The Stigmatization of Substance Use in U.S. Healthcare

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Introduction

DRUGS. The word evokes a broad array of mental images: pills, syringes, controlled substances, abuse, treatment, professionals, science, and crime. It is almost impossible for people living in the United States to go their whole lives without consuming human-created or extracted chemical substances, whether in caffeinated or alcoholic beverages, medications or unofficial substances. Many stereotypes, stigmas, and connotations persist around these substances, their method of use, and those affiliated with their creation, distribution, and use. There is no doubt the U.S. government's War on Drugs, societal norms, and our education system have directed our understanding and perception around substance use and its effects. This extends to providers and patients in our healthcare system which both deal with prevalent official and unofficial substance use. Healthcare providers have to compile a host of information to institute a treatment plan for their specific patient. However, their treatment plan may be tainted from accrued stigmas about their patients' lifestyles, lived experiences, features or demeanors. Although all these factors can provide a wealth of knowledge to the provider, they do not always need to impact the treatment. This uncertainty of motivation and its effects around diagnoses and treatment is where our problem starts. It is the goal of this paper to explore the ways the stigmas associated with substance use pervade the United States Healthcare system and to complicate the current perspective of the treatment and diagnoses of these related conditions.

I would like to preface that this issue of stigmatized substance use is very complex. How we define substance use, abuse, substances, and treatments of those conditions is not always straight forward. When reading about an issue like this, it can feel overwhelming and never-ending, however those who are affected by this stigmatization in healthcare likely feel this very real pain magnified in their lives. With our one life to live and our host of questions, concerns

and problems, everyone needs to have the ability to be transparent and honest with their physician or, sadly, risk having their extraordinary life cut short. Yet, there is not one solution, one complete guide, nor one person to end this problem or even entirely define it. It is a what we call a 'wicked problem'.

This seemingly impossible obstacle to human dignity and respect, our wicked problem, is defined by the difficulty of describing the problem with no obvious solution, a symptom of other problems, and it being a unique problem (Lavery, 2018). This wicked social and cultural problem of substance stigmatization is difficult to solve due to an incomplete knowledge, the sheer number of people and information, its burden, and the interconnectedness of it with other problems (Kolko, 2012). Stepping back to the uncertainty of healthcare providers' motivations and their effects, we really cannot get an accurate measure of provider sentiment toward substance use, nor dissect if a treatment was due to training or discrimination; many times, the treatment from both can be the same or similar. Opioid agonist therapy, sometimes called opioid replacement therapy, is a prime example of the wickedness of substance use stigma in healthcare. Doctors will frequently prescribe methadone or a related substance to treat the dependence of those who use opioids. However, there are other treatment options, and there are many advantages and disadvantages to these treatments. Did the doctor prescribe this, because they believed the patient would just transfer their addiction, or did they choose it over another treatment, because it is proven to work? We will probably never know in this instance. Nonetheless, there is still hope that a meaningful impact can be made for this problem.

This systematic review of literature and subsequent analysis further aims to fill the gaps in our knowledge of the complexities of our healthcare system and its intersection with substance use. This accessible knowledge can then be used to start chipping away at this wicked problem

and the other inherent related problems. It is by no means a solution, but a step in the right direction for people to acknowledge and engage with this matter. Through familiarizing more people, this story of human relationships, mistrust and marginalization can start being recognized and deliberated. I would like to think a solution to this problem would be human understanding and acceptance, but I recognize this is an unattainable answer. Nevertheless, why not get as close as possible? To begin confronting our wicked problem, I emphasized both sides of the patient-provider relationship. The patient can enter the health setting with a host of worries and perceived injustices, while the provider can perform discriminatory actions, hold complex prejudices, and even use substances at higher rates. Even more, both patients and providers have a limited knowledge and time for their interplay which can exacerbate the effects of the relationship. To add yet another factor, comorbidities are an additional complexity which does not simply add to the stigmatization of substance use but compounds the marginalization that patients feel, and providers can perpetuate. Notably, the language around substance use is extremely important and can begin to mitigate some of the effects of a negative patient-provider relationship. These different aspects of substance use stigmatization emphasize the intersectionality constantly at play when patients have to decide to receive care, adhere to treatment, interact with physicians, and fund their health.

