epidemic in modern U.S. history (Henninger & Sung, 2014). In the early 20th century, opiates were prescribed for primarily female maladies, e.g. menstruation and hysteria (Henninger & Sung, 2014). Due to their proximity to wealth and therefore medical care, opioid addiction impacted predominantly upper middle class white women (Henninger & Sung, 2014). In response, the first morphine maintenance clinic was opened in 1912, as opioid addiction became pathologized (Henninger & Sung, 2014). Patients experiencing opioid addiction were given decreasing amounts of morphine until they

were fully weaned off in order to control withdrawal symptoms (Henninger & Sung, 2014). There was also early experimentation with maintenance programs — remaining on a low dose rather than fully detoxing — but due to the narcotic options at this time still creating a sense of euphoria, these were ultimately found to be ineffective (Henninger & Sung, 2014). Other treatment methods included insulin induced comas, lobotomy, electroconvulsive therapy, aversion therapy, and cocaine to curb opiate withdrawal symptoms (Henninger & Sung, 2014).

Despite these early 20th century medical advancements, ideologies of addiction quickly shifted back towards one of criminalization, as different substances came to be associated with those not of the white upper class (Henninger & Sung, 2014). Chinese immigrants were associated with smoking opium, leading to the 1909 Opium Exclusion Act and an increase in anti-opium ordinances in Chinese immigrant populations (Dollar, 2019; Lindsay & Vuolo, 2021). White Southerners claimed that cocaine led Black men to rape white women, increasing public panic that led to the passing of the Harrison Narcotics Act of 1914, criminalizing all psychotropic drugs, and closing all morphine maitenance clinics (Dollar, 2019; Henninger & Sung, 2014; Lindsay & Vuolo, 2021). Physicians were prohibited from prescribing drugs for detoxification or maintenance, while jails and federal penitenceries became filled with those experiencing addiction (Henninger & Sung, 2014). The Temperance movement finally succeeded in the 1920s, as their push for abstinence led to the Prohibition era (1920-1933) where alcohol was criminalized (Henninger & Sung, 2014). This was reversed, as alcohol consumption only increased during the Prohibition period, but shut down treatment options until the 1940s (Henning & Sung, 2014). The Great Depression, overlapping the end of the Prohibition, also led to an increase in alcohol consumption (Dollar, 2019). Disenfranchised white populations using alcohol as a method of coping reframed who alcohol was associated with, followed shortly after by a return in medicalization for alcohol addiction (Dollar, 2019). With the passing of the Marijuana Tax Act of 1937 because marijuana was associated with Mexican immigrants, all psychotropic substances were removed from the free market via criminalization and negative association, the only

exception being alcohol (Dollar, 2019; Light, 2004; Lindsay & Vuolo, 2021).

In 1935, a self-help recovery group called Alcoholics Anonymous (AA) began, wherein a focus on religion and sobriety would come to turn unstructured meetings into a self sufficient organization with one of the strongest treatment ideologies that exists today (Henninger & Sung, 2014). Today, AA is widely known for its 12-step program to addiction recovery (Henninger & Sung, 2014). The program begins with the admittance of a problem and the need for help followed by making amends, finding faith in God, and pursuing lifelong sobriety (Henninger & Sung, 2014). Their focus lay not in why they became an alcoholic but how to maintain abstinence (Henninger & Sung, 2014). Prior to AA, hospitals saw addiction as a matter of morality and resisted treating it (Henninger & Sung, 2014). AA advocated for the perception of addiction as a disease, eventually convincing local hospitals to treat it (Henninger & Sung, 2014). AA trained hospitals in how to treat addiction, suggesting separate wards, peer management, and taking on the added financial pressure of treating addiction (Henninger & Sung, 2014, p. 2263). AA normalized the role of recovered peers in treatment settings (Henninger & Sung, 2014). A practice that was at first debated, would eventually allow for the professionalization of peer recovery, something seen as normal in treatment spaces for both drugs and alcohol today (Henninger & Sung, 2014).

The methods developed by AA would expand into prisons and psychiatric hospitals, returning addiction to a paradigm of disease (Henninger & Sung, 2014). The overcrowded prisons from the prior criminalization paradigm led to the creation of two Narcotic Farms; federally recognized facilities for drug offenders, one of which would house the first Narcotics Anonymous meeting (Henninger & Sung, 2014). Narcotics Anonymous (NA) welcomed those experiencing addiction to any other substances, otherwise replicating the AA model and eventually becoming internationally renowned (Henninger & Sung, 2014).

The late 1950s identified addiction as a transferable social disease, where people were immersed in a destructive lifestyle they were unwilling or unable to change (Henninger & Sung, 2014, p. 2265). The Minnesota Model of treatment began at this time, a method still used today (Henninger & Sung, 2014). It approached addiction treatment as multidisciplinary

and holistic, with a primary tenet being mutual respect (Henninger & Sung, 2014). It promoted the professionalized medical treatment provided by doctors and nurses, counseling by psychologists and social workers, and spiritual guidance by the clergy (Henninger & Sung, 2014). Civil Commitment ensured that substance users were treated rather than incarcerated through court ordered institutionalization, although they failed to be successful in initiating sustained abstinence (Henninger & Sung, 2014).

In the post WW2 rise to the Golden Era of Medicine, addiction's reconceptualization as a disease opened the door for funding opportunities, intervention, and research, taking part in the academic healthcare empires of this time (Henninger & Sung, 2014; Light, 2004). In 1961, a joint committee of the American Bar Association and the AMA, suggested resuming maintenance programs, followed by a Supreme Court decision to prohibit laws that criminalized addiction (Henninger & Sung, 2014). Researchers were finally validated in their claims that immediate and sustained abstinence was an unrealistic treatment method for all those experiencing addiction (Henninger & Sung, 2014). Previously prohibited in the U.S., what is commonly known today as methadone, returned to use in the 1960s as a narcotic option that curbed withdrawal symptoms and cravings (Henninger & Sung, 2014). With calls for new research on pharmacotherapies for addiction treatment, buprenorphine and naltrexone were both synthesized in the 60s (Henninger & Sung, 2014). Each of these three medications were bio-chemically different in their treatment of physiological dependence, but with buprenorphine and naltrexone not being Food and Drug Administration (FDA) approved until decades later, methadone's use in detoxification and maintenance was normalized (Henninger & Sung, 2014).

Despite the rise in pharmacotherapies, criminalization remained a common response to the use of substances. Those experiencing non-alcohol related addiction would seek treatment in psychiatric hospitals to avoid criminal charges (Henninger & Sung, 2014). While a few drug treatment programs began in New York City to treat rising heroin rates amongst youths, hospitals were still resistant and 28 day detoxifications took place at Riker's Island Penitentiary (Henninger & Sung, 2014). Prisons played an active role as drug treatment

facilities, with criminal justice referrals being the largest source of publicly funded drug treatment admissions, known as “coerced treatment” (Henninger & Sung, 2014, p. 2267). Drug Treatment Alternative to Prison (DTAP), leveled the threat of incarceration against the recovery process, to much debate at the role legal coercion played for those seeking treatment (Henninger & Sung, 2014). While legal coercion created incentives to enroll, coercion by itself did little when not supported by evidence based methods (Henninger & Sung, 2014).

Following the end of segregation and the passing of the Civil Rights Act of 1964, the early 1970s saw an influx of socially conservative policies as it pertained to the pharmaceuticalization of substance treatment (Fiscella et al., 2019; Heidbreder et al., 2023; Scarritt, 2022). The Controlled Substance Act of 1970 placed regulated substances into schedules of addictiveness and the Narcotic Addict Treatment Act in 1974 (NATA) regulated pharmacotherapies used for addiction treatment, primarily methadone at this time, in order to mitigate their potential misuse (“Drug Scheduling”, n.d.; Heidbreder et al., 2023; Henninger & Sung, 2014). Both pieces of legislation primarily impacted those experiencing racial and class marginalization, increasing disparity in treatment affordability, stigmatization, and negative stereotypes associated with these populations (Heidbreder et al., 2023). These were intentional goals of the Nixon (1969-1974) administration, as Nixon’s policy advisor, Ehrlichman, said as much:

> We knew we couldn’t make it illegal to be either against the war or blacks, but by getting the public to associate the hippies with marijuana and blacks with heroin, and then criminalizing both heavily, we could disrupt those communities. We could arrest their leaders, raid their homes, break up their meetings, and vilify them night after night on the evening news. Did we know we were lying about the drugs? Of course we did. (as cited in Taifa, 2021, para. 2).

A decade later, the Reagan Era (1981-1989) would continue the War on Drugs initiated by Nixon, passing the Anti-Drug Abuse Act of 1986 that strengthened criminalization as a response to substance use (Lindsay & Vuolo, 2021).

The Crack Epidemic that took place during the Reagan Era led to increased criminalization of crack cocaine, a solid form of cocaine that was widely associated with Black communities (Dollar, 2019; Lindsay & Vuolo, 2021; Taifa, 2021). These communities were met with decades of incarceration for small and first time drug offenses (Taifa, 2021). Health professionals found there would be no benefit for investing in the development of cocaine-maintenance programs, instead putting the onus on families to discuss the threats drugs posed with children (Dollar, 2019; Lindsay & Vuolo, 2021). Mass criminalization was used to justify a divestment from social welfare programs, choosing to allocate funds towards increased policing in targeted communities (Dollar, 2019). The Supreme Court determined these policies to be constitutional because although they were found to be cruel, they were not unusual due to the frequency of criminalization (Taifa, 2021)

The Opioid Epidemic followed shortly after the Crack Epidemic, although it presented vastly different responses from the public (Lindsay & Vuolo, 2021). Physicians, more likely to believe white patients' claims of pain than Black patients', positioned their white patients as the main victims in this epidemic (Lindsay & Vuolo, 2021). Today, prescription opioids tend to be misused more than illicit opiates, however patterns of opioid prescription disparity helps to understand how different opioids continue to be associated with different communities; fentanyl and heroin for Black people, and prescription opioids for white people (Dollar, 2019). It was not until the second and third stage of the epidemic — the flood of cheap heroin and fentanyl on the market, respectively — that it began posing a higher risk for non-white populations (Lindsay & Vuolo, 2021). By this time, the face of the opioid user had already been largely characterized as an upper middle class white woman — a demographic often graced with inherent morality from Western society — leading to a divestment in law enforcement and an expansion in the medicalization paradigm (Dollar, 2019; Lindsay & Vuolo, 2021). From the start of the Opioid Epidemic in 1995, criminal justice policy went from "get tough" to decarceration and rehabilitation (Lindsay & Vuolo, 2021, p. 942).

Despite debates surrounding the use of opioids in treating opioid addiction, physician accessibility of pharmacotherapies are supported by pro-medicine political candidates,

pharmaceutical companies, and the American Medical Association's Political Action Committee (AMPAC), one of the most powerful lobbies in the U.S. (Dollar, 2019). That said, abstinence and sobriety are still promoted internationally by the dominant AA / NA, and abstinence continues to make up the majority of medical curriculums for addiction treatment (Henninger & Sung, 2014; Madden, 2019). Criminalization is still reserved as a response for addiction within specific communities, maintaining and justifying the stigmatization of addiction (Dollar, 2019; Lindsay & Vuolo, 2021; Madden, 2019). Although overlapping, the pathologization of addiction is met today with three distinct ideologies of treatment (Dollar, 2019; Henninger & Sung, 2014; Lindsay & Vuolo, 2021; Madden, 2019).

The first of these is pharmaceuticalization. In the 1990s the National Institute of Health (NIH) endorsed the use of MAT (Medication-Assisted Treatment), specifically advocating for opioids methadone and buprenorphine as "the Gold Standard of addiction care" (SAMHSA, 2014 as cited in Madden, 2019). The history of MAT depicts unequal regulation dependent on the class and race of those using these medications (Madden 2019). Methadone came to be associated with urban (i.e. Black) heroin users, leading to strict regulations and stringent dispensing: "treated like inmates" (Madden, 2019, p. 329). Buprenorphine, on the other hand, came to be associated with white, suburban, prescription opioid users, a medication that "treats addiction like a true disease" (Madden, 2019, p. 329). Although both are prescribed as a means of managing physiological dependence, they both face significant stigmatization in healthcare (Madden, 2019).

The second dominant ideology is abstinence, or the process of treating addiction without the use of pharmacotherapies. Abstinence rejects the use of MOUDs with few exceptions (Madden, 2019). Madden (2019) labels this as "intervention stigma", differentiated from "condition stigma". Intervention stigma is associated with the medical intervention, e.g. buprenorphine or abortion, while the latter is associated with the medical problem, e.g. addiction or unwanted pregnancy (Madden, 2019). The common abstinent perspective is that MOUDs trade one drug for another, creating persistent negative judgement from multiple facets of society (Madden, 2019, p. 327). "Provider based stigma"

— the use of pejorative language, or the refusal to care for patients due to their condition or stigma — is indicative of the quality of care experienced by the patient (Madden, 2019, p. 325). Despite being pathologized, addiction still faces the stigma of a moral failing; patients often experience mistreatment from providers in this instance where pathologization and morality overlap (Madden, 2019). Patients possessing cultural capital, e.g. wealth or whiteness, are able to mitigate these instances (Madden, 2019). While condition stigma is addressed through ongoing education, healthcare curriculums continue to focus on abstinence, leaving many providers struggling to understand the medical science behind MOUDs (Madden, 2019).

The third dominant ideology is criminalization, incarceration being understood as the social consequence to a moral wrongdoing. Throughout the history of the U.S., race has played a central role in the conceptualization of substance use as socially abnormal (Lindsay & Vuolo, 2021). Today's discourse has reduced this to Black criminalization and white medicalization, but the only consistency in U.S. history is that medicalization is reserved for white people (Dollar, 2019; Lindsay & Vuolo, 2021). Criminalization has historically been used for any immigrant, racial or ethnic minority, or impoverished population, contributing to the understanding of addiction as moral badness (Dollar, 2019; Henninger & Sung, 2014; Lindsay & Vuolo, 2021; Madden, 2019). The influence of the white middle / upper class (the professional caste) on regulations, social policies, and nosology, has allowed for a historic framework that positions white populations as inherently superior, moral, and therefore deserving of medicalization (Light, 2004; Lindsay & Vuolo, 2021, p. 943; Szasz, 2006).

The medicalization of addiction saves money, reduces rates of addiction, and decreases crime, but despite similar rates of drug use, white populations overwhelmingly benefit from this treatment (Lindsay & Vuolo, 2021). Today's paradigm is one of disease, but after decades of narratives shaped by white supremacy, deviance amongst non-white populations is still responded to with criminalization, while deviance amongst white communities is responded to with medicalization (Dollar, 2019; Lindsay & Vuolo, 2021) White people living in poverty remain the exception to these benefits of whiteness (Dollar, 2019).

Not a part of the upper / middle class, nor part of the professional caste, their privilege of whiteness is limited as they are perceived as threats to the economic status quo (Dollar, 2019). Criminalizing addiction remains a tool for the social control of those perceived as threats to the social order, creating economic benefits to the maintenance of stigma and the conceptualization of addiction as a social deviance (Dollar, 2019; Scarritt, 2022).

Both medicalization and criminalization have their role in reproducing neoliberal agendas (Dollar 2019). Criminalization of addiction continues to push morality and subjugation onto certain populations found in need of increased surveillance and social control (Dollar, 2019; Lindsay & Vuolo, 2021). Medicalization, including pharmaceuticalization, promotes symptom management, therapeutics, and benefits the pharmaceutical industry through consumption (Dollar, 2019; Henninger & Sung, 2014). Neoliberalism seeks to privatize the economy and limit oversight of corporate behaviors, putting the responsibility of addiction on the individual (Dollar, 2019). Neither criminalization nor medicalization address the environmental component of addiction that contributes to the rates of substance use seen today (Dollar, 2019). Responsibility lies with the regulators to address environmental factors of accessibility, social welfare, and social violences, responsibilities they have chosen to ignore in exchange for increased policing (Dollar, 2019). The question of what role macro-structural inequalities play in the frequency of self-medication is left unchallenged, as existing hierarchies and dominant ideologies are left unquestioned (Dollar, 2019, p. 317). As historic crises threaten the current structure of healthcare, there is an opening for a fourth treatment ideology, one that does not reproduce individualism but addresses OUD at both an individual and structural level (Dollar, 2019; Dumit, 2012; Light, 2004).

2.2.3 Paradigms of Health in Opioid Use Disorder

With the rise of the global pharmaceutical industry, the paradigm of health has since shifted to account for the marketization of illness (Dumit, 2012). Older paradigms of health saw most people as healthy, with illness being an exceptional event in which to seek

treatment from a healthcare provider (Dumit, 2012). In the 1950s, medicine began relying on statistics in order to identify populations found to be “at risk”, creating targets for health interventions before the individual was ever found to be ill (Dumit, 2012). The rise of the RCTs at this time allowed for the identification of the best treatments at a level of statistical difference that was unidentifiable in day to day medical practice (Dumit, 2012). While many doctors resisted this idea, others celebrated that there was a clear, researched, best course of action for any given illness, a “gold standard” (Dumit, 2012; Jones & Podolsky, 2015).

In the 1990s, rather than the standard being health with exceptional events of illness, bodies were considered chronically ill due to different lifestyle risks, e.g. genetics, environment, or traumas (Dumit, 2012). Health became defined by perpetual feelings of insecurity, an insecurity that continues to grow with the expanse of research on illness and therapeutics (Dumit, 2012). It is now normal to know what risks threaten an individual’s health, but this has only led to further insecurity about what the future holds, while not being able to do much about it (Dumit, 2012). In expanding the rhetoric of risk — high cholesterol, family history, eating carcinogenic foods — risk is treated as if it were already an illness (Dumit, 2012). This new normal where everyone is at risk therefore everyone is ill, normalizes a state of public health crisis; is a patient normal because they have symptoms, or are they abnormal because they have none? (Dumit, 2012). “Normal” is a relative concept, but what has been predetermined to be statistically normal — risk, symptoms, treatments — are then implemented on to the individual regardless of their relative normal (Dumit, 2012; Szasz, 2006).

Environmental risk for OUD lies in socio-demographic disenfranchisement, genetics (40-60% of risk is attributed to genetics), and accessibility, but to patients it can be unclear what causes their opioid-seeking behavior (Hasin et al., 2022; Sharma et al., 2016). The demographic with the highest prevalence of both prescription and heroin use is young adults ages 18-25, most often among white men (Sharma et al., 2016). For women seeking opioids there is a higher prevalence of extremity — more using heroin, injection, and at a younger age — possibly explained by older romantic influences or adversity from gender based

violence (Sharma et al., 2016). Sociodemographic risks of heroin use include poverty, unemployment, homelessness, and a history of childhood adversity, while unemployment is associated with higher rates of overdose (Pettus, 2020; Sharma et al., 2016). Of the environmental factors, such as stress, adversity, and exposure from the surrounding community (friends, family, etc.), access to opioids is one of the most important (Sharma et al., 2016).

There is currently an ease of access for both heroin and prescription opiates leading to increased risk of OUD; opioid users are increasing, while the age associated with first using opioids is decreasing (Sharma et al., 2016). The affordability of heroin and fentanyl has made them more accessible to adolescents and impoverished communities (Lindsay & Vuolo, 2021; Sharma et al., 2016). The growth in prescription opioids within medical practice is associated primarily with white adults, although pediatrics has also experienced a growth in opioid prescriptions (Dollar, 2019; Sharma et al., 2016). Opioids are prescribed for treating pain, considered a highly prevalent condition that is both chronic and situational (Hasin et al., 2022). Prescription and illicit opioids alike, pose a risk for OUD as opioids are a highly addictive substance with a rapid progression to physiological dependence, tolerance, and withdrawal (Hasin et al., 2022; Sharma et al., 2016).

According to the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), addiction can range from mild to severe, with addiction to opioids being one of the most complex, advanced, and severe in terms of social and health consequences (Sharma et al., 2016, p. 479). Due to the material properties of the opioid receptor in the brain, opioids rank very high in the hierarchy of rewarding substances, creating a pull that encourages opioid-seeking behavior (Sharma et al., 2016, p. 2). In attempts to stop opioid use, the user experiences withdrawal — chills, diarrhea, nausea, cramps, anxiety, and extreme cravings — a push that also encourages opioid-seeking behavior (Sharma et al., 2016). In addition to the push-pull of opioid use, steady exposure produces neuroadaptation and physiological dependence (Sharma et al., 2016).

Although there is yet to be a prescription that manages the risk *for* OUD, prescription

opioids being a risk, MOUDs do help to manage the risks *of* OUD (e.g. co-morbidities, overdose) borne from physiological dependence (Henninger & Sung, 2014; Sharma et al., 2016). Abnormal substance-seeking behavior is medically defined as a Substance Use Disorder, a chronic and relapsing brain disease (Henninger & Sung, 2014, p. 2257). In order to maximize the market, there is an emphasis on the length of time one is on any prescribed medication, as any patient not consuming treatment is viewed as a loss (Dumit, 2012). This makes chronic diseases and long term treatments for them a valuable investment, while vaccines are divested from as one time treatments (Dumit, 2012). Guidelines for treating OUD are the use of pharmacotherapies as maintenance, or for long term use (Paul et al., 2022). Clinical trials rarely test the extended use of medications over the course of one's life, or if there are best routes that exclude the use of medications (Dumit, 2012).

In the new paradigm of health the average patient receives 9-13 prescriptions a year in order to maintain normality (Dumit, 2012). "Not to cure the condition but to reduce the risk factor and potential future events" (Dumit, 2012 p. 5). "Normal" and "health" have become severed concepts as Americans spend more time, more energy, and more money on health than ever before; health becomes simultaneously a national cost to be reduced and a market to be grown (Dumit, 2012, p. 4). As risk rather than disease is treated, it creates a paradox: are you sick because you're taking medication, or healthy because you're reducing risk (Dumit, 2012, p. 7). In the event of treating OUD, it is neither the disease nor the risk, but the behavior being interrogated: 'Are you still an addict because you are taking opioids, or are you recovered because they are a treatment?'. The distinction between healthy treatment and chronic illness is vague, as treatments are taken chronically (Dumit, 2012).

Demarcating chronic abnormal behaviors as diseases, allowed for the potential of many new markets to treat "mental illness", markets that could then be situated within a paying demographic (Dumit, 2012). In narrowing the definition of normal behaviors, e.g. outlawing substance-use, there is more space to market treatments for abnormal behaviors (Dumit, 2012; Light, 2004; Szasz, 2006). Of 400 identified diseases, only 50 are considered commercially attractive (Dumit, 2012). Due to the stigma associated with addiction, a lasting

impact from continued criminalization, it is likely not considered commercially attractive (Madden, 2019). Perhaps indicating an effort to increase marketability, there is a push in distinguishing between Opioid Use Disorder and Prescription Opioid Use Disorder (POUD) (Hasin et al., 2022).

Prescription and illicit opioids alike, share the same pharmacological features with evidence suggesting a relationship between the use of prescription, the non-medical use of prescriptions, and the use of heroin (Sharma et al., 2016). When using any opioid for an extended period, there will likely be efforts to maximize drug availability in order to manage physiological dependence ("How Opioid Use Disorder Occurs," 2024). This leads to different techniques of consuming substances, often beginning with oral (pills), to inhalation (snorting, smoking), to injection (Sharma et al., 2016). When diagnosing OUD, the DSM-5 has identified eleven criteria for SUD, grouping it with disorders such as Antisocial Personality Disorder, sensation-seeking, and impulsivity (Hasin et al., 2022). The criteria for OUD includes indications of physiological dependence, and nine behavioral criteria (Hasin et al., 2022). A complete OUD assessment distinguishes between three levels of severity and includes: reviewing medical and social history (i.e. environment), the presence of physical characteristics of opioid use, urine drug screens, and psychiatric evaluations (Hasin et al., 2022; Sharma et al., 2016, p. 8). Due to the subjectivity of identifying abnormal behaviors, it is difficult to identify OUD or track trends in its prevalence (Hasin et al., 2022; Szasz, 2006).

The criteria in the DSM-5 was initially developed with heroin users in the 1980s, and as such, is explored and legitimized for illicit substances but not prescribed opiates (Hasin et al., 2022). Individuals using opioids as prescribed, who still experience tolerance and withdrawal, are currently not recommended to be diagnosed with OUD, while others have disagreed proposing this phenomenon be labeled "Complex Persistent Opioid Dependence" (Hasin et al., 2022, p. 716). As this is not yet operationalized, the FDA is currently investing in further studies to develop, legitimize, and standardize a diagnostic criteria for Prescription Opioid Use Disorder (POUD) (Hasin et al., 2022). POUD is differentiated from OUD, proposing that the substance-seeking behavior is motivated by therapeutic effects (pain

relief), rather than externalizing symptoms (getting high) or internalizing conditions (depression and anxiety) (Hasin et al., 2022, p. 716). While OUD is considered the material manifestation of psychopathology, POUD is not characterized as such, instead being characterized by the therapeutic intent of pain management (Hasin et al., 2022, p. 716).

