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DISCIPLINING ADDICTIONS: THE BIO-POLITICS OF METHADONE AND HEROIN IN THE UNITED STATES

ABSTRACT. Biomedical understanding of methadone as a magic-bullet pharmacological block to the euphoric effects of heroin is inconsistent with epidemiological and clinical data. An ethnographic perspective on the ways street-based heroin addicts experience methadone reveals the quagmire of power relations that shape drug treatment in the United States. The phenomenon of the methadone clinic is an unhappy compromise between competing discourses: A criminalizing morality versus a medicalizing model of addiction-as-a-brain-disease. Treatment in this context becomes a hostile exercise in disciplining the unruly misuses of pleasure and in controlling economically unproductive bodies. Most of the biomedical and epidemiological research literature on methadone obscures these power dynamics by technocratically debating dosage titrations in a social vacuum. A foucaultian critique of the interplay between power and knowledge might dismiss debates over the Swiss experiments with heroin prescription as merely one more version of biopower disciplining unworthy bodies. Foucault's ill-defined concept of the specific intellectual as someone who confronts power relations on a practical technical level, however, suggests there can be a role for political as well as theoretical engagement with debates in the field of applied substance abuse treatment. Meanwhile, too many heroin addicts who are prescribed methadone in the United States suffer negative side effects that range from an accentuated craving for polydrug abuse to a paralyzing sense of impotence and physical and emotional discomfort.

In a halting voice, over the long-distance telephone lines between New York and California, Primo, the manager of the crack house I had lived next to for almost four years in East Harlem admitted that he was taking 80 milligrams of methadone every day. Profoundly embarrassed, Primo asked me not to mention his new methadone addiction in the epilogue to the book that I was preparing at the time of that telephone call (Bourgois 1995).[1]

The news that Primo was physically addicted to methadone was counterintuitive to me: By conventional standards, Primo had turned his life around in the year prior to that telephone conversation. He had stopped selling crack; he had found legal employment as a summer replacement porter for the mafia-controlled union[2] that represents service workers in primarily luxury apartment buildings; and he had stopped drinking alcohol and sniffing cocaine. In contrast, during the almost six years I had known

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him as a crack dealer, Primo had sniffed heroin and cocaine without ever developing a physical addiction to heroin.

Contradictorily, therefore, Primo's new legal $500/week job (a large sum by inner-city working-class standards in the 1990s) provided him with enough stable money, and enforced a sufficiently regular schedule for him to develop a physical addiction to heroin. Previously as a crack dealer his unsteady income and work schedule had prevented him from using heroin on a daily basis. He had consumed drugs solely on a binge/party basis depending upon how much money he had earned on a particular night of dealing. As a stable working class wannabe union member, Primo began sniffing two $10 bags of heroin every weekday before and during work, and six-to-eight bags each weekend to celebrate.

When Primo's union laid him off at the end of the summer he suddenly ran out of money and discovered that he "had a monkey – King Kong – on [his] back." He attempted to quit "cold turkey," but two days later in the midst of wrenching opiate withdrawal symptoms he received a phone call from the union offering to rehire him. They had laid him off simply to prevent him from having the seniority to qualify for union membership. In order not to lose this opportunity for well-remunerated – even if unstable – legal employment, Primo immediately enrolled in the methadone clinic that was located next to the luxury condominium where he mopped and hauled garbage.

Because Primo was legally employed, the methadone clinic offered him preferential hours – a 45-minute window of time – to receive his medication, during his lunch hour. For the next three years, Primo became a very stable porter despite the fact that he was laid off for at least 2 weeks every three months in order to prevent him from qualifying for seniority and health benefits. Because of his methadone addiction, Primo would travel downtown past his site of employment every day at lunch hour to continue receiving his medication even during the weeks when he was laid off. This provided Primo with the opportunity to verify in person with management on the up-to-the-minute flexible labor needs of the apartment complex.

