Interview with David Herzberg

*by Rafaela Zorzanelli**

THIS is the second interview in the journal's new "Conversations" section, and it is drawn from my broader project *Interviews with Researchers from the Anthropology, History, and Sociology of Pharmaceuticals: Mapping Out the Area*.[1] The following discussion features Professor David Herzberg.[2] The interview took place at a felicitous moment right after he had finished the manuscript for his new book, *White Markets Drugs,*[3] which was published in November 2020. One of the topics that pervades this book and his earlier work, *Happy Pills in America,*[4] *is* the often disparate historiography of the "drug war" versus "pharmaceutical history." Because these areas of study have frequently been seen as different fields, historians have been slow to study the artificial boundaries between, for example, "medical" and "nonmedical" uses of substances or between "licit" and "illicit" drugs. These divisions, Herzberg argues, are better understood as the ongoing results of a "legal, cultural, and political set of structures that divided these two types of substances."

The interview delves into many of the contradictions of the system of regulation in the United States. These include the idea that "medical" uses are good *per se* and that "nonmedical" uses are potentially harmful. Herzberg also centers such important topics as gender and substance use; race and substance use; consumer agency; and, finally, the establishment of white markets—legal, official, regulated, and authorized markets for substances, mostly destined for privileged (white) people. In a 2017 editorial in *Contemporary Drug Problems*, Herzberg and STS scholar Nancy Campbell emphasized their position that drug "scholarship can be strengthened by an engagement with questions about the intertwined effects of gender, race, class, and ethnicity on the social order."[5]

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1. Drug Trajectories: Interviews with Researchers, https://drugtrajectories.org. For more information about the project, see Rafaela Zorzanelli, "Drug Trajectories: Interviews with Researchers," *Pharmacy in History* 62, no. 1-2 (2020): 47–48, https://doi.org/10.26506/pharmhist.62.1-2.0047.
2. David Herzberg is an Associate Professor in the Department of History at the University of Buffalo; herzberg@buffalo.edu.
3. David Herzberg, *White Market Drugs: Big Pharma and the Hidden History of Addiction in America* (Chicago: University of Chicago Press, 2020), https://doi.org/10.7208/chicago/9780226731919.001.0001.
4. David Herzberg, *Happy Pills in America: From Miltown to Prozac* (Baltimore: Johns Hopkins University Press, 2008), https://doi.org/10.1353/book.501.
5. Nancy D. Campbell and David Herzberg, "Gender and Critical Drug Studies: An Introduction and an Invitation," *Contemporary Drug Problems* 44, no. 4 (2017): 252, https://doi.org/10.1177/0091450917738075.

The following interview has been edited for length and clarity. Professor Herzberg's original and unabridged video interview is now available,[6] and visitors can also view trailers of video interviews with other scholars. The accompanying images were chosen by David Herzberg. I hope that readers of *Pharmacy in History* enjoy this thought-provoking discussion.

***Rafaela Zorzanelli**: What kind of perspective can "a social history of addiction to pharmaceutical narcotics, sedatives, and stimulants" bring to the field of critical drug studies?*

David Herzberg: In history, generally, scholarship has been divided into two realms or into two fields. One is pharmaceutical history. This is a branch of the history of medicine and involves people who examine pharmaceuticals and the pharmaceutical industry and all the various factors related to that. And then there is another group—smaller—who are part of the alcohol and drug history field. And what I hoped to do by looking at a social history of medications like sedatives, stimulants, and opioids was to show that these two fields share more than is normally understood.

Because, as you know, it's very hard to keep up with the reading in even just one field, and so the people in each field, as it grew, developed a canon of the books that everyone has read. You had a tendency to have people working within a closed system here and in a closed system in alcohol and drugs as well. This reflected a legal, cultural, and political set of structures that divided these two types of substance.

And I thought it doesn't seem that the actual experiences of people making, selling, marketing, buying, using and otherwise transacting these substances was as different as that structure would imply. So, my hope in doing this [social history] is to give a clearer sense of how the actual experiences of people—particularly the people who buy and sell these drugs—may differ from the cultural and legal and economic structures that have built up around them.