That said, the diagnostic label differentiates not by motivation, but rather the supplier of the opioid, “Prescription”, emphasizing its association with the professional caste (Dollar, 2019). “The primary suppliers of the opioids being misused are White, male, financially wealthy, highly educated, and prestigious,” (Dollar, 2019, 314). This references the majority of doctors responsible for over-prescribing opioids who contributed to the current epidemic (Dollar, 2019). Despite being a minority, doctors who have been held publicly accountable for over-prescribing are typically foreign born or non-white (Dollar, 2019). The emphasis on the source of the opioid contributes to efforts where the supplier is factored into the social response of substance-seeking behavior (Dollar, 2019). Disparity in the social response to OUD is validated as the user with an illicit supplier is mentally ill and the user with a professional supplier is seeking pain management, regardless of suppliers’ ethics or patient intentions (Dollar, 2019). The push to differentiate between POUD and OUD, requires further research, as I identify a number of concerning implications[1].

Once diagnosed with OUD patients and physicians can then choose a course of treatment, the gold standard being pharmacotherapies (Hasin et al., 2022; Madden, 2019). Healthcare practitioners, concerned at the ease with which their patients could be put on medications but not taken off, became targeted as the gatekeepers between the patients and pharmacotherapies (Dumit, 2012). Sixty years ago, doctors pushed for personal diagnosis, insisting on symptomatic diagnoses, etiological treatments, and drugs as cures (Dumit, 2012). Physicians manage what they consider the overprescribing of opioids, even

[1] It creates a diagnosis with a commercial demographic — white, middle class, professional being more likely to have access to healthcare — increasing the marketability of addiction treatment (Dollar, 2019; Dumit, 2012). POUDs marketability increases profitability in the exploitation of those using prescription opiates, normalizing addiction as a potential side effect (Dumit, 2012; Hasin et al., 2022). While opioid prescriptions have started to decline, more than 14,000 people died from prescription opioid overdose deaths in 2019 (Hasin et al., 2022, p. 715). It fails to consider the physiological dependence regardless of the behavioral intention (Sharma et al., 2016; Szasz, 2006). Finally, it fails to consider environmental components in therapeutic motivations, where poverty, racism, or gender-based violence are not pain in need of treatment (Dollar, 2019; Szasz, 2006). It ignores the disparity in pain prescribing between different populations, or that therapeutic motivations could exist outside of traditional markets (Dollar, 2019).

when prescribed as treatments, in different ways (Madden, 2019). For instance, even though concurrent treatment is found to be more effective for OUD patients with other psychiatric illnesses, physicians can and will refuse medications until their patient can “get clean” (Sharma et al., 206).

To manage the power doctors hold as gatekeepers, pharmaceutical companies went straight to the consumer with direct to consumer advertising, working in collaboration with the public to broaden the definition of disease (Dumit, 2012; Szasz, 2006). Direct to consumer advertising allows patients to take their health into their own hands, becoming an “expert patient”, with gold standard treatments providing a focus for the expert patient to rally behind (Dumit, 2012; Jones & Podolsky, 2015). Patients are able to “shop around” for a healthcare professional who meets the standard of care they expect (Light, 2004, p. 19). As the hegemony of the healthcare practitioners’ professional caste shrinks, challenges to their dominance might increase risk for the patient (Light, 2004; Madden, 2019). Official treatment guidelines specify the collaboration between physician and patient, to discuss and consider the risks of ceasing pharmacotherapies for OUD, however, these are often not followed (Madden, 2019).

Despite the justifiable hesitancies of prescribing yet another opioid, Buprenorphine’s innovative characteristics make it extremely low risk, difficult to misuse, and protect the user against overdose (Grinspoon, 2024; Sharma et al., 2016). Being a partial opioid agonist, Buprenorphine attaches and activates the opioid receptor, but not to the full degree of an opioid agonist, alleviating symptoms of withdrawal and cravings, while not creating euphoric effects (Grinspoon, 2024; Henninger & Sung, 2014). Methadone is an opioid agonist, so it also alleviates symptoms of withdrawals and cravings, but while it is supposed to produce no euphoric effects there are reports of euphoria when using methadone (Henninger & Sung, 2014; Smith et al., 2025). Naltrexone and naloxone are both antagonists, meaning they bind to the opioid receptor but do not activate it, producing no euphoria (Henninger & Sung, 2014). These antagonists manage withdrawal symptoms while blocking euphoric effects when using other substances, however not being opioids means they do not suppress

cravings in the way of methadone and buprenorphine (Henninger & Sung, 2014). Buprenorphine is also often paired with an antagonist, providing the best characteristics of both methadone and naltrexone (Henninger & Sung, 2014).

As a partial opioid agonist buprenorphine produces a ceiling effect, meaning while someone might try to take more than the prescribed dose, the biological response is capped and independent from the size of the dose (Grinspoon, 2024; Henninger & Sung, 2014). Further, buprenorphine-naloxone medications are taken sublingually, a way in which buprenorphine can be absorbed but naloxone cannot (Sharma et al., 2016). As naloxone immediately reverses the effects of an opioid upon injection, when attempting to misuse a buprenorphine-naloxone medication, naloxone is able to be fully absorbed, putting the user into precipitated withdrawal (Sharma et al., 2016). Precipitated withdrawal happens when taking buprenorphine or naloxone while other opiates are still in the system (Brico, 2024). These medications rip opioids that are attached to the opioid receptors off of them, creating a highly uncomfortable, but lifesaving experience when at risk for overdose (Brico, 2024). Taking buprenorphine too quickly after other opioids will send the user into precipitated withdrawal, however, when using opiates after buprenorphine, it keeps the opiates from attaching and the user from experiencing any of their physiological effects (“What Happens if You Take Drugs While on Suboxone”, 2025).

Relapse is a natural part of recovering from OUD, with up to 91% of people in recovery experiencing it in their first year of recovery, defined as a full return to the normal patterns of behavior before initiating recovery (“A Guide to Addiction Relapse”, 2025). Although normal, relapse poses an increased risk as sustained abstinence decreases tolerance; a lower tolerance and a return to normal use puts someone at risk for accidentally overdosing as their body is no longer adapted to the amount prior to abstinence (“The Connection between Relapse and Overdose,” 2024). Buprenorphine and methadone being opioids, could protect against tolerance depletion in a way naltrexone may not. Despite the protective innovations of buprenorphine, it still possesses a lot of stigma as an opioid (Madden, 2019).

Currently the most popular option for those seeking addiction treatment is the 12-step program, promoting abstinence (Bedford, 2025; Madden, 2019). Such a course of treatment provides an instance of spirituality and community in a time that is characterized by individualism and a cultural distaste for religion (Bedford, 2025, p. 60). This environment provides the security of a shared code, where no one is turned away for having the wrong beliefs, in a rare instance where consumption is not the primary method of treatment (Bedford, 2025; Dumit, 2012; Gaudilliere & Sunder Rajan, 2021). Carrette & King critique this system, suggesting that it reproduces an individual responsibility for addiction and treatment, calling it “psychologized spirituality” (as cited in Bedford, 2025, p. 64). In response to their critique, Watts argues that 12-Step encourages an individual reflection on collective conscience, so what appears as individualism is in reality “moral and collective in nature,” (as cited in Bedford, 2025, p. 65).

Both responses have valid arguments, and both are correct. Even when collective in nature, 12-Step fails to hold structural systems accountable for their role in creating an environment correlated with substance-seeking behavior (Dollar, 2019; Muniesa, 2017; Sharma et al., 2016). However, the most popular course of treatment being one that is freely available, that focuses on community and spirituality, that often rejects consumption even as treatment, should also be acknowledged for the threat it poses to modern paradigms of health (Baus et al., 2023; Dollar, 2019; Dumit, 2012; Madden, 2019).

The privatization of biomedical research has created a healthcare system that prioritizes profit before health (Dumit, 2012). Shifts in power and legitimization need to be contextualized within the larger values of a for-profit industry that systematically pushes for consumption (Abraham, 2010; Dumit, 2012). Alongside the expansion of pharmaceutical treatments, their consumption is advocated for by the expertise of activists among patient-consumer organizations (Abraham, 2010). The pro-pharmaceutical customers, often outnumbering their adversaries, may see the expertise of the healthcare practitioner as unnecessary, treating the pharmaceutical as a commodity as they participate in its marketization (Abraham, 2010; Williams et al., 2008). A culture of consumerism shifts those

seeking healthcare into less a patient seeking expertise, and more so a customer seeking a commodity (Abraham, 2010; Williams et al., 2008). Pharmacists are aware they are running a business, and risk losing customers if they resist selling an in-demand product (Abraham, 2010; Williams et al., 2008). Doctors — overworked, constantly presented with cutting-edge advancements, and in crisis with insurance and pharmaceutical companies — are overwhelmed with demands that might be antithetical to their personal morals or understandings of best scientific practice (Dumit, 2012, p. 14).

2.2.4 Situating Buprenorphine

Although buprenorphine, naltrexone, and methadone, are often examined as one in the same, I attempt to focus my research on buprenorphine specifically. As such, I examine the development of this molecule, beginning with its synthesis in 1966 by John Lewis and Kenneth Bentley (Heidbreder et al., 2023). As depicted in 2.2.2 The History of Addiction Treatment, this decade passed two pieces of legislation that attacked the pharmaceuticalization of addiction treatment, however that did not stop buprenorphine's pharmacological profile being presented as an option for treating narcotics addiction (Heidbreder et al., 2023; Henninger & Sung, 2014). By 1985 the FDA approved buprenorphine as a painkiller, or Schedule V analgesic (Poliwoda et al., 2022). Schedules are used as a method of estimating a substance's level of addictiveness, so being Schedule V, this painkiller was amongst the lowest risk for addiction ("Dug Scheduling," n.d.; Poliwoda et al., 2022; Grinspoon, 2024). Once buprenorphine entered the market as a treatment for addiction, however, all buprenorphine products were reclassified as a Schedule III substance, on par with the addictiveness of ketamine or anabolic steroids ("Drug Scheduling", n.d.).

The standard process of a pharmaceutical innovation is the development of a New Molecular Entity (NME) and the ability to demonstrate therapeutic efficacy, where those found most therapeutic are then the most valuable in terms of patient health (Abraham, 2010). In determining a drug's price, the high cost of development and testing of NME are

used to justify the high cost of a medication (Barenie & Kesselheim, 2021). Buprenorphine's development, however, was initially discovered by academic researchers, before being tested and commercialized by pharmaceutical companies (Barenie & Kesselheim, 2021). It received significant public funding as millions of dollars in awards were invested in buprenorphine research by the NIH, dating back to the 1980s (Barenie & Kesselheim, 2021). In 1994 the manufacturer, Reckitt Benckiser, and the federal government entered into a partnership called the Cooperative Research and Development Agreement (CRADA), with the goal of commercializing and putting onto the market two buprenorphine products for OUD treatment in the next five years (Barenie & Kesselheim, 2021; Dorman, 2019; Heidbreder et al., 2023). Both products were a daily medication, however, Suboxone was a buprenorphine / naloxone medication that was briefly considered for take-home use, while Subutex was just buprenorphine (Heidbreder et al., 2023). The CRADA would last almost twice as long as originally planned, but did successfully meet their goal with the FDA's approval of Subutex and Suboxone in 2002, releasing them onto the market in 2003 (Heidbreder et al., 2023).

Despite significant investment using public funds, Reckitt & Benckiser was allowed prolonged monopolies that kept buprenorphine's prices high (Barenie & Kesselheim, 2021). One such instance was being granted Orphan Status (Barenie & Kesselheim, 2021). Typically reserved for diseases impacting less than 200,000 people, when the return is not expected to make up for the initial investment, it offers a financial incentive for manufacturers to invest and develop treatments for rare diseases (Barenie & Kesselheim, 2021; Dorman, 2019). Both buprenorphine medications were granted this status during the first stage of the Opioid Epidemic when rates of OUD were anything but rare, providing them extended market exclusivity (Dorman, 2019). It was not until 2019 when this status was finally rescinded (Barenie & Kesselheim, 2021; Dorman, 2019).

In addition to the Orphan Status, the Drug Addiction Treatment Act-2000 (DATA) was put in place, outlining strict requirements and regulations that would be used when prescribing and administering buprenorphine (Heidbreder et al., 2023). Although this was

reported as an attempt to bring OUD into primary care settings, it came with extreme limitations, the most significant being a form required for any physician seeking buprenorphine certification called the X-Waiver (Heidbreder et al., 2023). The Drug Enforcement Agency (DEA) issued the X-Waiver to physicians who had met the additional training and application requirement to become a prescriber, however this certification often resulted in greater scrutiny from regulators, occasional audits, and strict patient caps in the name of mitigating misuse (Fiscella et al., 2019). It is estimated that had the X-Waiver not been a factor, it could have lowered opioid related mortalities by 30,000 lives a year (Volpe, 2023).

Throughout Obama's administration, Reckitt Benckiser's end to their buprenorphine monopoly and their transition to become Indivior was taking place (Haffajee & Frank, 2019). Even with the additional support from public funding and the financial benefits provided by the Orphan Status, what was now Indivior resisted an end to their exclusivity on buprenorphine (Barenie & Kesselheim, 2021; Haffajee & Frank, 2020). Efforts to extend this monopoly included the use of "me too" meds (small adjustments to FDA approved medications), sham citizen petitions filed with the FDA (typically used by the public to request action), and an overall lack of cooperation with the FDA (Gaudilliere, 2021; Haffajee & Frank, 2020). Regardless, at the end of his administration Obama signed the Comprehensive Addiction Recovery Act — prioritizing drug treatment, rehabilitation, and prevention — and passed the Affordable Care Act, the expansion of public health insurance including the coverage of Substance Use Disorder and its treatment (Dollar, 2019; Lindsay & Vuolo, 2021).

Although denied by the FDA, referred to the Federal Trade Commission as taking part in anti-competitive actions, and receiving public investment from Obama these did not cease attempts to monopolize buprenorphine (Haffajee & Frank, 2020). In order to push more expensive options Indivior adjusted pricing and market availability, still holding today the most popular buprenorphine product (Haffajee & Frank, 2019; Haffajee & Frank, 2020; Poliwoda et al., 2022). Regardless of this asset, Indivior refused to cooperate with generic

manufactures, despite the FDA's demands (Haffajee & Frank, 2019). The U.S. healthcare system covered a substantial amount of the costs for these brand-name products, particularly with their coverage in public health insurance, Medicaid (Barenie & Kesselheim, 2021; Haffajee & Frank, 2020). Medicaid and Medicare, the two public insurances in the U.S. accounted for 32% of buprenorphine sales in 2017, and is estimated to cover 4 in 10 patients diagnosed with OUD (Barenie & Kesselheim, 2021; Haffajee & Frank 2019; Haffajee & Frank 2020).

To date, what is now Indivior, has faced numerous lawsuits with settlements regularly in the tens to hundreds of millions, including the sentencing of former CEO, Shaun Thaxter (Kansteiner, 2021). These lawsuits addressed claims from more than 400 civil lawsuits, a third of which pertained to Neonatal Abstinence Syndrome (NAS), thirty tooth damage allegations, and claims of RICO statuses and fraud (*Indivior FY 2023 Financial Results*, 2024). Despite these lawsuits, Indivior remains in good economic standing as the global buprenorphine market is now estimated to be worth $5.52 billion as of 2023, and they have plans to expand into markets for treating Alcohol Use Disorder and Cannabis Use Disorder ("Buprenorphine Market Size, Trends and Forecast to 2030," 2023; *Indivior FY 2023 Financial Results*, 2024).

During the first Trump administration Indivior released their monthly buprenorphine injection, Sublocade, that had been in development since 2009 (Heidbreder et al., 2023). This came in the form of a biodegradable depot that allowed for a safe and consistent dose of buprenorphine over the course of one month (Poliwoda et al., 2022). Due to the high risk of potential death associated with mis-administration this product had additional regulations, and has never been widely available in retail pharmacies ("How Does SUBLOCADE® Work?", n.d.). At this time, DATA-2000 and the X-Waiver were still in place making access to buprenorphine difficult. Over the years, there was established an illicit buprenorphine market, a tool used for accessing treatments outside of the demands of traditional healthcare (Baus et al., 2023; Smith et al., 2025).

Once Biden entered office (2021-2025), the X-Waiver was removed altogether as

part of the Mainstreaming Addiction Treatment Act (MAT Act) (Heidbreder et al., 2023). This piece of legislation eliminated patient caps entirely, promising to expand access to buprenorphine, and only requiring administrators to register with the DEA (Heidbreder et al., 2023; Volpe, 2023). The MAT Act included three approved medications: buprenorphine, methadone, and naltrexone (Leshner & Mancher, 2019). The MAT Act was limited to the federal level, and did not impact state laws and regulations (Volpe, 2023).

In an unusual turn of events, state, local, and tribal governments sued the U.S. pharmaceutical companies for the Opioid Epidemic and won (Pettus, 2020). The U.S. pharmaceutical companies were held accountable for their attacks on the working class and low income white populations, with billions of dollars to be distributed in settlements (Pettus, 2020). In an event of national scapegoating, the state blamed the pharmaceutical industry for their regulatory failure in the mass use of opioids seen today (Pettus, 2020). The policy response is one that "ritually demonizes 'opioids' and punishes the global pharmaceutical industry for fraudulently peddling them to vulnerable communities," (Pettus, 2020, p. 32). While some acknowledge the misplacement of blame — "I actually don't blame the pharmaceutical companies; I blame our healthcare system," — it has had a lasting impact as to how opioid-based medications are viewed (Light, 2004; Madden, 2019; Reznikoff MD as cited in Pettus, 2020, p. 34).

That said, the prices for buprenorphine products have and will continue to increase over time as rates of its use grow (Barenie & Kesselheim, 2021)[2]. Although many patients do not pay the full price for these medications, having insurance to cover some or all of the expense, affordability is still a significant barrier particularly for patients in poverty (Barenie & Kesselheim, 2021). The price determined by these products' therapeutic value (gold standard) and the investment put into their development by the manufacturer, justify the unaffordability, and consequent exclusivity these medications possess (Barenie & Kesselheim, 2021). These justifications remain unchecked, despite the prolonged

[2] The listing price of brand-name Suboxone was $4.79 per 8 / 2mg tablets, for Subutex it was $5.83 per 8 mg tablet (both daily medications), and for Sublocade it was $1327 per monthly injection (Barenie & Kesselheim, 2021).

investment and partnership that has existed with public funding throughout buprenorphine's synthesis, development, and release (Barenie & Kesselheim, 2021).

2.3 Theory: Value, Crisis, and Death

As stated, ideologies consist of a set of interests, aims and values, developed across space and time, that are expressed through the practice of the individual and the culture of the group (Gaudilliere & Sunder Rajan, 2021; van Dijk, 1993, p. 258). Ideologies and values become reflective concepts — ideologies consist of a set of values and values guide ideologies (van Dijk, 1993). Addiction treatment ideologies practiced by individual healthcare practitioners are coproduced with the macro-systems of value and the environments they create. While the macro-value systems inform the individual and their environment, the individual upholds or challenges these systems through mundane practices, such as the assertion of power in the patient-practitioner dynamic (Haskaj, 2018; van Dijk, 1993).

Value is typically understood in common discourse as something positive or virtuous, but it is also situated and changing, meaning what one person or culture considers valuable another may not (Gaudilliere & Sunder Rajan, 2021; Muniesa, 2017, p. 445). Value is complex, dictating the societal positioning of democracy, drug pricing, market monopolies, crisis, innovation, even who lives and dies (Datta Burton et al., 2022; Gaudilliere, 2021; Gaudilliere & Sunder Rajan, 2021; Haskaj, 2018; Mazzucato & Roy, 2018; Muniesa, 2017; Sunder Rajan, 2017). Theories of value in today's overarching systems of healthcare and pharmaceuticals provide the framework for analyzing how power dynamics are presented throughout the discourse.

Marx describes value not as a thing but a process (Gaudilliere & Sunder Rajan, 2021). Value is an attribute, something an item possesses that is realized through a process of exchange,

> Value is something that a commodity has: its utility, its beauty, its ability to be worn or eaten, while on the other hand, it is also something that money has: its ability to circulate itself, to mediate and measure other kinds of circulations, and to

quantitatively measure and exchange itself (Gaudilliere, 2021, p. 413)

For capital, value is value because it makes more value, “self-valorization”, it has no meaning unless it is in surplus (Gaudilliere & Sunder Rajan, 2021, p. 314). The presence of surplus value in one space suggests the presence of exploitation or exclusion in another; those experiencing surplus are able to do so because of those exploited and excluded, creating value in certain populations’ abandonment (Haskaj, 2018).

The morality of what is valued in Western society, i.e. value creation, is dictated through the economic, political, and corporate justification of economy and finance (Muniesa, 2017). Value creation is produced through the interconnection of innovation, finance, and democracy, determined by the investor and the entrepreneur (Muniesa, 2017). “Value is viewed as a product of strategic deliberation and collective investment between multiple actors — where both the rate and direction of value creation is contestable,” (Mazzucato & Roy, 2018, p. 2). In a culture that values surplus capital, the investor and entrepreneur are torn between producing a commodity and making money, maintaining a level of insecurity (Muniesa, 2017). The responsibility of financing innovations falls on the investor participating in a damaged financial industry, becoming indicative of their morality (Muniesa, 2017).

Finance is the science of the optimal allocation of funds led by a free and rational investor, and it is used as a political technology in order to make some of the most important decisions of society (Muniesa, 2017). The investor determines the allocation of capital: who will monitor it, what will be used today, and what will be reserved for the future (Muniesa, 2017). The “free and rational” investor is a key actor, making decisions both as situated within, and an influencer of this society (Muniesa, 2017). In this case, a society whose morality lies within a contemporary life of political ambition, profit accumulation, and neoliberalism (Muniesa, 2017). The political technologies borne from the intersection of democracy and finance, dictates what should be done and what (or who) should exist (Haskaj, 2018; Muniesa, 2017, p. 447).

According to Summers, there are two different views of this financial system (as cited in Muniesa, 2017). There is the production of the material (technologies), and the transaction

of the nonmaterial (financial claims) (Muniesa, 2017). While real things have real value, transactions of the nonmaterial have little social benefit (Muniesa, 2017). When determining the value, financial analysts are responsible for appraising the “fundamental value” of a technology, while the market (made up of financial analysts) is responsible for assigning a market value to a technology (Muniesa, 2017). This creates a conflict of interest, as the financial analyst is responsible for assigning both a fundamental and market value to an item (Muniesa, 2017). The difference falls between valuing an item as a commodity, lying in the concrete cost of materials and purpose, versus an asset, valued as an investment with the expectation of a return as value accumulates (Muniesa, 2017). A technology as an asset is promoted using its speculative value as a method of gaining investments, however, its value is just a speculation, only gaining validity through successful narratives of altruism, trust, and ethics (Data Burton et al., 2022, p. 396).

In health and pharmaceuticals, the pricing of a technology is determined by its therapeutic effectiveness; better therapeutics means better health outcomes, better health outcomes will be valued more and therefore can be priced more highly (Mazzucato & Roy, 2018). This is calculated based on the cost effectiveness (additional quality adjusted years of life), and prevention (an expense today is continued health for tomorrow) (Mazzucato & Roy, 2018). Prevention creates value that is again placed in the future, a promise of maintaining health, a value that quantifies the total economic value of health improvements and the amount of available health savings (Mazzucato & Roy, 2018). In order to further raise the value of a product, patients are included in this value-based pricing system (Mazzucato & Roy, 2018). As value rises, these prices can become inaccessible to the average consumer, who relies on the public health system to value the technology as highly as they do, raising concerns when public health systems are defunded, such as is the case in the U.S. (Light, 2004; Mazzucato & Roy, 2018). As the final listed price in value-based pricing does not factor in investments made by the public, the public ends up paying twice: first as an asset through the investment in research and second for the commodity, a therapeutic treatment (Mazzucato & Roy, 2018). Taxpayers excluded from both the market and as public health

targets, invest in the asset but experience no return (Datta Burton et al., 2022; Haskaj, 2018; Lindsay & Vuolo, 2021; Mazzucato & Roy, 2018).

The pathologization of addiction, the population being treated, the investment from public health, and its effectiveness in treatment, all become part of the calculation when determining buprenorphine's value and price as an asset (Dollar, 2019; Henninger & Sung, 2014; Lindsay & Vuolo, 2021; Mazzucato & Roy, 2018). Narratives focus on its effectiveness as a commodity: "This [treatment] program is the reason I can lead a normal life," (as cited in Baus et al., 2023, p. 82; Muniesa, 2017). A virtuous understanding of value is used to gain support through shareholder activism, participatory funding, or socially responsible investing from moral investors (Muniesa, 2017). Scannell states plainly, "value-based pricing evolved as a way of charging customers more," (as cited in Mazzucato & Roy, 2018, p. 9). Value-based pricing caters to the financial interests of shareholders, the most economically valuable course of action being prolonged monopolization and growing demand for the product (Mazzucato & Roy, 2018). In healthcare, this requires a chronic state of illness, and in addiction therapeutics, it requires a population experiencing addiction (Dumit, 2012). It relies on a monopoly — that is a monopoly due to finding economic value in exclusivity, privatization, and chronically sick, paying customers — to value making healthcare widely accessible (Gaudilliere & Sunder Rajan, 2021; Mazzucato & Roy, 2018). In reality, pricing is not about the therapeutic value of a product, but the value of pushing society to a place of crisis in order to maintain a monopoly (Mazzucato & Roy, 2018).