The symbiotic relationship between Primo's methadone addiction and his reliability at work fell apart when his conveniently located methadone clinic closed down due to budget cuts and neighborhood gentrification. He began arriving late from his lunch break due to the distant commute to his new ghetto-located clinic. His counselor promptly shifted Primo to LAAM, an experimental, longer-acting (and consequently even more physically addictive) opiate substitution product. The pharmacology of LAAM only obliged Primo to visit his dispensing clinic twice a week –

and one of those medication sessions could be coordinated with his day off from work.

Several months later, when Primo asked to be detoxed gradually from LAAM he was told that there was no precedent for quitting LAAM and that he would have to be switched back to methadone. He could not afford to return to methadone, however, as it made him late for work.

BIOPOWER, POWER/KNOWLEDGE, AND THE SPECIFIC INTELLECTUAL

This paper draws on Michel Foucault to argue that methadone maintenance, the largest biomedically-organized and federally controlled drug treatment modality in the United States, affecting approximately 115,000 heroin addicts, represents the state's attempt to inculcate moral discipline into the hearts, minds, and bodies of deviants who reject sobriety and economic productivity. Surprisingly, Foucault has relatively rarely been applied to studying illegal psychoactive drugs or to critiquing the social science and biomedical literatures on the subject (for some exceptions see Bourgois, Lettiere and Quesada 1997; Friedman and Alicea 1995; Moore and Wenger 1995; O'Malley and Mugford 1992; Smart 1984). Foucault's concepts of 1) biopower, 2) the disciplinary power/knowledge nexus, and 3) the political utility of the specific intellectual offer a means for critiquing the moral imperatives that drive most drug policy under the rubric of quantitative evidence-based science and health promotion.

To summarize briefly, Foucault's term biopower refers to the ways historically entrenched institutionalized forms of social control discipline bodies. The bio-politics of substance abuse include a wide range of laws, medical interventions, social institutions, ideologies, and even structures of feeling (Ong 1995; Caputo and Yount 1993; Foucault 1982: 208–226; Williams 1977; Rabinow (ed.) 1984: 258–272). The definition of methadone maintenance as "drug treatment" is a particularly concrete example of biopower at work. The state and medical authorities have created distinctions between heroin and methadone that revolve primarily around moral categories concerned with controlling pleasure and productivity: legal versus illegal; medicine versus drug. The contrast between methadone and heroin illustrates how the medical and criminal justice systems discipline the uses of pleasure, declaring some psychoactive drugs to be legal medicine and others to be illegal poisons. Ultimately, it can be argued that the most important pharmacological difference between the two drugs that might explain their diametrically opposed legal and medical statuses is that one (heroin) is more pleasurable than the other (methadone).

By interweaving fieldwork descriptions and street conversations of inner city-based heroin addicts this paper offers an ethnographic critique of methadone treatment programs in the United States. More importantly, it links the on-the-ground flesh-and-blood contradictions of methadone versus heroin addiction to the academic, medical, and social service discourses that constitute what Foucault would identify as the power/knowledge nexus of the science of substance abuse treatment. In Foucault's framework, power and knowledge constitute one another, and in that process they set the parameters for disciplining social life. He argues that academic, medical, and juridical fields of study and practice emerged historically as central components of social control through the construction of epistemological frameworks defined as legitimate science and health (Foucault 1981). Concretely, in the case of methadone, competing scientific, political, and populist discourses mobilize an avalanche of objective, technical and rigorously quantified data that render them oblivious to their embroilment in a Calvinist-Puritanical project (Weber 1958) of managing immoral pursuits of pleasure and of promoting personal self-control in a manner that is consonant with economic productivity and social conformity.