***RZ:** One important issue that pervades your different works on pharmaceuticals is the issue of boundaries. Could you talk about the history of classifications of drugs and pharmaceuticals in their social trajectory in the United States?*

DH: It's perfectly ordinary for a society to divide experiences in ways that are expedient for all kinds of purposes. And so, it's not unusual to discover that *psychoactive substances* have been divided into different kinds of categories and *use* has been divided into different kinds of categories. But the kinds of categories that have been operating in the United States for over a century—they had their origins in the emergence of market capitalism in the United States.

In the eighteenth century, you have a system of circulating psychoactive goods that is based on—I'm gonna call them very loosely—certain regulations. They're not necessarily regulations governed by the state but by the actors involved in the economy, and the loose term for this earlier form of regulation is *caveat emptor*, or "let the buyer beware. . . ." Starting in the mid-nineteenth century, as goods began to circulate more freely and you can buy them from farther away [and] from people that you don't know, and they—in the case of drugs—become much stronger. Buying mor-

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6. "David Herzberg," Drug Trajectories: Interviews with Researchers, https://drugtrajectories.org/?page_id=104.

phine is not the same thing as buying opium. Buying cocaine is not the same thing as buying coca, especially because in America, the active principle of coca leaves would not have survived the trip from the Andes region at that time. So, you suddenly have a greater variety of stronger goods that are easier to buy because their production has become more efficient and that produces a public health crisis. It comes when gin and inexpensive distilled liquors arrive, it comes when morphine and cocaine arrive, it comes down the road with barbiturates and amphetamine. A lot of people are being harmed and there's a lot of problems.

The categories that divide all these groups of substances [into "medicines" and "drugs"], they emerge out of an effort to deal with that problem. It's one of the ways of trying to impose regulation.

But nothing ever happens in a vacuum. . . . In the second half of the nineteenth century, there are a lot of different ways, for example, that you can buy morphine. You can get it prescribed by a doctor, or that doctor may sell it to you, or you may bring your prescription to a drugstore. And in a lot of states, drugstores are the only place they can legally sell something that's poisonous like that. But even so, there are drugstores that will sell it without the doctor's prescription—maybe the one around the back not on Main Street will sell to whoever wants to buy, and so, you can buy there. Or there may even be people who . . . manage to scrape together enough money to buy a larger amount from one of those drugstores and then they can sell individual amounts and make a profit from that. So, there are people buying just for another person who is not a pharmacist. There's all these different ways to buy these drugs. And they are all part of that stressed traditional market that is ruled by *caveat emptor*. Then when it becomes less expensive to buy, say, morphine, to maybe buy syringe needles. And maybe there's more of the product around, and there are larger populations to buy them, all of these different populations experience the public health consequences of suddenly having stronger, cheaper, and more easily accessible drug products. So, you have the rise of addiction amongst people who are visiting physicians, a rise of addiction amongst people who are buying in pharmacies with prescriptions, and you have a rise of addiction among people who are buying in informal markets.

From where I see this as a historian, this was a problem of early capitalism. It wasn't actually a drug problem. But, at that time, the people who were paying attention to drug problems, they didn't see these different groups [of consumers] as experiencing the same phenomenon—markets spiraling out of control. They believed that each of these different groups was experiencing addiction for different reasons. [This becomes the basis for] the creation or the formalization of categories of "medicines" and "drugs":

> We're gonna try to create a market for substances that is safe for consumers, but we're not gonna let all consumers shop in this safe market. We're only going to let a certain kind of consumer shop in the safe market. And other consumers we're just going to try to exclude from these safe markets. We're gonna call this area medicine, and we're going to call these consumers patients. And we're going to call these transactions therapeutic. And then on this other side we're gonna call these consumers 'junkies' or 'dope fiends.'

Remember, in some ways it's a strange thing to try to draw that line between therapy and abuse of a psychoactive drug. Where does the relief of suffering end and pleasure begin? So, the point being that these categories get constructed out of the particular configuration of political coalitions and reform agendas at a particular time. And then, once they're built, over time they become the basis for all kinds of human activities. People build professions around them; they build agencies around them. The Food and Drug Administration gets built to administer this whole world of thera-

peutic drugs. The Federal Bureau of Narcotics gets built to administer the other. And so, people become more and more invested in the categories over time. They come to take on a solidity and substance that they don't naturally have. So, that's particularly how this developed for medicines and drugs in the United States.

