

# Test or Talk

## *Empiric Bias and Epistemic Injustice*



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Drug tests are among the most overused, misused, and misinterpreted tests in the medical lexicon, especially during the birthing hospitalization. Given the consequence of a positive drug test result—a reflex report to child welfare—the question must be asked: Is drug testing a policing practice masquerading as clinical care?

This month's issue of *Obstetrics & Gynecology* (see pages 153 and 163) includes two articles that illuminate purported strengths and limitations of drug testing.<sup>1,2</sup> In the first, Smid et al<sup>1</sup> present public health surveillance data from statewide deidentified cord blood, which indicate that roughly 10% of newborns have prenatal substance exposure. The authors are unable to differentiate iatrogenic exposure, from prescribed medication, from treated addiction, from untreated addiction, yet they extrapolate the total number of substance-exposed neonates in the state.

The racist history of the medical response to cocaine in pregnancy, which undergirds our current regime of testing, is well detailed in the second article, by Kurtz et al.<sup>2</sup> They describe the common clinical practice of unconsented drug testing—a practice that violates autonomy and human rights and is in clear conflict with professional society recommendations—and suggest that drug testing is rarely clinically indicated and urge re-evaluation of routine testing.

What is a drug test? *Drug tests* (summarized well by Kurtz et al) capture parent compounds, metabolites, or both compounds and metabolites present in a biologic matrix at a particular point in time. The most common tests (called *presumptive*) use an immunoassay and report results within minutes as binary (positive or negative). Presumptive tests are inexpensive and widely used, yet the quality of information obtained is poor, because cross-reactivity in the immunoassays leads to high rates of false-positive results. In addition, the limited assay array biases potential results toward illicit substances. To wit, neither alcohol nor nicotine (the most common and developmentally consequential substances) are captured. *Definitive tests* use gas or liquid chromatography combined with mass spectrometry to report specific substances as a quantified value (for example, nanograms per deciliter). Definitive tests are considered the gold standard for drug testing and "...should be used when the results inform clinical decisions with major clinical or non-clinical implications for the patient..."<sup>3</sup> — a scenario arguably universal during the birthing hospitalization.

Though a definitive test is the gold standard over a presumptive test, neither presumptive nor definitive tests are the gold standard over information obtained through self-report, a validated screening instrument, or therapeutic dialogue. The comparison of drug testing with self-report data is common in the published literature. Though rates of test positivity are higher than rates obtained from patient history, the conclusion that because tests are more frequently positive they are more

See related articles on pages 153 and 163.

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accurate is erroneous, because it neglects both the uncertainty of test precision and the reality that disclosure is unsafe for patients and their families.

The practice of drug testing by health care professionals is based on misinformed assumptions:

- Tests accurately capture recent drug use (they don't);
- Tests identify people with addiction (they don't);
- Federal law requires testing and the reporting of positive results to local child welfare agencies (it doesn't); and
- (Illicit) drug exposure causes significant developmental harm (it doesn't).

In addition, the motivation for drug testing arises from mistrust and displays and perpetuates bias. Drug use during pregnancy differs little by race and class, yet people who are poor, Black, or from other historically underrepresented and underserved communities are more likely to be tested, reported to child welfare, have a child placed in foster care, and have their parental rights terminated.<sup>4</sup> This disproportionate testing results from the reproduction of structural relations of oppression within the clinical encounter. Physicians are more verbally dominant and less person-centered when talking with Black than with White patients,<sup>5</sup> a dynamic likely present across clinical encounters among individuals with other identities that have been rendered marginal, which includes pregnant people who use drugs.

One of the first principles medical students are taught on the wards is that a test should be ordered only if the results will influence clinical care. If drug tests during the birthing hospitalization are rarely clinically useful, why are they so pervasive?

The preponderance of testing during the birthing hospitalization is driven by a mix of misinformation, ennui, (well-meaning) naiveté, and the occasional dash of a callow disregard for the dignity of others. When we listen to the drug test and not the patient, we perpetuate a mistaken empiricism—one that falsely elevates the value of information collected from measurement over the value of information collected from a person. This is an *epistemic injustice*—a harm done by devaluing a person's credibility and undermining them as a giver of knowledge. The neglect, silence, or erasure of the patient's voice and perspective harms not only them, but it also harms us as physicians—it deflates us in our capacity to know and to heal.<sup>6</sup> To be blunt: dehumanizing people makes their care environment unsafe, and to expect people to be forthcoming about sensitive and potentially catastrophic information under such circumstances is irrational.