Value is again placed in the future, as pharmaceutical companies are valued less by profit than by the anticipated growth in profit (Mazzucato & Roy, 2018; Sunder Rajan, 2017). Capitalization, pharmaceuticalization, and globalization become entangled in multi-billion international markets, as the power of the state is marginalized (Gaudilliere & Sunder Rajan, 2021). Although Gaudilliere & Sunder Rajan (2021) state that neoliberalism did not intend to marginalize the state, during the transition to neoliberalism that took place during the Reagan administration, there was a concentrated focus on the reallocation of funds away from the state and towards the market (Dollar, 2019; Light, 2004; Lindsay & Vuolo, 2021).

The marketization of life has led to economies of manufacturing and sale, economies of knowledge, economies of clinical trials, and economies of health, life, and death (Haskaj, 2018; Sunder Rajan, 2017). This creates a system that is structurally reliant on crisis (Sunder Rajan, 2017).

Sunder Rajan (2017) states the global pharmaceutical market manages three actors in crisis, where “crisis” means something different to each of these actors: the multinational pharmaceutical industry, patients, and the national pharmaceutical industry (generics). Such crises rely on matters of access to essential medications, issues of expertise, a lack of innovation, and diminishing trust in the industry (Gaudilliere, 2021; Light, 2004). From an industry perspective, the health of a population does have value in that it maintains and ensures the reproduction of the current social and political order (Gaudilliere & Sunder Rajan, 2021). However, the social and political order being what it is, only those who value that order, are found worth investing in their health (Dollar, 2019; Haskaj, 2018). The value of those who threaten this order, or who are excess to its maintenance, lies more so in their active killing (e.g. prescription opioids to poor white people), their passive deaths (e.g. unaffordable treatment options), or the exploitation of their labor (e.g. labor provided by the criminalized) (Dollar, 2019; Haskaj, 2018; Scarritt, 2022). Health markets negotiate biocapital (capitalistic appropriation of healthcare), necro-economics (capitalistic appropriation of death), and biopolitical rationalities (the care of the population determined through governance) (Gaudilliere & Sunder Rajan, 2021; Haskaj, 2018).

The pharmaceutical company’s perpetual crisis exists structurally in the drive to maintain profit growth (Sunder Rajan, 2017). This has led to different methods of maintaining profit growth: increased privatization, companies purchasing their own shares to boost market value, and efforts to maintain exclusivity, e.g. “me too” meds (Gaudilliere, 2021; Gaudilliere & Sunder Rajan, 2021; Mazzucato & Roy, 2018). The inevitable end of a patent is an end to the economic benefits of monopoly, so in order to manage this crisis (a loss in revenue), companies use speculative markets to initiate mergers, cut out redundancies, and lay off employees (Sunder Rajan, 2017). Investors take on the risk of investment, risk being

unforeseen negative consequences, so to mitigate these risks they avoid investing in the expensive and time consuming process of the discovery and synthesis of new molecules (Gaudilliere & Sunder Rajan, 2021; Muniesa, 2017; Sunder Rajan, 2017). Companies instead rely on the release of slightly different therapeutics from already FDA approved molecules, “me too” meds, that often have the benefit of extending patents while taking much less time and money to produce (Gaudilliere, 2021; Gaudilliere & Sunder Rajan, 2021; Muniesa, 2017). Rather than discoverers, pharmaceutical companies instead function as banks, as they control, regulate, and bet on the flow of capital, leading to what is argued as a crisis in innovation (Gaudilliere, 2021; Sunder Rajan, 2017, p. 43).

Investing in this growth is also relying on the increase of therapeutic consumption (Sunder Rajan, 2017). Healthcare, and health itself, has come to be quantified through the consumption of pharmaceuticals (Gaudilliere & Sunder Rajan, 2021). In focusing medical intervention on consumption, scientific marketing has become an invaluable tool in order to construct markets, and allow for patient participation in the valuation of a product (Gaudilliere, 2021; Mazzucato & Roy, 2019). The impact on medical practice is that of quantifying prescription practices as a method of tracking healthcare needs, wherein medical practice contributes to redefining disease (Dumit, 2012; Gaudilliere, 2021). Value comes to be defined by the number of patient outcomes per dollar spent, i.e. the number of patients seen rather than the quality of care provided (Datta Burton et al., 2022). There are five main goals in medical practice today: reducing adverse events, adopting evidence-based care, changing hospital processes to improve care, increasing care transparency, and rewarding hospitals that provide high quality care at a lower cost (Datta Burton et al., 2022). When looking at these theoretical values as practice: “reducing adverse events” becomes reducing care of high risk patients; “adopting evidence-based care” is the adoption of “gold standard” absolutism; and “changing hospital processes to improve care” is maximizing the use of pharmaceutical treatments and prioritizing efficiency (Dumit, 2012; Heidbreder et al., 2023; Jones & Podolsky, 2015; Light, 2004; Szasz, 2006).

Due to high costs, and shrinking public health budgetary resources, state and private

healthcare are often overwhelmed with reimbursements (Datta Burton et al., 2022). The value of existing medication options, the value of the status quo, and the value of the patients are weighed against each other as healthcare systems are forced to buy health (Datta Burton et al., 2022; Mazzucato & Roy, 2019). Public health systems must choose between the allocation of funds and the restriction of treatment accessibility (Datta Burton et al., 2022; Mazzucato & Roy, 2019). The difference in value between the patient, the company, and the state leads to further crisis as the morality of growing a company rather than growing access to healthcare go unchecked by the state, impacting the reliability of their products (Gaudilliere & Sunder Rajan, 2021; Light, 2004; Mazzucato & Roy, 2019). This highlights the question of morality as democracy, finance, and innovation grapple with a pervasive state of crisis: environmental, financial, political, humanitarian, and healthcare (Muniesa, 2017). Muniesa (2017) suggests most instances of crisis represent a failure in valuing assets and the allocation of funds. Haskaj (2018) argues that instances of crisis are manufactured or permitted through regulator passivity, in order to release the value from populations' death through the creation of a necro-economy. The pressure of life and death as it pertains to health, makes morality inherent to the financing and accessibility of therapeutic technologies (Haskaj, 2018; Muniesa, 2017).

As depicted in the State of the Art, medical practice is also functioning in crisis, particularly as it pertains to behavioral diseases, suggesting a fourth actor that is both managed by the market and working within its own definition of crisis (Dumit, 2012; Henninger & Sung, 2014; Light, 2004; Sunder Rajan, 2017; Szasz, 2006). There has been a decrease in trust from healthcare practitioners towards pharmaceutical companies and the healthcare system, as trust in corporate social responsibility shrinks amongst the general public (Datta Burton et al., 2022; Dumit, 2012; Gaudilliere, 2021; Light, 2004; Sunder Rajan, 2017). Although pharmaceutical companies work to manage medical practice, medical practice has also become a representation of the failures of buyer based health for the patient (Dumit, 2012; Light, 2004).

While technoscientific capitalism is grounded in an ideology of innovation — taking

the form of therapeutics, diagnostics, surgical interventions, and public health targets — it is the iterative process of social interaction, the technosocial, that makes a technology valuable. (Datta Burton et al., 2022; Mazzucato & Roy, 2019, p. 11; Sunder Rajan, 2017). The non-technical aspect of integrating a new therapeutic innovation relies on human variables such as trust and practice (Datta Burton et al., 2022). Datta Burton et al. (2022) suggests that technocratic standards of valuation that do not consider non-technical matters of social interaction, setback socioeconomic and political processes that make things valuable (p. 400). The social, ethical, and personal dimension of valuing a technology, are often overlooked or underestimated in their influence (Datta Burton et al., 2022). The question, “What makes a thing valuable to society?” has a different answer than the question, “What makes a thing valuable to a pharmaceutical company?” (Datta Burton et al., 2022). “What makes a thing valuable to a healthcare practitioner?” produces yet another answer, influenced by both society and the pharmaceutical company (Datta Burton et al., 2022; Dumit, 2012; Light, 2004; Madden, 2019).

Determining what society values is much more varied, shifting depending on the individual and cultural understanding of specific technologies (Datta Burton et al., 2022). Loosely defined, society values healthcare that is distributed in an equitable and transparent manner that enhances peoples’ and communities’ capabilities (Datta Burton et al., 2022, p. 392). Public health values population level outcomes (Datta Burton et al., 2022). Clinical assessments value individual outcomes (Datta Burton et al., 2022). Mainstream methods value quantifiable outcomes, such that qualitative values — ethical, social, political — are left implicit and unexplored for both the population and the individual (Datta Burton et al., 2022, p. 405). Local knowledge on qualitative values allows for the creation of “alternative materializations”, methods of accessing healthcare that exist outside of traditional healthcare markets, e.g. buprenorphine’s illicit market (Baus et al., 2023; Datta Burton et al., 2022; Gaudilliere & Sunder Rajan, 2021).

According to Virno, wage is the “true apex of biopolitics”, situating healthcare practitioners far below the top executives of an international pharmaceutical industry, but far

above a patient excluded from the market (as cited in Haskaj, 2018, p. 15). Such a healthcare system is not just implemented from the top-down, but upheld in the mundane practice of everyday life, medical practice being one aspect of such mundanity (Haskaj, 2018). Naturalized in mundanity, we are:

> Reshaping our image of society as merely and always a market (you can buy love as well as death), it also determines both: a political ideal of how the state should look and act, what it should and should not do, and, most importantly, what its capacities and responsibilities are; and the core of human existence, who and increasingly what we are, and the ways in which we become value calculations, (Haskaj, 2018, p. 7).

Participants within this society become value calculators and a part of others' value calculations through the process of everyday decision making (Haskaj, 2018).

Homo Sacer establishes the idea that some individuals are not perceived to exist within the legal and social order, and being not a part of this order are therefore expendable (zoe), rather than culturally situated (bios) (Haskaj, 2018, p. 10). "The zoe-bios distinction demarcates the realm of the natural and the social [...] It is this power of the state to kill those who are only zoe" (Haskaj, 2018, p. 10). Reproducing larger societal values, healthcare practitioners' social power allows for their mundane "value calculations" to be the practice of zoe-bio demarcation, (Haskaj, 2018; Light, 2004). Determining the socially vulnerable OUD patient's value is determining whether to define them by zoe versus bio, animal versus citizen, and sinner versus sick, determinations that reproduce themselves throughout the marketization of addiction.

2.4 Methodology

In order to understand how the discourse surrounding buprenorphine articulates power dynamics in healthcare, I chose a Critical Discourse Analysis (CDA) as my methodological approach. This qualitative analysis is used to better understand the concept of power; how it is disseminated, reproduced, and legitimized throughout discourse (Mullet, 2018). More specifically, a CDA explores the role of dominance, defined as the abuse of

power when one group has control over another, i.e. social inequality (Mullet, 2018, p. 119). Discourse reflects the status quo, giving it the power to reproduce relationships of dominance and oppression throughout society (Mullet, 2018). Relationships of power are co-constituting, upheld by both the dominated and dominating (Haskaj, 2018; van Dijk, 1993). Social power is determined by access to resources such as capital, however it can also come in the form of group membership, education, or status (Haskaj, 2018; van Dijk, 1993, p. 254). Reproducing social power dynamics allows attributes of social dominance to be reproduced to the point of normativity, going unquestioned until being challenged (van Dijk, 1993). In the space of OUD treatment power is enacted through the practice of control over the relationship: who is allowed treatment, treatment modality, and environment (Mullet, 2018; van Dijk, 1993).

As was established in 2.2 State of the Art, there is a clear and established vulnerability among those with OUD, following years of subjugation and association with traits found undesirable to the hegemonic professional caste: poverty, blackness, criminality (Dollar, 2019). It has become normative to treat those with addiction as zoe; social outcasts undeserving of medical or community care (Haskaj, 2018). Patients possessing cultural capital, traits of the dominating class, are able to more easily manage the dominant actor, the healthcare provider (Madden, 2019). Pejorative or hyperbolic language that reinforces a negative representation (“junkie”), along with the positive representation of the dominating group (“profesional”), are used to justify reproducing an unequal dynamic (Mullet, 2018). For whom the healthcare practitioner chooses to practice their socially established responsibility becomes indicative of their own morality, their own value calculation, and their own zoe-bios demarcation (Haskaj, 2018; Muniesa, 2017). Practices are instances of production, where the social and the status quo are produced, and discourses pertaining to these practices, are able to give valuable insights into the ways power is articulated (Fairclough, 2001, p. 4).

In conducting a CDA, it is recommended that the author of the research make their own sociopolitical and positionality clear (Fairclough, 2001; Mullet, 2018; van Dijk, 1993). There are three aspects of this research I would like to establish my position on, as they

inform my empirical analysis of morality, abuse, and power in medical practice. The first is that of substance use. My position is that all substance use should be decriminalized and considered morally neutral as a natural aspect of the human experience that can include practices of community, fun, spirituality, self-harm, or escapism. It is when substance use turns into forms of self harm through over-consumption that this should be addressed through the active availability of both medical and social assistance. Those experiencing a state of self-harm should be given the capability to seek assistance when wanted. This is under the assumption that the actions of the individual remain non-violent.

My second position is on that of the best treatment option. Ultimately, there are four valid treatment options that address the physiological dependence of addiction: buprenorphine, methadone, naltrexone, and abstinence. All of these options hold both advantages and risks that the healthcare practitioner should be able to articulate clearly to their patient. As these are all individual treatments, ideally they will be provided alongside structural changes that increase the patient's capability to improve their quality of life. My position on buprenorphine specifically is that its innovation as a medical technology makes its risk exceptionally low when compared to other individual treatment options, and its use as a commodity should be expanded. One patient stated: "I am so tired of burying my friends. And I have yet to bury somebody who overdosed on Suboxone," (as quoted by Baus et al., 2023, p. 88). However, there remain social risks to buprenorphine; many feel a loss in community when choosing not to participate in abstinence and there is difficulty getting both on and off the medications due to provider practices (Baus et al., 2023; Madden, 2019; Smith et al., 2025).

My last position is on what medical practice should consist of. While limited in their ability to address the environmental component of addiction, healthcare practitioners' medical practice should actively challenge reproductions of discrimination, unequal treatment, and contributions to the "planeloads of avoidable deaths" (Institute of Medicine as cited in Light, 2004, p. 2). That begins as practicing people-first healthcare, challenging the reproduction of top-down profit-first care. Throughout this research I found the healthcare

practitioners closest to this ideal were versed in each of the four treatment options. Their effort did not focus on the behavior of their patient, but treating the risks of physiological dependence. They sought to find the best option for the individual, and trusted their peers to provide care they were unable to provide. They were able to balance the limitations of pharmaceutical science and experiential knowledge, finding value in both as they collaborated with patients and peers. Finally, they were able to use their power and expertise to foster appreciation for different treatment modalities. They did not turn away patients, treat from a place of moral judgement, use only their personal standard, or practice absolutism.

Analytical Framework

I began this CDA by identifying a relationship of dominance taking place in the dynamic of the healthcare provider and their patient seeking OUD treatment, dominance defined as: “The exercise of social power by elites, institutions or groups, that results in social inequality, including political, cultural, class, ethnic, racial and gender inequality,” (van Dijk, 1993, pp. 249-250). Healthcare practitioners function as gatekeepers, acting not just as individuals situated within larger trending paradigms of health, but as autonomous experts legitimized by the professional caste (Dumit, 2012; Light, 2004; Mullet, 2018; Szasz, 2006). While their dominance is increasingly delegitimized, they maintain the agency to practice ideological preferences regardless of whether this is reflective of the latest research (Dumit, 2012; Light, 2004; Madden, 2019). Addiction creates a particularly vulnerable population of people, but this is to varying degrees depending on other marginalizing identities, e.g. race, gender, class (Dollar, 2019; Lindsay & Vuolo, 2021). Buprenorphine, is marketed to and consists of an almost exclusively white patient population, as such, discourse around this medication is likely to depict power dynamics in medical practice that move beyond the inherent racial bias that is already well established (Datta Burton et al., 2022; Dollar, 2019; Gaudilliere, 2021; Light, 2004; Madden, 2019; Smith et al., 2025).

In selecting the discourse used for this analysis I chose five academic papers examining healthcare practitioners’ perspectives on buprenorphine. The papers selected are

documented in Table 2.1 (See 6 Appendix) which contextualize these texts, e.g. demographics of authors (white / non-white)[3], year of publication, etc. These texts were found through google scholar, the criteria being peer reviewed articles published after 2020, with research taking place in the U.S, consisting of a qualitative analysis. The key words used to find the texts consisted of: prescriber, perspective, Opioid Use Disorder, buprenorphine, OUD, treatment, as well as varying synonyms. This resulted in numerous searches with various combinations, as primary results featured patient perspectives, were published outside the U.S., or were published prior to 2020. The five articles selected feature a qualitative analysis that include the use of direct quotes from healthcare practitioners. The primary source of analysis will be the direct quotes from practitioners, while the academic texts themselves will function as a secondary source of analysis. One barrier that was not able to be navigated effectively was papers that distinguished between the three approved pharmacological treatments. Despite incurring a bio-chemically different response, and being situated in society differently, only two papers specifically examined buprenorphine (Franz et al., 2025; McCollum et al., 2023), while the others looked at MOUDs more generally (Madden et al., 2022; Paul et al., 2022; Stewart et al., 2021) (Henninger & Sung, 2014; Madden, 2019).

Criteria that attempted to find research taking place after the implementation of the MAT Act, which deregulated buprenorphine, acted as another barrier I was unable to navigate, the only article meeting this criteria being Franz et al., 2025. As the other four papers conducted research prior to buprenorphine's deregulation, it is established that healthcare practitioners working with buprenorphine went through extra certification and training, be it through an institutional move or a voluntary individual choice, in order to prescribe this medication, known as the X-waiver (Heidbreder et al., 2023).

In order to provide consistency for this research, I clarify my use of specific

[3] Whiteness has been identified as the most privileged race in the U.S., seen throughout the history of medical professionalism, medicalization, pharmaceuticalization, and criminalization (Dollar, 2019; Lindsay & Vuolo, 2021). Identifying an academic's whiteness is a marker of this privilege. "Non-white" is not to minimize the intersectionality of privilege for non-white people experienced through colorism, misogynoir, Islamophobia, and anti-Blackness, but is rather to note an absence of privilege in this area, in addition to managing ambiguity and assumptions.

terminology and their definitions. “Healthcare practitioner” is defined by anyone practicing treatment, not limited to the label of physician, such that nurses, peer recovery, social workers, and private practitioners are included. Medicalization is used in the event of addiction being treated as a disease, be it with abstinence or with pharmaceuticals. Pharmaceuticalization is the response to addiction being treated with pharmacotherapies. Abstinence is treatment without pharmaceuticalization. Throughout this research, I identified three types of providers. The authoritarian provider enacts their beliefs without regard to their patients' needs. The benevolent provider enacts their personal beliefs with good intention for their patient, but regularly to their detriment. Lastly, the capabilities provider collaborates with the patient and their peers to ensure their patient has the information and capability to access the care they need, including resources that address environmental components.

It should be acknowledged that the patient populations experiencing these interactions, particularly if they are pertaining to buprenorphine, are most likely white and middle / upper class (Dollar, 2019; Lindsay & Vuolo, 2021; Madden, 2019; Smith et al., 2025). Although not explicitly defined, it can be presumed there is a level of social capital in the form of wealth and race in these interactions with patients (Madden, 2019; Smith et al., 2025). In the event healthcare practitioners are conducting medical practice with those not possessing such capital, such as in discourse including methadone, there will be additional vulnerabilities (Dollar, 2019; Lindsay & Vuolo, 2021; Madden, 2019). Healthcare practitioners possess social capital in the form of a professional caste, education, knowledge, possessing valued resources, and the vast majority being white men, similar to that of a researcher (Dollar, 2019; van Dijk, 1993). Although race and racial bias will not be explicitly outlined in these texts, these underlying dynamics of power in a patient – healthcare practitioner relationship are important to acknowledge.

The empirical work consists of four levels of analysis: the immediate language, interdiscursive relations, immediate social context, and broad social context (Mullet, 2018). In the first and second level of analysis I began by isolating direct quotes from healthcare practitioners, consisting of one or more sentences, within the academic research. In the first

level of analysis I use deductive coding with a framework developed from the preliminary research of the 2.2 State of the Art. I use established ideologies (criminalization, abstinence, pharmacotherapies); medical practices (medical monotheism, gold standard absolutism, expert patient); and overarching themes (crisis, stigma, risk). With this framework, I use the immediate vernacular to identify articulations of power within the discourse.

The second level of analysis examines the interdiscursivity of the physician discourse using abductive coding. In analyzing the interdiscursivity, I look at social practices and social relations within the discourse. I first worked with an established framework from older ideological paradigms that addressed substance use in the binary of vice or disease. Both focus on the behavior of using substances rather than the physiological dependence or environmental components of addiction. One attempts this with punishment and one attempts this with treatment. I then use inductive coding in order to identify emerging ideologies, themes, and patterns of practice. These are practices that challenge reproductions of dominance, power, and autonomy in the practitioner-patient relationship. The interdiscursivity of this section examines how both these older paradigms and new paradigms are borne from the technosocial aspects of these treatments, e.g. the Opioid Crisis, the Crack Epidemic, The Harrison Act, etc. Again power is explored through the responsibilities the provider exhibits in their patterns of practice.

The third level of analysis situates the practitioner discourse in the immediate social context of academic research. I use inductive coding in order to identify their positionality as gold standard absolutists as well as their intentionality behind this position. I analyze ways the researchers reproduce power dynamics as they attempt to expand the use of a valuable commodity.

The final level of analysis situates the entirety of the discourse, both researcher and practitioner discourse, into the larger technosocial understanding of buprenorphine as a treatment. I analyze the influence that marketizing addiction, participating in an epidemic, and maintaining an environment of crisis has had in naturalizing the three approaches to power in practice. I examine common contradictions existing within this healthcare system

as imbalances that reproduce certain power dynamics. Finally, I suggest adjustments that can be made in interventions and practice that address these imbalances.

3 Empirical Analysis

3.1 Healthcare Practitioners' Discourse

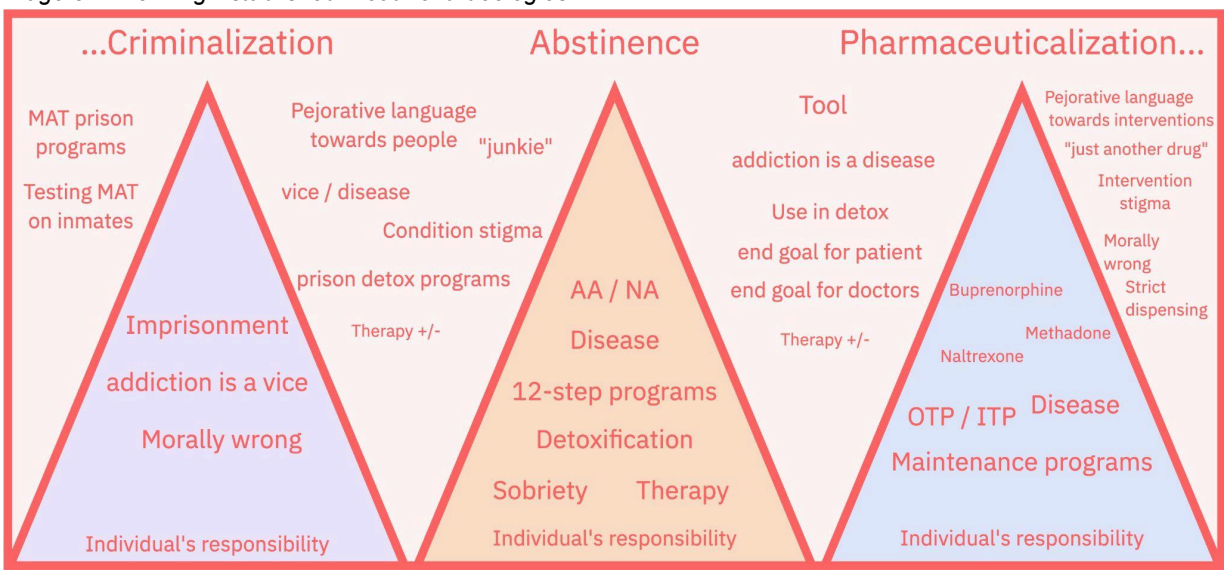
In the first level of analysis, I examine solely the direct quotes provided by healthcare practitioners, contextualizing the question of power dynamics within the practitioner-patient dynamic. I began by removing all the quotes to be analyzed independently from the discourse, assigning each author a specific color. If there was identifying information attached to the quote, e.g. [Name, position], those were included in the quote, otherwise quotes were examined independent from the context of the academic literature they were situated within. Each quote was assigned a reference number: the number, the entire quote and its citation can be viewed in Table 3.1. (See 6 Appendix). Next I created a framework based on the technosocial history established in 2.2 State of the Art and 2.3 Theory, using deductive coding to analyze the discourse. This was done by topic of the quote, not by the position of the practitioner being quoted. Some quotes were used more than once, but not every quote was used in this first level of analysis. I conclude this section with the first analysis, returning to the research question and articulations of power.