Literature Review

The United States' Healthcare System is a multitrillion dollar economy taking up 17.1 percent of the GDP in 2017. Every year this spending rises with hospital care, professional services, and prescription drugs being in the top four expenditure categories (Nunn et al., 2020). For those with the poorest health and/or the medically underserved, these expenditures are high and variable due to lack of insurance and a host of other reasons (Nunn et al., 2020). The U.S.

system directly, if not indirectly, impacts nearly every American's life. Ironically, U.S. healthcare was designed to primarily fight acute and infectious diseases in its early era of inception with this mindset still permeating as we fight the global pandemic on home turf. However, our neglected system needs a shift from primarily treating emergency and acute conditions to chronic long-term disease. There is a need for half of the nation's population, the 157 million Americans dealing with a chronic disease, to receive highly specialized care as frequently as daily in order to live healthy lives (*The U.S Healthcare System Is at a Crossroads*, 2019). This presents quite a demand for our health professionals and system which deal with some of the most complex factors of any institution, such as economic repercussions, social stigmas, educational inadequacies, and public health crisis.

One of these chronic conditions, which is the most stigmatized and misunderstood by the general population and medical professionals, is substance use disorders (SUD). These disorders include substance use and subsequently dependence which cause significant impairment and failure to meet major responsibilities (*Trends in Substance Use Disorders Among Adults Aged 18 or Older*, 2017). In the health system's treatment and prevention of SUD, it has typically been separated from general health care services and other mental health services with SUD being viewed as a social or criminal problem. Even worse, there is limited access to treatment due to the affordability of the already disparate treatment options, and the healthcare system's belief that prevention is not their job (Administration (US) & General (US), 2016). Worse, these effects of substances and treatments on people can be exaggerated in a physician's diagnoses and lead to harmful social and political effects. This can make one wonder, where is the line between abuse, use, treatment, and enjoyment? There are official uses of substances in healthcare and unofficial uses in society. These limits are not clearly defined and can be heavily individualistic, depending

on gender, race, ethnicity, culture, tolerance, weight and height. Especially in the current environment of legalization and decriminalization for the recreational use of cannabis among other substances, exaggerations of drug use from draconian and antiquated drug policies and norms can have broad effects for minorities and other marginalized populations.

Dr. Carl Hart argues addiction represents a minority of drug effects even for those who use the most stigmatizing of drugs, such as methamphetamine or heroine. However, he points out drugs can cause distress and problems, but these effects are not consistent with the current portrayal by the justice system, healthcare system, or society. Researchers, who create the knowledge health professionals base their diagnoses from, can consistently exaggerate the harmful effects of drugs (Hart, 2020). These exaggerated effects in turn can be used to create discrimination, prejudice, and harmful stigmas which have broad implications. If the effects are exaggerated, are the conditions and diagnoses for something like SUD also distorted? For example, cannabis and psychosis have been linked many times by researchers assuming cannabis increases risk of psychosis. Instead, cannabis should be considered as an indicator for individuals who have an increased risk of psychosis (Ksir & Hart, 2016). The same may be true for SUD and mental health. Instead of blaming substances and their magnified effects, we may need to look deeper into mental health, genetics, emblematic treatments, and each person's complex lived experiences. Where we aim our criticism of substance use, at the person using the substance, may be misguided and not always true of the diagnoses or conclusion by the provider and society.

