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Chiarello's Policing Patients: Treatment and Surveillance on the Frontlines of the Opioid Crisis

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Book Review

Review of Chirarello, Elizabeth. 2024. *Policing Patients: Treatment and Surveillance on the Frontlines of the Opioid Crisis*. Princeton, NJ: Princeton University Press.
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In *Policing Patients: Treatment and Surveillance on the Frontlines of the Opioid Crisis* (2024), Elizabeth Chiarello details how the US healthcare industry functions as an agent for the police state, blurring the lines between healthcare and law enforcement altogether. Focused on the adoption of prescription drug monitoring programs (PDMPs), Chiarello reveals that new technology systems in medicine are strategically deployed by frontline workers to confront the opioid or overdose crisis, marking a novel era of electronic policing and increasing technology-facilitated capacities for surveillance. With this, Chiarello argues that PDMPs have expanded patient policing into more efficient, digitally enabled realms, framing medicine surveillance as a necessary part of care. While debates about the opioid crisis center on whether rising overdose rates should be categorized as a medical problem or a criminal one, *Policing Patients* exposes a more complex reality, where healthcare providers must act as enforcement agents themselves to treat patients and judge care.

Policing Patients contributes to science and technology studies (STS) as well as critical surveillance studies by providing new knowledge about how techno-solutionism facilitates carceral logics and reinforces surveillance capitalism. The book draws on drug and medical surveillance research to illustrate the implications of introducing PDMPs as solutions to wide-ranging social problems, particularly on the fields of law enforcement, medicine, and pharmaceuticals. Through her "Trojan Horse Framework" of technology, Chiarello makes visible the insidious ways new digital tools, namely PDMPs, usher in hostile logics of dataveillance and punishment that undermine existing logics of care.

Chiarello's concept of "trojan horse technologies" closely relates to the surveillance web associated with the application of "big data" in health communications nurtured by growing collaborations between government agencies and private tech companies. She explains how PDMPs rely on black box algorithms trained on discriminatory data, resulting in systematically biased algorithms that reproduce inequalities across race, gender, and class, forcing workers to make judgements about patients based on inaccurate "data doubles" (61). Chiarello further describes the ways PDMPs continue to advance technologically, and soon hold drug arrest and conviction data in sequence with prescription data, and even incorporate data from the

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banking, real estate, and auto industries. This holds major implications for aggregated data sharing across public-private sectors, aiding the proliferation of big data surveillance technologies rooted in punitive logics.

Although Chiarello's findings point to an absence of personal-data protections for patients, her analysis could benefit from further scrutiny into how bio-surveillance impacts drug users' privacy and autonomy, as well as patient advocacy and informed consent. Additional engagement with questions about AI and biometric technologies in healthcare settings, the effects of pandemic surveillance under COVID-19, and the role of newly advanced surveillance technologies in criminalization of care, such as self-tracking devices or CCTV monitoring in hospitals and pharmacies, would strengthen *Policing Patients*' arguments overall.

Policing Patients could help advocate for non-carceral approaches to addiction treatment. For example, one solution Chiarello proposes is to expand telemedicine as a means for stronger access to care. However, she does not interrogate how video chats and phone calls may promote "smart surveillance," justify privacy invasion, and increase digital divides. In thinking about Chiarello's proposed solutions, we are still left asking: what programs, laws, or services would need to exist in tandem to protect the patients most vulnerable to digital injustices?

While *Policing Patients* contributes to conversations about how surveillance occurs or is made capable in hospital information systems, it does not explore the ways PDMPs may be individually resisted or systematically constrained. The book offers policy solutions to intervene in existing police-assisted diversion programs and drug courts that dominate treatment but does not address how PDMPs should be used or changed to be more ethically deployed, or whether PDMPs should continue to be utilized in healthcare at all. By avoiding these vital questions, Chiarello misses opportunities to discuss how healthcare professionals may ensure that they do not reproduce inequalities or reinforce carceral logics in their work, as well as how they may creatively develop their own sousveillant systems.

Chiarello's qualitative methodology utilizes a "nested maximum variation sample" to gather data from the broadest sample of participants with the most variation possible across states, counties, organizations, and professions. She interviewed hundreds of healthcare providers including physicians and pharmacists who allocate, prescribe, and dispense pain medications, as well as prosecutors and investigators who surveil and police physicians and pharmacists. This approach yields highly variable results; however, it presents serious limitations in its exclusion of patients' perspectives on carceral surveillance by PDMPs, despite patients' marginalization being centered in the book.

Chiarello critiques the hypersurveillance and restrictive nature associated with federally certified opioid treatment programs (OTPs)—the only locations where patients can access methadone—and emphasizes the need to invest in community-based social services, public health, and harm reduction: a "three-pronged" solution based on treatment, harm reduction, and prevention.

She then calls for "large scall harm reduction" and quotes drug users' mantra "nothing about us without us" to encourage the involvement of people who use drugs, but she does not include patients' first-hand experiences of carceral surveillance with PDMPs and claims "it is up to physicians to set the standards of care and fight for their patients" (194). This begs the question, what if patients with chronic pain and opioid addiction—who are themselves at the forefront of the nationwide harm reduction movement—were allowed to *lead* these efforts? It also begs the question, how might physicians better support drug-using leaders in the harm reduction movement and tactically resist carceral surveillance within their clinics?

Chiarello's arguments in *Policing Patients* circumvent key issues within the field of surveillance studies. Nevertheless, the book urgently spotlights how technology has exacerbated criminal justice logics in healthcare and worsened disparities, as healthcare norms have moved from an emphasis on treating patients to policing them. Chiarello sought to answer how healthcare leaders and law enforcement work together

and in opposition to address the growing opioid crisis. In this regard, *Policing Patients* achieves its goals and paints an important picture of the criminalization of patient care and pain management in the twenty-first century. It exposes the logics of enforcement driving PDMPs that aim to effectively reframe policing as treatment in physicians' and pharmacists' work, revealing the fact that surveillance technologies are not removed from greater social, political, and cultural forces. For these reasons, Chiarello's *Policing Patients* can be a valuable source for social scientists, policy makers, and those in the fields of law, criminal justice, or medicine alike.