3.1.1 Established Ideologies

Beginning with an analysis of the physician discourse, I first created Image 3.1 to more explicitly define the practices exhibited within the three ideological responses to OUD; the ways in which they stand alone, overlap, and co-constitute each other. Due to the nature of this research taking place in spaces of healthcare, criminalization is not depicted in an overt way. However, where criminalization-abstinence and criminalization-pharmaceuticalization overlap is in pejorative language, treating the patient as zoe, and viewing substance use as morally bad. Pharmaceuticalization is the use of any of the three

pharmacotherapies in a treatment setting. While the focus of this research is on buprenorphine, these three pharmacotherapies are often conflated as one in the same within research spaces. An instance of pharmaceuticalization-abstinence is the overlap when pharmaceuticalization is used as a tool to reach the end goal of abstinence. Short or long-term detoxification with the end goal of abstinence can either be a personal goal of the patient or the ideological belief of the physician imposed on the patient. Abstinence is simply when pharmacotherapies are not used, but still includes other methods of medicalization: 12-step, therapy, treatment programs. Abstinence, alone, does not include any pejorative language towards other treatment modalities nor the condition, but is simply the preference not to use pharmaceutical assistance in treatment.

Image 3.1: Defining Established Treatment Ideologies



3.1.1.1 Criminalization

While overt criminalization was not presented in healthcare settings, covert criminalization presented itself in how patients were treated, medication distribution, or the use of pejorative language. For each of these examples there was a level of treatment that contributed to the patient being understood as zoe, expendable, and undeserving of medical care (Haskaj, 2018). In the medicalization of OUD medical treatment would be expected to reflect the professionalism of medical vernacular, however this was often not the case.

There was regular reference to the difficulty of this population, and in them being

difficult, this made it permissible for them to be treated as zoe. “It’s like a hard population to work with. You know, they’re often late to their appointments. [...] So, I think there’s a lot of providers who are like, ‘not my problem.’” ([32]). Due to the environmental component of OUD, the sociodemographics of populations seeking treatment often include poverty, unemployment, houselessness, and adversity (Sharma et al., 2016). The reality of existing within these demographics could be a lack of accessible transportation, a lack of childcare, or being unable to take time off work (McCollum et al., 2023; Sharma et al., 2016). A healthcare system that values quantity over quality, makes certain patient populations that are unable to conform to this order as being expendable, rather than in need of additional care ([33], [39], [96]) (Haskaj, 2018; Light, 2004). In generalizing a patient population as difficult healthcare practitioners reproduce a social order; simultaneously contributing to a populations’ expendability due to their inability to conform and treating the population who is able to conform (Gaudilliere & Sunder Rajan, 2021; Mullet, 2018; van Dijk, 1993).

Similarly to the refusal of healthcare is the use of pejorative language when referencing populations with OUD. Although ‘junky’ only appears once ([1]), the use of pejorative phrasing appears multiple times ([99], [93], [86], [95], [96], [98]). One such instance was referenced by a buprenorphine prescriber’s colleagues as a concern before they started prescribing: “‘Well, once you start, then that population’s going to come trickling in, and then our clinic is going to be all that.’” ([98]). Referring to a population as ‘that’ or ‘these people’ is another instance of rhetoric that demarcates OUD patients as zoe, not existing within the legal and social order to receive healthcare (Haskaj, 2018). The demarcation of those with OUD as zoe, places the power into the healthcare practitioners’ hands to act as judge, jury, and executioner without legal restraint (Haskaj, 2018).

The final way covert criminalization appears in the discourse is in reference to the way pharmacotherapies are prescribed and distributed. This was reminiscent of being a criminal with strict distribution times, compliance, and regulations. “[Patients] have to see their doctor at 5 o’clock in the morning every morning to get the medicine.” ([13]). While this is to mitigate risk for a use disorder, it is ultimately inhibitive when attempting to receive

treatment ([8], [12], [41]). In one quote, the difficulty of keeping up with these regulations was compared with the difficulty of maintaining an active addiction ([11]). That said, while buprenorphine still required strict regulations in order to get coverage from insurance ([41]), it was considered closer to diabetes in the humanness of its distribution when compared to methadone ([12]).

3.1.1.2 Abstinence

The second established ideology is abstinence. While this is simply leading with medication free treatment, it frequently coincided with covertly criminalizing language for both the patient and the pharmacotherapies. Although perhaps due to interview question bias, abstinence-based practitioners rarely promoted the quality of abstinence-based treatments outside of the use of therapy ([7]). Instead language more so attempted to villainize or devalue the use of pharmacotherapies. Abstinence as an ideological framework was grounded in three main justifications; distrust in the pharmaceutical companies, a lack of scientific understanding in pharmacotherapies, or not considering taking pharmacotherapies to be 'in recovery'.

The first of these, distrust in the pharmaceutical companies, is not unwarranted; the pharmaceutical industry has established their prerogative to be profit more than health oriented (Dumit, 2012; Muniesa, 2017). One consequence from such an industry is a lack of trust (Light, 2004). A few healthcare practitioners referenced the marketization of healthcare, the Opioid Epidemic, and the ways in which their fellow physicians acted during that period as a reason they did not want to partake in pharmacotherapies ([21], [22], [104], [105], [106], [107], [108]). "He saw this opioid epidemic explode in his face. And for him, from the get-go before this even started, he said, 'We are not the office that does chronic pain meds,'" ([108]). The ways in which pharmacotherapies are promoted by the pharmaceutical industry, for chronic use or maintenance, does little to ease these concerns ([21], [103]).

The second justification was due to a lack of scientific knowledge about how pharmacotherapies work, resulting in them being perceived as just using another opioid

([15], [16], [58], [64], [65], [109]). “I don’t think they get taught it in school and their own personal bias doesn’t allow them to look into it because, as counselors, most of us have addiction pasts and go through 12-steps where it’s not welcoming to [agonist MOUD],” ([15]). This lack of scientific understanding in what pharmacotherapies do that is different from heroin or fentanyl, leads to a conflation of the two types of opioids ([43], [44], [56], [57], [61], [77]). In one extreme example, an abstinence-based treatment director stated: “I would rather take the risk of helping somebody through withdrawal from opiates [and] risk them relapsing, possibly overdosing, than trading one addiction for another,” ([7]). Despite pharmacotherapies assisting with the physiological dependence of addiction — helping with the management of co-morbidities and allowing people to live a normal life, ([17], [20]) — it becomes the immorality attributed to using substances that trumps the risk of overdose.

The last justification for abstinence is that the use of pharmacotherapies does not qualify as being in recovery ([43], [44], [56], [57], [61], [77]). “It’s kind of a, keeps them in a neutral mode, so they’re at least surviving, they’re not OD-ing, and, that as long as they’re using it properly, okay, then, then when they’re ready, really ready for recovery, then they can move forward,” ([77]). Unlike diabetes, a chronic condition with lifelong treatment, someone would not be expected to stop taking insulin in order to be considered ‘ready for recovery’ from diabetes. While this touches on the pathologization of the behavior, it also is an example of healthcare practitioners using autonomy to create their own parameters for treatment (Light, 2004).

3.1.1.3 Pharmaceuticalization

The final established ideology that was presented was the use of MOUDs. The use of MOUDs appeared in a hierarchy of risk, with naltrexone being considered the least and methadone being considered the most risky to the patient. Even in relating the use to risk, there was still a variety of treatment modalities.

The first way pharmacotherapies were used was in conjunction with abstinence. Despite the use of pharmacotherapies, there was often the conflation of abstinence and

pharmaceutical treatment, justified due to it being used for detoxification ([1], [2], [12]) or due to it not being an opiate in the case of naltrexone ([2], [7], [18]). “The nurses at our facility only give you [naltrexone] for a year,” ([2]). Despite this quote coming from an abstinence-based counselor, there is still the use of pharmacotherapies in treatment. The conflation of abstinence and pharmacotherapies depicts healthcare practitioners that are more tied to the label of an ideology than to its practice. “What had to happen organizationally is we had to change – not just approach, but our perspective of what abstinence based includes,” ([73]). While this negates any justifications of not using pharmacotherapies, e.g. distrust in pharmaceutical companies, it also negates the value of abstinence as a method of treatment. Not everyone seeking treatment wants to use pharmacotherapies. In conflating the two it removes abstinence as an option ([54], [55]).

Buprenorphine shifted between being closer to naltrexone or methadone in terms of its association with risk, depending on the practitioner ([1], [12], [16]). From a bio-chemical perspective, there does seem to be more risk associated with methadone in terms of overmedication or with reactions to other medications ([3], [4]). One buprenorphine prescriber voiced these concerns: “A lot of patients that I see at the urgent care where I work at times who are on methadone are overmedicated. That doesn’t happen here [at buprenorphine clinic]. You can’t get that kind of effect from buprenorphine because of how the drug works,” ([4]). It is still possible to have adverse reactions between buprenorphine and another medication, but buprenorphine’s ceiling effect limits the risk of being overmedicated where methadone still has this risk as an agonist (Henninger & Sung, 2014).

That said, with proper dosing, methadone should not produce any side effects of sedation ([5]). “If someone notices sedation, the doctor reduces their dose to make sure it’s not methadone,” ([5]). So while it may pose more risk, with proper medication oversight this risk should be easily managed. Healthcare practitioners who work with methadone and buprenorphine tended to practice less absolutism towards the type of medication, or the duration of use ([5], [10], [20], [75], [79], [80]). “They need to be on as long as they need to be on. If you push people off of methadone, or buprenorphine, they die. You do not push

these patients off. You don't," ([80]). Practitioners who worked with methadone and buprenorphine clearly differentiated between opioids in treatment and opioids in addiction: "'Using IV, they collapse the veins, run the risk of getting Hep C,' all the negative effects of using heroin compared to methadone,'" ([20]). Further, those working with buprenorphine or methadone seemed to be less likely to possess condition stigma, "I see my patients get better; in society with their families, going to parks, at restaurants, working in the community. That's proof it works, even though 50% of our patients might be still actively using, they do it more safely," ([17]). While there was a significant amount of animosity from abstinence-based practitioners (including those using naltrexone) towards those using pharmacotherapies, only a couple providers reportedly called out the conflation of naltrexone and abstinence ([6], [19]). "It's unethical to promote any one of those three forms of [MOUD] as superior to another or to call any one of them 'abstinence' and not the others…Because it's ignoring science," ([19]). These physicians conceptualize treatment as a biochemical response taking place at the opioid receptor regardless of the MOUD used.

3.1.2 Established Patterns in Practice

There were three patterns of medical practice identified throughout the 2.2 State of the Art. The oldest was medical monotheism, which was the practice of absolutism based on personal ideology (Light, 2004; Szasz, 2006). Medically monotheistic practitioners practiced autonomy in their relationships with their patients, not necessarily based on medical science but rather on their personal beliefs (Light, 2004). Gold standards again represented the theologic 'one right way' of medical monotheism (Dumit, 2012; Jones & Podolsky, 2015). Practitioners using gold standards also practiced absolutism, but instead tied this to pharmaceutical science and statistics (Dumit, 2012; Jones & Podolsky, 2015). These practitioners follow pharmaceutical research unquestioningly and without variability between patients. The final established practice was that of the expert patient (Dumit, 2012). Where the first two practices reproduce top-down power wherein patient opinion has no place, expert patients struggle against these two types of practices in efforts to express their

specific needs. This is identified not by collaboration, but rather struggle, as both the patient and the practitioner fight for the position of dominance.

Medical monotheism was marked by statements of absolutism, baseless standards, and statements grounded in feeling, e.g. “I think” ([1], [2], [7], [12], [16], [44], [64], [65], [70], [71], [73], [77], [108], [110]). This was a practice found most often when referencing the use of MOUDs: “I think [methadone is] too habit forming. [...] and [buprenorphine] is only ok for [short-term] detox,” ([1]). For those practicing abstinence-based treatment the absolutism was against any use of MOUDs ([16], [44], [64], [65], [107], [108]). However, it also appeared by those prescribing MOUDs: “He had in his mind that I’m not going to write anything more than 80 Morphine equivalent per day,” ([110]); “The nurses at our facility only give you [naltrexone] for a year. A year makes sense,” ([2]). For those prescribing MOUDs, medical monotheism appeared in the unscientific standards ascribed to their use ([1], [2], [7], [12], [77], [110]). The last way it showed up was in the top-down management of an organization, both amongst prescribers and abstinence-based practitioners. “I’m the CEO here, so what I say goes,” ([70]). For those practicing with MOUDs, this began to drift into gold standard absolutism.

Gold standard practice was much less frequent than medical monotheism, as it took place only amongst those who were prescribing MOUDs ([19], [50], [69], [76], [100], [101]). Gold standard practice was more difficult to identify, however, those included had indications of top-down management, lack of care for the patient, and unwavering trust in pharmaceutical standards: “You can’t abuse [extended-release naltrexone], it was marketed that way,” ([69]). Gold standard practice focused more so on quantitative standards of retention rather than the improvements or desires of their patients ([76]).

Lastly, there were those practitioners who were facing the expert patient. The expert patient was experienced by those prescribing MOUDs when they wanted to pursue medication free treatment or cease MOUD treatment ([54], [55]). “They get their mindset that they want to be completely drug-free,” ([54]). They were also experienced by the abstinence provider, when the patient wanted to use MOUDs ([89], [90]). This struggle could turn violent,

reportedly resulting in threats, restraining orders, and in one case a shooting as the patient fought for the care they wanted ([89], [90]).

3.1.3 Themes

Throughout the State of the Art, there were recurring themes related to the pathologization of substance use and the marketization of health. Three of the most significant themes related to the construction of crisis, stigma, and risk (Dumit, 2012; Haskaj, 2018; Madden, 2019; Mazzucato & Roy, 2019; Muniesa, 2017; Sunder Rajan, 2017). The discourse around using buprenorphine / MOUDs in OUD treatment depict the impact of these themes.

3.1.3.1 Crisis

Understanding addiction as a market depicts the structural value in a public health crisis; a space of marketing pharmacotherapies as treatment for manufactured problems (Dumit, 2012; Gaudilliere & Sunder Rajan, 2021; Haskaj, 2018; Muniesa, 2017). In sustaining a market of addiction, healthcare practitioners become yet another actor in crisis. They manage not just the structural changes to accommodate a for-profit healthcare system — privatization, efficiency, and pharmaceuticalization — but the patients who manage a variety of their own maintained crises (Gaudilliere, 2021; Gaudilliere & Sunder Rajan, 2021; Light, 2004; Mazzucato & Roy, 2019; Muniesa, 2017). The consequence was an overarching lack of security that impacted trust and practice; the human variables that influence the value of a technocratic innovation (Datta Burton et al., 2022). I identified four clear instances of crises accommodated by the healthcare practitioner — a crisis in infrastructure, a crisis in trust, a crisis in education, and crisis with patients — that impacted their approach to care.

A crisis in infrastructure has led to an MOUD treatment system that was reportedly so complex that mentorship after the initial training was highly valued ([35], [52], [53]). “I mean, not just the prescribing, but there’s so much like red tape and just the getting the system in place,” ([35]). The difficulty in navigating such infrastructure requires time and resources in

order to implement it at an individual or institutional level. Despite investment from the public and NIH, the FDA and DEA did not contribute to an ease in prescription infrastructure (Barenie & Kesselheim, 2021; Madden, 2019). In a structure built for efficiency, a product with difficult implementation easily inhibited practitioners from the use of pharmacotherapies as they manage a lack of time and resources ([46], [48], [49], [99]), unless accommodated by an institutional move towards pharmacotherapies ([25], [71]). Practitioners reported extremely strict prescription regulations — “People often don’t want to prescribe it because they’re afraid that they have to keep a record in a special way or the DEA may swoop,”([51]) — leading to a fear that prescribing pharmacotherapies would increase prescriber vulnerability to the DEA ([14], [51], [97]). In one extreme scenario, the failure to adopt pharmacotherapies led to significant job loss: “In May I fired my whole management team except for one. I was tired of the massive implementation and the drift,” ([71]). In this case, ideological misalignment was a structural crisis managed through firing.

The second space was a crisis in trust; distrust was experienced towards and from every major actor. OUD treatment practitioners were suspicious of their colleagues’ justifications for prescribing pharmacotherapies, citing the corruption that led to the severity of the pandemic with prescription opioids ([22], [103], [107]). This was mostly due to a fear that the regulators would again fail in their duty to protect the health of its citizens. “I guess my big issue is I don’t trust the FDA and I don’t trust pharmaceutical companies anymore. I worry that they’re doing exactly what they did last time that got us to where we are,” ([104]). The consequence of the regulators failure to regulate falls mostly on the patient and their ability to access healthcare, keeping them in crisis. Patients then also became actors warranting distrust in the opinion of healthcare practitioners. This distrust was placed in patients' ability to show up safely for practitioners, and their motivations for seeking an opioid-based treatment ([26], [92], [106], [109]). Distrust in patient motivations were contributed to by the X-waiver, as it suggested there should be a lack of trust in patients that desired ceasing buprenorphine treatment ([106]). This push for the chronic use of the medication had an adverse effect, exacerbating distrust in pharmaceutical companies.

The next crisis was one of knowledge and education. Despite the years of education that are required to become a healthcare provider there were frequent misunderstandings in how pharmacotherapies acted as a scientific medical technology. There seemed to be a general failure to stay up to date with medical research, leading to outdated medical practices ([15], [20], [31], [104]). “Who has the time to go back to those original research studies that say buprenorphine really works and are they legit?” ([104]). Time and resources have been exchanged for efficiency, contributing to an environment that is unsuitable for implementing up-to-date practices. A historical examination of medical practice depicts that a culture of autonomy and absolutism has also created a structure that neither values nor accommodates the implementation of evolving medical standards for the general public (Light, 2004). Additionally, “are they legit”, points towards the crisis in trust also impacting pharmaceutical science ([104]). Due to the complexity of OUD and the lack of scientific education on treating it, there are numerous hesitancies, misconceptions, and confusions, even after certification ([17], [19], [20], [34], [50], [52], [53], [93]). “I’ve come across some treatment professionals barely starting their career [who] think that methadone has to do with meth[amphetamines],” ([20]). A culture of medical practice that evolved out of not challenging peers has instead set a standard of practicing out of date or unscientific healthcare (Light, 2004).

The final space of crisis was the interpersonal relationship between healthcare practitioner and patient. Patients, also existing in a culture of crisis, are continuing to manage growing rates of unemployment, poverty, and systemic inequalities, all of which are correlated with the use of opiates (Haskaj, 2018; Muniesa, 2017; Sharma et al., 2016). As OUD includes physiological, behavioral, and environmental components, treating OUD should include minimizing crises patients are living within ([37]). However, these structural crises are much too significant for the individual healthcare practitioner to manage, requiring regulator action and cultural adjustment. Unfortunately, a prolonged state of crisis has led to increasingly extreme behaviors that risk the wellbeing of the healthcare practitioner ([89], [90]). “We had a physician just across the border in Indiana, that actually got shot and killed.

He wouldn't prescribe pain medication, and so the patient went out and got his gun and came in and killed him and another person in the clinic," ([90]). Patients exist in crisis with providers as much as providers exist in crisis with patients, creating a feedback loop of increasing distrust and severity of reactions ([1], [7], [13], [89], [90]).

3.1.3.2 Stigma

Stigma was a highly influential factor in how healthcare practitioners proceeded, not just with a preferred treatment ideology, but how they would perform medical practice. Using the terminology provided by Madden (2019), discourse was sorted into the presence of intervention stigma, condition stigma, or both intervention and condition stigma.

Intervention stigma was directed towards MOUDs, opioids generally, and the prescribing physician. Prescribing physicians would report getting put in a box: "he's a 'sub doctor.' And that creates a stigma, a perception that these doctors, that's all they do,"([100]). The stigma of the intervention would carry over into association with the medication ([100], [101], [102]). The stigma of the medication was frequently reported on, but to varying degrees depending on the medication's association with opiates ([15], [56], [57], [58], [61], [63], [64], [65], [78]). "I can tell you what is dangerous. Having people in their facility that all they want to do is be on buprenorphine and they are sitting in a facility with people that are serious about what they're doing is a bad thing. Somebody nodding out and falling out of a chair in a group is a bad thing," ([64]). Despite a buprenorphine prescriber referencing the scientific unlikelyness of someone 'nodding' on buprenorphine, and a methadone prescriber reporting that nodding is an indication of the wrong dosage, this type of rhetoric did take place ([4], [62], [64]). It ultimately came down to the conflation of opiates used in OUD treatment and opiates used in active addiction ([7], [56], [58]). "People think you're trading a drug for a drug and is that recovery," ([56]). In conceptualizing OUD as behavioral, discourse that stigmatizes interventions that continue that behavior are socially justified.

There were numerous instances where no strong opinions were discussed towards the intervention, but there was stigma associated with the condition of addiction ([26], [32],

[33], [77], [91], [92], [94], [95], [96], [98], [106]). “I was worried that if we started prescribing Suboxone, that [...] you know, we’d have lines around the building trying to get in to get Suboxone,” ([26]). In this discourse the focus was on the zoe demarcation of individuals with OUD — “No one wants them in their waiting rooms,” ([96]) — rather than concerns about the MOUDs. This stigma was used to justify numerous practitioners’ exclusion of treating a vulnerable population, despite the pathologization of OUD ([91], [92], [94], [95], [96], [98]).

Finally, intervention and condition stigma showed up congruently ([1], [2], [7], [11], [16], [29], [30], [44], [59], [66]). In this discourse practitioners reported stigma towards substance-using behavior generally: “They are still polysubstance abusers. It’s not fixing the problem,” ([16]). For this practitioner the problem is not the risk of co-morbidities, overdose, or criminalization, but the use of substances specifically. In the conflation of opioids for treatments with opioids in active addiction, this stigma carries over into the treatments: “I am so relieved and grateful that I did not know about methadone or [buprenorphine]. Otherwise, I would not be clean and sober and clearheaded today. I’d probably be on that crap,” ([16]). This type of discourse not only stigmatizes the treatment, but it stigmatizes those who have chosen to use the treatment for maintenance, as this practitioner has determined those using MOUDs for maintenance do not qualify as being clean or sober. Even in the event that substance-use was controlled and patients were able to return to a normal life, the stigmatization of the treatment did not allow that to be a milestone in recovery ([17]).

3.1.3.3 Risk

Risk was also a recurring theme when discussing paradigms of health and patterns of pharmaceutical development (Dumit, 2012). However, in OUD treatment, risk did not just refer to patients’ health, but also to practitioners’ safety and to MOUDs for their potential in continuing an epidemic.

Risk for OUD itself lies in the accessibility to prescription and illicit opiates (Hasin et al., 2022; Sharma et al., 2016). Managing the risk of physiological dependence — co-morbidities, overdose, neuroadaptation — lies in the treatment of OUD (Sharma et al.,

2016). Neuroadaptation and physiological dependence are material, physical side effects of prolonged opioid use. MOUDs manage the material risk by lowering the potential for life-threatening consequences. In ignoring or being uneducated on the medical science behind these medications, healthcare practitioners increase a preventable risk to patient health ([7], [20], [19], [30], [79], [80], [109]). “It’s unethical because it’s convincing patients that a reasonable guideline-based, science-supported standard of care is wrong…it’s setting people up to die,” ([19]). The crisis in education surrounding the usage of MOUDs pose real, life-threatening risks for those seeking treatment for OUD.

The value in manufactured crises also pose a risk, both in and outside of a healthcare setting ([23], [30], [85], [87], [88]). There is first the difficulty in getting those who are seeking help, what could be a very short window of time, into detox and treatment ([30], [88]). One practitioner compares the emergency medical response to a heart attack versus someone who is ready to stop using: “But if someone says at 4:00 pm on a Friday afternoon, I finally want to stop using, you know we are just like well, come back Monday. You know? We have a whole weekend we gotta get through now,” ([88]). Outside of the immediate healthcare setting, there is risk due to value-based pricing as many are unable to afford treatment. “This all goes back to, rich, upper class, suburbia, kids dying, they’ll have more access to [extended-release naltrexone] than low socioeconomic status people who don’t have $1,000 every month,” ([23]). When treatments are made unaffordable due to value-based pricing, risk increases with a decrease in wealth ([23], [39], [40]).

Risk for patients, and disparity in how that risk is distributed, leads to risk for staff health ([89], [90], [92], [93]). “I think most of us, in the rural setting, have been threatened by people like this too,” ([89]). Patients functioning in a state of crisis, distrust, and risk posed to their health, become risks in and of themselves. A state of desperation and fear does not make for a safe patient population, which is increasingly becoming the case as the environment outside of a healthcare setting becomes one of increasing and manufactured crises (Haskaj, 2018; Muniesa, 2017).