A huge part of our misguided criticism comes from the current view of substance use. Type in drug use on an internet search, and you will immediately be bombarded with terms like "addiction", "drug abuse", and "illegal drugs". It is almost already concluded that when someone

in the U.S. uses cocaine, amphetamines, opiates or even occasionally cannabis that these people are addicted criminals and are abusing these drugs (Yang et al., 2017). When comparing these substances to alcohol which has become heavily normalized especially in media (Cin et al., 2008), it seems to be a socially attributed difference, not one based on chemistry nor effects (Breijyeh et al., 2021; Palmer et al., 2019). Someone is said to have “misused” opioids if they take the medication for the effect it causes or to get high (Abuse, 2020). Do people not typically drink to feel a buzz or smoke cannabis to feel a high? I am not pointing this out, because I think opiates are not dangerous. I believe quite the contrary, but I also believe alcohol to be a very dangerous and an addictive substance as well. I am merely pointing out the discrepancies in perception which have broad impacts across our society.

The most worrying impact of these perceptions of substances is on marginalized communities. Health professionals and researchers are not immune to these broad societal perceptions of substance use; their treatment of marginalized patients can have a compounded effect, if these patients use substances even close to the same rate as the whole nation. When individuals report having co-occurring mental illness with substance dependence and other chronic medical conditions, the increasing number of conditions is generally associated with poverty and, of course, poorer health (Walker & Druss, 2017). Walker and Druss suggested broadening our view of illness and its complexities to address disadvantage and other social determinants of health. It is hard to deal with substance use, if wellness, housing, employment, and other social determinants are not first acknowledged and mended. It increasingly seems that when an individual experiences poverty and chronic medical conditions, SUD can be tacked on by medical professionals. These individuals’ lives are problematic, and they are not being remedied by society, the government, nor the health care system. Poverty and illness are

reciprocally related creating an immeasurable amount of stress and difficulty in an individual's life. SUD, in general, seems to be more of a symptom of injustice and an irresponsive nation, instead of a chronic medical condition which is solely to blame. It should be noted when race and socioeconomic status (SES) are taken into account, higher SES is linked with earlier substance use, however this higher SES seems to play a protective role for the use of drugs being labeled or diagnoses as a SUD. Minority status, experiences of racism/discrimination, and lower SES are contributors to stress and heavier and more frequent use of substances later on in life (Lewis et al., 2018). With all of this taken together, marginalized groups do not seem to use earlier than those who are Caucasian and have a higher SES. However, these marginalizing contributing factors do seem to increase the likelihood of a diagnoses of SUD and indicative of a limit of resources to treat this diagnosis. This data presents clearly that marginalization impacts treatment and diagnoses.

The language behind drugs, drug use and SUD in healthcare needs to be closely examined if we are to explore the impact of SUD diagnoses, drug use history, and the type of drugs used in the treatment of people from marginalized communities and backgrounds. Cultural competency has been an increasing theme in health care to minimize stigmas and inherent discrimination. This approach of cultural competency needs to be taken when approaching people who use drugs as well. Words such as abuser, addict, drug user can alienate the patient who may already be untrusting of an unrepresentative and inaccessible health care system (Wakeman, 2013). The Global Commission on Drug Policy stated language such as this can present people who use drugs as physically inferior or morally flawed ((“Avoid Saying ‘drug User’ to Combat Stigma, Report Urges,” 2018). In Poverty and Human Capability Studies at Washington and Lee University, we emphasize person-first language, such as people who use

drugs or people who use substances, for this very reason. The intentionality of language is very important and can make a huge difference for the person who is the speaker or the spectator in a patient-provider interaction. Despite the importance of language, there seems to be a lack of research in the area of language to describe people with non-problematic substance use. If drugs are detected or suspected, treatment options can change, and stigmas can start to creep into the medical care of the patient. One of the quintessential examples of substance use impacting treatment is organ transplant. Up until 2015, people in California could be denied a lifesaving organ simply due to testing positive for cannabis or using cannabis. However, there is much less research on cannabis and other substances' impacts on transplanted organs compared to alcohol (Majumder & Sarkar, 2020). Behind closed doors where health workers deliberate these important policies and treatments, they must ensure they are using appropriate and caring terminology. Conscious language can be one small step to confronting their prejudices and ultimately better relating to their patients.

