

## The Opioid Crisis Viewed Through the Lens of a Black and White Camera

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### Abstract

*The United States' opioid epidemic is a national public health emergency. As opioid use has not been shielded from health care disparities furthered by economic, gender, race, and sex biases, discrepancies in the rates of abuse and access to treatment exist among non-white minorities. This narrative literature review is an evaluation of the literature centered on minority racial disparities in opioid use, abuse, and care in the United States. Racial disparities in prescribing opioid-containing compounds are staggering among non-white individuals. A historical review of opioid regulatory control is offered as an explanation for the cognitive biases demonstrated by clinicians. Governmental regulation is among the polyfactorial roots of racial inequity in the opioid epidemic. Literature describing physician bias and portrayals of racial and sexual disparities in opioid abuse disorders are presented. As part of the national response to this evident disparity, addressing these issues will be an important factor in curbing this epidemic and tools to assist in mitigating these obstacles are presented.*

### Introduction

Pain is defined as the unpleasant sensation resulting from a noxious sensory stimulus, and the practicing clinician is no stranger to the difficulties in achieving optimal pain therapy.<sup>1</sup> Clinicians must balance a patient's needs and individual characteristics with available scientific evidence when deciding whether to prescribe opioid medications. The act of prescribing involves many subtle influences and ethical issues, yet the consequences are almost wholly borne by the patient [1-4]. All clinicians have an ethical obligation to prescribe responsibly and cautiously to diminish the potential for opioid diversion and to help minimize the growth of the current opioid abuse epidemic. Each year, millions of patients are treated for a variety of serious medical conditions with prescription drugs whose therapeutic benefits can alter behavior, mood, or consciousness. This is particularly true in the management of acute, chronic, and postoperative pain, which often involves potent opioid pain relievers. Clinical providers use their own discretion in prescribing opioid medications over others, and it is imperative that such decisions are justifiable. Further, physicians and other healthcare professionals face the challenge of minimizing the potential for misuse of these important medications without impeding patients' pain relief. An immutable fact is during the description of a patient's chief complaint, they uttered to the clinician that they desired or wished to become "an opioid or heroin addict."

Opioid abuse is among the most consequential and preventable public health threats in the United States, and this critical issue needs to be addressed by all healthcare professions. Clinical practices should establish procedures to better control and limit opioid prescriptions and must develop analgesic regimens to treat pain. Opioid analgesics should be prescribed by balancing their beneficial and adverse effects [1-4]. While the ramifications of prescribing opioids are both social and economic, the specific act itself involves two parties – the practitioner and the patient. Through alterations in the attitudes of patients and physicians, opioid prescribers can manage the pain of the patient while minimizing abuse potential through careful procedural techniques, alternative therapies, and by keeping prescriptions limited to appropriate quantities for when opioids are deemed necessary [1-4].

The seasoned astute prescriber will remember that in 1996, the national push for identification of pain as a primary medical disorder and oxycodone hydrochloride, known with its brand name as OxyContin™, was approved by the Food and Drug Administration (FDA) as a "minimally addictive pain reliever" [1, 5-7]. On July 17, 2020, Mann [8], relying on public data to include up-to-date government studies and new reports in medical literature, reveals that prescriptions are being written each year

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for half of all Americans to have at least one opioid. Patients are still receiving more than twice the volume of opioids than what is considered normal before the prescribing boom began in the late 1990s [1, 8]. Given that opioids are currently being prescribed across the United States, a need arises to examine if there exist variations in the medication treatment plans of pain management and opioid use disorder received by racial and ethnic minorities as well as women and if this variation has a negative health outcome associated with these differences. This narrative literature review will first examine a historical perspective of the legal regulations with narcotic control, as they may have been racial, and or cultural bias at the time of their creation. Secondly, published data centered on both pain management and opioid use disorder treatment for racial and cultural bias will be examined and offered. Lastly, proactive initiatives tools will be offered in an attempt to limit racial and or cultural bias during this ongoing opioid epidemic.