If the goal of drug testing is to identify individuals who might benefit from behavioral health

services, why not simply offer treatment? Yet, fewer than 2% of obstetrician–gynecologists are currently waived to prescribe buprenorphine.<sup>7</sup> If the goal of drug testing is to identify children who may be at risk of developmental issues, why not test for lead as opposed to cocaine and support early childhood development for all families? Yet, only 8% of eligible pregnant people receive a referral to early Head Start programs.<sup>8</sup> If the goal of testing is to identify families who would benefit from various social services, why not mandate support?<sup>9</sup> Instead, we have chosen to test and report, to prioritize surveillance and family policing<sup>10</sup> over humility and service. In short, we have chosen to act as the gatekeepers of the human right to parent.

The overwhelming majority of child welfare reports are not simply unnecessary; the sequelae are destroying families and communities.<sup>4,11</sup> The medical establishment, in drug testing, has become a threat to health, an example of a social iatrogenicity wherein, to paraphrase Illich, physicians have become “the sickening agent.”<sup>12</sup>

The humanistic purpose of medicine has been lost in the overuse, misuse, and misinterpretation of drug tests. The assumption that “hard” facts are more accurate than “soft” knowledge, that measurement is superior to empathy, is morally injurious and steals bits of our humanity. Medicine is, above all, a moral practice, albeit one constructed on a markedly uneven platform of power. But our actual power, our value, our humanistic purpose as physicians, is ultimately derived from leveraging our privilege, concern, and ability to help, heal, and serve others. It is time to abandon routine, reflexive, and nonclinical drug testing.

## REFERENCES

1. Smid MC, Allshouse AA, McMillin GA, Nunez K, Cavin T, Worden J, et al. Umbilical cord collection and drug testing to estimate prenatal substance exposure in Utah. *Obstet Gynecol* 2022;140:153–62. doi: 10.1097/AOG.0000000000004868
2. Kurtz T, Smid MC. Challenges in perinatal drug testing. *Obstet Gynecol* 2022;140:163–6. doi: 10.1097/AOG.0000000000004808
3. Jarvis M, Williams J, Hurford M, Lindsay D, Lincoln P, Giles L, et al. Appropriate use of drug testing in clinical addiction medicine. *J Addict Med* 2017;11:163–73. doi: 10.1097/ADM.0000000000000323
4. Sangoi L. Whatever they do, I'm her comfort, I'm her protector. How the foster system has become ground zero for the US drug war. Accessed May 27, 2022. <https://www.movementforfamilypower.org/s/MFP-Drug-War-Foster-System-Report.pdf>
5. Johnson RL, Roter D, Powe NR, Cooper LA. Patient race/ethnicity and quality of patient-physician communication during medical visits. *Am J Public Health* 2004;94:2084–90. doi: 10.2105/ajph.94.12.2084



6. Fricker M. Epistemic injustice: power and the ethics of knowing. Accessed May 27, 2022. <https://oxford.universitypressscholarship.com/view/10.1093/acprof:oso/9780198237907.001.0001/acprof-9780198237907>
7. Nguemeni Tiako MJ, Culhane J, South E, Srinivas SK, Meisel ZF. Prevalence and geographic distribution of obstetrician-gynecologists who treat Medicaid enrollees and are trained to prescribe buprenorphine. *JAMA Netw Open* 2020;3:e2029043. doi: 10.1001/jamanetworkopen.2020.29043
8. Children's Defense Fund. The state of America's children 2021. Accessed May 21, 2022. <https://www.childrensdefense.org/wp-content/uploads/2021/04/The-State-of-Americas-Children-2021.pdf>
9. JMacForFamilies. Mandated supporting. Accessed May 21, 2022. <https://jmacforfamilies.org/mandated-supporting>
10. American College of Obstetricians and Gynecologists. Opposition to criminalization of individuals during pregnancy and the postpartum period. Accessed May 27, 2022. <https://www.acog.org/clinical-information/policy-and-position-statements/state-ments-of-policy/2020/opposition-criminalization-of-individuals-pregnancy-and-postpartum-period>
11. Roberts D. Torn apart: how the child welfare system destroys Black families—and how abolition can build a safer world. Basic Books; 2022.
12. Illich I. Medical nemesis: the expropriation of health. Marion Boyars; 1995.

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