There are clear ethical challenges with and reasons we should be researching healthcare-related stigmas. Patients who experience stigma are often hard to recruit, have greater risk of harms, and the research could further marginalize them or their community (Millum et al., 2019). However, due to their "socially deviant" or "undesirable" characteristics, these patients are at greater risk of stigmatization and discrimination. The patients who are most stigmatized are the hardest to study further marginalizing them. To attempt to impede this cycle of marginalization, we need to fill the gaps in our knowledge and mend the respect this population deserves. When researching a topic like this, it is important for the author and then the reader to first confront their own prejudices towards groups like these and seek to understand their neighbors, family, friends, and fellow humans.

Methodology

To explore the stigmatization of substances in healthcare and its subsequent impact on marginalized communities, I used a comprehensive review of the current literature on this subject. I performed a similar systematic review as van Boekel et. al used in 2013 which explored the attitudes of health professionals toward substance use in the first decade of the 21st century (van Boekel et al., 2013). This is the best approach to use as there are many articles and research on this topic, and many conclusions can be missed when trying to read and analyze such a vast amount of material. Much information needed to be pulled from each piece of literature, and this approach allowed the categorization and documentation of each study or analysis. Compared to van Boekel et al, I took a much broader approach as my question does not simply ask, "Is there stigmatization?', but also recognized the intersectionality of each of the problems with one another. This is a very complex issue, and I believed more articles than van Boekel's final 28 literary sources were needed.

The database PubMed was primarily used to find articles related to this topic. Google scholar was used to supplement this search when it was deemed PubMed may be inadequate (I have noted these very few articles). PubMed was chosen as the primary database for this comprehensive review as it has more than 30 million citations and abstracts of biomedical literature (National Center for Biotechnology Information, n.d.). If the full article could not be found on PubMed but was still displayed, I requested access to the article through my university's library at library.wlu.edu. PubMed is a free resource and is used across all areas of biomedical reviews and research. Using this resource made it both accessible and vast in the literature available across various complex topics and areas of science. Literature from the past ten years was used from 2011 through 2021. The past decade was used due to the massive size of

our healthcare system and the broad implications and effects which are still felt by people who were treated by this system. However, in order to get an accurate view of the current system's attitudes, policies, and effects only the past ten years were used. Further, only articles on the United States' Healthcare System were used, because this is the scope of my research.

To assemble the initial selection of articles, defined phrases and search words were used. The rationale and organization of the 8 searches are displayed in the Appendix at the end. "AND" and "OR" were used to separate the search term combinations. Parenthesis were used for words like "mental health" so not just results for "health" would be displayed. Literature was excluded if it did not pertain to substance use, health professionals, stigma or attitudes present in patient-provider interactions. It was also excluded if the whole article could not be found, if it did not relate to the research question, or presented data or results from other countries. At least 50 literary articles in science were my aim to obtain in the final selection of articles, almost twice that of van Boekel's systematic review.

To distill the data from each of the remaining articles, the main results or conclusions were summarized and written with the most concise language which would still allow the complexities to shine. For the results, population studied, and other measurements, these were noted next to the conclusions and title of the article. How each study and research was related to the research question of this paper was noted. Emphasis was placed on surveys and statistics on diagnosis and treatment of SUD or substance use, since these were prominent in my research of the background of this study and allowed conclusions to easily be drawn by the reviewer. If any studies repeated the same conclusions or relation to this research question, they were grouped together. This is why I ended up siting close to 35 articles and not the full 52 articles I ended up reviewing. Many of the articles had similar conclusions, and for the depth of my research, some

articles could present generalized conclusions of a few research papers at one time. A side note, each of the highlighted information and data taken from each source was viewed through the lens of reflexivity with an emphasis on human dignity and respect.