### Historical Review of Narcotic and Opioid Control

Opium has been used in many ancient cultures such as the Assyrians, Egyptians, Arabs, Greeks, Romans, and Chinese. Medical usage of opioids traces back to 3400 BC when the Sumerians in lower Mesopotamia cultivated the opium poppy (known as the “joy plant”) [1, 7, 9-12]. In 460 BC, Hippocrates dismissed the “magical” attributes of opium but acknowledged its usefulness as a narcotic and styptic in treating internal diseases and epidemics. By 1527, the Swiss-German alchemist Paracelsus had introduced the use of opium pills [1, 6, 9-12]. In 1680, English apothecary Thomas Sydenham introduced Sydenham’s Laudanum, a compound comprising opium, sherry wine, and herbs that became a popular remedy for numerous ailments [1, 9-12].

In 1803, German chemist Friedrich Wilhelm Adam Sertürner isolated morphine from opium using ammonia to neutralize it, naming it “Morpheus” after the ancient Greek God of Dreams. In 1827, E. Merck and Company of Darmstadt, Germany, began commercial manufacturing of morphine [1]. In 1843, Dr. Alexander Wooden of Edinburgh discovered a new technique of administering morphine: the injection syringe [1]. He found that the effects of morphine on his patients were instantaneous and very potent. By the 19<sup>th</sup> century, morphine had become a mainstay for the following: anxiety digestion, endocrine disorders hunger, mood disorders, pain, respiratory problems, and consumption [1, 6, 9-13].

In America, from early colonial times into the 20<sup>th</sup> century, opium was indispensable. During the 19<sup>th</sup> century, opium was easily available and affordable throughout the United States [1, 9-12]. By the end of the Civil War, there were so many soldiers hooked on morphine that the addiction became known as the “soldier’s disease.” Heroin was synthesized in 1898, which Bayer offered as a cough suppressant and non-addictive morphine substitute. In 1890, the US Congress passed its earliest law-enforcement legislation on narcotics, which imposed a tax on opium and morphine. Congress banned opium in 1905, and then passed the Pure Food and Drug

Act [1, 9-13].

The most passionate support for the legal prohibition of narcotics has been the associated fear of a given drug’s effect on a specific minority. American concern about opium addiction in China was driven both by economic and political issues and by the use of the drug itself [6, 9-13]. In the 19<sup>th</sup> century, addicts were identified with foreign groups and internal minorities who were already actively feared and the objects of elaborate and massive social and legal restraints. Two repressed groups that were associated with the use of certain drugs were the Chinese and the African Americans [9-14]. Fear that smoking opium facilitated sexual contact between Chinese and white Americans was a factor in its total prohibition. Chicanos in the Southwest were believed to incite violence after smoking marijuana [14]. Heroin was linked in the 1920s with a turbulent age group: adolescents in reckless and promiscuous urban gangs [14]. Furthermore, heroin was claimed to be an important factor in the “crime wave” which followed World War I, as well as being implicated as part of the Communist conspiracy against the United States in the 1950s [14].

To meet China’s crisis, the State Department pushed for an international conference to solve the opium problem. The conferences in Shanghai in 1906 and at The Hague in 1907 resulted in the first international opium agreement in 1912. These two conferences put forth recommendations, not policies, and little changed in the manufacture, distribution, and consumption of opiates [1, 14-19]. The US swiftly ratified the conference in 1913, and this paved the way for American domestic opiate control policies [1, 9-14].

There were Americans who faulted the Chinese immigrants for causing narcotic addiction in the United States; however, narcotic addiction was well established in the United States prior to their arrival, during the time of Presidents Roosevelt, Taft, and Wilson, all of whom relied primarily on Reverend Charles Henry Brent and Hamilton Wright to address the nation’s drug concerns. Both had assured the Shanghai Conference that the US would follow its recommendations on establishing controls on opiates. After returning from the Shanghai Conference, Hamilton Wright took the lead in structuring US policy for the control of opium and cocaine. Wright’s first effort, the Foster Bill of 1911, ultimately died when the proponents were unable to convince Congress that cocaine and opium were a threat to the American public. There was more concern about the abuse of alcohol at that time. Under pressure to deliver, Wright and the proponents employed racist imagery and rhetoric to pass the Harrison Act of 1914 [14]. The Harrison Act limited the illicit supply of opium and morphine but failed to control the addiction; thus, a black market emerged to fill the need [1, 9-14]. This legislative initiative was passed in response to the sudden emergence of street heroin abuse as well as iatrogenic morphine dependence [1, 6, 9-14].