Lastly, healthcare practitioners expressed concerns for the risk posed by MOUD ([3],

[60], [81], [103], [104], [107], [108]). While some healthcare practitioners expressed distaste for the ways in which MOUDs are dispensed, stating that it increased stigma ([13]), others stated that MOUDs posed a risk of overdose and needed to be strictly regulated ([60], [81]). “How many licensed facilities do [different areas] have? How many all-cash Subutex facilities do they have, and what are the overdoses in that ZIP code? [...] But we tend to not talk about the treatment side, and it being related to the epidemic,” ([81]). Although the causation of this correlation should be further expanded on, the risk posed by MOUDs was an underlying fear throughout certain discourse.

3.1.4 Level 1 Analysis

In the first level of analysis I was able to depict ways in which established ideologies, practices, and themes articulate different power dynamics in healthcare. Beginning with the established treatment ideologies, despite OUD being defined as a chronic and relapsing disease, it was regularly not responded to as a disease. Instead I identified responses of covert criminalization through the use of pejorative language, stigma, and moralizing the behavior of substance-use (Henninger & Sung, 2014). This seemed to take place more often by those who had a preference for abstinence or those who demarcated populations with OUD as zoe, and refused to treat them.

There were instances where practitioners seemed to be tied more to the label of ‘abstinence-based’ than the ideology itself, particularly when using naltrexone. Abstinence, despite traditionally meaning treatment with no use of pharmaceuticals, has often come to include the use of naltrexone. While there should be no stigma attached to the use of naltrexone, it should also not be called abstinence as it consists of the use of pharmaceuticals. Being more willing to change the practices of the ideology than the title of the ideology, suggests that there is a perception of power or superiority that comes from the title of “abstinence-based”, most likely due to its association with religion, morality, and purity (Bedford, 2025).

Use of buprenorphine was never regarded as being abstinent, but its perceived risk

would shift between being closer to naltrexone or methadone, depending on the provider. Even while practicing as an opioid-based treatment provider, buprenorphine providers would occasionally contribute to the stigmatization of methadone, finding it riskier than their own treatment methods. The association of risk to the treatment practice, although not grounded in science, had an inverse correlation as the practitioners providing perceived riskier treatments exhibited less instances of authoritarian practice and more willingness to treat the physiological components of OUD rather than the behavioral components.

The social-historical trend of pathologizing vice has contributed to the practice of moralizing the behavior of using substance rather than addressing the ways in which behavior, physiological dependence, and environment all contribute to OUD (Hasin et al., 2022; Pettus, 2020; Sharma et al., 2016; Szasz, 2006). In practicing from a place of morality, it has become socially permissible to respond to the OUD population with neither scientifically backed healthcare nor professional medical vernacular (Dollar, 2019; Henninger & Sung, 2014; Szasz, 2006). The presence of rhetoric that reproduces a criminalization ideology within healthcare spaces further moralizes the behavior of substance use, and justifies this populations' lack of treatment.

Finding a population with a common condition undeserving of healthcare, particularly when the condition is preventable but has a high risk of death, is a biopolitical rationale that reproduces a current social order (Gaudilliere & Sunder Rajan, 2021; Haskaj, 2018). Healthcare practitioners become actors in this market of addiction, holding the power to direct its reproduction when choosing to treat the population as bios (culturally situated) or zoe (expendable) (Haskaj, 2018). The more social capital the patient possesses (i.e. whiteness, wealth), such as buprenorphine's consumer base, the less likely they will be demarcated as zoe, and thus the social order continues (Gaudilliere & Sunder Rajan, 2021; Haskaj, 2018; Smith et al., 2025; van Dijk, 1993). Such a position of dominance is identified in medical practice as the authoritarian provider wherein their treatment is grounded in the absolutism of their specific ideology. While these practices of absolutism appeared both independent of medical science (medical monotheism) and dependent on medical science

(gold standards) neither valued the individual experience of their patient. The authoritarian provider's unwillingness to work with patients was depicted in discourse with the expert patient who struggled to have agency in their healthcare. This practice demarcated both treated patients and untreated patients as zoe, based on the superiority — be it moral, scientific, class — of the provider.

Finally, the medical industrial complex that values efficiency and profit does not allow healthcare practitioners the power to effectively treat OUD. For a long time manufacturing crises were profitable due to the resulting consumption and the perceived disposability of certain populations (Haskaj, 2018; Sunder Rajan, 2017). The Opioid Epidemic, where those possessing more social capital became the primary targets of value extraction, acted as a catalyst that resulted in a rapid degradation of trust in regulating bodies and pharmaceutical interventions. Many healthcare practitioners are as disillusioned as their patients in the belief that health still holds any value to the pharmaceutical industry as they exhibit only intentions of profit accumulation (Dumit, 2012; Gaudilliere & Sunder Rajan, 2021; Mazzucato & Roy, 2019). This has resulted in practices that work to protect against, manage, and challenge the values of larger regulating structures, while also impacting how pharmacotherapies get integrated into treatment settings (Datta Burton et al., 2022). The discourse depicts instances where healthcare practitioners' understand buprenorphine's value as an asset which leads them to not trust in its value as a commodity. An example of providers who lack scientific knowledge of MOUDs and possess experiential knowledge of structural values. The healthcare practitioner resists participating in the OUD market through their unwillingness to participate in the marketization of addiction.

From these articulations of power I identified the benevolent provider. The benevolent provider was often indicated in their understanding of the Opioid Epidemic as the catalyst that led to the delegitimization of pharmaceutical science. Distrust and betrayal was enacted by the benevolent provider through misplaced good intentions at the cost of patients' health. Healthcare practitioners wanted to provide the best treatment for their patients, however, they grappled with the belief that a product produced by the pharmaceutical industry,

particularly one classified as an opiate, would result in another Opioid Epidemic. Their power was enacted through top-down control, but good intention, unlike the authoritarian provider who acted with little regard for their patients' wellbeing. Those healthcare practitioners who understood the medical science of MOUDs valued them as a commodity. Their resistance found other ways to challenge the marketization of addiction that did not include refusing valuable treatments.

3.2 Interdiscursivity

In the second level of analysis, I use abductive coding in order to continue exploring how discourse pertaining to buprenorphine in addiction treatment articulates power dynamics. I again code only the healthcare practitioners discourse, expanding to include larger social contextualizations. My deductive coding framework uses older ideological paradigms of vice and disease, both moralizing responses to an unwanted behavior. I use inductive coding to identify emerging paradigms in the social response to substance use and the medical practice in OUD treatment. These emerging paradigms identify ideologies that do not reproduce the status quo through top-down power relations, individualized responsibility, or absolutism, but challenge the market of addiction through shifts in mundane practice.

3.2.1 Older Ideological paradigms

While the response to vice is one of punishment and the response to disease is one of treatment, both are a moralizing attempt to change a socially situated behavior (Szasz, 2006). Criminalization and abstinence are situated ideologies borne out of viewing substance use as a vice, with the use of incarceration as a space for detoxification and punishment (Henninger & Sung, 2014). Medicalization and abstinence are situated ideologies borne out of the pathologization of substance-seeking behavior with the implementation of AA in hospital settings (Henninger & Sung, 2014). In this framework I sought to identify ideologies that only responded to the behavioral component of OUD, be it

through punishment or treatment, rather than the physiological or environmental components.

Punishment for the behavior of substance seeking most often appeared in reference to those who simply refused to treat people experiencing OUD ([30], [32], [33], [91], [92], [94], [95], [96], [98]). “No one wants them in their waiting rooms, and it can be challenging,” ([96]). Responding to a population who is in need of healthcare with the refusal of care, is punishing that population — be it for the behavior of substance use or existing without middle class privileges (e.g. insurance) — in a way that passively accepts their death. Punishment for the behavior also appeared in the way medications were prescribed and distributed: “But you pretty much had to get a urine showing compliance to Suboxone,” ([41]); “The patient might say, ‘It’s because they don’t trust me enough to give me my medicine,’” ([13]). Treating a population seeking treatment like criminals, further ingrains a belief that they are criminals who are conducting a behavior that is deserving of punishment. The final way punishment showed up was in the discourse of those treating people with OUD. Some peer practitioners saw MOUDs as taking the easy way out. While these peer providers might have struggled using abstinence, they ultimately succeeded and others should be able to as well ([1], [15]). Others set strict standards based on a presumed timeline of treatment ([2]). Some simply looked at the use of substances as one that was deserving of overdose or illicit treatment modalities ([7], [11]). “It would be so much easier if they get some of that stuff [methadone] off the street and you can do it at your own time. It’s just weird,” ([11]). Although not always explicitly stated, the desire to punish the behavior was still a common mindset even in healthcare spaces.

Although there are three components to treating OUD, this mindset limited treatment to address only the behavior, ignoring components of physiological dependence or environment ([1], [7], [16], [31], [44], [45], [50], [56], [58], [61], [63], [64], [65], [77], [81]). “I am so relieved and grateful that I did not know about methadone or [buprenorphine]. [...] They are still polysubstance abusers. It’s not fixing the problem,” ([16]). This quote outlines explicitly what the problem is: polysubstance use. Despite numerous testimonials from

patients and practitioners about the ways in which these medications allowed the patients to get their life back, regardless of if they continued to use substances recreationally, the biggest problem to this practitioner is the use of substances (Baus et al., 2023; [17], [19]).

The ramifications of focusing only on the behavioral component is that it provides incomplete treatment, again reproducing the passive deaths of these patients: “The data is so clear, especially with opioid use disorder that 90% of people who go without [MOUD] relapse, the mortality rates are astronomical,” ([19]). Practitioners who do manage physiological dependence end up compensating for the practitioners who only focus on the behavior ([19], [29]). “They come, they get treated, but when they’re ready to go to this particular, faith-based treatment they’re telling no medications [...] They will go there, and then within 48 h, they’re back to our [emergency room],” ([29]). Practitioners who focus on changing the behavior, rather than seeing OUD as material, behavioral, and environmental practice healthcare from a moral high ground ([1], [7], [16], [44], [56], [58], [61], [63], [64], [65], [77], [81]).

3.2.2 Emerging Paradigms

In the evolution of pathologizing bad behaviors, there was the supposition that it would replace moral judgement for treatment (Henninger & Sung, 2014; Szasz, 2006). This argument fell apart when religiously inclined providers began to treat homosexuality, or other such behaviors found sinful based on subjective biblical standards (Szasz, 2006). While ‘normal’ substance-use behaviors have narrowed over the past century with the criminalization of most substances, substance-use remains a normative part of the human experience (“Harm Reduction Principles”, n.d.; Henninger & Sung, 2014). The behavioral aspect to opioid use could be due to any number of reasons, however, when the behavior is overdone it can risk physical dependence that has further risks of overdose or comorbidities (Sharma et al., 2016). Getting to this point of risk happens quickly with opiates due to their bio-chemical characteristics: withdrawal, euphoria, and neuroadaptation (Sharma et al., 2016). Responding to the overconsumption of opiates as possessing an environmental

component, e.g. a reaction to social adversity, is emerging in new paradigms of medical responses to addiction. This will examine the discourse first as emerging ideologies, then emerging patterns in medical practice, and finally emerging values.

3.2.2.1 Emerging Ideologies

Emerging ideologies recognized that practitioner responsibility did not include behavior management ([5], [17]), instead focusing treatment on the physiological dependence and environmental components of OUD ([9], [14], [28], [37], [39], [40], [85], [88]), while respecting the individual's choice in their path to recovery ([66], [68], [72], [74]). This was represented in a variety of new practices, but ultimately came down to a shift in provider culture from one of authoritarianism to one of expanding the patient's capabilities. A capabilities provider came to be practiced through the expansion of services addressing the quality of life, ensuring that these services were available and accessible when sought out by the patient.

Practitioners whose discourse indicated that they did not take responsibility for addressing the behavior of substance use were able to provide healthcare regardless of their patients' choices. "Even though 50% of our patients might be still actively using, they do it more safely because we tell them about harm reduction," ([17]). Harm reduction is a method that accepts the use of substances and seeks to manage the harms associated with its use ("Harm Reduction Principles", n.d.). When treatment is sought it is provided based on the parameters set by the patient ("Harm Reduction Principles", n.d.). While the adoption of certain harm reduction practices have been integrated into traditional healthcare spaces, it exists primarily as a social justice and grassroots movement that recognizes the humanity and autonomy of people who use drugs ("Harm Reduction Principles", n.d.).

For those whose ideology considered the environmental component to OUD, additional care was provided to address these vulnerabilities ([9], [14], [28], [37], [39], [40], [85]). These practitioners worked with their patients in order to better understand their state of life: "The focus of your treatment is counseling…The medication helps us to level out your

mind so that we can dig deeper and find out your problems," ([9]). Further they offered an array of resources, from food closets to social workers, recognizing that their patients could be coming from disadvantaged socioeconomic backgrounds ([28], [37], [39], [40], [85], [88]). Healthcare practitioners used a significant amount of their own time and resources — word-of-mouth education, getting patients immediately from "help-seeking" into treatment, and keeping track of vulnerable individuals — working in direct contradiction with "efficiency" in order to manage this component of OUD ([37], [47], [84], [85], [86], [87], [88]).

Within this new ideology of providing patients the capability to access resources and healthcare, there was also the recognition of patient autonomy. Recognizing patient autonomy did not promote absolutism in treatment, but rather encouraged those seeking treatment to also respect others' route to recovery ([66], [68], [72], [74]). "One way they did this was by mixing peers of all kinds to drill down this point that, 'everybody's path to recovery is a valid one.'" ([74]). These practitioners worked with their patients to give them informed autonomy in their treatment. Expert patients struggling for autonomy were not met with a struggle ([82], [83]). "So, I think it's hard for a patient to understand: What [do] I have; Where do I go to get help?; What's the best help?; [...] I don't know how to clear that up," ([82]). These capability practitioners recognized the existence of the expert patient, but responded with concern that there was no centralized source for them to have the capability to inform themselves of their options ([82], [83]).

3.2.2.2 Emerging Practice

With this emerging ideology came new patterns of practice. Primarily this was represented in the discourse as instances of collaboration, both with the patient and between other practitioners who have specialized expertise. Medical practice has traditionally encouraged top-down care and practitioner autonomy in efforts to legitimize the expertise and professionalism of the medical caste (Light, 2004). Within an ideological framework that focuses on expanding the capabilities of a patient, it has shifted power dynamics from top-down domination to ones of mutual respect, collaboration, and shared knowledge.

A particularly fundamental shift in practice was the simple inquiry into the patients needs and desires ([10], [14], [37], [39], [79], [80], [88]). One such instance was this practitioner's approach to therapy as supplemental to buprenorphine and methadone treatment: "We firmly believe in therapy as a huge important tool, [...] [it] helps them or works better if someone really wants to do it," ([10]). This type of practice was flexible rather than uniform and absolute, acknowledging that wanted care will be more effective. The therapy was made available to the patient, when and if they chose to utilize it as a resource.

The capabilities provider did not rely on patients' lay knowledge to make these decisions, but included sharing expertise, allowing patients to have informed autonomy ([47], [62], [66], [68], [72], [74], [82], [84]). "Ultimately we try to mix our groups together because in the name of our vision in stigma reduction by singling people out [...] I find that we can cause that stigma to root even deeper. We try to mix all of our groups together and just deal with matters of recovery," ([66]). In this instance physicians exert power over controlling the environment, but they are not practicing absolutism. Control over mixing patients with different courses of recovery is an effort to foster mutual respect and education, rather than to exert dominance. Practitioners' expertise also came in the form of standards, informed by medical science, but practiced without absolutism: "If we see someone nodding it means there is possibly an interaction with their other medications (prescribed or not), or that we need to adjust their dose. This is something we check in on every single day with every single patient," ([62]). It came down to practitioners viewing their patients' as culturally situated, i.e. bios, often providing healthcare that fell outside of paid hours ([17], [27], [47]).

Another emerging practice was integrating new information rather than practicing rigid medical monotheism ([17], [18], [20], [24], [28], [53], [75]). Although some practitioners initially met pharmacotherapies with resistance, they evolved in their opinions as they saw the benefits it provided for patients, including those who still considered it abstinence-based ([17], [18], [24]). Others looked to their patients as a place of education, recognizing their lack of expertise on the complexities of addiction and recovery and allowing their patients'

expertise to be a place of personal growth ([20], [75]).

The final new practice was taking advantage of the growing specializations in healthcare through collaboration rather than individualization (Light, 2004). Practitioners recognized their situated expertise and referred to instances when they would rely on others' expertise ([34], [36], [85], [93]). "Those are the kind of cases where if I'm worried about the patient, because of the complexity, I never hesitate just to call [an addiction specialist] and ask for help," ([36]). Other practitioners admitted that treatment for OUD was complex and would take time, again recognizing the environmental component of OUD in treating it ([20], [86], [95], [97], [102]). Practitioners who did not have access to opportunities of collaboration or peer support felt that absence, with others who did have it reporting that they would stop offering treatment if they were to lose the collaborative support ([35], [38], [53]).

3.2.2.3 Emerging Values

With emerging ideologies there were emerging values that did not align with the values of marketizing addiction. These values were represented in practices that challenged existing structural values of crisis and profit. In the simple practice of collaboration they challenged the crises in trust, education, and relation. In collaboration, healthcare practitioners valued trust, placing it in their peers' and patients' intention to best provide and receive treatment ([37], [42]). They valued the experiential knowledge of their peers and patients, allowing it to supplement their understanding of the pharmaceutical science of MOUDs ([3], [6]). Finally, they valued their patient as a culturally situated individual, creating a relationship built on mutual respect.

Healthcare practitioners also found less value in the larger medical industrial complex, instead finding value in challenging the knowledge produced by the pharmaceutical industry ([13], [21], [45], [104], [105], [106], [107]). "The way the programs were designed? They're a billion-dollar industry. It's not for the client, it's about profit," ([21]). In challenging the medical industrial complex, many healthcare practitioners reflect on their own professions' role in the Opioid Epidemic with prescription opiates ([28], [108]) "I feel like I

have a responsibility to my patients to help fix this because physicians also helped create this. We need to take accountability in that and try to fix the errors that we've made in the past," ([28]). The values reflected in an ideology of capability were ones that tend to challenge, question, or reflect on what has been established as the status quo.

3.2.3 Level 2 Analysis

In the second level of analysis, the interdiscursivity of power dynamics were examined through older ideologies of morality and newer paradigms of addiction treatment. Older ideologies that understood substance abuse as a moral failure were defined by efforts to address the behavior through criminalization or pathologization, ignoring treatment of physiological dependence or environmental components. For practitioners who sought to punish the behavior, this power most often came in the refusal to treat people with OUD. Practitioners who sought to treat the behavior appeared when enacting their power to ignore the medical science of treating OUD, finding MOUDs to be a reproduction of the behavior they find morally bad. Pharmaceutical science was not necessarily delegitimized, but rather, MOUDs did not address the component of addiction that these practitioners understood to be in need of treatment. Both mindsets represent an abuse of power — baseless standards, unscientific care, moral judgement — practices that reproduce a market of addiction, as patients are unable to get the care they need, maintaining a public health crisis.

Although an overemphasis on the behavioral component of OUD was frequent throughout the discourse, there was also depicted emerging paradigms that do not respond to substance use as inherently bad. Emerging ideologies depicted a capabilities provider; a provider that focused on making available the necessary resources to expand the quality of life for the patient, when the patient sought their assistance. These practitioners used their professional power to address the physiological dependence and environmental components of addiction in collaboration with their patients, rather than practicing authoritarian care. They used their situated expertise to mutually educate peers and patients, as patients became autonomous individuals rather than an object in which to implement personal standards. This

emerging ideological trend influenced the practice and values of these providers. Rather than replicating the top-down power of traditional providers, these emerging practices relied on collaboration, trust, and evolving knowledge. In adopting these practices, the manufactured crises of the medical industrial complex were challenged as new values emerged. Practices adjusted care to the individual's needs, situating pharmaceutical science as valuable but possessing market biases.

In these emerging paradigms, practitioners depicted comfortability with decentralized power. There was an absence of struggle, and acknowledgment of others' autonomy and situated expertise. This is inherently contradictory to the larger value systems of today's medical industrial complex. Whereas the status quo promotes top-down power hoarding in the form of monopolization, shifts in mundane practice demonstrated by these healthcare practitioners challenge this approach. Participating in MOUD treatment seemed to foster more opportunities for practitioners to unlearn the socially normative behavioral understanding of substance-use, instead encouraging opportunities of personal growth and community care.

3.3 Immediate Social Context

In the third level of analysis, I situate the prior discourse into their immediate social context: qualitative research published in an academic journal. I analyze the ways in which the researchers' own ideological preference influences their research, followed by my own interpretation of power in healthcare. I break the research up into three components: the title / introduction, empirical content / graphics, and discussion / conclusion. Although there was an expected bias for gold standard treatment due to the nature of the research material, this was done using inductive coding in order to see what other themes emerged.

3.3.1 Title and Introduction

Each article that met the criteria for my CDA sought to understand what was keeping healthcare practitioners from using a gold standard treatment option for a significant

healthcare crisis. This was outlined in the title, the first sentences of the introduction, and the thesis statement.

In each of these titles, the underlined words outline the barrier that is being investigated: stigma, ideology, perception, willingness, motivations.

1. *Physicians' experiences with buprenorphine: A qualitative study of motivations for becoming X waivered and barriers to and facilitators of prescribing the medication for opioid use disorder* (McCollum et al., 2023)
2. *Variation in intervention stigma among medications for opioid use disorder* (Madden et al., 2022)
3. *It's not just the money: The role of treatment ideology in publicly funded substance use disorder treatment* (Stewart et al., 2021)
4. *Provider perceptions of medication for opioid used disorder (MOUD): A qualitative study in communities with high opioid overdose death rates* (Paul et al., 2022)
5. *Different forms of stigma and rural primary care professionals' willingness to prescribe buprenorphine* (Franz et al., 2025)

Each of these pieces of research explores possible interventions to navigate the underuse of MOUDs. However, what is first indicated in the title of these papers is the agency of the healthcare practitioner to decide the treatment modality, regardless of state or federal standards. While the autonomy of the practitioner is implicitly explored, it is not explicitly pointed towards as the common inhibitory factor in the underuse of MOUDs.

Each article makes an implicit preference for MOUDs within the first few sentences. All except one article reference the exceptionally high rates of OUD, every article discusses the exceptionally low use rates of MOUDs, and every article references the "researched", "findings", "evidence", "recommended", "effective" option of buprenorphine, methadone, and to a lesser extent naltrexone. The general content of the introduction varied, including unexamined barriers, intervention strategies, and the role of abstinence, race, and socioeconomic disenfranchisement.

One term referenced by Madden et al. (2022), and Paul et al. (2022) was that of "retention". "Of the greater than 2 million identified individuals with OUD in the U.S., it has been estimated that less than 7% initiate MOUD treatment. Moreover, of those started on

MOUD, retention is only about 30–50%," (Paul et al., 2022, p. 2). Retention is never clearly defined as to whether it is in reference to continued treatment with MOUDs, continued treatment after MOUDs, or whether the patient considers themselves recovered and is no longer in need of MOUDs. Due to the emphasis from regulators on maintenance usage, and the lack of clarity on the patient's state of recovery, the use of "retention" as a quantitative standard of measurement indicates a bias towards the use of MOUDs more than patient autonomy.

Each researcher concluded the introduction by stating their intent to explore specific barriers as an attempt to understand the low rates of use for MOUDs. The thesis statement of each article focused on barriers at the provider level, and as depicted in the prior two levels of analysis, these were widely varying in justification. Despite the variability in the specific research setting — rural, publicly funded, high use neighborhoods — the implicit goal of expanding the usage of MOUDs remained a constant across five academic papers.

3.3.2 Research and Graphics

I used inductive coding in order to analyze and thematically organize the research discourse of these five articles. This was particularly difficult when attempting to draw the line between analyzing the content and analyzing the discourse. I proceeded by first analyzing the vernacular used by the researchers. I then examined how the disparity in how scientific knowledge and experiential knowledge is valued between researcher and research subject, translates into what was being researched. I concluded by looking at what topics were the focus of this research.

In first looking at the vernacular, the academic articles took on the medical scientific language expected of academia. OUD was only referred to as such, and those with OUD were only ever referred to as patients or people, never addicts or junkies. McCollum et al. (2023) provided sample interview questions that reflect such academic professionalism with questions like: "What are some factors that have contributed to your ability to treat patients with OUD," (p. 7). Although interview questions were only explicitly outlined by McCollum et

al. (2023), it could be presumed that professional interview language emphasizing the medicalization of addiction was likely used across all five research practices. Working with that understanding, the recorded responses from healthcare professionals depicted in 3.1 and 3.2, exhibit a wide range of vernacular from professional to derogatory. This seemed to indicate a scientific and professional disparity between researcher and medical provider.

The variability in professional medical vernacular suggested a dynamic that was more reminiscent of an academic interviewer and lay person, than an academic interviewer and medical professional. From the perspective of power, an academic researcher and a medical professional would likely hold similar spaces of dominance based on socially prescribed expertise, higher education, and the likelihood of being white, male, and middle to upper class (Dollar, 2019). However, the disparity in bio-medical knowledge between academic researcher and medical professional suggested that while the academic researcher had dominance in their research specialization the medical professional held dominance in experiential knowledge.