Even with the many strengths of a systematic review, there are many limitations and biases which are still present. If the search terms and the associated phrases which are built from them are not dynamic enough, a potentially huge portion of pertinent research could be missed by the searches. The surveys and statistics on diagnoses and treatments can really limit the human factor of emotions and judgements which are present in the patient-provider interaction. This needs to have special attention, since diagnoses, treatment and their effects are built on this interaction. I also risk the simplification of conclusions and ignoring complexities if I am too concise with the wording of each conclusion drawn from each source. Potential biases which may be present are those around reporting substance use, health professional attitudes, and oversimplification of trends. Many people do not report their use, and I risk drawing incorrect conclusions from this bias which could be present across many sources. This same non-reporting could occur by health professionals where they attempt to take the moral high ground and minimize their role in the perpetuation of marginalizing their patients. Finally, if I oversimplify each conclusion and then draw a conclusion from this collection, I risked drawing an overly simple determination which is actually wildly incorrect. With this acknowledgement, I hope to be able to draw a more complex yet accurate depiction of the stigmatization of marginalized communities and their associated substance use in the U.S. Healthcare system.

Analysis

Of the 252 articles, I will be drawing conclusions from 52 of the most relevant articles obtained through this systematic review of the stigmatization of substances in the United States'

Healthcare System from work published since 2011. The general findings of these searches emphasize the intersectionality of substance stigmatization, especially its impact on marginalized populations. A large portion of the research focused on HIV, hepatitis C virus (HCV), the LGBTQ+ community, addiction, mental health, military veterans, opioid maintenance therapy (OMT), women, stress, cultural differences, low socioeconomic status, injection drug use (IDU), rural populations, substance use disorders, minorities, and justice-involved individuals. Throughout the literature, there is constant attention on the complex interrelatedness of these topics; something a whole book could barely scratch at discussing entirely. Each of these factors can increase a patient's difficulty receiving medical care, if they happen to use an official or unofficial substance. Comorbid diseases, an increasing number of marginalizing indicators, or an increasing number of substances can add to the stigmatization the patient feels and lead to subpar diagnoses, treatment, and adherence from medical professionals, the patient, and the general public. Sadly, the language used to refer to substances was not explicitly discussed in length; however, each author went to great efforts to refer to each population being studied and described their conclusions in the most humanizing and dignifying way. Throughout my reading, I began to learn better phrases which seek to understand and elevate those who are most marginalized. Terms like justice-involved individuals, to refer to those in our correctional system, and opioid agonist therapy, instead of opioid substitution or replacement therapy, calls attention to how we usually discuss substance use and the populations who use these substances. At the end of my research, I conclude, with all these interrelated factors and holes in research, it's one big mess that sadly we are not close to fixing yet. However, scratching the surface is what must be done.

Language, attitudes, implicit bias, and stigmas can be very problematic in the patient-provider interactions and relationship. These factors can create mistrust between the patient and provider and cause negative experiences which build up and lead to further marginalization. In one study with women who were seeking substance use treatment, they cited the stigma behind addiction, judgmental providers, and feelings of being labeled by these providers from prior experiences as leading to a general distrust for the health care system (Cockroft et al., 2019). From the provider perspective, women veterans seeking treatment had barriers of stigma, shame, discomfort, and mental health concerns in their interactions with providers which affected the patients' openness and disclosure of substance use (Abraham et al., 2017). From these perceived or explicit labels and stigmas associated with substance use, such as the term addict or the idea they are unclean, there is the potential for these ideas to influence medical care and perceptions of substance use disorders (Ashford et al., 2019). Besides the effect on diagnoses and treatment, adherence to the treatment by the patient might be affected by these interactions with healthcare providers, the healthcare system, or even the patient's culture; this poor adherence can become a potential contributor to increased disparities in health outcomes, as well (McQuaid & Landier, 2018). Yet another factor which chips away at this relationship is the manner in which people consume substances. People who inject drugs (PWID) have to constantly battle stigmas in healthcare settings. They have common experiences of dehumanization through discrimination or unfair treatment by providers. This leads to them delaying their visits to medical care, not disclosing use, downplaying their condition, or seeking care elsewhere (Biancarelli et al., 2019). Even though these very experiences may be real or purely perceived, medical professionals are constantly battling fear of addiction and detrimental outcomes of their treatment in those patients who use substances. Each treatment carries, especially in the case of treating HCV, potential

risks which further reinforce stigmatization of substance use and can have broad implications in public health (Jordan & Perlman, 2017). Any attempt at simplifying these vast challenges and effects of this patient-provider relationship is at risk of ignoring marginalization and unfortunately perpetuating the injustice people who use substances can face.