In 1916, in an attempt to maintain the pain-killing effects of

morphine and heroin but lessen the risk of dependence, German scientists synthesized a new wonder drug, “oxycodone” [1]. In 1919, the US Supreme Court made changes to the Harrison Narcotics Act, limiting the ability of doctors to prescribe opioids to those struggling with dependency. The US Treasury Department’s Narcotics Division (the first federal drug agency) banned all legal narcotics sales in 1923 [1, 9-14]. With the prohibition of legal venues to purchase heroin, addicts were forced to buy from illegal street dealers. In 1924, the Heroin Act made the drug illegal even for medical use [1].

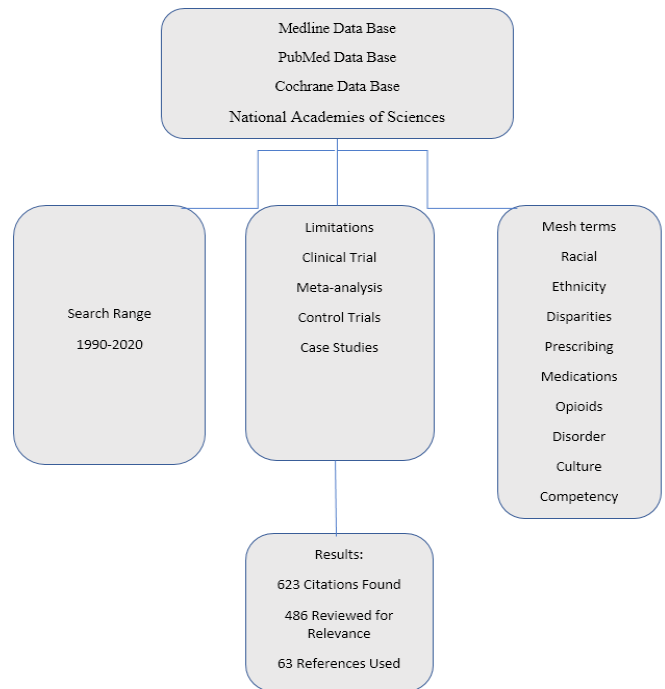
For nearly 45 years, medical professionals remained fearful of prescribing opioid drugs. The World Health Organization (WHO) endorsed the medical use of morphine in 1969, concluding that it did not “inevitably lead to dependence,” though they made a distinction between physical dependence and drug dependence, which they defined as “difficulty controlling consumption, compulsive use, and inappropriate social behaviors [1, 9-14].” In 1970, the Controlled Substance Act was passed in the US, which allowed for more vigorous regulations on the issuing of prescription drugs [1, 9-14]. This Act was a marked improvement over the Harrison Act as it placed controls on all substances with the potential for abuse and accounted for the five drug categories based on their risks. On July 1, 1973, President Nixon created the Drug Enforcement Administration (DEA) under the Justice Department to consolidate virtually all federal powers of drug enforcement in a single agency [1, 6, 9-17].

Throughout American history, race, ethnicity, and class have influenced the public’s opinion of drug use and addiction. This was observed most recently on a large scale during the crack cocaine epidemic of the 1980s in the United States. During this period, the political campaign, known as the “War on Drug”, was used as a response to counteract the increasing rates of use and abuse of this compound [1, 6, 9-17]. Minorities, specifically African Americans and Latinos, in urban inner cities were frequently depicted as addicts and criminals while the Whites were portrayed by the media as “victims” [6]. Santoro and Santoro present a review of historical literature and excellently accentuated an argument for a multi-factorial origin for racial inequity response to the opioid epidemic.6 They emphasis that this racial inequity was steered by local, state, federal governmental agencies a clinician’s own bias, and the media portrayal of opioid abuse and opioid use disorders [6]. An investigation of the published literature by the means of electronic surveillance to furrow out possible answers to address these factors will be an important step to develop a mechanism for curbing and halting racial inequities as healthcare professionals address the opioid epidemic.

