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“Genocide by Prescription”: Drug Induced Death in America

The ‘Natural History’ of the Declining White Working Class in America

By Prof. James Petras and Robin Eastman-Abaya
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The white working class in the US has been decimated through an epidemic of ‘premature deaths’ – a bland term to cover-up the drop in life expectancy in this historically important demographic. There have been quiet studies and reports peripherally describing this trend – but their conclusions have not yet entered the national consciousness for reasons we will try to explore in this essay. Indeed this is the first time in the country’s ‘peacetime’ history that its traditional core productive sector has experienced such a dramatic demographic decline – and the epicenter is in the small towns and rural communities of the United States.

The causes for ‘premature death’ (dying before normal life expectancy – usually of preventable conditions) include the sharply increasing incidence of suicide, untreated complications of diabetes and obesity and above all ’accidental poisoning’ – a euphemism used to describe what are mostly prescription and illegal drug overdoses and toxic drug interactions.

No one knows the total number of deaths of American citizens due to drug overdose and fatal drug interactions over the past 20 years, just as no central body has kept track of the numbers of poor people killed by police nationwide, but let’s start with a conservative round number – 500,000 mostly white working class victims, and challenge the authorities to come up with some real statistics with real definitions. Indeed such a number could be much higher – if they included fatal poly-pharmacy deaths and ‘medication errors’ occurring in the hospital and nursing home setting.

In the last few years, scores of thousands of Americas have died prematurely because of drug overdoses or toxic drug interactions, mostly related to narcotic pain medications prescribed by doctors and other providers. Among those who have increasingly died of illegal opioid, mostly heroin, fentanyl and methadone, overdose, the vast majority first became addicted to the powerful synthetic opioids prescribed by the medical community, supplied by big chain pharmacies and manufactured at incredible profit margins by the leading pharmaceutical companies. In essence, this epidemic has been promoted, subsidized and protected by the government at all levels and reflects the protection of a profit-maximizing private medical-pharmaceutical market gone wild.

This is not seen elsewhere in the world at such a level. For example, despite their proclivity

for alcohol, obesity and tobacco – the British patient population has been essentially spared this epidemic because their National Health System is regulated and functions with a different ethic: patient well being is valued over naked profit. This arguably would not have developed in the US if a single-payer national health system had been implemented.

Faced with the increasing incidence of returning Iraq and Afghanistan veterans dying from suicide and overdose from prescription opioids and mixed drug reactions, the Armed Forces Surgeon General and medical corps convened 'emergency' US Senate Hearings in March 2010 where testimony showed military doctors had written 4 million prescriptions of powerful narcotics in 2009, a 4 fold increase from 2001. Senate members of the hearings, led by Virginia's Jim Webb, cautioned not casting a negative light on 'Big Pharma' among the largest donors to political campaigns.

The 1960's public image of the heroin-addicted returning Vietnam War soldier that shocked the nation had morphed into the Oxycontin/Xanax dependent veteran of the new millennium, thanks to 'Big Pharma's' enormous contracts with the US Armed Forces and the mass media looked away. Suicides, overdoses and 'sudden deaths' killed many more soldiers than combat.

No other peaceful population, probably since the 1839 Opium Wars, has been so devastated by a drug epidemic encouraged by a government. In the case of the Opium Wars, the British Empire and its commercial arm, The East India Company, sought a market for their huge South Asian opium crops and used its military and allied Chinese warlord mercenaries to force a massive opium distribution on the Chinese people, seizing Hong Kong in the process as a hub for its imperial opium trade. Alarmed at the destructive effects of addiction on its productive population, the Chinese government tried to ban or regulate narcotic use. Its defeat at British hands marked China's decline into semi-colonial status for the next century – such are the wider consequences of having an addicted population.

This paper will identify the (1) the nature of the long-term, large-scale drug induced deaths, (2) the dynamics of 'demographic transition by overdose', and (3) the political economy of opioid addiction. This paper will not cite numbers or reports – these are widely available. However they are scattered, incomplete and generally lack any theoretical framework to understand, let alone confront, the phenomenon.

We will conclude by discussing whether each '*death by prescription'* is to be viewed as an individual tragedy, mourned in private, or as a corporate crime fueled by greed or even a pattern of '*Social-Darwinism-writ-large'* by an elite-run decision making apparatus.