Providers just like patients are not immune from substances impacting their lives. Medical students, physicians in training, and those practicing are all at increased risk of substance use and present severe roadblocks to care, including stigma (Martinez, n.d.). There are certainly different attitudes for a provider when they use substances compared to the providers who do not. However, there is not much research which discussed this matter from my searches. Subsequently, I had to augment this review with data from outside the search. About 10 to 15 percent of all doctors have substance use disorder at some point in their career with rates of addiction highest for psychiatry, emergency medicine and anesthesiology (Kaliszewski et al., n.d.). Those specialties which deal most with substance use are most impacted by the substances. How can health providers who diagnose mental health conditions, who are critical decision-makers in a crisis or specialize in drug interactions and effects, give unprejudiced care for someone who uses substances, when they themselves use substances? We really do not know. Could these professions give better care or more understanding care due to identifying with their patients? We may never truly know the extent of this prejudice or health care providers' dependencies on substances. Further, health care providers understand the signs of use and how they present; this unique knowledge can get in the way of us delineating prejudice due to training and prejudice due to their individual experience with substances. These gatekeepers of medicine police the moral boundaries of medicine and either exclude or include patients in treatment (Buchbinder, 2017). What is to stop them from self-treating or coping without ever reporting and

still impact their treatment of patients? To better understand the patient-provider interaction, we must first better understand the provider and target the gap in our knowledge of their experiences with substances.

Besides the provider aspect of the relationship, patients can have many barriers to obtaining treatment which stem from their substance use. The criminality of substance use, discriminate treatment, perceived discrimination, co-morbidity, and non-adherence to treatment all accompany the marginalization people feel from both substance use and other factors like race, gender-identity, and socioeconomic status. PWID commonly experience dehumanization in healthcare settings and develop strategies to avoid either visiting health care or disclosing their use; this is compounded in large healthcare institutions (Biancarelli et al., 2019). This in turn affects adherence to treatment and provides yet another factor for those who are marginalized to worry about. Many of these problems stem from visible issues like signs of substance use or difference in skin color or appearance, however the criminality of substance use and co-morbidities are not typically easy to process or see. When the justice system is involved in medicine, this can present unique challenges for the patient and even the provider. One study done on women who use substances and experience incarceration found there to be a significant positive association between hardship, homelessness, feeling unsafe, and stressed. Jail frequency and mental health problems like substance use were also associated (Lambdin et al., 2018). Besides these associations of hardship, substance use treatment can be poorly understood in courts, and they often can issue treatments which further stigmatize the patient like methadone maintenance therapy: sometimes seen as a replacement of the addiction (Csete & Catania, 2013). Having these conclusions included in the search results gives hope that healthcare and researchers are focusing on the complexities of their interaction with the justice system and its

impact on their patients. However, this presents very real barriers that providers need to take into account when treating. State-mandated treatment and the stigma of that treatment can cause increased stress and worry for those who are involved in the justice system further decreasing health.

Substance use disorder does not occur in a vacuum, and many diseases and diagnoses can accompany substance use making treatment difficult. Other mental health disorders, HCV, HIV, and other substances often co-occur with substance use disorders further stigmatizing the afflicted person. Besides general mistrust, patients can view healthcare providers as judgmental and unresponsive of their condition due to these diagnoses, and they can view the treatment and its side effects as worse than the disease itself. The presence of needles and other substances can be obstacles for those who previously used or injected substances (Zeremski et al., 2013). Cost of health care and general ignorance on these conditions combined with a transmission vector, like needles, or risky behavior, like unprotected sex, can further exacerbate social stigmatization of substance users. Although the interaction of a viral and/or chronic disease with substance use may have very real implications for treatment, combining these stigmas may result in even worse treatment.