**Methods: Data Base Search**

A search profile was compiled using key terms to perform Boolean logic electronic searches to identify relative primary literature citations from 1990 to 2020 (Figure 1). Furthermore, a manual review of the reference lists and bibliographies was undertaken to gather any additional information that might have led to further

material for this review. Citations (n = 623) were reviewed and evaluated as defined by the search limitations. Accounting for duplication, 78% (n = 486) of the citations were reviewed for significance and relevance for inclusion in this review. Only 63 citations were found to satisfy the defined parameters of the search limitations. The databases used were PubMed, MEDLINE, Cochrane Library, and the National Academies of Sciences, wherein the search terms used were related to the keywords: culture, competency, racial, ethnicity, disparities, prescribing, medications, disorder, and opioids. Articles were excluded if they did not include a statistical analysis of differences in drug treatment based on ethnicity, provider bias, race, ethnicity, or sex. Data regarding the frequency of the reported race, ethnicity, sex differences in medication treatment, types of treatment differences observed, and associated health outcomes were extracted. The literature was reviewed and evaluated for quality and relevance as it pertained to opioid pain treatment as well as opioid use treatments with an emphasis on culture, competence, race, ethnicity, disparities, prescribing, medications, disorder, and opioids. Data regarding the frequency of the reported race, ethnicity, sex differences in medication treatment, types of treatment differences observed, and associated health outcomes were extracted.



**Figure 1:** Citations (n =623) were reviewed and evaluated as defined by the search limitations. Accounting for duplication, 78% (n =486) of the citations were reviewed for significance and relevance for inclusion in this review.

**Results**

This review identified 63 journal articles describing the effect of a patient’s race, ethnicity, and social and economic disparities on

pain assessment and management as well as treatment of opioid use disorder. Six studies centered on the influence of social and economic disparities to include: Medicare, Medicaid, Veterans Administration, and private third-party payors, opioid prescribing, and opioid use. Nineteen studies examined emergency department pain assessment and opioid treatment and revealed that minority patients are more likely to have their pain underestimated by providers and less likely to have pain scores documented in the medical record compared to Whites. Seven studies examined inpatients or institutions that reported pain assessment and opioid treatment and revealed that minority patients are more likely to have their pain underestimated by providers compared to White patients. Twelve studies examined outpatient pain assessment to include acute, chronic non-malignant, as well as cancer pain with opioid treatment and revealed that minority patients are more likely to have their pain underestimated by providers compared to White patients [30]. Furthermore, eighteen studies evaluated opioid use disorder, illicit drug use, and opioid Medication-Assisted Treatment (MAT) for Opioid Addiction found patient-related, provider-related, and pharmacy-related barriers to effective management.

## Discussion

A 2003 published study by Tamayo-Sarver et al. analyzed Black, Latino, and White patients from 1997 to 1999 in the National Hospital Ambulatory Medical Care Surveys to compare prescriptions of any analgesics and opioid analgesics by race and ethnicity [18]. They deduced that physicians were less likely to prescribe opioids to Blacks with great disparity appearing for migraines and conditions with fewer objective findings [18]. Although Rosenbloom et al. reported from retrospective data based on the National Hospital Ambulatory Medical Care Survey data from 2010 to 2014, there is no statistically significant interaction between race/ethnicity and sex for the administration of opioid analgesia to people presenting to the emergency department with appendicitis or gallbladder disease [19]. They concluded that their results suggest that the joint effect of patient race/ethnicity and sex may not manifest in disparities in opioid management [19]. Alternatively, Goyal et al. report contrary results, supporting the findings of Tamayo-Sarver et al. from their cross-sectional study, suggesting that appendicitis pain is undertreated in pediatrics and that racial disparities with respect to analgesia administration exist [20]. Black children are less likely to receive any pain medication for moderate pain and less likely to receive opioids for severe pain, suggesting a different threshold for treatment [20].