While these academic articles took on the scientific medical vernacular expected from medical professionals, examining the scientific understanding of MOUDs amongst their research subjects went relatively unexplored, except by Madden et al. (2022). In a section on pharmacological properties, they (2022) explore critiques of different MOUDs based on scientific rather than ideological justifications. Madden et al. (2022) begins by stating that there are bio-chemical differences between the three medications, but examines their varying reception as an instance of intervention stigma. Madden et al. 's (2022) concludes this section with the providers who argue that the three medications should not be placed in a hierarchy, as each of them uses chemicals to block the effects of other opioids. Madden et al. (2022) suggests a communication intervention to flatten the scientific understanding to one of “blocker” across all three MOUDs.

Due to the nature of the literature, practitioner barriers were the focus of most topics, with empirical sections that depicted regulatory burdens, stigma, and moralizing substance use across all five pieces of literature. Amongst regulatory inhibitors there was the dominant

perception that regulations were one of the main inhibitors of using MOUDs, responsible for increased stigma and difficulties for patients and staff alike (Madden et al., 2022; McCollum et al., 2023; Stewart et al., 2021). Regulations could pertain to the burdens (Madden et al., 2022), the barriers (McCollum et al., 2023), or the discomfort (Stewart et al., 2021), that took place when becoming an MOUD prescriber. While lower regulations were perceived to be de-stigmatizing, Madden et al. (2022) could not fully explain buprenorphine's high stigma despite its much lower regulations compared to methadone (Madden et al., 2022). While some provider discourse certainly referenced the regulations as a difficulty, there were also those providers who would have seen deregulation as suspicious. Following the Opioid Epidemic, regulator decisions to deregulate any opioid, even when used as treatment, could foster suspicion amongst benevolent providers who have insufficient scientific knowledge of the medication. Both Madden et al. (2022) and Franz et al. (2025) further expand on the impact of the Opioid Epidemic in the discussion and conclusion.

3.3.3 Discussion and Conclusion

In the discussion and conclusion I found that stigma, institutional influence, personal ideology, and the heterogeneity of medical facilities were prominent themes across multiple sources. In addition to these larger themes, there were less pronounced topics including the market interventions, communication interventions, and future quantitative analyses.

Perhaps the most prominent theme examined in the discussion and conclusion chapters was the role stigma has in inhibiting the use of MOUDs. It is discussed in reference to community stigma, stigma towards different actors, structural influences that exacerbate stigma, and how to reduce stigma through researched interventions (Franz et al., 2025; Madden et al., 2022; McCollum et al., 2023; Paul et al., 2022; Stewart et al., 2021). However, Madden et al. (2022) was the only article to discuss MOUDs association with illicit opioids as a key driver in stigma. None of the articles discussed the association to criminalization — criminalized substances and criminalized populations — as potentially influential to social stigma surrounding the treatment of OUD and the usage of MOUDs. Nor

did they explore why practitioners have the agency to practice healthcare that was guided by stigma rather than science.

In a similar vein to stigma was discussion of the contradiction in regulation; regulators promoted MOUDs as a gold standard while keeping them highly regulated. The need for infrastructure support that facilitates MOUD usage by addressing delivery, deregulation, and funding were addressed by multiple authors (Madden et al., 2022; McCollum et al., 2023; Paul et al., 2022; Stewart et al., 2021). Stewart et al. (2021) suggests changes to value-based purchasing structures. McCollum et al. (2023) suggests that an institutional mandate in becoming x-waivered was a driving reason for adopting MOUDs. Franz et al. (2025) states educational interventions are needed across all aspects of OUD treatments in order to fight misinformation. Madden et al. (2022) suggests there is significant discomfort among healthcare practitioners with the processes of pharmaceuticalization, finding ideological practice may not always come from a place of stigma but one of protection and distrust. Additionally, Madden et al. (2022), highlights the individualization of treatment, suggesting neoliberalism as a contributory factor in the lack of healthcare advocacy to address the environmental contributors OUD.

Again related to stigma, was the discussion of the role of personal ideology. Stewart et al. (2021) states that while addressing the structural barriers to MOUDs is important it is not sufficient due to the role ideological preference has in adopting the usage of MOUDs. They (2021) suggest changes through using narrative messaging rather than data from RCTs, targeting traditional definitions of recovery, and using the term MAT over MOUD. The suggestion to use MAT was in order to emphasize the medications' position as assisting more widely accepted psychosocial counseling. Franz et al. (2025) discusses the influence the prescription Opioid Epidemic has in their opioid prescribing habits, with many rural practitioners experiencing the epidemic first hand not trusting any opioid medication. Madden et al. (2022) discusses the 'research to practice gap', stating that most research typically takes 17 years to be accepted into medical practice. However, in the case of methadone this gap has taken 50+ years (Madden et al., 2022). Madden et al. (2022)

explores the role of different types of knowledge, coming to the conclusion that those who stigmatize MOUDs rely too heavily on experiential and professional knowledge rather than scientific knowledge.

Stewart et al. (2021) and Paul et al. (2022) discuss the heterogeneity of healthcare facilities. Stewart et al. (2021) suggests that due to medical facilities heterogeneity, they require specific implementation strategies that are curated to that organization. Paul et al. (2022), on the other hand, widely accepts that there is a long-standing cultural bias against OUD and MOUD in medical and non medical facilities. They (2022), take a strong stance on universality and uniformity of treatment. However, their (2022) standard was reflective of gold standard absolutism, promoting the uniformity of treatment practices that align with government backed duration guidelines of long term usage and top-down power.

As is normal with research, almost all of these articles suggest further research on the topic of implementing MOUDs (Franz et al., 2025; Madden et al., 2022; McCollum et al., 2023; Stewart et al., 2021). These research suggestions closely align with the larger themes discussed, including empirically backed destigmatization interventions, the overreliance on experiential knowledge rather than scientific knowledge, and implementation strategies. Within these suggestions are inferences to quantitative research examining treatments that are working, rates of recovery, and rates of retention (Madden et al., 2022; Stewart et al., 2021). Despite the usage of these terms, no clarification as to their parameters was made.

Finally, there was the exploration of patient knowledge and their role in the uptake of MOUDs (Madden et al., 2022; Paul et al., 2022; Stewart et al., 2021). Madden et al. (2022) states that there is a lack of direct to consumer advertising contributing to a lack of knowledge about or on MOUDs amongst the general population. While Stewart et al. (2021) contradicts this somewhat, quoting multiple media campaigns that have taken place across major cities, Paul et al. (2022) validates this statement by referencing an overreliance on word of mouth communication. Although there have been some untraditional approaches of direct to consumer advertising with the use of media campaigns, there is a general lack of education surrounding the existence of MOUDs let alone their use (Stewart et al., 2021). In a

singular move away from medical vernacular, Stewart et al. (2021) briefly refers to patients as consumers, highlighting the market aspect of MOUDs. Referring to patients as consumers and treatment modalities as consumer preferences, Stewart et al. (2021) frame the patient as the expert consumer. With an increase in consumer demand, healthcare practitioners will be forced to make the change towards implementing MOUDs (Stewart et al., 2021).

3.3.4 Level 3 Analysis

As was depicted in 3.3.1 Title and Introduction, the goal of each of these articles was to expand the usage of MOUDs. In pursuing this goal, each of these researchers sought to explore a specific feature of the gatekeepers' decision making in providing OUD treatment: stigma, ideology, motivations, perceptions. In these articles, the researchers all discuss a matter of access to a gold standard commodity, touching on numerous infrastructural, financial, environmental, and educational inhibitors to these life saving medications. Throughout the five articles the researchers challenge these structural inhibitors, finding that even in their specific area of exploration, solutions to address that area were complex, requiring both top-down and bottom-up changes. In efforts to expand access, the researchers tended to exhibit ideologies of pharmaceuticalization and absolutism that unintentionally reproduce the same power dynamics that inhibit the use of MOUDs.

While the researchers and I naturally come to analyze similar themes, my feature of study is power, leading to salient differences in our analysis. The researchers come to conclusions based on their position as gold standard absolutists. While their position is not explicitly defined by the parameters I use in this research, I come to this conclusion due to references to the 'gold standard of addiction treatment', inferences towards absolutism, and a preference for retention and long term use of MOUDs regardless of patient wants. Additionally, the four courses of treatment for physiological dependence I identified were never presented as equally valid options. Instead they were presented on a hierarchy, with abstinence being the least valid route to recovery and buprenorphine / methadone being the

most valid. For each source the data are interpreted from a position where gold standard treatment is the ideal for all patients, making the researchers valuable actors in the top-down pharmaceuticalization of addiction treatment. That said, while their position as gold standard absolutists reproduce certain practices of top-down care, this is not the intention of the researchers who simultaneously challenge structures that contribute to profit-first health. Rather, it is their belief in MOUDs as a commodity and their medical understanding of OUD that leads them to the conclusion of gold standard absolutism.

Stewart et al. (2021) and Madden et al. (2022) both touch on top-down implementation programs as one of the most effective approaches for widening access to MOUDs. Top-down changes are needed to expand accessibility, as an institutional mandate was a primary rationale for becoming X-waivered (McCollum et al., 2023). That said, providers who use MOUDs were found to be less likely to endorse abstinence as a treatment option (Stewart et al., 2021). 12-Step, although still possessing risks, is the most widely available resource for those seeking recovery and its value as a freely accepting community should not be minimized in efforts to expand MOUD (Bedford, 2025). Interventions that expand the use of MOUDs as absolute and without patient collaboration risk exploiting patients' vulnerability, participating in MOUDs as a market rather than a commodity.

Within publicly funded SUD treatment facilities, administration was becoming less tolerant of ideological barriers amongst their staff (Stewart et al. 2021). Madden et al. (2022), on the other hand, found that in her environment of study stigma was still widespread. While the most valuable intervention against stigma was found to be counseling, Madden et al. (2022) questions this as reproducing individualism, noting a lack of advocacy used for combatting systemic biases that contribute to stigma. Madden et al. (2022) challenges the prevalence of neoliberal discourse, finding that it focuses too much on individual agency rather than structural influences. Personal ideology and stigma should be challenged for their use in healthcare, however systemic biases require addressing the criminalization of both substance users and substances, a factor in stigma that goes unaddressed in each research article.

Despite the medical profession being founded on a socio-cultural celebration of science, it has become normalized that medical science is not centered in medical practice (Light, 2004). This postulate by Light (2004) was found to be true by these researchers, who depicted numerous instances of an overreliance on experiential knowledge in medical practice. Franz et al. (2025) stated that there was inadequate training and institution support, possibly contributing to the prioritization of experiential knowledge over scientific knowledge identified by Madden et al. (2022). Neither Madden et al. (2022) nor Franz et al. (2025) challenge these providers' agency, instead suggesting interventions that challenge their experience of MOUDs to ones that translate into positive experiential knowledge. The technosocial of MOUDs was too great to simply supersede experiential knowledge with scientific knowledge, instead interventions sought to balance both as intrinsic (Franz et al., 2025; Madden et al., 2022; Paul et al., 2022). Even as education interventions compensate for the use of experiential knowledge, there are limits to what experiential knowledge should be accepted in healthcare. Experiential knowledge that reproduces harmful structural biases — authoritarian relationships, absolutism, demarcating patients as zoe — should be challenged in their existence. Experiential knowledge that values patient health but is distrustful of market bias in science, should be adjusted in its limitations.

Multiple authors found that in order to address MOUD access they must also address the perception of OUD, as numerous studies still depict a longstanding bias against treating OUD in healthcare (Franz et al., 2025; Madden et al., 2022; Paul et al., 2022). Madden et al. (2022) discussed how historical influences of racism and classism were never addressed by their research participants as impacting their care. Franz et al. (2025) discussed a need for increased empathy through positive interactions with those who have OUD. In the initial conceptualization of OUD as a socially bad behavior, and as that position was validated over decades of criminalizing substances and those who use them, the ongoing perception is that OUD is not in the jurisdiction of medical intervention (Paul et al., 2022; Szasz, 2006).

The role that criminalization has played in today’s perceptions of both MOUDs and OUD was perhaps the most overlooked structural factor in all five articles. On the contrary,

some researchers emphasized the role of prescription opiates in stigma (Franz et al., 2025; Stewart et al., 2021), with Madden et al. (2022) being the only one to touch on the influence of illicit opiates. Patients seeking medical treatment experience the environmental component of OUD in various ways, due to varying degrees of vulnerability. In attempts to expand access by destigmatizing the population, it is important to not overlook the ongoing criminalization that is taking place for a large part of the population. Doing so overlooks one of the biggest justifications for not considering OUD treatment to be the responsibility of the healthcare practitioner, consequently impacting the use of MOUDs.

In their desire to expand access to MOUDs, researchers need to be aware of practices that reproduce a market of addiction. While MOUDs' usage should be expanded, there first needs to be acknowledged that this is a consumer base that should be shrinking as the public health crisis is addressed. Quantitative data that show sustained rates of growth in the use of MOUDs should not be the long term desired outcome, as it cannot exist without the expansion and maintenance of the Opioid Epidemic. Care for OUD must go beyond the use of MOUDs (McCollum et al., 2023). MOUDs treat one specific component of OUD, physiological dependence, and treatment efforts that address the environmental and behavior components should not be overlooked in their value. Abstinence, particularly the 12-step program, is valuable as a free, accessible, and established resource to anyone seeking recovery support. While MOUDs are a valuable and life saving commodity, without radical changes to the U.S. healthcare system there will continue to be a disparity in MOUD accessibility. In expanding MOUD access, it is important that more accessible recovery modalities are not devalued.

3.4 Level 4 Analysis: Broad Social Context

In the fourth and final analysis I examine the broad social context of this discourse, situating it entirely within the larger technosocial understanding of buprenorphine / MOUD treatment for OUD and the reproduction of power dynamics in healthcare. I explore articulations of power from both healthcare providers and researchers as mundane practices

that reproduce or challenge the hegemonic market of addiction (Haskaj, 2018). Reproduction takes place through the care of a population that will sustain the current social and political order, while challenging takes place when practice is in contradiction to what sustains that order, primarily in expanding care to those who threaten its reproduction (Dollar, 2019; Gaudilliere & Sunder Rajan, 2021; Haksaj, 2018).

Critics of this healthcare system often end up arguing in contradictions, simultaneously discussing matters of access to essential medicine and matters of oversaturation of pharmaceutical solutions (Sunder Rajan, 2017). Where the former perspective conceptualizes the pharmaceutical as a commodity, the latter conceptualizes the pharmaceutical as an asset (Muniesa, 2017). As depicted in 3.3.4, contradictions go beyond the economic conceptualization of a pharmaceutical into matters of intervention and knowledge. An overreliance on top-down interventions reproduce top-down power dynamics, however individual interventions tend to reproduce systemic influences of racism and classism (Madden et al., 2022; Stewart et al., 2021). In a similar vein, an overreliance on experiential knowledge produces healthcare practices based on personal standards, while an overreliance on scientific knowledge ignores the lived realities of those treating and being treated for OUD. I reframe each of these not as contradictions, but as imbalances that without restoration reproduce harmful power dynamics. Imbalances can be restored with interventions that recognize the existence of multiple realities within a shared goal to provide people-first care. In this final analysis I examine each of these imbalances and their reproduction of power in the patient-provider relationship.

The first imbalance is conceptualizing MOUDs as a commodity versus an asset; the former encourages expanding access while the latter critiques an overuse of pharmaceutical solutions (Sunder Rajan, 2017; Muniesa, 2017). Public health researchers are valuable actors in the marketization of addiction, producing ample research that vouches for the expansion of a gold standard medication, inadvertently raising the value of the product used in value-based pricing (Datta Burton et al., 2022; Light, 2004; Mazzucato & Roy, 2019). The scientists' participation in the product's assetization is used to justify distrust in the

commodity, challenging the scientists for their intention, accuracy, and participation in the market (Dumit, 2012). While public health values population outcomes, an overuse of mainstream methods that value quantifiable outcomes depict an image of market participation rather than expansion of an essential commodity (Datta Burton et al., 2022; Dumit, 2012; Mazzucato & Roy, 2019).

In the current healthcare system, participation in this market is unavoidable. However, frequent references to rates of retention and rates of use, rather than positive narratives of recovery, validates the benevolent provider in their distrust of medical science (Datta Burton et al., 2022). Science used to expand access to MOUDs should emphasize its value as a commodity, prioritize experiential knowledge of peers in recovery, and minimize the use of quantitative data (Datta Burton et al., 2022). Qualitative data will balance positive narratives of MOUDs as a commodity — still depicting value as a public health investment — while limiting the frequency of data that depict MOUDs as an asset (Datta Burton et al., 2022).

The second imbalance is that of top-down interventions versus individual interventions. An overreliance on top-down interventions — policies, mandates, high level changes — does not address individual practitioners' understanding of their social responsibility or harmful patterns of practice. An overreliance on top-down intervention led to an entire team being fired, as interventions that challenged the individual provider's belief system went underaddressed (Stewart et al., 2021, [71]). Top-down implementation that does not accommodate patients seeking various treatment modalities risks reproducing absolutism and authoritarian dynamics not just in patient care, but in providers' security in their career. However, an overreliance on individual interventions does not account for the regulators' responsibility in reproducing structural failures and systemic biases. Instead it relies on the provider to take on the responsibility of reconceptualizing OUD in a way that is not reflected in policy, regulation, or culture. It expects the individual practitioner to practice in contradiction to structural conditions that enhance disparities in healthcare based on race and class (Dollar, 2019; Madden et al., 2022). Interventions that address both the individual

and the structural issues disseminate responsibility, while also holding accountable reproductions of harmful power dynamics from various actors. Both are needed to adjust the current cultural conceptualization of OUD that impacts treatment, but without balance it reproduces further crises within healthcare spaces.

Finally, there was the matter of translating medical science into practice, wherein a crisis in education and trust has led to imbalances of experiential knowledge and scientific knowledge in medical practice. Scientific knowledge is incredibly valuable for OUD treatment, providing a bio-chemical understanding of both OUD and MOUDs that should assist in destigmatization. However, scientific knowledge does not compensate for the environmental and technosocial forces that lead to a variety of preferred treatment modalities. Pharmaceutical science, specifically, has market biases that value chronic illness, long-term treatment, and pharmaceutical treatments; these treatments are presented as the ideal modality (Dumit, 2012; Jones & Podolsky, 2015). Experiential knowledge compensates for the variability in reality, assisting the provider on how to best inform the patient of their treatment options while making adjustments to care that is failing in some regard (Stewart et al., 2021, [62]). Further, experiential knowledge has become heavily relied on in a healthcare environment that fosters crisis and efficiency, where staying up to date on current science is becoming increasingly difficult (Franz et al., 2025, [104]; Light, 2004). However, an overreliance of experiential knowledge reproduces practices based on personal ideology, contributing to the use of personal standards and variability in care in a way that does not enhance a patient's capabilities but fosters absolutism.

An imbalance of either knowledge type reproduces authoritarian or benevolent providers, while a balance of these two knowledges reproduce a capabilities provider. The authoritarian provider relies too heavily in either direction, practicing absolutism and having little to no care for their patients' preference or health. They practice their responsibility more as a judge than a healthcare provider. Education interventions must first target their inherent lack of care for their patients, redefining their professional responsibility and increasing empathy. The benevolent provider cares for the patient but is absolute in their personal

ideology of best practice. While still harmful, their approach to power is more reflective of a parent. Shifting the benevolent provider to a capabilities provider requires more of either knowledge that is lacking (e.g. a scientific understanding of the three components of OUD or discussions with peer providers who have used different treatment modalities). The capabilities provider is able to balance the market biases in scientific knowledge and the personal biases in experiential knowledge, providing scientifically informed but personal care. While a restandardization of healthcare is needed, to not reproduce harmful practices it must be balanced in its value of experiential and scientific knowledge as both possess biases and strengths.

4 Discussion

This CDA uses the technosocial history of treating OUD with buprenorphine as a method of understanding how power dynamics are reproduced in healthcare. Medical science, social constructions, and fear from the ongoing Opioid Epidemic, explored throughout 2.2 State of the Art, are weighed against each other as they inform the provider's ideology and practices. I ground the medical system they are expected to work within in my theoretical approach to pharmaceutical value that finds value in crisis, monopoly, and death (Gaudilliere & Sunder Rajan, 2021; Haskaj, 2018; Muniesa, 2017). This environment creates an increasingly difficult, expensive, and unsafe space in which to practice healthcare (Light, 2004). Using an STS perspective, I touch on numerous topics examined in this field such as the construction of standards, the role of trust, and the competition between varying types of knowledge production. Moreso, this research interrogates the power dynamics that are articulated at the intersection of science, technology, and society when discussing buprenorphine in OUD treatment. Using Mullet's (2018) analytical framework, I analyze healthcare practitioners' discourse situated in an academic research article on four different levels: the immediate discourse, the interdiscourse, the immediate social context, and the broad social context.

As I stated in 2.4 Methodology, I outline three of my salient positions. The first of

these is the behavior of substance use is morally neutral. While addressing the behavioral component of OUD is ideal in recovery, it is not primary and should more often be guided by the patient. Addressing components of physiological dependence (the responsibility of the healthcare provider), and environmental components (the responsibility of the regulators, even when failing to act on that responsibility) are much more important when addressing OUD treatment. Assuming the actions of the individual remain non-violent, criminalization is never the appropriate social response to OUD. In identifying the primary responsibility of the healthcare provider as treating physiological dependence, there are four valid routes to this healthcare matter: buprenorphine, methadone, naltrexone, and abstinence. Each of these options possess both risks and benefits, and it is the responsibility of the provider to be able to fully inform their patients of these attributes. A healthcare provider that enhances a patient's capability is the most ideal when addressing components of OUD, as they provide the resources the patient needs when they are ready to receive them. My own positionality directly informs my analysis and conclusions of power dynamics in healthcare.

Results

Throughout these four analyses I identify three types of providers based on their approach to power. I examine the ideological preferences of these providers, how they practice their care, and the values they exhibit. I then analyze their contextualization in research that has a specific goal of expanding access to MOUDs. I look at the interventions suggested by these researchers and their unintentional reproduction of power dynamics that inhibit their research goal. Finally, I analyze the broad context of marketizing addiction, discussing imbalances that occur when expanding the use of MOUDs that reproduce harmful power dynamics. I suggest interventions that enhance trust, standardization, and care. My results are as follows:

Authoritarian Provider

Ideology: The authoritarian provider can appear as any of the three established ideologies – abstinence, pharmaceuticalization, or criminalization (no treatment).

Practice: The authoritarian provider practices top-down care with little concern for their patients' health as both treated and untreated patients are demarcated as zoe. This provider practices absolutism based on their personal standards. Practice is more reflective of a judge than a healthcare provider. The patient becomes an object in which healthcare is enacted rather than a participant in their healthcare. There is the use of pejorative language to reinforce their superiority.

Values: The authoritarian provider values associations with power. Moral judgement establishes a moral high ground, gold standards establish a scientific high ground, abstinence establishes a purity high ground, performative care establishes an ethical high ground while not participating in the work it requires.

Interventions: The authoritarian provider reproduces harmful patterns of power hoarding while lacking empathy toward vulnerable populations. Interventions need to first target the empathy and superiority of the provider. The adopted social responsibility of a judge needs to be challenged while centering people-first healthcare. Interventions that enhance collaborative practices, that recenter the patient, and balance experiential and scientific knowledge will challenge the authoritarian providers' reproduction of these harmful patterns.

Benevolent Provider

Ideology: These providers most often appeared among those preferring abstinence, however they can also appear in pharmaceuticalization of treatment.

Practices: The benevolent provider practices top-down care, but with great concern for their patients' health. Due to this provider frequently being based in abstinence, there was often an overreliance on experiential knowledge with the use of an outdated conceptualization of OUD that treats a pathologized behavior. The practice of the benevolent provider is more reflective of a parent than a judge.

Values: The benevolent provider often valued experiential knowledge, particularly as it pertains to the Opioid Epidemic and opioid usage. While they valued their patients' healthcare, this was associated with valuing patient autonomy. The benevolent provider valued the expertise of their professional caste, even in instances where they no longer trusted the medical science this profession was founded on. As their patients' lacked this expertise, they did not get a say in their treatment.

Interventions: Interventions for the benevolent provider address an imbalance of scientific and experiential knowledge. Interventions should clearly establish a medical understanding of OUD and its three components. It should initiate conversations between peer practitioners

who have used different modalities of recovery. Interventions should use qualitative data that depicts the value in MOUD as a commodity and minimize the use of quantitative data that depicts MOUDs marketization. Exercises that foster trust and education will naturally challenge top-down power, allowing for the patient-practitioner dynamic to restructure itself.

Capabilities Provider

Ideology: The capabilities provider enhances a patient's capability by medically informing them of their treatment options and available resources.

Practices: The practices of the capabilities provider begin with being knowledgeable of both OUD and the four routes to addressing physiological dependence. These were able to be articulated clearly to the patients. New information was sought after from their peers and patients, which was then used to enhance their practice as a healthcare provider. These providers practiced putting trust in their peers' and patients' intention of providing and receiving OUD treatment. Care often went beyond the paid limitations of their position, taking on the management of environmental components to ensure patients were aware of available resources. Top-down expertise was exhibited when fostering practices of collaboration, curiosity, and mutual learning from patients.