With complicated treatment comes a need for time and increased knowledge. Many times, both physicians and patients lack the time and knowledge for a productive relationship which seeks to remedy marginalization. Physicians themselves even cite a lack of time as a barrier of them seeking support for their own problems associated with substance use (Hu et al., 2012). In this same study, uncertainty of whom to see and difficulty accessing services for the majority of physician respondents further prevented providers from seeking care. This reminds us of the emotions and perceptions patients have of providers. Patients who have co-morbid

diseases and use substances cite providers as judgmental, unresponsive, and disdainful (Zeremski et al., 2013), but these experiences may not even be about providers who are necessarily these characteristics. Physicians barely have time to seek care for themselves and the knowledge to act on their own troubles. What makes us think they have the time and knowledge to diagnose a complex disorder in a marginalized patient population without special training? This adds yet another intricacy in our discussion of stigmatized substance use. There is an aspect of care that may not be prejudice in nature, like time and knowledge, but presents in the patient-provider interaction as prejudice.

Even though it can be disorienting, it is important to highlight the intersectionality of all these stigmatizing and marginalizing factors which serve to reduce our health care of those who use substances. For example, lack of time and knowledge is not independent of a general patient distrust for providers. Less experience and interest in physicians can result from a population which has less enthusiasm to use the healthcare system and its resources. It would be impossible to highlight every interaction and measure the compounding of each variable with one another, however examples like lack of time/knowledge and patient distrust or physician substance use and quality of patient interaction serve to expose the types of relationships that each of these marginalizing factors has with one another and the associated stigma within the healthcare system. Unfortunately, many of the articles in the eight searches did not feature these relationships, and more needs to be done in the future to dissect these complexities.

Conclusion

The one defining aspect, which is not discussed in this research, maybe because it is implied, is the shear wickedness of this issue and the challenges of studying stigmatized substance use. All of these articles are looking to contribute something substantial to science;

saying a problem is complex, hard to solve, and generally just evil will not get one published in the top journals. However, it should at least be mentioned. Substance use should have an impact on a healthcare provider's diagnoses and treatment but only in terms of substance interactions and for patient history purposes. It is illegitimate to allow prejudice to shape a treatment of someone who uses substances. However, we cross into murky territory, or the wickedness of the problem, when the treatment influenced by prejudice and treatment determined by evidence are the same thing. How can we pull these apart? The same inseparability is present with stigma and marginalization. Healthcare treats every patient regardless of color, wealth, and status; however, they cannot mend the preconceived notions patients have before their subsequent interaction nor the permanent damage from experiencing poverty. It can be hard for the providers to acknowledge their own prejudices, as well. Regardless, the patient's experience of marginalization may or may not intersect with the stigma present in healthcare. This messy and sometimes impossible distinction makes my subject, the implications of substance use stigma in healthcare, that much harder.

Substances present very real problems for people who use them chronically and evenly acutely. It is the healthcare provider's job to distinguish these problems and build a relationship with their patient. From this relationship and understanding, providers can attempt to transcend the worries and bias which their patients bring with them while also trying to confront their own stigmas and discriminatory behavior. When their patients' marginalization couples with substance use and health services, providers and patients have to work together to start combating the entrenched societal attitudes. This is not a "one plus one equals two" scenario. Combining marginalization like homelessness or minority status with substance use, itself marginalizing, leads to increased stress, furthered substance use, perceived discrimination,

comorbid diseases, expenses and non-adherence to vital treatments. These effects seem to be an interaction of these complex factors like race, housing status, and preferred substance, not a simple integration of these factors.

This research may not be surprising to some. Healthcare providers and patients are of course people, and every person seems to have, to at least some degree, innate stigmas toward people that do not think like them, act like them or look like them. However, I could not stop myself from thinking, throughout this whole process of research compilation and drafting, "This should not be an issue". Substance use often surpasses race, ethnicity, socioeconomic status and cultural differences, so everyone is feeling these painful effects of substance use stigmatization when they visit their doctor, right? The answer to this is complicated, of course. The ugly truth which confronts healthcare providers is the intersectionality of these issues. When a wealthier or member of the majority uses substance, there seems to be a protective effect on the stigmatization of their substance use. There are these complex relationships at every turn and at every factor. For example, how will we ever separate prejudice from treatment? This does not make substance use in healthcare a lost cause. It should motivate us to do more and do better for those who are most impacted and marginalized by its effects.