RZ: *You have written that in the early twentieth century, it was common for medical journals to recommend the use of minor tranquilizers for many situations. The so-called "misuses" of pharmaceuticals have been present since the launch of these drugs. Could you comment on that?*

DH: It's a great question. I think your question clearly implies: what does the word "misuse" mean? What does the concept of misuse mean? When—let's say [dealing with anxious] tension in noisy places or [coping with] a bereavement—if taking a drug in that situation to feel better is appropriate as medical? When is it *not* appropriate to use a drug?

And it's a little bit of a tautology; it's circular logic to say that when a doctor tells you to do it, it's medical and that's how we determine it. I mean, if it's literally just what a doctor says then how can a doctor ever do anything wrong? What is a "dope doctor" if the only definition is, as long as you're following a doctor's orders.

And so, the more you investigate it from this side, the more it looks like the medical, once again, is just a term for . . . almost like a segregated market for psychoactive drugs. . . . There are people who get to walk in the front door of the movie theater and see the movies at reasonable times, and people who have to go in the back door and only are allowed to see them, you know, when it's not convenient for the privileged people. Or some people get to sit in the nice car on the train and other people are put somewhere else. This kind of logic colors—literally within the United States because so much to do with race—it colors access to these kinds of drugs, and when you step back at it from this perspective, the concept of misuse seems to be, you know, people want to say misuse because it sounds less stigmatizing than abuse. But it still borrows from the same concepts and still suggests the same paradigm which assumes somehow that the medical really means "good for you" and non-medical really means "bad for you."

And then no one even bothers to ask whether nonmedical drug use is good for you. Obviously, I don't keep up on all the ethnographic and interview literature, but I know that, broadly speaking, that isn't a large mainstream area of study. So, it raises this question about what "misuse" means other than as a way of classifying people and which social privileges they have access to. Because life is hard; it involves suffering for all of us, and when used safely most of us find that [at least sometimes] drugs can help us get through the suffering of life.

I've always found the concept of medicalization as it's often applied to be a little frustrating, because it assumes this kind of uniform block of what is the medical. And that when something gets plonked into the medical, the medical, itself, remains whatever it was, that . . . there isn't a dialogue back and forth. So that when something is medicalized that represents a victory of whatever force within the medical wanted that against whatever forces inside the medical didn't want that. And changing the boundaries of what is the medical also changes what you mean when you say medical. It's a very complex and multilayered process that involves all these different actors who aren't always on the same page—commercial actors, professional actors, activist political actors. And so when we talk about, in the classic sense, the medicalization of an experience like let's just say fear: to call some of that "anxiety" or to call some of that "panic" and then treat it as medical, the classic narrative would have that

either physicians or drug companies kind of steal this aspect of human experience and then they own, and then they control it. They dictate the terms that you narrate your own experience with. So that, not only are you paying them money, but you're colonized by their ideas about what you are experiencing, and you are losing so many levels of control. I'm very convinced that's not anything close to a complete description of what's going on. It massively overestimates the power of very powerful actors: the pharmaceutical industry, physicians, organized medicine. It turns consumers into dunces, into a completely passive pawns who are acted upon and don't pursue their own agendas, and are incapable of having a thought like, "Ah! They're trying to medicalize my bad experience because they want my money, but I think I'm smart enough to get what I want out of it."

I think that only by acknowledging all of the agency of everyone involved and the massive power differentials, then you can understand what's happening, and you can get a sense of how to act to improve the situation. What you want is to help people achieve their agendas safely and that's just a complicated activity to do.

There is a tendency . . . [in] these medicalization narratives not to acknowledge that consumers have a role in this and have legitimate agendas and desires—that it is actually legitimate to want to use drugs to help deal with the stuff that happens in life. And not only is it legitimate, but almost everybody already does it. The question is, are they doing it in ways that are safe for them or not? And a lot of people, both medical consumers and non-medical consumers, are doing it in ways that are not safe because of the weird ways that we think about those things. And the tendency to think, for example, that this group of people that we call "patients," don't have any independent desire for drugs at all. Any desire they have for drugs must have been created by an advertisement. Whereas these other people, who don't have great access to medical system—they're racial minorities or they're poor, etc.—that they don't have any desire for health; that they only have desire for pleasure.