Since the advent of major political-economic changes induced by neoliberalism, America's oligarchic class confronts the problem of a large and potentially restive population of millions of marginalized workers and downwardly mobile members of the middle class made redundant by 'globalization' and an armed rural poor sinking ever deeper into squalor. In other words, when finance capital and elite ruling bodies view an increasing 'useless' population of white workers, employees and the poor in this geographic context, what 'peaceful' measures can be taken to ease and encourage their 'natural decline'?

A similar pattern emerged in the early 'AIDS' crisis where the Reagan Administration deliberately ignored the soaring deaths among young Americans, especially minorities, adopting a moralistic 'blame the victim' approach until the influential gay community organized and demanded government action.

The Scale and Scope of Drug Deaths

In the past two decades, hundreds of thousands of working age Americans have died from drugs. The lack of hard data is a scandal. The scarcity is due to a fragmented, incompetent and deliberately incomplete system of medical records and death certificates – especially from the poorer rural areas and small towns where there is virtually no support for producing and maintaining quality records. This great data void is multi-faceted and hampered by the problems of regionalism and a lack of clear governmental public health direction.

Early in the crisis, medical professionals and coroners were largely in 'denial' and under pressure to certify '*unexpected'*deaths as '*natural due to pre-existing conditions'* – despite overwhelming evidence that there had been reckless overprescribing by the local medical community. Fifteen to twenty years ago, the victims' families, isolated in their little towns, may have derived some short-term comfort from seeing the term '*natural'* attached to their loved-one's untimely death. Understandably, a diagnosis of '*death by drug overdose'* would evoke tremendous social and personal shame among the rural and small-town white working class families who had traditionally associated narcotics with the urban minority and criminal populations. They thought themselves immune to such 'big city' problem. They trusted 'their' doctors who, in turn, trusted 'Big Pharma's' assurances that the new synthetic opioids were not addicting and could be prescribed in large quantities.

Despite the local medical community's slowly growing awareness of this problem, there was little public attempt to educate the at-risk population and still fewer attempts to rein in the over-prescribing brethren physicians and private 'pain-clinics'. They, or their nurse practitioners and PA's, did not counsel patients on the immense dangers of combining opioids and alcohol or tranquilizers. Many, in fact, were not even aware of what their patients were prescribed by other providers. It is common to see healthy younger adults with multiple prescriptions from multiple providers.

Through the last few decades under neo-liberalism, rural county heath department budgets were stripped because of business-promoted austerity programs. Instead, the federal government mandated that they implement expensive and absurd plans to confront 'bio-terrorism'. Often, health departments lacked the necessary budget to pay for the costly forensic toxicology testing required for documenting drug levels in suspect overdose cases among their own population.

Further compounding this lack of quality data, there was no guidance or coordination from the federal and state government or regional DEA regarding systematic documentation and the development of a usable database for analyzing the widespread consequences of overprescribing legal narcotics. The early crisis received minimal attention from these bodies.

All official eyes were focused on the 'war on drugs' as it was being waged against the poor, urban minority population. The small towns, where over-prescribing doctors formed the pillars of the local churches or country clubs, suffered in silence. The greater public was lulled by media mis-education into thinking that addiction and related deaths were an '*inner city'* problem, one that required the usual racist response of filling up the prisons with young blacks and Hispanics for petty crimes or drug possession.

But within this vacuum, white working class children were starting to dial '911'…because,

‘Mommy won’t wake up…’. Mommy with her ‘prescribed Fentanyl patches’ took just one Xanax too many and devastated an entire family unit. This was the prototype of a raging epidemic. All throughout the country these alarming cases were growing. Some rural counties saw the proportion of addicted infants born to addicted mothers overwhelm their unprepared hospital systems. And the local obituary pages published increasing numbers of young names and faces besides the very elderly –never printing any ‘cause’ for the *untimely* demise of a young adult while devoting paragraphs for a departed octogenarian.

