Thank you Chairman Burke, Vice Chair Huffman, Ranking Member Antonio and members of the Ohio Senate Health, Human Services, and Medicaid Committee. My name is Madeline Watson and I am writing to testify in support of Senate Concurrent Resolution 14 (SCR14) declaring that racism is a public health crisis.

I am a medical student at The Ohio State University College of Medicine, and I would like to discuss the experiences thus far in my medical education that have made me acutely aware of racial biases and their impacts on clinical practice and patients' outcomes. Racial bias in healthcare is unfortunately so widespread that it is difficult to focus on a single example or issue to discuss. However, I am writing today to discuss the effects of racial bias on the clinical approach to opioid use disorder. As an addiction researcher, I would like to inform the committee of the racial disparities regarding this issue.

As a native of Dayton, Ohio, I have witnessed the devastating effects of the opioid epidemic on our communities firsthand. Opioid addiction is clearly a public health crisis, and it is impossible to live in America today without hearing horrific stories of opioid deaths, overwhelmed foster care systems, and emergency services that lack sufficient resources to respond to countless overdose calls. However, what many Ohioans do not know about the opioid epidemic is that there are racial biases underlying the clinical approach to the treatment and rehabilitation of patients with opioid use disorder. Currently, there are two well-known treatments for opioid addiction or dependence: buprenorphine and methadone. Buprenorphine was developed more recently in response to the surge in opioid deaths, and it functions similarly to the older drug, methadone, to treat opioid addiction. However, buprenorphine is widely believed to be the preferable option because it has a lower probability of overdose and misuse than methadone. Additionally, buprenorphine can be prescribed by a physician and taken at home while methadone generally must be administered in regulated clinics. Though buprenorphine has been widely established as the gold-standard, black patients are less likely to receive this evidence-based treatment. 91% of patients receiving buprenorphine are white, while patients still receiving methadone are much more likely to be non-white [1].

Racial bias surrounding opioid addiction is not limited to treatment and rehabilitation methods. In fact, racial disparities exist in addiction risk reduction measures targeted toward

patients that are prescribed opioids for long-term chronic pain. Despite the fact that the large majority of recent opioid addicts are white, healthcare providers target strategies to reduce the risk of addiction to black patients, disproportionately impacting adequate access to pain controlling medications. In one study, in 1600 patients that had been prescribed opioids for pain, providers were significantly more likely to require urine drug testing, regular office visits, and restricted early refills for black patients than for white patients [2]. These are examples of clinical practices designed to prevent patients from abusing prescribed opioids or becoming addicted, however, their skewed implementation shows continued racial bias from providers. When providers choose to drug test their black patients more than their white patients, this indicates that they suspect that black patients are more likely to abuse these drugs despite evidence to the contrary. A main tenet of medical school education is that a sense of mutual trust and respect is vital for a successful physician-patient relationship. However this practice demonstrates bias and mistrust of healthcare providers towards their black patients. When a patient's race clearly has an impact on how they are viewed by their healthcare provider, this bias negatively affects other aspects of their care.

Treatment and rehabilitation for opioid use disorder is sadly just one of many examples of racial bias in healthcare. The opioid epidemic is clearly a public health crisis, yet it is deeply intertwined with the even larger public health crisis of racism. I urge the committee to consider this example within the larger context of implicit biases and racial disparities that exist within the medical field, making racism a public health crisis.

In conclusion, I would like to thank the committee and the sponsors of this resolution, Sen. Sandra Williams and Sen. Hearcel Craig.

Sources:

1. Mendoza, Sonia, Rivera-Cabrero, Allyssa, and Hansen, Helena. "Shifting blame: Buprenorphine prescribers, addiction treatment, and prescription monitoring in middle-class America". *Transcult Psychiatry,* volume 53, issue 4, 2016, pp. 465-487. www.ncbi.nlm.nih.gov/pmc/articles/PMC5540139.

2. Becker, WC, Starrels, JL, et al. “Racial differences in primary care opioid risk and reduction strategies”. *The Annals of Family Medicine,* volume 9, issue 3, 2011, pp. 219-25. www.ncbi.nlm.nih.gov/pubmed/21555749.