A theoretically informed ethnographic approach, in contrast, can offer specific practical insights into the slippery and often contradictory ways power operates in the health sciences. In this vein, in an attempt to take Foucault out of a theoretical realm that often paralyzes political or even practical engagement, I will render him "specifically applied" by addressing the relative pharmacological merits of heroin versus methadone from the perspective of harm/risk reduction, despite the conundrum of falling into the power/knowledge trap of drug treatment debates that camouflage moral judgements behind medical objectivity. I hope to contribute, however humbly, to Foucault's political challenge of developing technically useful, applicable "specific knowledges" around the controlling micro-practices and discourses that engulf our everyday lives and desires (Rabinow (ed.) 1984: 67–75). At the same time, it is important to be aware that the role of what Foucault calls the "specific intellectual" who engages "... real, material everyday struggles" and poses concrete alternatives through technical positioning can be treacherous (ibid.: 68). In an attempt to reduce structurally imposed social suffering by applying one's knowledge to promote one particular drug treatment modality or public policy over another, the specific intellectual risks merely tinkering with the efficiency of biopower and missing the more complicated picture of the multi-faceted ways power operates. Even the best of intentions to help or to serve the socially vulnerable can also simultaneously perpetuate

– or even exacerbate – oppression, humiliation and dependency of one kind or another. Nevertheless, in this paper I raise the politically taboo possibility that heroin may be less harmful than methadone. In fact, contrary to the standard biomedical definition of the two drugs as incompatible pharmacologically, they may actually be complementary to one another in the context of treatment.

FROM 'DOPE' TO 'MEDICATION'

Both heroin and methadone addicts are physiologically addicted to a drug that alters their metabolisms and their states of consciousness. A heroin addict however, is defined – and often acts – as a self-destructive, irresponsible criminal. A long-term methadone addict, in contrast, is defined – and often acts – as a worthy, well-disciplined citizen/patient who is dutifully on the road to recovery from substance abuse. Methadone addicts are referred to as "patients," "clients" and even "consumers." In contrast heroin addicts are "criminals," "sociopaths," "deviants," or at best "sick."

An ethnographer who watched the introduction of methadone maintenance as the primary treatment modality in New York City from 1973 to 1975 astutely noted: "The 'dope' became 'medication,' the 'addict' became a 'patient,' 'addiction' became 'treatment' ... " (Agar 1977: 176; see also Agar and Stephens 1975). This dramatic metamorphosis was made possible in the United States by the biomedical theories of two doctors in the late 1960s. They redefined heroin addiction as an objective, identifiable "metabolic disease." It became a physiological imbalance at the level of the brain's synapses requiring medical stabilization through pharmacological intervention (Dole and Nyswander 1967).

Like heroin and cocaine which were originally hailed as cures for morphine addiction in the 1800s when they were first synthesized, methadone in the Post-World War II era is considered to be a cure for heroin addiction. The specific biomedical term for the way methadone intervenes pharmacologically in the brain's synapses is as an "opiate agonist." It blocks both the pleasure and the pain that heroin produces by generating alternative sensations of its own at the "μ" opioid receptor sites in the brain's synapses. According to the biomedical paradigm:

> Methadone is a slow-onset, long-acting, mu opiate receptor agonist that reduces the craving for heroin and largely prevents the reward or euphoria if the patient slips and takes a dose of an opiate (O'Brien 1997).

In other words methadone is a biomedical technology that facilitates a moral block to pleasure.

Ironically, methadone's effectiveness at blocking opiate-driven euphoria is predicated upon methadone being more highly physically addictive than heroin or morphine. Most methadone addicts develop such a rapid physical tolerance to the drug that they are no longer able to feel significant pleasurable effects from its consumption after only a few weeks of daily consumption. By stimulating the neurotransmitters in the brain synapses so intensively that they cannot process the electromagnetic signals for feeling the euphoria that heroin consumption triggers, methadone is supposed to enable addicts to reorganize their lives productively and healthfully. They can no longer nod away their days in unemployed bliss (or agony); they are no longer constrained to engage in risky injection practices (Ball et al. 1988), or to pursue illegal income-generating strategies. Indeed, for a significant minority of heroin addicts methadone maintenance stabilizes their lives and enables them to withdraw completely from street-based substance abuse. For the majority, however, the effects of methadone maintenance are much more mixed, and for some they are virulently counter-productive.