RZ: *Second-wave feminism played an important role in the social history of tranquilizers, holding out hope for liberation from "mother's little helper." What is the position of the current waves of feminism on tranquilizers nowadays?*

DH: I can't claim to speak for that group of people, and I'm a historian not attuned to the present day, so I could be pretty ignorant about it. But . . . Valium became such an important issue because one particular group of feminists found it extraordinarily useful for conveying a very specific story about a group of women that they defined as . . . well-educated relatively affluent women who expected more but got housewifery. And it was so perfect for telling that story. But I'm not sure that that's a story that really captures a lot of women's experiences or self-perception right now. . . . For people who care about gender politics who are involved in drugs, I see a push back against that Valium story that I heard about in *Happy Pills*. . . . That was a story of passive, apolitical women who became political when they realized that they had been forced to take Valium and become addicted. There's a lot of reason to question that story. . . . The second wave feminists used Valium to tell a story like, "We were just brain-dead housewives and then when we came to be politicized." And if you look into the stories, there's a lot of reason to be very dubious. There's some women who are telling different stories about drugs. In the sense of, can they be used strategically, if carefully, and [used] with a greater sense of caution about the medical industry [while] recognizing that your interests and the interests of the medical world are not the same? That kind of legacy [is] the feminist version of the patients' rights

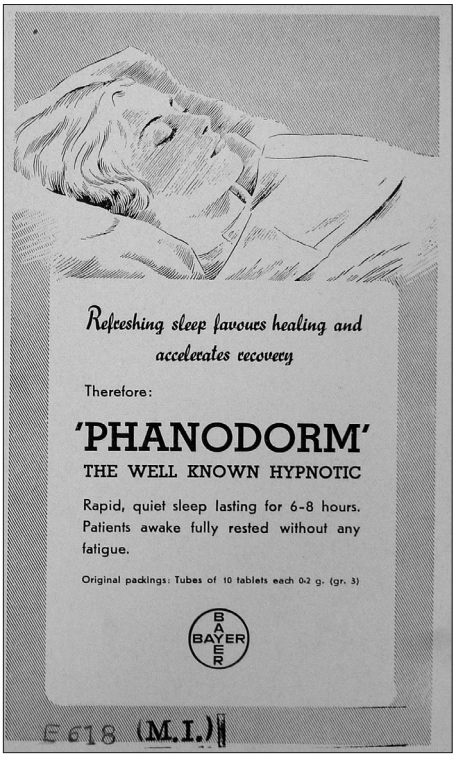

Figure 1. 1926 advertisement for Phanodorm connected its psychoactive product with "medicines" rather than "drugs" by prominently featuring stereotypical patients like white women of middle or upper class status. Image from the Sterling Drug, Inc. Records, Series 3: Sales and Marketing, Smithsonian Institution, National Museum of American History.

movement, but [women] also [were] saying, "I have the right not to be stigmatized for using this drug to try to accomplish my goals." So, it's simply not as useful for reaching people . . . is my sense of it.

RZ: *The role of advertisements [Figure 1] in building up the allure of psychotropic drugs in the US is one central subjects of your work. When researching the history of tranquilizers you found a lot of popular culture material. How do you react to this?*

DH: One of the engines of psychoactive drug history is the circulation of knowledge outside the halls of medicine. So, there's this defined formal kind of knowledge that is really structured by certain narrow paths overseen by guardians of those fields. . . .

But then there's this massive amount of knowledge from people who have taken the drugs talking to other people. . . . Paying attention to that stuff is really important. . . . All those knowledges matter and they also shape how people interact with doctors, and they shape how people, when they see a drug advertisement, how they read that drug advertisement.

And so, this is another way of bringing back the agency of consumers and potential consumers. Because the first thing when you see that—the first you'll be trained to do, at least in the United States—is you're trained to think of drug consumers, pharmaceutical consumers as kind of this passive, feminized group that you have some contempt for because, whatever, pick your reason: they are taking the easy way out; [they are] being manipulated by drug companies; they are drug takers. Whatever it is;

you think that these people are less agentic than you who are observing it. And you see something like this and your first thought [on seeing people wearing, for example, Quaalude jewelry] would be . . . "Look, people are so dumb, they're doing free marketing for Rorer pharmaceuticals even though the drug is dangerous, and they shouldn't be."

So, I think [advertising and popular culture] is really very interesting and hard to understand without a lot of study.