Romanelli et al. examined racial and ethnic differences in opioid prescribing and dosing for long bone fractures at emergency department discharge using morphine milligram equivalents, which allows for a true understanding of opioid dosing [21]. They examined differences in opioid prescribing at the emergency department at the time of discharge and among patients with a prescription, differences in opioid dosing (measured as morphine

milligram equivalents) by race/ethnicity, using regression modeling with statistical adjustment for patient, fracture, and prescriber characteristics [21]. They examined a total of 11,576 patients with long bone fractures. The study population is described as 64.4% of non-Hispanic Whites; 16.4%, 7.3%, 5.8%, and 5.1%, respectively, were Hispanic, Asian, black, and of other or unknown race; and 65.6% received an opioid at discharge [21]. After adjusting for other factors, rates of opioid prescribing were not different by race/ethnicity; however, among patients with an opioid prescription, total morphine milligram equivalent units prescribed were 4.3%, 6.0%, and 8.1% less for Hispanics, blacks, and Asians relative to non-Hispanic whites [21]. Racial and ethnic minority groups with long bone fractures receive similar frequencies of opioid prescriptions at discharge with a small potency difference [21].

Evidence accumulated over many years shows that stable methadone maintenance patients who withdraw from methadone have relapse rates approaching 80–85 % within 1 year [22, 23]. In methadone-maintained patients, there are demonstrated reductions in death rates, reductions in the rates of intravenous drug use, reductions in crime, and reductions in rates of HIV seroconversion [22, 27-35]. Methadone maintenance treatment for opioid use disorder has been in existence for half a century in the United States [22]. There is robust evidence demonstrating its effectiveness and safety. Methadone maintenance treatment has decreased the prevalence of significant infections, such as HIV and hepatitis and saved lives [22].

Lister et al. research provides gender-specific findings to improve African American methadone maintenance outcomes [30]. They studied 211 African American patients that described males: n = 137, (64.9%) at an urban university-affiliated methadone maintenance treatment clinic [22]. Their study offers an analysis of gender differences in risk factors, methadone maintenance outcomes, and gender-specific predictors among African American patients. 30 Methadone maintenance treatment clinics should tailor assessments and treatment protocols to address gender-specific needs [30].

Pro and Zaller declare that disparities in methadone maintenance therapy outcomes have received limited attention with the medical literature, which may lend to important negative outcomes associated with methadone maintenance that warrant examination [31]. Racial discrimination has been cited as common in healthcare settings, and it affects opioid use disorder treatment and comorbidities [31]. They assert, however, that race/ethnicity alone may not fully explain experiences of discrimination [31]. Methadone maintenance therapy itself remains highly stigmatized and may compound the effect of race/ethnicity on discrimination in healthcare settings [31]. They concluded that race and ethnicity alone did not sufficiently account for racial discrimination in healthcare settings among those with a lifetime of opioid use disorder [31]. An interesting finding was that methadone



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maintenance therapy status was strongly associated with racial discrimination among American Indian/Alaska Natives [31]. A more significant obstacle that minority groups face in opioid abuse treatment is limited access to qualified healthcare clinicians who can provide pharmacological treatments through medication-assisted treatment programs [6]. Non-white minorities utilize the services at methadone maintenance therapy clinics at half the rate of Caucasians due to the financial burden associated with overcoming multiple barriers [6, 32]. Furthermore, methadone clinics must be visited on a daily basis to receive proper dosing, which can burden the patient (from both a logistical and economic perspective) and hinder adherence [6, 32]. One recommendation that can be used to overcome these obstacles that are rooted in racial and ethnic disparities is for pharmacy involvement in methadone maintenance therapy by becoming a medication unit with an already established and certified opioid treatment program to ease the currently over-taxed established program locations. A pharmacy setting could be used as a medication unit in a convenient, comfortable location for dispensing opioid maintenance program and to provide counseling and supportive services.