Values: Capabilities providers valued collaboration and curiosity. Their patients were firmly situated as bios, requiring respect, trust, and understanding in their OUD treatment. These providers valued trust, evolving education, and people-first healthcare, decentering profit and power from their profession.

Interventions: Interventions for the capabilities provider are primarily structural changes that enhance the capabilities of the providers. As they regularly go beyond the limitations of their profession, interventions will include expanding social welfare resources, accessibility of treatment, and decriminalizing their patient population. Advocacy that holds regulators accountable in their responsibility to address the environmental components of OUD is extremely necessary in order to manage the burnout amongst these providers.

In focusing my empirical research on power dynamics in OUD treatment, I am able to approach expanding the use of MOUD's from a people-first methodology. I outline the ways in which providers' approach to power increase or decrease the vulnerabilities of a vulnerable patient population, reproducing the values of a profit-centered healthcare structure. The marketization of addiction values the ideological approach of gold standard absolutism, wherein there is the long term use of a pharmaceutical treatment that is

accessible to those who can afford it (Dumit, 2012; Haskaj, 2018; Jones & Podolsky, 2015). Authoritarian practices of absolutism in medical practice inherently devalue patient preferences, reproducing top-down power structures; the more vulnerable the patient the less likely they are to receive the care they need (Madden, 2019). Benevolent providers, although possessing care for their patients, are still harmful in their reproduction of top-down healthcare. Both authoritarian and benevolent providers reproduce practices of OUD treatment that require social capital to navigate their dominance, i.e. middle class, white, educated (Haksaj, 2018). Those unable to navigate such providers are dissuaded from accessing their preferred treatment, coming to rely on illicit sources or 12-step programs for their recovery, thereby increasing their risk of overdose and death (Baus et al., 2023). Further research is needed on the role of moral judgement in the reproduction of markets that address behavioral diseases, e.g. the Obesity Epidemic.

Paradoxically, the use of MOUDs as a treatment modality seemed to foster more capabilities providers rather than authoritarian providers. The decision to treat with MOUDs required a reconceptualization of the cultural understanding of OUD, as it emphasizes the material rather than behavior components of addiction. In increasing these patients' capability in healthcare there will naturally follow an appropriate increase in MOUD usage as they choose to access the treatment they need for their recovery. As providers make the decision to ignore, protect, or treat a patient with OUD, power to practice ideological preference remains the most important factor in the treatment of OUD. Standardization in healthcare became essentially obsolete when compared to the agency of the provider.

Limitations

While every academic article has its biases, the value of a CDA is that my position of analysis is clearly stated rather than presumed to be objective (Fairclough, 2001; Mullet, 2018; van Dijk, 1993). To mitigate cognitive biases I conduct an in-depth technosocial and sociohistorical examination that informs my analysis. That does not negate that there are inherent limitations and biases in my analysis due to my positionality on key features of this

research: drug use is morally neutral and should be decriminalized, health should be people-first, and treatment for addiction should enhance the patients' capabilities. My theoretical approach of value in the U.S. healthcare system further informs the way in which I analyze mundane practices as reproductions of structural power that passively allow for the large-scale deaths of those found threatening to the status quo (Dollar, 2019; Haskaj, 2018).

Furthermore, my qualitative analysis of healthcare practitioners' discourse is secondary to the original researchers. Practitioner quotations are limited and cut to fit the narrative and positionality of the original researchers, e.g. discourse from abstinence providers centering MOUDs. When conceptualizing different practitioners' approach to power, it should never be interpreted as absolute, as identified dynamics were based on limited data. Practices depicting one approach to power could easily be limited to a specific patient population, changing based on other vulnerabilities, e.g. racism, sexism, or classism.

Any conclusions drawn on the first two levels of analysis are inherently limited, with ideal data being a primary analysis or the full transcript between interviewee and interviewer. Despite this limitation, I found the immediate social context of an academic article to add an interesting dynamic in my analysis of power in healthcare that I would not have gotten had I used primary qualitative data. Further research that uses primary data is necessary to better understand these power dynamics and the role of morality and power in medical practice. Lastly, as I was unable to navigate the generalization of MOUDs, future research that examines power dynamics specific to different MOUD treatment providers is also necessary.

5 Conclusion

The intention of this research was to use an STS approach in the analysis of power dynamics in healthcare. I did so using a CDA on qualitative research that examines the underuse of buprenorphine / MOUDs in the treatment of OUD. I use a technosocial and sociohistorical understanding of these actors — buprenorphine, addiction treatment, and medical practice — in order to inform my analysis. I further contextualized practices of power using a theoretical approach of value in healthcare, finding a healthcare market that fosters

an environment of crisis, efficiency, and corruption as a means of profit accumulation. In identifying addiction as a market, I was able to conceptualize pharmaceutical treatments within this market as existing as both a commodity and asset simultaneously.

Each medicalized route to treat physiological dependence — buprenorphine, naltrexone, methadone, and abstinence — possesses both risks and advantages (See 2.2.3). While buprenorphine is an innovative treatment option that significantly lowers the risk of physiological dependence, its use carries social risks of exclusion from recovery communities and long term treatment, while decades of market exclusivity has maintained unaffordable products (Barenie & Kesselheim, 2021; Baus et al., 2023; Smith et al., 2025). Throughout my analysis, the best route to OUD recovery was one that closely replicated the Minnesota Model; a multidisciplinary approach to addiction treatment founded on mutual respect (Henninger & Sung, 2014). Due to the risk of OUD possessing behavioral, physiological, and environmental components, its treatment must consider all of these as well (Hasin et al., 2022; Sharma et al., 2016). Ideologies that accounted for each component of OUD practiced a human-first approach to care, adopting a variety of treatment modalities that were made available and accessible to the medically informed patient.

In examining the social power of the healthcare providers today, it is interesting to ask why a historically powerful professional monopoly has fallen to the delegitimized and disorganized institution it is today. One of the ways to explore the discrediting of powerless groups is to pay attention to the threat they pose to the hegemonic powers (van Dijk, 1993). While academics and healthcare practitioners are largely still made up of the white, male, and upper middle class demographic, following the civil rights movement there was an opening for those who threatened the status quo to be in spaces of professional power (Dollar, 2019; Fiscella et al., 2019; Light, 2004; Scarritt, 2022). Growing professional accessibility re-introduced a level of care, empathy, and responsibility for those who threaten the status quo.

> For the younger generation, this is something that we've been growing up in…this opioid epidemic. [...] And I, I feel like, me personally, I feel like I have a responsibility

> to my patients to help fix this because physicians also helped create this. We need to take accountability in that and try to fix the errors that we've made in the past (McCollum et al., 2023, p. 4)

Within 3.2.2 Emerging Paradigms, there were many instances where healthcare practitioners' discourse began to challenge the reproduction of the status quo. The conceptualization of the Opioid Epidemic as a professional failure, rather than as socially acceptable deaths of a population demarcated as zoe, challenges necro-economies as an implicit facet of U.S. healthcare (Gaudilliere & Sunder Rajan, 2021; Haskaj, 2018). The delegitimization of those challengers becomes a matter of the self preservation of a biopolitical rationale that values the reproduction of the white, American middle class (Datta Burton et al., 2022; Dollar, 2019; Mazzucato & Roy, 2019; Scarritt, 2022). Healthcare that recenters collaboration, empathy, and humanization are the most politically threatening practices to a healthcare monopoly that has historically relied on individual agency, absolutism, and profit (Light, 2004).

There are a number of implications that arise from this analysis of power. The first is the infrastructural failure to address OUD as one would any other medical crisis. Training that only consists of abstinence is incomplete and harmful to both providers and patients. The second is that criminalization will continue to permit abuses of power when treating OUD, characterizing it as a morally bad behavior deserving of social outcasting. The third is that a healthcare system that permits the practicing of moral judgement is one that gives the social responsibility of a judge to a healthcare practitioner, with no legal limitations. The fourth is that while medical science is fundamental to the bio-medicine of the West, it cannot be conflated with pharmaceutical science. The market biases inherent in pharmaceutical science and the information biases of experiential knowledge should recognize both knowledge types as limited in their contribution to medical science as a whole. There is little value to the medical industrial complex to thoroughly address any of these structural issues that maintain MOUDs exclusivity. Rather, interventions that reproduce the ideologies, values, and practices of a capabilities provider will return addiction treatment to a people-first

paradigm of care. Emerging paradigms that address OUD as both individual and structural pose the biggest existential threat to the addiction market.

At the time this research concluded, Trump has taken office as President of the United States once again (2025-). He calls for an end to the Opioid Epidemic, but has slashed public funding that addresses this public health crisis while using it as a political tool to justify his Trade War (“Federal Cuts Threaten Overdose Prevention”, 2025; Mann, 2025). The negative impact this will have on public accessibility to OUD treatment is dire. While both researcher and healthcare practitioner work within the limitations of their profession, interventions and practices that reconfigure top-down power structures have the ability to challenge the structural marketization of healthcare. Advocacy for structural changes that remain at the behest of the regulators — decriminalization, strengthening the social welfare system, and re-standardizing healthcare — can and should be done by anyone who continues to be impacted, or see others impacted, by the Opioid Epidemic. As power is decentralized in mundane practice, reproductions of top-down power hoarding that are present in the configuration of healthcare monopolies will begin to be challenged in their existence.

6 Appendix

Table 2.1: Social Contextualization of Selected Discourse

Title	**Author/s (Name, gender, race)**	**Publisher**	**Year of publication**	**Year of empirical research**	**Research design**	**Location of research**	**DOI:**
Physicians' experiences with buprenorphine: A qualitative study of motivations for becoming X waivered and barriers to and facilitators of prescribing the medication for opioid use disorder	C. Greer McCollum Man, White Ellen Eaton Woman, White Thomas Creger Unknown Aaron Lee Man, Non-White Kelly Gagnon Woman, White Li Li Woman, Non-White	Journal of Drug and Alcohol Dependence (Elsevier)	2023	Dec. 15, 2021 - July 21, 2022	-Semi-structured interviews -27 physicians -Framework-guided Rapid Qualitative Analysis technique to analyze the transcripts for themes aligned with the Social Cognitive Theory	Birmingham, Alabama	https://doi.org/10.1016/j.drugalcdep.2023.109777
Variation in intervention stigma among medications for opioid use disorder	Erin F. Madden Woman, White Kristen K. Barker Woman, White Joshua Guerra Man, Unknown Corey Villanueva Unknown Sandra H. Sulzer Woman, White	Journal of SSM-Qualitative Research in Health (Elsevier)	2022	Texas: 2017 - 2018 New Mexico: 2017 - 2020	-Semi-structured interviews -Individuals who worked in substance use treatment -Issue of provider-based stigma towards MOUD became later focus -59 professionals participated in the study -Used Constructivist grounded theory	Most research collected in Texas, some interviews collected in New Mexico	https://doi.org/10.1016/j.ssmqr.2022.100161
It's not just the money: The role of treatment ideology in publicly funded substance use disorder treatment	Rebecca E. Stewart Woman, White Courtney B. Wolk Woman, White Geoffrey Neimark Man, White Ridhi Vyas Unknown Jordyn Young	Journal of Substance Abuse Treatment (Elsevier)	2021	Dec. 2018 - June 2019	-All (n=53) drug and treatment agencies in Philadelphia County invited to participate -Contacted administrative and leadership -Conducted interviews with 25 organization leaders -13 Interviews with organizations	Philadelphia County, Pennsylvania	DOI: 10.1016/j.jsat.2020.108176

	Woman, Unknown Chris Tjoa Man, Non-White Kyle Kampman Man, White David T. Jones Man, Non-White David S. Mandell Man, White				adopting agonist medications -5 Interviews who were adopting specifically antagonist medications -7 Interviews from non-adopting organizations		
Provider perceptions of medication for opioid used disorder (MOUD): A qualitative study in communities with high opioid overdose death rates	Nicole Paul Woman, White Amy J. Kennedy Woman, White Simone Taubenberger Unknown Judy C. Chang Woman, Non-White Karen Hacker Woman, Unknown	Substance Use & Addiction Journal (Sage Journals)	2022	March 7, 2018 - March 5, 2019	-Semi-structured qualitative interviews conducted with 45 self-identified providers treating people with OUD -Used open coding and thematic analysis -Chain referral	Allegheny County, Pennsylvania	https://doi.org/10.1080/08897077.2021.2007518
Different forms of stigma and rural primary care professionals' willingness to prescribe buprenorphine	Berkeley Franz Woman, White Lindsay Y. Dhanani Woman, Non-White Sean Bogart Man, White Cheyenne Fenstemaker Woman, White William C. Miller Man, White O. Trent Hall Man, White Daniel Brook Man, White Vivian Go Woman, Non-White	Journal of Substance Use and Addiction Treatment (Elsevier)	2025	Dec. 2022 - March 2023	-23 Primary Care Professionals -Semi-structured Interviews -Prior experience with Buprenorphine	Rural Ohio	DOI: 10.1016/j.josat.2025.209633

Table 3.1: Direct Quote Reference Table

Reference Number	Direct quote:	Author, page number
[1]	*"Because we have [buprenorphine] and [extended-release naltrexone] now, methadone has no place in our field ... [extended- release naltrexone] doesn't have any sort of mood-altering effects. It plays a really clever mental trick when somebody knows that for the next 30 days, even if they did do heroin, they wouldn't feel anything, and therefore have less mental and then physical cravings for the substance ... I think [methadone is] too habit forming. It's too much of an easy way out ... I honestly thought that [buprenorphine] would replace it, and [buprenorphine] is only ok for [short-term] detox ... [methadone treatment is] just a way for junkies to keep themselves well but not get any further than that ... It's a dependence very similar to dependence on opioids." (Lorenzo, abstinence-based inpatient facility director)*	Madden et al., 2022, pp. 3-4
[2]	*"We do a lot of naltrexone, which is anti-craving. It burns your opiate receptors. We offer [extended-release naltrexone] and the daily [naltrexone] pill at our facility because it doesn't have any physical addictive properties, but it does help with cravings ... [Naltrexone] doesn't replicate the effect of opioids ... Just because methadone is legal doesn't make it any better for you or your physical health at all ... [Naltrexone] doesn't get you high, it literally locks [out] your [ability to get] high. That's how I compare the two ... The nurses at our facility only give you [naltrexone] for a year. A year makes sense ... At that point you should be functioning normally if you've been sober for that long." (Selena, abstinence-based clinic counselor)*	Madden et al., 2022, p. 4
[3]	*"The thing I don't like about methadone is that it can increase your risk of low testosterone which increases your risk of prolonged QT interval, so if you take an antibiotic or something, there is drug interactions with that ..." (Dr. Scott, buprenorphine prescriber)*	Madden et al., 2022, p. 4
[4]	*"... This is a generalization, but a lot of patients that I see at the urgent care where I work at times who are on methadone are overmedicated. That doesn't happen here [at the buprenorphine clinic]. You can't get that kind of effect from buprenorphine because of how the drug works. The methadone patients are coming in [imitates a long low grunt]. I'm, like, 'are you on methadone or did you just shoot up? What happened?' I know I'm not going off evidence right now, I'm just going by what I personally see at the urgent care when they come in they have a little slur on them. [I ask,] 'How much do you take?' [They respond], '160 ml twice a day.' Damn!" (Dr. Scott, buprenorphine prescriber)*	Madden et al., 2022, p. 4
[5]	*"If you're dosed right [with methadone], you don't get sedated, you live your normal life and nobody knows you're on [methadone] ... [If patients] take something they are not supposed to like [a benzodiazepine for anxiety] before or after [you take methadone]—and, again, we can't control that part of it, all we can do is control the methadone. If someone notices sedation, the doctor reduces their dose to make sure it's not methadone." (Manuel, OTP counselor)*	Madden et al., 2022, p. 4
[6]	*"I would like someone to explain to me the difference between naltrexone and methadone and buprenorphine. With naltrexone, you're giving something to alter the chemicals in the body in order to help with the recovery, which is the same thing we're doing ... Methadone also blocks cravings. If you know the research, let's go back to the diagram of the receptors. Methadone blocks the receptor, not allowing the opioid to go in, therefore it's a blocker just like naltrexone." (Yvonne, OTP counselor)*	Madden et al., 2022, p. 4
[7]	*"... I'm happy that we have [extended-release] naltrexone in our tool belt. If it's presented by itself as any sort of cure or the only thing that you have to do, it can be really dangerous. But it's wonderful as one part of a recovery program, which includes talk therapy, trauma therapy, reconnection, healthy connections, et cetera ... Because we have [extended-release naltrexone] now, methadone has no place in our field ... I think methadone and [buprenorphine] start out as a tool to get free from opiate dependence, but they're not encouraged to accept any other sort of help, like talk therapy. I think that [OTPs] have to officially offer therapy or require therapy, but from what I've heard, it's bullshit, just a form that you sign that says you went to therapy.... [and patients are] not able to fulfill life goals or find happiness ... I would rather take the risk of helping somebody through withdrawal from opiates [and] risk them relapsing, possibly overdosing, than trading one addiction for another." (Lorenzo, abstinence-based treatment facility director)*	Madden et al., 2022, p. 5
[8]	*"With [methadone] treatment programs in the state of Texas, and what I've seen in other states, there's so much regulation on the paperwork, and the assessments, and the treatment plans, and the frequency, that really what you're doing is trying to catch up and maintain those requirements, and then the counseling comes second. If you try to make counseling the priority, usually you fail at some of the other documentation requirements that could put your clinic or your company in jeopardy. As far as receiving fines, citations ..." (Raul, OTP director)*	Madden et al., 2022, p. 5
[9]	*"... Our primary goal is counseling. When I'm doing an orientation with a patient, I'm telling them that, 'Though you're getting methadone, that is not the focus of your treatment. The focus of your treatment is counseling ... The medication helps us to level out your mind so that we can dig deeper and find out your problems.'" (Audrey, OTP director)*	Madden et al., 2022, p. 5

[10]	*“There’s studies that have compared [buprenorphine] or methadone alone versus [buprenorphine] and therapy. And there's no significant difference seen with therapy. We firmly believe in therapy as a huge important tool, but we also firmly believe that it's something that is generally more adjusted towards a certain population type—[it] helps them or works better if someone really wants to do it. Not just going through the motions of, ‘I have to do this in the program.’ Sharing that kind of information with our [provider] team is really important. And then having different champions on the team who are like, ‘no, [agonist MOUD] itself is a huge step for patients.’ That's definitely helped.” (Dr. Kamra, primary care doctor and former OTP physician)*	Madden et al., 2022, p. 5
[11]	*“The hoops they have to jump through to stay on [methadone] is like keeping an active addiction ... I did have a client who was on methadone ... he had to get up early every single day, having to stay in line for a while just to get that medication. What other medications require you to get out in the wee hours in the morning every day? It just seems like a lot of effort. It would be so much easier if they get some of that stuff off the street and you can do it at your own time. It's just weird.” (Sheila, counselor at an abstinence-based outpatient facility)*	Madden et al., 2022, p. 5
[12]	*“I'm fine with medication-assisted detox, but then the patient should be weaned off [MOUD] ... [Buprenorphine] is dispensed more humanely, more like a ‘normal’ medication for diabetes or heart disease because you can get a month's supply ... But providers need extra steps to be able to do [buprenorphine prescribing] and so many won’t ... The way these drugs are dispensed is stigmatizing. They promote stigma around treatment, but methadone does this more than [buprenorphine]” (Ruth, director of an abstinence-based outpatient facility)*	Madden et al., 2022, p. 5
[13]	*“[Patients] have to see their doctor at 5 o'clock in the morning every morning to get the medicine. The patient might say, ‘It’s because they don’t trust me enough to give me my medicine, so I got to come here, hang out with a bunch of other people that have similar problems and being treated similarly very disrespectfully.’ ... For me to be like, ‘You're not good enough to get a month's supply of medicine, so you got to show up here every morning at 5 o'clock so I can watch you take the medicine.’ That's offensive!..The government set that up, so they got to change that ... That’s the thing that annoys me the most; the patient experience is not very good. It sounds very demeaning to me” (Dr. Scott, buprenorphine prescriber)*	Madden et al., 2022, p. 5
[14]	*“Sometimes the methadone clinic is your only form of socialization ... So, we didn't want to lose that ... I’m really sensitive about asking people, ‘do you want your step level [increased]?’ And if they say ‘no,’ then “why don’t you?’ A lot of it is, ‘I enjoy coming once a week, I know I’ll relapse if I have bi-weeklies’ ... It provides an important structure for some people. For other people it’s a burden to have to come every day, the transportation, jobs ... or on vacation, not wanting family to know that they're going to a clinic. And I think it’s that [OTPs are] afraid of lawsuits, getting in trouble for patient overdose and diversion.” (Carmen, OTP counselor)*	Madden et al., 2022, p. 6
[15]	*“Most [treatment professionals with a substance use history] believe that the way they did [treatment] is the way everybody should do it ... The majority don't like methadone or [buprenorphine]. First of all, they don't know much about it ... It's much easier to just kind of go by what everybody else is saying instead of really looking into the research ... I don't think they get taught it in school and their own personal bias doesn't allow them to look into it because, as counselors, most of us have addiction pasts and go through 12-steps where it's not welcoming to [agonist MOUD] ... It's a lot easier to just comply with everybody else in 12-step than tell people we have to start thinking differently. People don't like that because they feel you're saying what they've done over years and years is totally wrong ... The problem is that people have [recovered] without methadone or [buprenorphine], so they say, ‘Well, I did that!’ I know you did that, but on what time did you do it? Your 30th time?” (Sid, counselor at an overdose prevention program)*	Madden et al., 2022, p. 6
[16]	*“I am so relieved and grateful that I did not know about methadone or [buprenorphine]. Otherwise, I would not be clean and sober and clearheaded today. I'd probably be on that crap ... It's not a cure-all for all people. It was never meant to be utilized for half of somebody's adult life. From what I see, most people are not only on [buprenorphine] or methadone. They are still polysubstance abusers. It's not fixing the problem ... I have no experience with naltrexone, so I can’t speak to that.” (Angel, abstinence-based clinic coordinator)*	Madden et al., 2022, p. 6
[17]	*“When I first started working in treatment, I was totally into abstinence because I went from being on [buprenorphine] to methadone and then to [being in] a 12-step program ... But then I started working at the OTP, I see my patients get better; in society with their families, going to parks, at restaurants, working in the community. That’s proof it works, even though 50% of our patients might be still actively using, they do it more safely because we tell them about harm reduction—we tell them how to prevent disease, reverse an overdose ... People should have the freedom to make their choice to get clean or not.” (Roberto, peer support worker at an OTP)*	Madden et al., 2022, p. 6
[18]	*“Right off the bat, when [extended-release naltrexone] came to town, we had a guy come and do a presentation, and I was fussing at him, ‘Well, I'm concerned about [naltrexone]’ I had never discouraged anybody from taking it, but expressed my concern that if you're taking [naltrexone], then maybe you feel like you've got the answer in a pill, and you don't need to do the work. But it hasn't been my experience that [naltrexone is] a barrier. It increases their ability to go to meetings, because if they're less twisted up around cravings, it’s easier to get out of the house.” (Gerald, abstinence-based treatment facility administrator)*	Madden et al., 2022, p. 6