RZ: *You have emphasized the discourse of the "reformists" during the heydays of Valium and Miltown—the people "who were concerned about the weakening of physicians' authority in this consumerism setup," as you put it. Who are these therapeutic reformists nowadays?*

DH: It's such a complicated question, but the easiest place to find them—in terms of psychoactive drugs right now—are the people who successfully introduced new limits on opioid prescribing and sales in the United States. That's pretty clear. But, for example in 1998, I might have said they were the people pushing to relax rules on opioid prescribing. [This seeming paradox can make sense from a historical perspective.] From the early twentieth century through at least the 1970s, there was this thing that historians refer to as therapeutic reformers, therapeutic elites. They were people who believed that medicine could be improved through the application of science in terms of the production of knowledge about medicine and the application of knowledge in clinical practice. So, they both wanted, for example, randomized controlled, double-blind controlled trials—that was for the production of knowledge on the one side—and then they wanted evidence-based medicine—in the sense of once we have those trials we want doctors to do what those trials say. They were this discrete group of people, and you can have debates about their impact on various fields, but they were pretty easy to define.

[At some point,] the pharmaceutical industry realized that they [therapeutic reformers] could be useful and that it was possible to invest in them. And so, in the case of opioids, for example, [some therapeutic reformers] legitimately had come to believe that [conservative] opioid prescribing and the regulations constraining opioids sales were bad for people's health and that they were racist. . . . And obviously, the opioid industry is like:

> These people are great! You're telling this hard truth that takes a lot of courage to say. You know what, maybe it'll be easier for you to say it with a couple of million dollars and, you know, how about a whole organization like that, an advocacy organization, or a professional organization and you can be president and, you know, you'll have all these other ways to get your message out.

So, this story of who the therapeutic reformers are now just becomes more complicated because, just like patient activism, the boundaries between them and the profit-driven world of pharma, profit-funded world of . . . medical research, makes it unclear that that term means the same thing today that perhaps it did at one point.

RZ: *Your work has also shed some light on how tranquilizers have also impacted ideals of masculinity. You wrote that the use of Miltown was a symbol of masculine decline. Could you comment on that?*

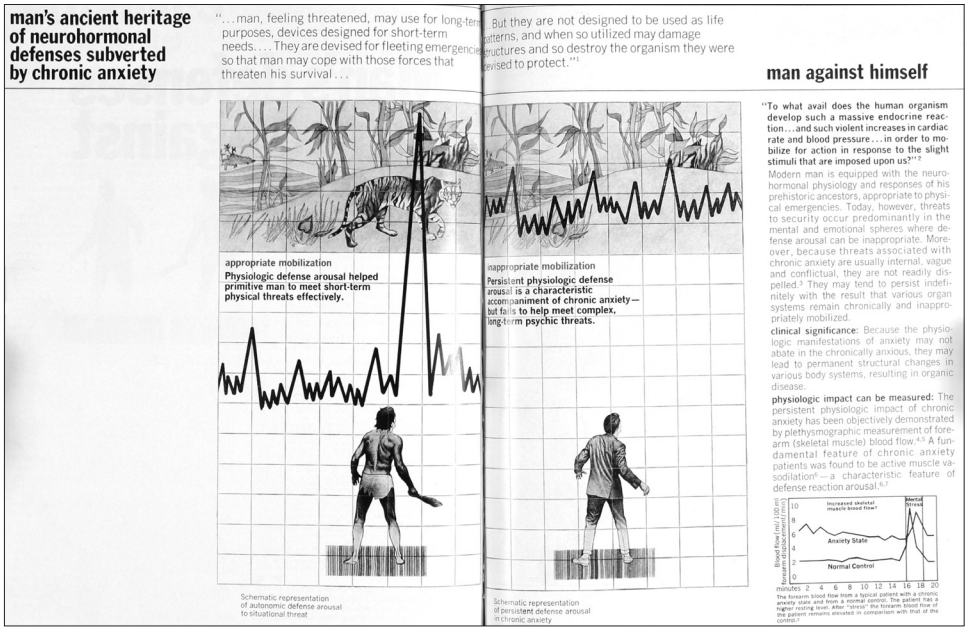

Figure 2. Librium, a benzodiazepine tranquilizer, was advertised to help men meet normative gender standards by soothing their inner caveman. Librium ad, Journal of the American Medical Association*, September 15, 1969. Courtesy of New York Academy of Medicine Library.*

DH: As a sidebar, most of the libraries that preserve the medical journals, they cut the drug advertisements out before they save the journals. And I was only able to find most years at the New York Academy of Medicine, which saved the whole journal. And it's so fascinating the thought process that goes behind saying that the advertisements are irrelevant. To a historian that's horrifying. . . . The idea—this kind of snooty thought—that doctors don't even notice the advertisements, and so they're just a waste of space is hilarious elitism.