Cintron and Morrison's (2006) systemic review accentuates that 35 identified journal articles described the effect of patient race and ethnicity on pain assessment and management [33]. The majority of studies reveal racial and ethnic disparities in access to effective pain treatment akin to disparities found in other medical services [33]. These authors emphasize that educational interventions should aim to improve patient-provider communication regarding pain, its treatment, provide support around substance abuse issues, as well as discuss pain treatment outcomes and to determine and identify health care system factors that may lend to racial, ethnicity, gender, and sex disparities.

The skillset and attitudes of racial competence require a human to develop and maintain healthy cross-racial relationships, notice, and analyze racial dynamics, and confront racism in the environment and within themselves. Unfortunately, a glaring human fault is that we are not born racially competent. The literature points out that herculean factors like the economy, ethnicity, gender, race, and sex competencies remain in its infancy or only have grown to childhood stature as healthcare professionals approach prescribing medications and specifically opioids and medications for opioid use disorder. During the patient encounter, often questions are not asked that would give the healthcare provider greater insight into disparities because healthcare providers may fear that they could expose existing gaps in economic, ethnicity, gender, and racial competence, and their patients might think health providers are racist themselves. But without asking questions or taking risks, providing healthcare can grow beyond where it is today. When clinical providers adopt a growth mindset centered on race, gender, and sex competence, then we can create a culture in which everyone is continuously developing their competence to fight healthcare disparities.

In 2018, Smith has researched and published the central theme sex competency by highlighting data related to known sex and gender differences of opioid pharmacology, opioid adverse effects, opioid misuse, and the development of opioid use disorder to argue that women are an "at-risk population" when opioids are prescribed to them and that this data was available but not utilized by stakeholders [34]. First, he presents both the epidemiology centered on pain prevalence and the rate of opioid use as it pertains to females and compared it with comparable data for males [34]. Then, he presented historical data centered on opioid use and misuse specific to females to accentuate the observed differences with males [34]. Finally, he presents data documenting gender and sex differences in opioid-mediated analgesia and opioid fate in humans [34]. Smith believed that providing this data would educate prescribers and allow for gender and sex competence as it pertains to opioid prescribing and opioid use disorder prescribing to assist in alleviating noted healthcare disparity regarding sex and gender [34].

In 2018, Santoro and Santoro offer an explanation for current disparities in opioid use for pain relief and opioid use disorder treatments may not be only the medical system bias but study assessing the opinions of white laypersons, medical students, and medical residents identified a continued belief that the black body is biologically "different" from the Whites and actually "stronger" [6, 35]. These beliefs may stem from the days of slavery in the United States where scientists and physicians used pseudo-scientific studies on slaves to justify the need for slavery, often citing biological differences between White and non-White persons [6, 35].

Johnson et al. obtained results from their 2004 investigation which revealed evidence that racial and ethnic minority respondents are more likely to perceive bias and lack of cultural competence when seeking treatment in the health care system [36]. These perceptions have somewhat diminished over time, but persist, even when controlling for demographic factors, health literacy, self-rated health status, source of care, and reports of medical communication [36]. Many efforts have been made by professional organizations and medical educational institutions in recent years to develop standards for cultural competence [36]. Finally, Johnson et al. concluded that demographics, source of care, and communication explain most racial and ethnic differences in patient perceptions of their prescribers cultural competence; however, these differences in perceptions of the health care system-wide bias and cultural competence are not fully explained by these factors [36]. Health care institutions that are to include individual providers should consider how to address patient concerns of inequalities as a part of routine quality improvement. Cultural competence is widely seen as a foundational pillar for reducing disparities through culturally sensitive and unbiased quality care. Culturally competent care is defined as care that respects diversity in the patient population and cultural factors that can affect health and

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health care, such as language, communication styles, beliefs, attitudes, and behaviors.

The term “cultural competence” is not well defined for the many populations and is often conflated with patient-centered or individualized care. There are many gaps in the literature; many large subpopulations are not represented. To build a healthy environment and an objective dialogue between the clinician and patient requires supporting every patient to have a positive racial identity. Prescribers cannot do this until they develop a positive racial identity for themselves. For White providers, having a positive racial identity does not mean feeling good about being White. Rather, it involves understanding what it means to be White in a society that has systemically favored White people above people of color (POC). On the other hand, having a negative racial identity does not mean feeling bad about being White. Instead, it means understanding racial misconceptions, falsehoods, stereotypes, and unexamined biases.