ETHNOGRAPHIC DISSONANCE

Long-term participant-observation ethnographic fieldwork among middle-aged homeless addicts in San Francisco and among younger heroin addicts in East Harlem and Montreal demonstrates that the official biomedical discourse on methadone makes little sense pharmacologically or socially – at least for the majority of opiate addicts one encounters on the street.

My decade-long archive of fieldwork notes on street drugs contains dozens of matter-of-fact references to methadone addicts and users "nodding out," "throwing up from overdoses," and aggressively and gleefully consuming cocaine, wine, prescription pills, and even heroin to augment the euphoria of their opiate agonist:

East Harlem, 1989:
Stumbling like a drunk; slurring his words; drooling and nodding, Tito almost in tears begged me to give him $10 to buy some powder cocaine, "Para arreglarme [to straighten myself out]." As a street dealer Tito has a big heroin habit. He claims that it is over $60 a day.

Today was Tito's first day of methadone maintenance, and the 35 mg initial dose that they gave him was knocking him off his feet. I felt sorry for him because he reports to work [selling heroin on 124th St.] at 3:00 p.m. He will be fired – or worse – if he arrives stumbling, slurring, and nodding.

A fieldwork note in a very different setting at a Montreal methadone clinic describes my concern when an HIV-positive transgender heroin addict threw up all over my feet. Once again methadone's interference

with the addict's capability to perform his/her job emerges as the primary concern and justifies a craving for cocaine.

Montréal, March 1997:
Annie's body simply could not tolerate the 35 mg initial dosage the clinic doctors had prescribed. She could barely stand up, but it was past the clinic's closing time and she had to leave.

When we stepped outside, slipping and sliding on the ice and snow on our way to the prostitute stroll where she was looking for work well after midnight in below-zero weather I offered to pay for a hotel room for her.

She replied with a sigh, "No thanks, what I really need is a shot of coke to straighten me out. I have to get back to work."

Biomedical treatment experts would explain away these ethnographic vignettes as portraying the initiation phase of methadone treatment prior to dosage stabilization. Their explanations certainly sound biomedically convincing. Nevertheless, on dozens of occasions I watched Primo, the former crack dealer now working as a building porter, nod blissfully after sniffing a small $10 packet of heroin even after his methadone clinic had increased his daily dose to the maximum allowable level of 120 mgs per day.

East Harlem, July 1996:
I read Papito, (Primo's 12-year-old son) the passages in my book where his father talks of not having money to buy him a birthday present. Primo nodded out in the middle of my reading and even dropped his slice of pizza; his mouth drooped open drooling ever-so-slightly.

Later Primo insisted that he had not consumed any extra heroin that day. He claims that the nodding was strictly due to the methadone. His wife confided to me disgustedly, however, that Primo has "been sniffing dope on the sneak-tip." His son Papito, who is not supposed to know anything about his father's methadone addiction, looks profoundly depressed to me.

Primo's wife might not be right because three months later Primo apologized to me for not being able to comment on the manuscripts I had given him, claiming that he always nods out whenever he starts to read. "I can only just barely even watch television . . . I hate methadone!"

As Primo's addiction illustrates, methadone maintenance treatment is often experienced as a hostile and/or arbitrary forum for social control and enforced dependency among street addicts. It seeps into the fabric of one's most intimate relationships, distorting (in Primo's case) respectful interaction with children, wives, intellectual friends. Methadone addiction elicits a panoply of practices ranging from resistance, anger and depression, to compliance and relief as the following notes from another telephone conversation with Primo document:

East Harlem, April 1997:
Primo told me that not a day passes without him thinking about his mother who died of

AIDS over a year ago. He was laid off from his porter job and has not been called back in over two months – his longest hiatus of unemployment yet.