Recent trends demonstrate that drug deaths (both opiate overdose and fatal mixed interactions with other drugs and alcohol) have had a major impact on the composition of the local labor force, families, communities and neighborhoods. This is reflected in the lives of workers, whose personal life and employment has been severely impaired by corporate plant relocations, downsizing, cuts in wages and health benefits. The traditional support systems, which provided aid to workers damaged by these trends, such as trade unions, public social workers and mental health professionals, were either unable or unwilling to intervene before or after the scourge of drug addiction had come into play.

The Dynamic Demography of Drug-Induced Death

Almost all publicized reports ignore the demography and differential class impacts of prescription-related drug deaths. The majority of those killed by illegal drugs were first addicted to legal narcotics prescribed by their providers. Only the overdose deaths of celebrities manage to hit the headlines.

Most of the victims have been low wage, unemployed or under-employed members of the white working class. Their prospects for the future are dismal. Any dream of establishing a healthy family life on one salary in ‘Heartland America’ would be met with laughter. This is a huge national population, which has experienced a steep decline in its living standards because of deindustrialization. The majority of fatal overdose victims are white working age males, but with a large proportion of working class women, often mothers with children. There has been little discussion about the impact of an overdose death of a working age woman on the extended family. They include grandmothers in their 50’s living with three generations under one roof. In this demographic, women often provide critical cohesion and stability for several generations at risk – even if they had been taking ‘Oxy’ for their chronic pain.

Apparently the US minority population has so far escaped this epidemic. Black and Hispanic Americans had already been depressed and economically marginalized for a much longer period – and the lower rate of prescription drug deaths among their populations may reflect greater resilience. It certainly reflects their reduced access to the over-prescribing private-sector medical community – a grim paradox where medical ‘neglect’ might indeed have been ‘benign’.

While there may be few class-based studies looking at comparative trends in ‘overdose deaths’ among urban minorities and rural/small town whites from sociology, public health or minority-studies university departments, anecdotal evidence and personal observation suggest that minority urban populations are more likely to provide assistance to an overdosing neighbor or friend than in the white community where addicts are more likely to be isolated and abandoned by family members ashamed of their ‘weakness’. Even the practice of ‘dumping’ an overdosed friend at the entrance of an emergency department and

walking away has saved many lives. Urban minorities have greater access and familiarity with the chaotic big-city emergency rooms where medical personnel are skilled at recognizing and treating overdose. After decades of civil rights struggles, minorities are possibly more sophisticated in asserting their rights regarding use of such public resources. There may even be a relatively stronger culture of solidarity among the marginalized minorities in rendering assistance or an awareness of the consequences of not taking someone's neighbor to the ER. These urban survival mechanisms have been largely absent in the white rural areas.

Nationwide, US doctors had long been dissuaded from prescribing powerful synthetic opioids to minority patients, even those in significant pain. There are various factors here, but the medical community has not been immune to the stereotype of the Hispanic or black urban addict or dealer. Perhaps, this widespread medical 'racism' in the context of the prescription opioid epidemic has had some paradoxical benefit.

Whatever the reason, urban minority addicts, while experiencing overdose in large numbers are more likely to survive an opiate overdose than small town or rural whites, unfamiliar with narcotics and their effects.

In the rural and small-town (deindustrialized) US heartland there has been an enormous breakdown in community and family solidarity. This has followed the destruction of a century-old stable employment base, especially in the manufacturing, mining and productive agricultural sectors. Only post-Soviet Russia experienced a similar pattern of declining life expectancy from 'poisoning' (alcohol and drugs) following the nationwide destruction of its socialized full employment system and the breakdown of all social services. Furthermore the loss of the tough Soviet police apparatus and the growth of an oligarch-mafia class saw the tremendous in-flooding of heroin from Afghanistan.

The growth of opioid addiction is not based on 'personal choice', nor is it the result of shifts in cultural life styles. While all class and educational levels are included among the victims, the overwhelming majority are younger white working class and the poor. They cover all age groups, including adolescents recovering from sports injuries, as well as the elderly with joint and back pain. The surge of addiction is a result of major shifts in the economy and the social structure. The regions most affected by overdose deaths are those in deep, prolonged and permanent decline, including the former 'rust belt' regions, small manufacturing towns of New England, Upstate New York, Pennsylvania and the rural South and agricultural, mining and forestry regions of the west.