[19]	*"Some organizations speak against methadone and buprenorphine, but they offer treatment with naltrexone ... One time one of these [abstinence-based treatment professionals] said, 'Hey, methadone and buprenorphine are replacing an addiction with an addiction. I don't believe in that.' At which point I asked, 'Is this a question of faith or is this science? This is not about belief or not.' It's unethical to promote any one of those three forms of [MOUD] as superior to another one or to call any one of them 'abstinence' and not the others ... Because it's ignoring science. It's introducing one's bias and promoting it as authorities on this topic as healthcare providers, or even just as clinic owners who talk about this treatment. It's unethical because it's convincing patients that a reasonable guideline-based, science-supported standard of care is wrong ... it's setting people up to die ... Negative opinions are often based on a handful of negative experiences ... but it's important that we not project that onto our patients. The data is so clear, especially with opioid use disorder that 90% of people who go without [MOUD] relapse, the mortality rates are astronomical." (Dr. Arnold, physician at a hospital substance use program)*	Madden et al., 2022, pp. 6-7
[20]	*"I've come across some treatment professionals barely starting their career [who] think that methadone has to do with meth[amphetamines]. They don't know what methadone is and it's just another drug. It's lack of [MOUD] field experience. I explain to them the alternative, 'Using IV, they collapse the veins, run the risk of getting Hep C,' all the negative effects of using heroin compared to methadone. 'So, which one of the two would you rather them be on?' ... Sometimes you learn more from your patients than from your counselor classes. I think those individuals [who criticize methadone] haven't really been exposed to enough [of] the methadone population ... with the people I work with [at the OTP], they see at work that [methadone] is a good thing for the clients." (Hector, OTP counselor)*	Madden et al., 2022, p. 7
[21]	*"Methadone and [buprenorphine] ... the way the programs were designed? They're a billion-dollar industry. It's not for the client, it's about profit ... Sometimes you wonder if the goal is to keep them on [the medication] as long as possible to make money." (Angel, abstinence-based clinic coordinator)*	Madden et al., 2022, p. 7
[22]	*"A lot of corruption has come into that part of our industry, the methadone clinic. I think that people who end up taking jobs at a methadone clinic are burnt out, never were passionate, or have lost their passion for helping people. They're really just working for a paycheck. This is purely opinion, and maybe it's a little bit hyperbolic, but it's a lot of trouble to help somebody get off of [methadone], and they're also focused on their bottom line; if somebody gets off, then they've lost a customer ... It sounds fairly profit-driven." (Marcos, abstinence-based treatment facility counselor)*	Madden et al., 2022, p. 7
[23]	*"Naltrexone is great. But with [the patented form], is insurance going to cover it? It's still a pretty expensive medication, a thousand dollars a shot? ... This all goes back to, rich, upper class, suburbia, kids dying, they'll have more access to [extended-release naltrexone] than low socioeconomic status people who don't have $1,000 every month." (Lauren, director at medical detoxification facility that offers naltrexone treatment)*	Madden et al., 2022, p. 7
[24]	*"The owner [of the treatment facility is] very passionate about just wanting to make a difference. We want to provide something that works, is going to be effective towards the clients, and so although it's technically for-profit, he's not for much profit. He just wants to make a difference ..." (Yesenia, counselor at an abstinence-based clinic that offers naltrexone treatment)*	Madden et al., 2022, p. 7
[25]	*"We had an initiative in our department in order to be able to offer medication assisted therapy for patients with OUD, and to be able to offer more resources to our patients. So, I went ahead and got waiver training at that time."*	McCollum et al., 2023, p. 4
[26]	*"I was a little skeptical. I work in the [emergency room]. I was worried that if we started prescribing Suboxone, that [...] you know, we'd have lines around the building trying to get in to get Suboxone [...] I guess that was my main [concern]... that we would be having a much-increased workload."*	McCollum et al., 2023, p. 4
[27]	*"I feel like it's one of the most impactful things I do."*	McCollum et al., 2023, p. 4
[28]	*"For the younger generation, this is something that we've been growing up in... this opioid epidemic. And we see it all the time where, you know, there are so many young people that are just dying senselessly [...] if they could only have just gotten the help that they needed, you know, to get through this. And, so, I think we are more sympathetic and compassionate towards the patients in that regard. And I, I feel like, me personally, I feel like I have a responsibility to my patients to help fix this because physicians also helped create this. We need to take accountability in that and try to fix the errors that we've made in the past."*	McCollum et al., 2023, p. 4
[29]	*"That is something that I think that is a significant stigma that I see here, where they tell that by prayers, everything will go away [...] Unfortunately, mental [health] does not work like that. So, I think that is one of the biggest stigmas that I've seen here. They come, they get treated, but when they're ready to go to this particular, faith-based treatment they're telling no medications [...] And unfortunately, you already can tell me what's gonna happen. They will go there, and then within 48 h, they're back to our [emergency room]."*	McCollum et al., 2023, p. 5

[30]	*"The patients that have gotten to us [at the emergency room] tend to be help-seeking, but they probably have delayed care because of stigma in the community. So, we're getting them when they really have hit rock bottom and are coming to us in desperation."*	McCollum et al., 2023, p. 5
[31]	*"More than stigma, I would say, it is the lack of knowledge was the predominant [reason for hesitancy]. Before we got certified, [we] knew there was Suboxone, but [we] didn't know how well it was controlled, like how the system was in place. You didn't really know what sort of systems were in place to make sure that patients were compliant [...] So, it's more of the fear of misusing your prescription from a physician perspective."*	McCollum et al., 2023, p. 5
[32]	*"It's like a hard population to work with. You know, they're often late to their appointments. They often don't show up and then you have to accommodate them outside of your clinic hours. They often need transportation set up to get them to clinic. So, I think there's a lot of providers who are like, "not my problem."*	McCollum et al., 2023, p. 5
[33]	*"I think there's on the far end, you'll see that manifested as, you know, providers are just overtly refusing to provide treatment, even if they're not consciously making that choice [...] Then the providers that are sometimes supportive of these patients getting services in words, I think, sometimes that's not always met by action, unfortunately."*	McCollum et al., 2023, p. 5
[34]	*"So, the first time I prescribed it, I was scared, but I was like, "Okay, I'm gonna do this." And, then the more I did it, the more comfortable I got with it. Now, I still [...] with a really complicated patient, will still refer them to an addiction specialist. But, you know, in a pinch or in an emergency or continuing somebody [on buprenorphine] that [another provider] has started, I won't hesitate to do that now."*	McCollum et al., 2023, p. 5
[35]	*"I mean, not just the prescribing, but there's so much like red tape and just the getting the system in place. Like if I was just an alone provider somewhere, it would be really hard to just get that. But the institution adopted it and there's someone that had been doing it [for a long time]. You know, [somebody who has] the actual knowhow, like, "This is how you get the medicine paid for, and this is where you send the prescriptions." [...] So, yes, like having a mentor [...] was really helpful."*	McCollum et al., 2023, p. 5-6
[36]	*"So just if there's a situation, like someone turns up with fentanyl in their toxicology screen, and I'm worried about precipitating withdrawal, or it's a complicated case where they have both benzo and opiate use disorders and we're navigating a challenging detox. Those are the kind of cases where if I'm worried about the patient, because of the complexity, I never hesitate just to call [an addiction specialist] and ask for help."*	McCollum et al., 2023, p. 6
[37]	*"We have behavioral healthcare services and social work services on site. And, so, those things make my job tremendously easier...to have someone to do behavioral health coaching with them at the same visit, to fill out all the paperwork with them, to go over the paper- work [...]. We have group therapy visits if they want to be part of group. Then, you know, if they're having transportation problems or food issues or whatever, like the social worker can help with that. We have like a food closet. So, we just have like a bunch of resources at our disposal at the same clinic, which is really nice."*	McCollum et al., 2023, p. 6
[38]	*"If I ever lose [integrated psychosocial services], I don't know if I would continue to do [buprenorphine] because it's a lot. Yeah, it's a lot on just [one] position."*	McCollum et al., 2023, p. 6
[39]	*"It's very difficult. Like a lot of our patients are uninsured, underinsured, are coming from disadvantaged socioeconomic backgrounds. So, you know, just finding the resources that are necessary for them to be able to continue the medications has been a real struggle, you know, just finding appointments. COVID has made everything even harder with like tele-appointments. Cause if it's telepsychiatry, my patient needs to be in a position where they have a smart phone and enough data and need to be cognitively intact."*	McCollum et al., 2023, p. 6
[40]	*"[factors] closely associated with lower socioeconomic status are probably the biggest barriers that I've encountered."*	McCollum et al., 2023, p. 6
[41]	*"Every insurance, more so Medicaid, has really strict criteria for what they'll pay for [Suboxone]. So, Medicaid in the beginning you had to—I think now you can get like a couple week waiver—but you pretty much had to get a urine showing compliance to Suboxone and then they would approve it for 30 or 90 days. And you had to reapprove that every time. So, they get a [prior authorization] every single time with a new urine every single time. And so, that is a lot of red tape."*	McCollum et al., 2023, p. 6
[42]	*"We don't just prescribe. We have to provide treatment with it."*	Stewart et al., 2021, p. 3
[43]	*"It's not treatment. It [MOUD] doesn't take the place of psychological treatment."*	Stewart et al., 2021, p. 3

[44]	*"They're giving them more powerful drugs to protect them, but if you think that's how you're going to solve addiction, you got a problem there. It doesn't stop you from smoking crack or [synthetic marijuana] so you got to treat addiction. If you don't treat addiction they got drugs the docs don't have a drug for."*	Stewart et al., 2021, p. 3
[45]	*"Listen, what happened to treatment? This [MOUD] was supposed to be integrated with treatments."*	Stewart et al., 2021, p. 3
[46]	*"Everything is lack of resources. Most agencies have a hard time running just on what exists right now."*	Stewart et al., 2021, p. 3
[47]	*"One of the biggest problems is the additional non-billable support services that are required in order to sustain treatment for this population. There's a lot of outreach that has to happen so people don't disappear."*	Stewart et al., 2021, p. 3
[48]	*"Where is the money for the psychiatrist [who] is going to write and manage that prescription? Where is the money for someone to come in and educate my staff?"*	Stewart et al., 2021, p. 3
[49]	*"I think from an administrative point of view it would be a nightmare to manage."*	Stewart et al., 2021, p. 3
[50]	*"When you talk about suboxone, there's a heavy burden around management of that. When the patient comes in, how long do you continue to see them? The induction period and all of that and I think for outpatient settings and some clinicians, it's much different even when they're used to treating different types of medical concerns."*	Stewart et al., 2021, p. 3
[51]	*one CEO commented: "People often don't want to prescribe it because they're afraid that they have to keep a record in a special way or the DEA may swoop. They'd rather not dabble in [prescribing MOUD]."*	Stewart et al., 2021, p. 3
[52]	*"Front-line staff are also uncomfortable and a little confused about what the obligations are even when they've had training in suboxone."*	Stewart et al., 2021, p. 3
[53]	*"It would be great to have a mentor agency or someplace out in the community where we could go with all of those day-to-day questions that come up in the management and administration of a program such as that. That would be something that would sway us in a direction more quickly."*	Stewart et al., 2021, p. 4
[54]	*"I find a lot of guys come in, and they don't want to be on any medication. They get their mindset that they want to be completely drug-free."*	Stewart et al., 2021, p. 4
[55]	*"The access issue isn't that there aren't places willing to accept; it's that people aren't interested in what we have to offer."*	Stewart et al., 2021, p. 4
[56]	*"There is still that hardcore principle to overcome that people think you're trading a drug for a drug and is that recovery."*	Stewart et al., 2021, p. 4
[57]	*"Folks feel as though if you are going to be abstinent then you are going to not use anything and that the medication is just the crutch."*	Stewart et al., 2021, p. 4
[58]	*"They [other organization] detox with methadone, which is not a detox. It's still an opiate!"*	Stewart et al., 2021, p. 4
[59]	*"The main objection is abuse. I'd rather not mess with all that."*	Stewart et al., 2021, p. 4
[60]	*"MAT as itself is a good principle if it's possible to keep it under control. We dispense [instead of writing prescriptions], and I think that's definitely the part of our managing the diversion."*	Stewart et al., 2021, p. 4

[61]	*“Sure, being alive is better than not alive but, man, what kind of life is that?”*	Stewart et al., 2021, p. 4
[62]	*“If we see someone nodding it means there is possibly an interaction with their other medications (prescribed or not), or that we need to adjust their dose. This is something we check in on every single day with every single patient.”*	Stewart et al., 2021, p. 4
[63]	*“It’s a whole different person you’re talking to than the guy who is drug-free.”*	Stewart et al., 2021, p. 4
[64]	*“I can tell you what is dangerous. Having people in their facility that all they want to do is be on buprenorphine and they are sitting in a facility with people that are serious about what they’re doing is a bad thing. Somebody nodding out and falling out of a chair in a group is a bad thing.”*	Stewart et al., 2021, p. 4
[65]	*“I too am in recovery, and the thought of bringing opiates into an opiate treatment facility is troubling to me but terrifying to the men in recovery. Our guys couldn’t understand why you were giving drugs to people; it triggers them.”*	Stewart et al., 2021, p. 4
[66]	*“Ultimately we try to mix our groups together because in the name of our vision in stigma reduction by singling people out and saying ‘Well, you’re on methadone, and you shouldn’t be in groups with other people recovering in other ways.’ I find that we can cause that stigma to root even deeper. We try to mix all of our groups together and just deal with matters of recovery.”*	Stewart et al., 2021, p. 4
[67]	*“I feel like I personally don’t know a ton about Vivitrol because none of my clients is on it. I don’t know why it’s not talked about more.”*	Stewart et al., 2021, p. 4
[68]	*“The guys are fine with it, who is on it, who is not, they don’t care.”*	Stewart et al., 2021, p. 4
[69]	*“You can’t abuse Vivitrol, it was marketed that way.”*	Stewart et al., 2021, p. 4
[70]	*“I’m the CEO here, so what I say goes. If I put my foot down, jump up and down, insist demand and push, I get my way. That’s tough because I have people who are married to an ideology that’s against what I’m teaching.”*	Stewart et al., 2021, p. 4
[71]	*“In May I fired my whole management team except for one. I was tired of the massive implementation and the drift, and we would drift back if we didn’t have completely new personnel.”*	Stewart et al., 2021, p. 5
[72]	*“We’ve retained the traditional folks who don’t have full support of MAT... everybody is entitled to their opinion but we need to support the organization and they need to support other people’s paths to recovery. I told them this is the direction we are going.”*	Stewart et al., 2021, p. 5
[73]	*“What had to happen organizationally is we had to change - not just approach, but our perspective of what abstinence based includes.”*	Stewart et al., 2021, p. 5
[74]	*“...one way they did this was by mixing peers of all kinds to drill down this point that, ‘everybody’s path to recovery is a valid one.’ Once they started talking to each other they found out they had a lot more in common than they didn’t.”*	Stewart et al., 2021, p. 5
[75]	*“Those of us working with the MAT population were just getting excited about the work. Then we started asking, ‘How can we do more of this,’ because this [MOUD] clearly is what seems to be helping these individuals.”*	Stewart et al., 2021, p. 5
[76]	*“our retention rates have tripled”*	Stewart et al., 2021, p. 5
[77]	*“I think [MOUD is] a good way to help somebody get through a process until they realize “wait a minute, this isn’t the right thing, it’s more negative than positive for me.” It’s kind of a, keeps them in a neutral mode, so they’re at least surviving, they’re not OD-ing, and, that as long as they’re using it properly, okay, then, then when they’re ready,*	Paul et al., 2022, p. 744

	really ready for recovery, then they can move forward, and they have to do it cold turkey, they have to do it with meetings, peers that have been through it can help them through it, that's the way it seems to be, the most sustainable is really been."	
[78]	*"Sometimes this medication becomes a curse ... you have to take that Sub every morning ... go to the doctors every month ... you just want to live your life without these things every day ... like [diabetics] have to take their insulin [every day]."*	Paul et al., 2022, p. 744
[79]	*"It's a very individualized treatment. I have one guy who has been on it for 8–9 years and is doing really well. He doesn't want to get off. He's successful, and has a great life, but is afraid. He says, "I'm not sure I quite trust myself. If I got a really bad urge, would I, or wouldn't I? Why risk it?" ... There's a move to viewing addiction as any other chronic illness. You would never cut off treatment for another chronic illness."*	Paul et al., 2022, p. 744
[80]	*"They need to be on as long as they need to be on. If you push people off of methadone, or buprenorphine, they die. You do not push these patients off. You don't."*	Paul et al., 2022, p. 744
[81]	*"How many licensed facilities do [different areas] have? How many all-cash Subutex facilities do they have, and what are the overdoses in that ZIP code? If your treatment is different, in an area versus another treatment, then your outcomes are going to be different ... But we tend to not talk about the treatment side, and it being related to the epidemic."*	Paul et al., 2022, p. 745
[82]	*"So, trying to help get a clear direction on how to take care of addiction is often – there's a lot of static that comes from online groups. So, I think it's hard for a patient to understand: What [do] I have; Where do I go to get help?; What's the best help?; and Who's made it?–Who's a good example for me? I don't know how to clear that up, but that static makes it tough."*	Paul et al., 2022, p. 745
[83]	*"So, um, you know, the internet's not updated ... To prescribe Suboxone, you have to have the data waiver; and it's public record who has that data waiver on their medical license. So anybody on the internet can find that, and post it, and say "Here's the number on their license" that they're prescribing this medication, but that's not accurate."*	Paul et al., 2022, p. 745
[84]	*"We track things to determine where our marketing dollars should go and have found that word-of-mouth is the most common way that folks hear of us."*	Paul et al., 2022. P. 745
[85]	*"You need to have ... really knowledgeable case managers that have worked in this area before. Because you may not get that person on the phone again. You may not get them in front of you again. So having really knowledgeable staff, really knowledgeable about what resources are out there for them, being able to do things rapidly, intervene rapidly, because their window of wanting [help] might close too. So, you kind of have to [pause] get them when they are ready too. Yeah, so I think that is, that takes a lot of work."*	Paul et al., 2022, p. 745
[86]	*"I don't think we are doing a good job of getting people into treatment and I don't know where that comes, but somehow they are out there and they are not coming in and we don't have a centralized way of getting them to the appropriate place. I don't know if it is because the appropriate place doesn't exist or we don't do a good job of outreaching these people, but even now, with our Suboxone clinic, there was a change in the person who is the coordinator for the drug and alcohol program that we talk to, and they had a couple of therapists that changed, so I don't know if that is why it has been slow."*	Paul et al., 2022, p. 745
[87]	*"So I can give a patient a list of twelve methadone clinics, Suboxone clinics to call, and they can call and make an appointment in any one of them, they're gonna get them in and they're eventually gonna get treatment, but when they show up to our door, in withdrawal, struggling, wanting something immediately, I can't always get them into detox, I can't always get them something that's gonna make them feel better and become invested in treatment."*	Paul et al., 2022, p. 745
[88]	*"It is being able to have services available for them when they need the services. Again, if someone has a heart attack at 4:00 pm on Friday afternoon, we send them to the cath lab and everybody comes in and does a cardiac catherization. But if someone says at 4:00 pm on a Friday afternoon, I finally want to stop using, you know we are just like well, come back Monday. You know? We have the whole weekend we gotta get through now."*	Paul et al., 2022, p. 745
[89]	*"Burnout is absolutely real, and we all get frustrated, and I think most of us, in the rural setting, have been threatened by people like this too. I have had to get a restraining order for a patient in the past, that's threatened me, because I wouldn't prescribe medication for them." (#8, family medicine physician, non-prescriber)*	Franz et al., 2025, p. 3
[90]	*"Well, we had a physician just across the border in Indiana, that actually got shot and killed. He wouldn't prescribe pain medication, and so the patient went out and got his gun and came in and killed him and another person in the clinic. And the physician was a relative, our practice manager was a brother. It hits home. So yeah, there's a lot of*	Franz et al., 2025, p. 3

	stigma, but there's a lot of where people are scared too, to get too involved in those situations." (#8, family medicine physician, non-prescriber)	
[91]	*"I think if I were to talk to my husband, for example, and say, "I think I'm going to start prescribing Suboxone," I think he would be like, "No, I don't want people showing up to our doorstep asking for it." I think there's that connotation behind it still. And so, I think that there's still a lot of growth that needs to happen even personally with it, because that would still be a hesitation for me." (#20, family medicine PA, non-prescriber)*	Franz et al., 2025, p. 4
[92]	*"Other PCPs felt safer knowing they worked in clinical spaces that did not contain controlled substances. For example, one NP explained: "I don't think it would be safe to have buprenorphine on hand at our clinic just because of the nature of our clients. I think that would just create, if people knew that was there, it's just not really a secure area" (#1, family NP, non-prescriber)*	Franz et al., 2025, p. 4
[93]	*"We did a lot of education about these people already being in our building. There's also always a concern with staff safety. So, we had to do a lot of stigma training. We actually hired a public relations firm to help us with our community, as well as with our staff" (#10, family physician in clinical leadership role, buprenorphine prescriber)*	Franz et al., 2025, p. 4
[94]	*"He kept saying over and over again, "This will change the character of your waiting rooms"" (#18, family medicine physician working in clinical leadership, non-prescriber)*	Franz et al., 2025, p. 4
[95]	*"Yeah. I would say it's taken a lot of time and culture shifts. It's not something that was easily received overnight. There was stigma amongst the staff. It was, "We don't want these people in our building"" (#10, family physician in clinical leadership role, buprenorphine prescriber)*	Franz et al., 2025, p. 4
[96]	*"No one wants them in their waiting rooms, and it can be challenging" (#15, family NP, buprenorphine prescriber)*	Franz et al., 2025, p. 4
[97]	*"We must have had phone calls for months...because we were prescribing opioids, so we had all kinds of calls for new patients who wanted to come in. In fact, we've had the nice folks from the FDA [U. S. Food and Drug Administration] and the DEA [Drug Enforcement Administration] and the State of Ohio out before to say, 'Oh, by the way, just so you know, your percentages are really high...Well, let me tell you where I work and what I do.' I said...but our biggest concern was if we started doing the Suboxone, then are we going to get an influx of other people's folks who didn't want to do it for them?" (#6, family medicine physician, buprenorphine prescriber)*	Franz et al., 2025, p. 4
[98]	*"I know that the other physician who has [buprenorphine] training...received comments like, 'Well, once you start, then that population's going to come trickling in, and then our clinic is going to be all that.'" (#19, family medicine physician, buprenorphine prescriber)*	Franz et al., 2025, p. 4
[99]	*"I think a lot of people were very hesitant to do the Suboxone training because, oh my gosh, then I'm going to have to prescribe it, and I'm going to see all these people, and I don't have time, I don't have the capabilities, I don't have the infrastructure to take on a whole new patient panel" (#8, family medicine physician, non-prescriber)*	Franz et al., 2025, p. 4
[100]	*"when you talk about doctors that do addiction medicine, mostly nowadays has evolved to opioid use disorder and buprenorphine and Suboxone...he's a 'sub doctor.' And that creates a stigma, a perception that these doctors, that's all they do" (#4, addiction medicine physician, buprenorphine prescriber)*	Franz et al., 2025, p. 4
[101]	*"Due to our desire to provide medication-assisted treatment services to our community we have been pigeonholed into the community seeing us as the clinic that ONLY provides medication-assisted treatment services, and we constantly strive to let the community know we offer many more services" (#13, family physician working in clinical leadership, buprenorphine prescriber)*	Franz et al., 2025, p. 4
[102]	*"I definitely still think there's a stigmatism to it...I think Suboxone set itself up for that by doing these freestanding clinics where you came in and paid cash instead of treating it like a treatment like you would any other disease process. I think there's still a lot of stigma around it for sure. I don't know how to fix that, to be honest" (#22, family NP, non-prescriber)*	Franz et al., 2025, p. 5
[103]	*"Everybody knows that that is, you pay your 200 bucks and you're going to get a script, and there's not going to be anything added to that. And again, it's a little bit of a cash grab. People aren't ignorant to that because they went through it with the pain clinics, the pill mills, if you will. People have circumvented that pill mill into something else. And for every one of those that's doing that, there are some solid treatment facilities that are really trying to do whatever they can to help a population that, without them, [I] have no idea where we would be, to be honest" (#15, family NP, buprenorphine prescriber)*	Franz et al., 2025, p. 5

[104]	*“I guess my big issue is I really don’t trust the FDA and I don’t trust pharmaceutical companies anymore. I worry that they’re doing exactly what they did last time that got us to where we are and who has the time to go back to those original research studies that say buprenorphine really works and are they legit? And so, I do worry that they’re just replacing one opiate with another. But I also think it’s still better than people being on the street. So, I have a real quandary because I don’t trust the regulators at this point.” (#1, family NP, non-prescriber)*	Franz et al., 2025, p. 5
[105]	*“what they’re telling us from the pharmaceutical perspective is, ‘Oh, it’s probably for life.’ And I’ve had so many patients come to me and say, ‘I want off of this, but I can’t get off of it.’ And then they’re stuck taking it” (#1, family NP, non-prescriber)*	Franz et al., 2025, p. 5
[106]	*“the training, at least with the DATA waiver, is really do not focus on discontinuation, which is, I think, where the big pharma part comes into that. They’re trying to say something very different, which is don’t focus on this...question the motives of people who come in and say, “I’ve got to get off of this”, “if they’re otherwise doing well”.” (#18, family physician working in clinical leadership, non-prescriber)*	Franz et al., 2025, p. 5
[107]	*“A physician got the ear of our chief medical officer and said: ‘this is all just big pharma. It’s a lot of risks, and they have co-opted, even the federal government, to selling something that’s dangerous and comes with lots of risk and that sort of thing.’”*	Franz et al., 2025, p. 5
[108]	*“He would never, ever, ever on his dying bed prescribe [buprenorphine]...he saw this opioid epidemic explode in his face. And for him, from the get-go before this even started, he said, ‘We are not the office that does chronic pain meds. We’re not going to do benzodiazepines. We’re not going to do these controlled substances...’ So he was not wanting me to even go after that [X-waiver] license.” (#20, family medicine PA, non-prescriber)*	Franz et al., 2025, p. 5
[109]	*“Well and so newer docs...don’t prescribe opioids. We went from, ‘Everybody gets them’ to, ‘You better have a great reason.’ So now the pendulum has swung all the way and now we just need to come back just a little bit so we can do that [prescribe buprenorphine]. Because I know there is a lot of fear...You’ll have a residency [where the preceptor says], ‘this patient has a broken leg, I’m just going to give him Tylenol.’” (#7, family medicine residency director, non-prescriber)*	Franz et al., 2025, p. 5
[110]	*“When they initially put out the report how many morphine equivalents there was for buprenorphine to morphine, he had in his mind that I’m not going to write anything more than 80 Morphine equivalent per day. And buprenorphine was way over that initially. Now they’ve walked that back, but he quit seeing this one patient of his, and I still see this guy. I’m like, Dr. [redacted], you could still do this. You could still see this guy, but he doesn’t want to take on that stigma of writing too much Morphine” (#16, Addiction medicine physician, buprenorphine prescriber)*	Franz et al., 2025, p. 5-6

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