



## The pill hustle: Risky pain management for a gunshot victim



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### ABSTRACT

How do gunshot victims manage pain without health care? This paper examines this question through ethnographic data of a single gunshot victim who self-medicated with Percocet. The observations for this paper were collected in Philadelphia between January of 2010 and October of 2011, and were part of a larger ethnographic study that included 40 gunshot victims recruited from an outpatient trauma clinic. Although this victim was able to manage his pain, he ultimately became addicted to Percocet and became entangled in the personal stress and conflicts of his pill hustlers. His story shows how health care insecurity can funnel victims of gun violence into increasingly risky ventures to find pain relief. The findings from this study show the pressing need to expand rehabilitative care to all gunshot victims.

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### Introduction

I met “Paul” on a Friday afternoon.<sup>1</sup> He was two weeks removed from an execution-style shooting and was in pain. At 3pm, I walked into an exam room and found him slumped over a table. He motioned for me to check out his hand, “Ain’t that some shit?! It don’t go straight now!” I stared at his hand. His pinky and ring fingers were tightly coiled, like an eagle’s claw. “Does it hurt?” I asked. Paul’s eyes widened, “Shiiiiit! Does it hurt?! Every morning I wake up, this shit hurts!”

Paul was a line cook at a sports bar when he got shot. Although the “tips were pretty good,” Paul was bad at managing his money. He drank heavily, loved to wine and dine women, and often bought cocaine on the weekends. His lifestyle became a sore spot with his roommate and landlord, Cordell, whom Paul owed money for rent and shared utilities.

Tensions between the two reached a boiling point when Paul fell behind on his fourth month of rent. He came home one day and discovered that Cordell had pawned his TV and Blu-Ray disc player. Paul was livid. “I told that bitch ass nigga to put his ‘twins’ (fists) up. He ain’t said shit after that!” On another occasion, Paul got home and discovered that Cordell changed the locks to their apartment.

And then, on a brisk Saturday morning, Cordell stormed into their shared apartment with what Paul thought was a bb gun. Paul thought Cordell was blustering and yelled, “Whatchoo gonna do

with that little gun, you bitch ass nigga!?” Cordell fired the first of 3 shots from a Kel Tech .380.

The first bullet nicked Paul’s scalp and ricocheted off his index finger. Paul saw blood squirting out of his finger and got on his knees. He begged, “Please don’t shoot!” Cordell fired a second round, which entered and exited the side of Paul’s chest. He then fired the third round, which ripped through Paul’s shoulder and came out of his armpit. Paul grew weak and collapsed.

Cordell then rolled Paul into an IKEA area rug and dragged his bullet-riddled body into the kitchen. Paul “played dead” for the next half hour, silently watching Cordell clean up the crime scene. He remembers Cordell cutting out chunks of bloodied carpet with a steak knife; he watched Cordell crawl around on hands and knees collecting bullet casings; and in his most terrifying moment, Paul remembers Cordell staring into his eyes and kicking his feet—to check if he was still alive. One of the bullets damaged nerves in his face, making it difficult for him to blink his eyes. “I couldn’t blink my eye. I just stared back at him like I was dead! I think that saved my life, cuz to him, I was gone!”

At one point, Paul tried to escape. He freed himself from the rug and screamed for help out of a rear door that lead into an alleyway. This did not work. Cordell quickly dragged Paul back into the kitchen. He then placed the still hot muzzle of his gun against Paul’s face and fired a fourth round. This bullet shattered Paul’s jaw, ripped through this throat and neck, and zigzagged its way through his chest. The bullet finally got stuck in a band of muscle just beneath his collarbone.

Cordell then left Paul alone. Paul was slipping in and out of consciousness. To stay alert, he focused on the sounds of water running through old pipes in the ceiling. Paul felt a surge of adrenaline in the middle of his haze. He quickly freed himself from

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<sup>1</sup> I use pseudonyms throughout this paper to protect the confidentiality of victims. This is consistent with my IRB protocol #811465.

the rug and made a clumsy sprint to the front door. Cordell heard him and came running down the stairs with his gun drawn. Paul recalls this tense moment as if it happened yesterday, “I turned around and that nigga look like he saw a ghost!” As he reached for the front door, Cordell pointed and tried to fire his gun. Paul closed his eyes, expecting to get shot again. But, the gun jammed and Paul managed to escape. Minutes later, Paul was discovered by someone who saw him lying in a pool of his own blood.

Paul’s story haunted me. The details of Cordell’s execution-style shooting were much different than the accounts I got from other gunshot victims in the outpatient trauma clinic at the University of Pennsylvania. Most of the victims I met had been shot during stick-ups, drive-by shootings, and other street altercations. Paul’s shooting was different. It was cold and calculated and occurred in his home—a place where he was supposed to be safe. This was unsettling for Paul, who suffered from terrifying flashbacks.

Paul was also in a lot of pain. He was worried about his expiring Oxycodone (Percocet) prescription. Although Percocet made him feel “out of it,” he liked vanquishing pain from his body. Percocet helped him feel control over a life and body that suddenly felt out of his hands.