It is helpful for a healthcare provider to look to cultural competency as the first step toward building an anti-racist treatment point of view. While a multicultural approach is important, it is only one factor that contributes to an open approach to treating patients with opioids and medications for opioid use disorder. As clinicians develop their racial identities, they will be better equipped to see the many ways that race affects their patients beyond the treatment plan and to begin to make changes in those areas that need attention. Understanding that as a healthcare provider you have a racial identity and that it is possible to have a positive one is the most critical step in being anti-racist while engaging opioid pain therapy or opioid use disorder therapy approaches. Such an understanding is not simply another tool; it is the toolbox. The stronger and more robust a prescriber’s racial identity, the more tools they will be able to carry. Without a positive racial identity, the clinician will not be able to hold any of the other tools that they acquire.

Given the increasing diversity in the United States population and continued evidence of health and health care disparities, it is critically important that health care professionals are educated on how their own and their patients’ demographics, such as gender, income, race, and ethnicity, as well as culture as defined by language or religion are factors that influence health, health care delivery, and health behaviors. In 2000, the Liaison Committee on Medical Education introduced two standards about cultural competence that inspired medical schools to integrate cultural competence education into the undergraduate curriculum. The Tool for Assessing Cultural Competence Training was developed to advance these efforts. This tool is a 67-item self-administered assessment tool that can be used by medical schools to examine all components of the entire medical school curriculum. It enables schools to identify gaps and redundancies in their curricula, gather

information from various stakeholders, students and faculty, and serves as a blueprint of where, what, and when cultural competence content exists in the curriculum.

The effectiveness of interventions to improve culturally appropriate care needs to be assessed by reviewing provider and patient intermediate outcomes. By providing provider interventions like training and motivation outcomes, such as post-test competencies, knowledge, changes in attitudes, beliefs/cognitions about the priority population, such as reducing stereotyping and stigmatization will enhance improved culturally appropriate healthcare. Improved specific knowledge of health needs to be unique to the selected community and the provider’s behavior, such as clinical decision-making, and communication. Further, patient learning/knowledge, including linguistic competence regarding gender-diversity, improved patient access to health services, patient utilization of health services, patient experience and satisfaction, such as improved perceptions of care, patient health behaviors, such as tobacco use or health-seeking behaviors and the patient use of preventive services. A final intervention centers on health or patient-centered health outcomes including, but not limited to the following: improved mental health outcomes, such as depression, anxiety, suicidality, peer/familial/intimate relationships, and substance use especially as these subjects relate to opioid pain therapy and opioid use disorder treatments.

Cultural competence must continue to be developed as a major strategy to address health inequities regarding opioid pain treatment, as well as opioid use disorder treatments. Competence studies should measure the patient outcomes used in opioid treatment outcomes, health behaviors, involvement in opioid care, and evaluations of opioid treatment care. Further, studies should measure the impact of these types of interventions on healthcare organizations, as these are likely to affect uptake and sustainability. The need exists for long-term, standardized, multi-center randomized control studies to compare different types and intensities of culturally appropriate health education within defined ethnic minority groups so that clinically important health outcomes can be identified and thus sustained.

## Conclusions

It would be helpful for a healthcare provider to look to cultural competency as the first step toward building an anti-racist treatment point of view. This narrative literature review first presented an examination of the historical perspective of the legal regulations with narcotic control with an emphasis on race and or cultural bias during their creation. Secondly, published data centered on both acute and or chronic pain management, opioid use disorder treatment for racial and cultural bias was presented. Lastly, proactive initiatives tools were presented in an attempt to limit racial and or cultural bias during this ongoing opioid epidemic. Cultural competence must continue to be developed as

a major strategy to address health inequities regarding opioid pain treatment, as well as opioid use disorder treatments.

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