To make matters worse the New York City Housing Authority has set a court date to evict him from his mother's apartment where he has lived all his life and where she died. Primo has a past felony record and Public Housing now has a "one-strike-you-are-out" ruling. To top it off last week his methadone clinic raised him another 10 milligrams because of a dirty urine.

One of Primo's sisters offered to allow him to live with her in New Jersey, where he can work with a cousin who is a contractor. Primo cannot move in with his sister, however, because New Jersey does not give methadone to New York emigrants.

Primo is too embarrassed to tell his sister about his methadone addiction, as a result his sister and everyone are convinced he is being a flake who does not want to work or turn his life around.

Last week Primo's counselor threatened to discontinue him because he has not obtained an updated tuberculosis test. He also owes $1,000 to the program in lapsed monthly payments. For some reason, however, the dispenser did not "write him up" and he has been "getting dosed" despite non-payment.

Once again, we see how profoundly methadone articulates in Primo's case with his structurally exacerbated depression to affect intimate definitions of self-respect. The political economic constraints limiting Primo's life chances (i.e., unemployment, felony record, medical bills, housing market etc.) are already overwhelming, and methadone's rigid institutional regulations further curtail his options for autonomous change. They even isolate him from his kin-based social support network at a time of personal despair when threatened by homelessness. The ethnographic literature on methadone confirms widespread resentment as well as a passive self-deprecating obedience on the part of structurally vulnerable methadone addicts (cf. Rosenbaum and Murphy 1984). One study quotes addicts as referring to their relationship to methadone as "a ball and chain" (Johnson and Friedman 1993: 37); other researchers cite methadone addicts as complaining of "feeling like automatons," and of "becoming robotic" (Uchtenhagen 1997; Koester et al. 1999). In Denver street addicts had nicknamed methadone "methadeath" (Koester et al. 1999).

FEDERAL BIOMEDICAL VERSUS POPULIST PROHIBITIONIST AND ABSTINENCE DISCOURSES ON METHADONE

The biomedical discourse of addiction as a disease is promoted at the federal level through the National Institutes of Health (NIH), which officially declared methadone maintenance to be the most effective modality for treating heroin addiction in the 1980s and 1990s. Their conference titles and publications invariably display the aggressive/defensive slogan

"Treatment Works", for the benefit of congressional budget committees and a tax paying public which prefers to punish criminals than to treat them. Methadone is especially appealing to treatment scientists because the biomedical world is dedicated to solving complex social ills by developing laboratory-based, high-tech potions that promise quick-fixes and easily replicable efficient outcomes. Methadone is understood to be the technocratic magic bullet that can resolve social, economic, and human existential quandaries by intervening almost surgically at the level of the brain's synapses. Indeed methadone has become the model for all drug treatment: short-circuiting pleasure sensations within the brain's synapses. Hundreds of millions of dollars have been spent on laboratory research to develop similar magic bullets to combat addiction to other street drugs (cf. Balter 1996).

The federal U.S. commitment to methadone was formally reconfirmed in 1998 by a NIH National Consensus Development Panel (NCDP), entitled "Effective Medical Treatment of Opiate Addiction." The biggest opponent to the NIH biomedical discourse celebrating methadone treatment comes from the "Just-Say-No-To-Drugs" moral abstinence discourse (see critique by Rosenbaum 1995) that dominates the U.S. Congress, law enforcement, popular culture, churches, 12-step recovery programs, and the health fad movements (from aerobics and cholesterol monitoring to new-age holism). The Just-Say-No camp is oblivious or else hostile to the "addiction is a metabolic disease" discourse of doctors who prescribe methadone and attempt to control and rehabilitate bodies through pharmacological therapeutics. Instead they exhort citizens to personal abstinence based on individual willpower and spirituality.