Later that day, Paul asked his doctor for a refill on his Percocet. Paul’s doctor listened to his story, but denied the request, saying, “Percocet is not a long-term kind of pain option. You can try taking Motrin or Extra Strength Tylenol. They should help you.” Paul protested, but to no avail. We sat in silence after his doctor left. Paul let out a deep and frustrated sigh, “Motrin?! Percs barely do the trick! These mawfuckas don’t care about shit!” Paul would have liked physical rehabilitation, but he did not have health insurance and could not pay for it out-of-pocket. In the meantime, Percocet helped him regain some semblance of his former life. Without it, pain invaded his body and disrupted his sleep. As we left the clinic, I asked Paul what he was planning to do. He shrugged, “I know some people who got Percs. You can get everything on the streets. I just gotta make some phone calls and see who’s holdin’.”

### Making sense of Paul’s story

How do gunshot victims manage their pain without continued health care? What survival strategies do they use? How do these survival strategies impact their health?

Paul’s story opens insights into these questions. He was one of 40 gunshot victims that I enrolled in a larger ethnography of gunshot victims in Philadelphia. I use the term “victim” throughout because this is how participants referred to themselves. The term represented the various challenges that individuals faced during life after the shooting. In addition to feeling victimized by their shooters, gunshot victims also felt victimized by a health care system that did not continue to care for them.

Paul was one of 5 key participants that I interacted with weekly between January of 2010 to October of 2011. I spent time with Paul at homeless shelters; I attended his meetings with social workers; I also spent time with him in his old neighborhood, which was located next to one of Philadelphia’s largest and most racially-segregated housing projects.

As a young man, Paul became a low-level drug dealer. Like other young men in his neighborhood, he came of age in a world where there were few good jobs for young people who did not go to college. Instead of working in low-wage service sector jobs, Paul and some of his best friends gravitated to drug dealing. This lifestyle exposed Paul to gun violence. By the time he reached adulthood, Paul had witnessed 11 close friends, family members, and acquaintances murdered in shootings. He knew many more people who survived shootings only to live with chronic pain and disabilities.

At first blush, it is easy to assume that this back-story explains Paul’s eventual shooting. But, as John Rich (2009) shows in his work, it is a mistake to assume that gunshot victims are caught up in illicit drug dealing, gangs, or other risky activities. These stereotypes are not only gross misrepresentations of the risks that people encounter in high poverty and crime neighborhoods, they also provide a moral rationale for unequal care and suffering. Although Paul had grown up immersed in street culture, he was not actively dealing drugs when he got shot. He had left this life behind and often remarked that he did not miss the stress and anxiety that came with drug dealing.

After the shooting, Paul spent most of his days trying to control sharp and throbbing pains in his body. This is a shared dilemma faced by thousands of gunshot victims that are wounded each year in our nation’s most dangerous neighborhoods. Most of these victims are uninsured or under-insured when they get shot (Dozier et al., 2010). Indeed, while fatal shootings dominate news coverage, most people do not die from shootings. The Centers for Disease Control and Prevention show that approximately 1 in 5 shootings are fatal.

Under current laws, all gunshot victims are entitled to emergency and follow-up care when they arrive wounded in hospitals. But, once they are deemed healed by providers and released from continued care, victims like Paul continue to struggle with injuries, chronic pain, and health problems that diminish their quality of life (Lee, 2012; Rich, 2009). Getting shot is often the beginning of a downward spiral in a person’s health. Similarly, gunshot injuries can have other ripple effects on a victim’s life. Sudden and unanticipated disability can jolt gunshot victims out of the labor force—sometimes indefinitely. A wounded body presents particular problems for working poor victims like Paul who depend on an able body for their livelihood.

During our time together, I learned about the various sources of social support that Paul relied upon when he was in pain. I went with Paul when he bought Percocet from drug dealers and other pill hustlers. Although he found temporary pain relief, his pain management also introduced new health and safety risks into his life. Over time, Paul became *entangled* in his social support. He inherited the stress and personal conflicts of his various pill hustlers. Ultimately, his experiences show how health and safety risks flow through support networks amongst the vulnerable. I return to this theme throughout the paper, but for now place Paul’s injury into a larger context.

### Black men, gunshot victimization, and structural violence

At a macro-level, Paul’s story could be conceptualized as a case of “structural violence” (Farmer, 2001; Farmer, Nizeye, Stulac, & Keshavjee, 2006). Originally coined by the Norwegian sociologist Johan Galtung (1969), “structural violence” links individual level outcomes with larger, historical, political, and social forces. This idea has gained traction in medical anthropology and has been further developed by scholars like Paul Farmer. Writing about the AIDS epidemic across developing parts of the world, Farmer et al. (2006) write,

Many doctors have focused on what are termed the ‘behaviors’ or ‘lifestyles’ that place some at risk for AIDS, while others are shielded. Yet risk has never been determined solely by *individual* risk behaviors. Susceptibility to infection and poor outcomes is aggravated, instead, by *social* factors, including poverty, gender inequality, and racism (2006: 278). Farmer shows us how preventable illnesses and injuries are linked to concentrated poverty, institutionalized discrimination, and other structural

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