This wicked problem of healthcare's treatment of substance use will not ever be entirely solved, just like we will never live in a utopia. However, this should galvanize our commitment to increasing human dignity and respect. We see there are distinct areas where we can improve. Do we know what impact this information will have on this exact topic, no, but we can certainly improve the lives of each patient, healthcare provider, and those they impact, one at a time. I want this paper to serve, more than anything, as a call to action. It is for everyone in the United States; we are all affected by the complexities of healthcare, human suffering, and substance use.

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Appendix

This index displays the 8 searches and method of systematically partitioning these articles into our final repertoire for analysis. From the 252 articles of the 8 searches, articles which were out of scope of the U.S. or substance use were excluded as well as duplicates. This left 185 articles which were reviewed by reading abstracts and results. Those which were not relevant to the research question were excluded. This left 52 articles for to me fully analyzed with their conclusions and contributions recorded.

Lists were initially generated on 02/26/21 and 02/27/21

20-50 results per search

Total Articles from 8 searches: 252

Total Articles after exclusion of those out of scope: 191

Total Research Articles after exclusion of duplicates: 185

Final Selection (with relevant results/conclusions): 54

SEARCH 1

This combination was used in order to compile the articles which dealt with the stigma of mental health and substance use pertaining to healthcare professionals.

stigma AND "mental health" AND healthcare professionals AND substance use AND United States from 2011-2021

28 results

Exclude 6 for out of scope (i.e. not US centered)

22 Total Results

11 Final Relevant Results

SEARCH 2

This search was used to find the articles which focused on how healthcare professionals discriminate against substance use or can cause structures of discrimination.

discrimination AND substance use AND healthcare professionals AND United States from 2011-2021

38 Results

Exclude 11 for out of scope or non-substance use

27 Results Total

10 Final Relevant Results

SEARCH 3

The mina focus of this search was the patient-provider relationship in the healthcare system of the United States.

drug use AND patient-provider interaction AND attitudes AND United States from 2011 to 2021

25 results

Exclude 8 for out of scope

Exclude 1 for PDE5 inhibitors

16 Results Total

3 Final Relevant Results

SEARCH 4

I included this search in order to capture the effects of substance use on marginalized communities.

United States AND drug use AND substance use disorder AND marginalization AND health care from 2011 to 2021

45 Results

Exclude 1 HIV treatment

Exclude 15 for out of scope of US

29 Results Total

9 Final Relevant Results

SEARCH 5

Using the three most commonly used substances, besides caffeine, I wanted to identify the impact of the substance on the delivery of healthcare.

United States AND healthcare delivery AND cannabis, opioids, alcohol from 2011 to 2021

20 Results

None excluded

20 Results Total

7 Final Relevant Results

SEARCH 6

I used the next two most commonly used substances which are sometimes paired together in order to see if they impacted healthcare delivery.

United States AND healthcare delivery AND amphetamine cocaine from 2011 to 2021

40 Results

5 out of scope of US and substance use

35 Results Total

8 Final Relevant Results

SEARCH 7

Perceived discrimination was a constant observation in my review of literature before the analysis, so I wanted to make sure to include this topic in at least one search.

United States and drug use and perceived discrimination, discrimination, prejudice, stigma from 2011 to 2021

14 Results

Excluded 5 out of scope

9 Results Total

1 Final Relevant Results

SEARCH 8

Motivation and satisfaction can be very impactful for the healthcare provider and patient and lead to many accrued experiences which can be negative. I wanted to present this aspect in at least one of my searches.

United States AND substance use AND attitudes, motivation, satisfaction, treatment from 2011 to 2021

42 results

10 Excluded for out of scope or teaching material

32 Results Total

5 Final Relevant Results