I finally got a look at all these advertisements [while researching *Happy Pills*], and it was a great blow to me and to my thoughts about . . . my analysis [to see] that half the advertisements had men in them. And I thought I don't understand: tranquilizers were this famous symbol of sexism; they're these women's drugs, so why do half the advertisement have men in them? That's a curious thing because we've assumed that drug companies wanted to sell these drugs to women because companies were sexists. I'm sure that's true, that they were sexist, but were they so sexist that they wanted to just write off half of their costumers? And the answer . . . is obviously no! They were desperate to sell these pills for men.

My question is, why didn't it work? Why do women get twice the tranquilizers that men do? And then it seemed that, just like the feminists did later, there's a group [of men] that we don't really have a term for—we don't call them the "patriarchs;" we don't call them the "masculinists"—and that's in part because they weren't rebels against the dominant gender paradigm of their day; they were the henchmen of it, they were the ones enforcing it. And so, they were very widely dispersed. Like you didn't need an organization of these people to do this; you could just find people who were very interested in espousing these views and punishing non-conformists every-

where. Maybe they were a magazine editor; maybe they were a car salesmen; maybe there were somebody's husband and their brother. So, out of all these dispersed areas I saw that there was a really strong reaction to just the very idea that you could pacify American men.

There was this huge furor about it in the 1950s, and then, lo and behold, when the next drug comes out, they're more careful in how they try to sell it to men. It's very much more targeted to particular groups [Figure 2]. Men like me with graduate degrees; we're not "real men," anyway, so nobody is gonna care if we get tranquilized; or if they're gonna sell it to sports guys, they're going to sell them as muscles relaxants—you're not anxious; you're not fearful, you just need a muscle relaxant and that's what Valium will do for you. It's like somebody touched a hot stove and the whole industry learned the lesson like, oh, that [claiming to "pacify" men] is gonna really freak out a lot of people who have a big platform. They can make a lot of noise. Do we need that kind of scrutiny? We can diversify the way that we sell to men [and] acknowledge that we're not going to sell as many to men and to women, but we're not gonna touch that hot stove, we're not gonna poke the tiger to get mad at us.

And I like that story . . . because it shows how people, ideas, and actions that take place outside of the medical world are really central movers in this story. The people upset about tranquilizing American's manly-men; those were not therapeutic reformers; those weren't medical actors in any sense, and yet, they shaped that trajectory.

RZ: *Your work on the social history of Miltown in the USA, as well as Valium and Quaalude, sheds light on many issues that could also be applied to Latin America. As far as I understand it, you are suggesting that the historiography of the "drug war" and "pharmaceutical history" are part of the same process. The division between "medical" and "nonmedical" uses and sales was an attempt to enable these "white markets." Bringing together these two histories changes the lens through which we tend to look at drugs and pharmaceuticals. Would it be fair to say that any work or research on substances should look into them from an intersectional [gender, class, race] and multilayered [popular demands, physicians' interests, pharmaceutical industry, political and economic forces at stake, social values] viewpoint?*

DH: Absolutely. . . . Not doing that is, in fact, just doing that poorly, if you know what I mean. To not do that, at least in the United States context, is just to assume that you're studying white people or to assume you're studying black people in a context where the racial story may be very different or to assume you're studying middle-class people. And so that's why I think one has to do those things [use intersectional, multilayered analysis] and those are the appropriate categories because those are the categories out of which this [binary] infrastructure [of the medicine/drug divide] was built: it was built out of race; it was built out of profit; it was built out of professional agendas; it was built out of genuine concern for health; it was built out of, you know, all of these different things that can often be described as mutually exclusive. They're all in there like twisted and warped into . . . this whole structure that then we just kind of label "medicine" or "drugs" and try not to look at it too hard, because it'll all fall apart. And if we want to rationally and intelligently and analytically disassemble it and maybe build something that'll suit our purposes better, those are the tools that we need to use to do that because they are appropriate to the task.