The healthist/abstinence discourse (Crawford 1984) complements a third influential position that criminalizes drugs. The criminal emphasis is so hegemonic in the United States that the biomedical disease model can only resist it passively. Indeed one of the self-proclaimed yardsticks for the success of methadone treatment is that it reduces crime. There is room for a "good-cop/bad-cop" complementarity between the biomedical and the criminal discourses since criminals can be both punished and rehabilitated.[3] The healthist vision, on the other hand, tolerates no pharmacological tampering whatsoever with addicted brains. Methadone patients, for example, are not usually welcome at 12-step Narcotics Anonymous meetings.

The 1998 National Consensus Development Panel document promoting methadone was primarily concerned with arguing against the prohibitionist criminalizing discourse of the drug warriors who dominate Congress and the US criminal justice apparatus. To gain credibility, despite being

federally-convened and funded, the authors introduced themselves as "a non-advocate, non-federal panel of experts." They directed their most pointed criticism at "unnecessary federal regulation" which they considered "a major barrier to providing methadone maintenance treatment" (NCDP 1998; CESAR Fax 1997). Using the twentieth century language and values of biopower, the consensus panel's arguments in favor of methadone emphasize its impact on health, mortality, productivity, and morality. Their summary presents methadone as being "effective in reducing illicit opiate drug use, reducing crime, enhancing social productivity and reducing the spread of viral diseases such as acquired immunodeficiency syndrome (AIDS) and hepatitis" (NCDP 1998: 1937). The consensus document specifically notes that the death rate of heroin addicts is "more than 3 times greater than that experienced by those engaged in MMT [methadone maintenance treatment]" (NCDP 1998: 1939). In a special section entitled "Joblessness" the report assures readers that methadone addicts have superior citizenship qualities as measured according to the most objective index available in the late twentieth century: "Persons dependent on opiates who are in MMT earn more than twice as much money annually as those not in treatment" (NCDP 1998: 1939). It is disconcerting to contrast the statistical certainties of the NIH consensus statement to the ways Primo, Tito and Annie in the preceding ethnographic vignettes explain their lived experiences on the street of the interface between methadone and employment/income generation.

LOCAL DISCOURSES ON METHADONE: NEW YORK VERSUS SAN FRANCISCO

The tension between the medical, the prohibitionist, and the abstinence discourses play themselves out in the all-American terrain of states' rights. In eight states methadone treatment is illegal. Even where it is legal, however, dramatically different local cultures of treatment have emerged depending upon local constellations of forces between the medical and criminal justice establishments, the size of the street addict population, and the cultural politics of the region. In New York City (and in general along the Eastern Seaboard) the biomedical model of substance abuse as a metabolic disease requiring pharmacological intervention dominates. Long-term methadone maintenance is relatively easy to obtain. Methadone treatment is a multi-million dollar treatment and research for-profit industry located at dozens of accessible, usually federally-subsidized clinics and research hospitals.

In contrast, San Francisco is dominated by an almost New Age (but profoundly Puritanical) celebration of healthy, drug-free bodies. There is even a cultural nationalist, identity politics conspiracy theory discourse that equates methadone to genocide against people of color. Methadone, in short, is morally suspect and access to long-term maintenance clinics is extremely limited (see critique by Rosenbaum 1995). Methadone maintenance is provided preferentially to heroin addicts with terminal or dangerously contagious diseases like Tuberculosis and HIV who need to be carefully monitored and controlled. As a compromise for the long lines of addicts seeking any kind of treatment whatsoever, a panoply of badly organized for-profit and sometimes corrupt 21-day detox venues have emerged (National Alliance of Methadone Advocates 1997). They prescribe methadone on a temporary basis at low doses that do not exceed 40 mgs per day despite the fact that biomedical researchers insist that 60 to 80 mgs is the minimum effective dose to block the brain's synapses. In fact, some epidemiological studies conclude that the minimum effective dosage is as high as 80–120 mgs (Caplehorn et al. 1993; Cooper 1989; D'Aunno and Vaughn 1992; Dole and Nyswander 1982).