This is the product of private executive decisions to (1) relocate productive US companies overseas or to distant, non-union regions of the country, (2) force once well-paid employees into lower paid jobs, (3) replace American workers with skilled and unskilled foreign immigrants or poorly paid 'temps', (4) eliminate pension and health benefits and (5) introduce new technology – including robots- which cuts the labor force by rendering human workers redundant. These changes in the relationship of capital to labor have created enormous profits for senior executives and investors, while producing a surplus labor force, which puts even greater pressure on young first-time workers and workers with seniority. There have been no effective job protection/ sustainable job creation programs to address the decades of declining well-paid employment. Good jobs have been replaced by minimum wage, service sector 'MacJobs' or temporary poorly paid manufacturing jobs with no benefits or protections. All across this devastated heartland, expensively touted programs, such as 'Start-Up New York', have failed to bring decent jobs while spending hundreds of millions of

public money in free PR for state politicians.

The drug addiction epidemic has been most deadly precisely in those regions of industrial job loss and working wage decline, as well as in the depressed, once protected, agricultural and food processing sectors where union jobs have been replaced by minimum wage immigrants. The loss of stable employment has been accompanied by a slashing of social services and tremendous cuts in benefits – just when such services should have been bolstered.

Precisely because the so-called 'drug problem' is linked to major demographic changes resulting from dynamic capitalist shifts, it has never been the focus of elite-run government and corporate foundation grant research – unlike their fixation on the 'radicalization of Muslims' or 'trends in urban crime'. Research tended to focus on 'minorities' or merely nibbled at the periphery of the current phenomenon. Good studies and data would have provided the rationale and basis for major public programs aimed at protecting the lives of marginalized white workers and reversing the deadly trends. The decade-long, nation-wide absence of research and data into this phenomenon has justified the glaring absence of an effective governmental response. Here the 'neglect' has not been 'benign'.

In parallel with the increase in opioid addiction, there has been an astronomical increase in the prescription of psychotropic drugs and anti-depressants to the same population – also highly profitable to 'Big Pharma'. The pattern of prescribing such powerful, and potentially dangerous, mood altering medications to downwardly mobile Americans to 'treat' or numb normal anxieties and reactions to the deterioration in their material condition has had profound consequences. Such individuals, often on unemployment assistance or MEDICAID, may be expected to follow a complex daily regimen of up to nine medications – besides their narcotic pain medications, while trying to cope with their crumbling world.

Where a dignified job with a decent wage would effectively treat a marginalized worker's despair without unpleasant or dangerous 'side effects', the medical and mental health community has consistently sent their patients to 'Big Pharma'. As a result, post-mortem toxicological analyses often show multiple prescribed psychotropic medications and anti-depressants in addition to narcotics in cases of opioid overdose deaths. While this may constitute an abdication of the medical provider's responsibility to patients, it is also a reflection of the medical community's utter helplessness in the face of systemic social breakdown – as has occurred in the marginalized communities where drug overdose deaths concentrate.

Demographic studies, at best, identify the victims of drug addiction. But their choice to treat their despair as an 'individual problem' occurring in a 'specific, immediate context' overlooks the greater political and economic structures, which set the stage for premature death.

The Political Economy of Overdose Deaths

When the remains of a young working class overdose victim is wheeled into a morgue, his or her untimely demise is labelled a 'self-inflicted' or 'accidental' opioid overdose and a great cover-up machine is turned on: The sequence leading up to the death is shrouded in mystery, no deeper understanding of the socio-cultural and economic factors are sought. Instead, the victim or his/her culture is blamed for the end-result of a complex c**hain of elite capitalist economic decisions and political maneuverings in which a worker's**

premature death is a mere collateral event. The medical community has merely functioned as the transmission belt in this process, rather than as an agent for serving the public.

The vast majority of overdose fatalities are, in reality, victims of decisions and losses far beyond their control. Their addictions have shortened their lives as well as clouded their understanding of events and undermined their capacity to engage in class struggle to reverse this trend. It has been a perfect solution to the predictable demographic problems of brutal neoliberalism in America.

Wall Street and Washington designed the macro-economy that has eliminated decent jobs, cut wages and slashed benefits. As a result millions of marginalized workers and the unemployed are under tremendous tension and resort to pharmacologic solutions to endure their pain because they are not organized. The historical leading role of trade union and community organizations has been eliminated. Instead, redundant workers are 'charged by Big Pharma' to dig their own graves and class leaders are nowhere to be found.

