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Abstracts

B3 Medicine or Drugs?

1. Eva Ward, University of Strathclyde
"Rather accounted a good fellow than a bad one": Medical ethics and colonial drug laws in the American Philippines

In 1905, the United States colonial government of the Philippines prohibited all recreational sale and use of opiates and cocaine. The law took effect in 1908 and permitted continued distribution and consumption of narcotics and cocaine for medical purposes. Doctors' access to these controlled substances meant they were frequent points of contact in illicit as well as state-sanctioned distribution. This seemingly binary theoretical demarcation of legal-medicinal and illegal-recreational was not as straightforward in practice, however, as the case study of Dr. Dominador Gomez demonstrates. In 1924, the Filipino doctor Dr. Gomez was acquitted of illegal possession and distribution of opium, morphine and cocaine on grounds of lack of intent to violate the Opium Law. The trial court judge "held in substance that Doctor Gomez violated the Opium Law but that he probably did not realize that he was doing anything illegal; that he, consequently, did not act with criminal intent." The medical profession in the Philippines then took action against him, as the Board of Medical Examiners opened an administrative investigation against him for "his alleged medical treatment of morphine addicts." Following his death in 1932, an editorial in the Journal of the American Chamber of Commerce described Dr. Gomez as "rather accounted a good fellow than a bad one, he seemed unable to distinguish between right and wrong and was always thought to administer morphine to people habituated to its use, especially to Chinese whom it served in lieu of opium." The Chamber of Commerce did not consider that Gomez may have viewed the distribution of morphine "to people habituated to its use" as a legitimate medical practice regardless of its legality. The trial judge appears to have taken this into account given the acquittal, but the Board of Medical Examiners was less convinced. The case study of Dr. Gomez and the legal and professional response to his criminal charges illustrate the myriad ways of contesting colonial drug regulations in the American Philippines, the liminal nature of drug consumption for medicinal purposes and the plurality of the colonial state's response to violations of the Opium Law.

Develop the capacity for critical thinking about the nature, ends and limits of medicine
Promote tolerance for ambiguity of theories, the nature of evidence, and the evaluation of appropriate patient care, research, and education
Recognize the dynamic interrelationship between medicine and society through history

2. Mariana Broglia de Moura, Ecole des Hautes Etudes en Sciences Sociales
Confessions of some Brazilian Paperwork-Eaters: a material history of boundary-work between licit and illicit drugs through the health professionals control

The first international conventions on drugs during the 1920s established that drugs should only be sold and used to satisfy medical and scientific needs. In so doing, they built a drugs regulation system that granted the monopoly of the legitimate uses of drugs to health professionals and set new boundaries between licit and illicit uses of drugs. This system has often been studied either by emphasizing the role of some key actors for its establishment and development (in particular industrial countries such as the United States or European countries), or by focusing on international conventions and national laws that reinforced the division between licit and illicit uses and on their effects on illegal traffic and consumers. This paper proposes a double shift from these approaches by developing a material history of drug regulations in Brazil between the 1920s and 1950s focusing on the material effects of daily drug control on the medical and pharmaceutical professionals. On the one hand, I will analyse drug regulations from the point of view of a “peripheral” country that was not a producer or an industrialist of narcotics. I will focus on a set of governmental tools often neglected in the historiography, which had direct effects on the daily practices of doctors and pharmacists: administrative instructions, authorization forms, narcotics control books, official prescription forms and so on. On the other hand, I want to question the effects of these administrative tools on the daily negotiations concerning the divide between licit and illicit uses, in a more situated way, in order to propose new ways of thinking about the legality and illegality of drugs. I will not focus on laws or conventions but rather on the daily bureaucratic work that health professionals had to face and on how it defined the borders of licit and illicit uses. In order to escape the accusation of being the main cause for the development of drug addiction and illicit traffic, doctors and pharmacists had to demonstrate a strong capacity for paperwork and compliance to evolving administrative rules.

1.1) Understand the historical process by which drugs regulation have transformed the relationship between state and health professionals
1.2) Acquire a historically nuanced understanding of the distinction between drugs and medicines
1.3) Complexify power relationships between state, health professionals, layman
1.4) Understand the dynamic history of drug regulation in redefining health professional practices
1.5) Recognise other political, social and economic processes that have an impact on the work routine of health professionals
1.6) Understand how the focus on "war on drugs" has hidden the complexity of the divide between licit/illicit drugs and the problem of regulating health professional practices

3. Anne Kveim Lie, University of Oslo

Free dope or medical treatment? The coming into being of substitution treatment in the Scandinavian welfare states

During the last 30 years, substance dependency has increasingly become conceptualized in neurobiological terms as a biobehavioural disease residing at the molecular level, as part of a bid to transform this stigmatized phenomenon from moral defect into a chronic disease. As user organizations and other social movements now struggle with the challenge of questioning the biomedical model of addiction without falling back into the trap of moralization and criminalization, careful historical engagement is all the more important. In this paper, I will discuss how substitution treatment was introduced in Scandinavia in the long 1990s, with a particular focus on Norway. The Scandinavian welfare states all had a restrictive drug policy, relying on social work rather than medical approaches. Until the hiv epidemic, substitution treatment was severely opposed, and policy makers, politicians and clinicians saw substitution treatment as a way to disempower drug users and take away their "natural resilience". Prescribing opioids outside of the hospital setting was strictly forbidden. The hiv epidemic introduced some to harm reduction approaches, but it should take another decade (until 1998) until a very small centralized state program with strict gatekeeping was introduced in Norway. It was designed with abstinence as a main long-term goal, and combined with social services and psychological assistance. Drawing on archival studies, oral history interviews as well as policy papers I will argue that during these crucial years, processes of (bio)medicalization and demedicalization were negotiated and borders were drawn, both diachronically and synchronically across different social subgroups. Physicians, nurses as well as patients pushing for pharmaceuticals as necessary survival tools were crucial in this process, but their respective roles changed over time. Social and psychological comprehensive support were still considered such an important part of the treatment program in the state system of opiod maintenance, that it caused centrally placed physicians in that system (who had previosly been crucial in promoting opiod maintenance) to fiercely resist physician prescribing outside of the state system.

Develop the critical capacity for thinking about the nature, ends and limits of medicine
Recognize the dynamic interface between society and medicine through history
Respond to changes in medical practice guided by a historically informed professional responsability and patient advocacy