Secondly, the workplace has become much more dangerous under the 'new economic order'. Bosses no longer fear unions and safety regulations: many workers are injured by the accelerating pace of work, longer hours, faulty job training and lack of federal supervision of working conditions. Injured workers, lacking any judicial, trade union, or public agency protection rightly fear retaliation for reporting their work injury and increasingly resort to prescription narcotics to cope with acute and chronic pain while continuing to work.

When employers allow workers to report their injuries, the low coverage and limited treatments available, encourage providers to over-prescribe narcotics on top of other medications with potentially dangerous interactions. Many pain clinics, contracted by employers, are eager to profit from injured clients while pharmaceutical companies actively promote powerful synthetic narcotics.

A vicious chain is formed: The pharmaceutical industry's mass production of narcotics has been among its most profitable products. Corporate pharmacy chains fill the prescriptions written by tens of thousands of 'providers' (doctors, dentists, nurses and physician assistants) who have only a limited amount of time to actually examine an injured worker. The deteriorating work conditions create the injury and the workers become consumers of Big Pharma's miracle relief – Oxycontin or its cousins – which a decade of drug salesmen had touted as 'non-addicting'. A long line of highly educated professionals, including doctors and other providers, pathologists, medical examiners and coroners carefully paper over the real cause, the corporate decision makers, in order to protect themselves from corporate reprisals should they 'blow the whistle'. Behind the scientific façade there is a Social Darwinism that few are willing to confront.

Only recently, in the face of incredible numbers of hospitalizations and deaths from narcotic overdose, the federal government has started to release funds for research. Academic-medical researchers have started to collect and publicize data on the growing epidemic of opiate deaths; they provide shocking maps of the most affected counties and regions. They join the chorus in urging the federal and state agencies to become more actively involved in usual panacea: 'education and prevention'. This beehive of activity has come two decades too late into the epidemic and reeks of cynicism.

Funding for research into this phenomenon will not result in any effective long-term programs for confronting these small community-based 'crises of capitalism'. There is no institution willing to confront the basic cause: the devastation of capitalist– labor relations in post-millennial America, the corrupt nature of state-corporate-pharmaceutical linkages and the chaotic, profit-driven character of our private medical system. Very few writers ever explore how a national, public, single-payer, health system would have clearly prevented with epidemic from the beginning.

Conclusion

Why does the capitalist-state and pharmaceutical elite sustain a socio-economic process, which has led to the large-scale, long-term death of workers and their family members in rural and small town America?

One ready and convincing hypothesis is that the modern dynamic corporate elite profits from the results of 'demographic change by overdose.'

Corporations gain billions of dollars in profits from the 'natural decline' of redundant workers: slashing social services and job benefits, such as health plans, pension, vacation, job training programs, allowing employers to increase their profits, capital gains, executive bonuses and raises. Public services are eliminated, taxes are reduced and workers, when needed, can be imported – fully formed – from abroad for temporary employment in a 'free labor market'.

Capitalists profit even more from the technology gains – robots, computerization, etc. – by ensuring that workers do notenjoy reduced hours or increased vacations resulting from their increased productivity. Why share the results of productivity gains with the workers, when the workers can just be eliminated? Dissatisfied workers can turn inward or 'pop a pill', but never organize to retake control of their lives and future.

Election experts and political pundits can claim that white American workers reject the major establishment parties because they are 'angry' and 'racist'. These are the workers who now turn to a 'Donald Trump'. But a deeper analysis would reveal their rational rejection of political leaders who have refused to condemn capitalist exploitation and confront the epidemic of death by overdose.

There is a class basis for this veritable genocide by narcotics raging among white workers and the unemployed in the small towns and rural areas of American: it is the 'perfect' corporate solution to a surplus labor force. It is time for American workers and their leaders to wake up to this cruel fact and resist this one-sided class war or continue to mourn more untimely deaths in their own drug-numbed silence.

And it is time for the medical community to demand a 'patient-first' publicly accountable national health system that rewards service over profit, and responsibility over silent complicity.

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