The San Francisco treatment community's pure body discourse can be read between the lines of the handout published by the City's Public Health Service listing the rules governing access to methadone treatment clinics:

> Maintenance Program 1 ... No Waitlist. Languages: English, Egyptian, and Norwegian. Requirements: to be eligible you need to have one failed detox attempt and at least one year of heroin addiction (that you can prove – from a medical record, police record, etc.) You will also need a TB test, a Syphilis test, and a general physical. MediCal accepted.
>
> Maintenance Program 2 ... Waitlist varies depending on your health. Preference is given to people who are seriously ill. Requirements: letter of diagnoses of HIV positive or *active* TB (not just skin-test positive. If you are not ill you may need to detox several times. (7-day wait to get back on detox).
>
> Maintenance Program 3 ... Requires several years of heroin addiction and previous failed detox attempts ... If you have recently been in another methadone detox you must wait: 7 days for a $225 slot; 28 days for a $100 slot ... Bring proof of income ... and a *MONEY ORDER* for the price of the detox (no cash or personal checks accepted) [Original emphasis].

This handout sheet full of byzantine rules that counselors, community-based health outreach workers, and harm reduction activists are supposed to use to facilitate street addicts into recovery is a good example of multiple discourses (puritanical, healthist and culturally correct) run amok in a for-profit medical economy with a decaying public health sector (see Crawford 1994; Rosenbaum and Murphy 1987a; Murphy and Rosenbaum 1988). The primary fear of treatment centers which promote a healthist abstinence discourse is that individuals who are not truly heroin addicts will

wheedle their way into methadone addiction – or worse yet, that individuals who actually enjoy methadone may become addicted to methadone for its latent euphorigenic properties (Spunt et al. 1996). The front-line service providers who treat street addicts, consequently, focus their energy on hair-splitting triages between healthy and unhealthy bodies (i.e., being positive for the TB skin test vs. having active TB; or between accepting money orders instead of MediCal cards and cash). At the same time in tune with Californian identity politics they even strive to stretch cultural categories (Egyptian and Norwegian!) to promote diversity goals.

COMPUTERIZED BIOPOWER: AN ETHNOGRAPHIC CONVERSATION AT THE CLINIC

On the ground San Francisco's panoply of methadone detox versus maintenance rules promote confusion, mistrust, hostility and even rage. We filmed and tape recorded the following conversation outside a private, for-profit methadone clinic that costs $12 a day – and where cash is eagerly accepted by the staff.

Tenderloin, San Francisco, November 1996

Max: Just now when I was in the hospital for three-and-a-half weeks they were giving me so much methadone per day, that by the time I got out of the hospital I was actually hooked on it.

So now I'm on a detox. I'm trying, but the last three days have been real hard because the dose they've been giving me is cut way down now. I mean, I could hardly walk this morning. But I'm still gonna try to hang in there.

I had to wait for my dose until 8:00 because I ain't working. Monday through Friday they open at 6:00–6:30 for the workers. People who ain't working have to wait. Then they take a break at 9:45 and reopen again at 11:00 and close at 1:30. Sound weird?

Philippe: How does methadone work for you?

Max: It sort of stops you from craving the heroin, which is the hard part. Or craving the methadone like I do right now cause I've been so used to drinking it every day. But it has kept me off the heroin.

Philippe: But wasn't that heroin that you just shot a half hour ago?

Max: Today I broke down and fixed some dope because I was sick. I told them yesterday at the office [pointing to the doorway of the clinic] that I've been starting to feel really ill for the last three days.

But there's nothing they can do about that. Unless I had the money to pay to keep myself on the methadone – thirty or forty milligrams, which would be fine. I could maintain on that. It would cost $12 a day.

But it's the whole idea of the methadone . . . Got cigarettes?

Philippe: What happens to your body when you need methadone?

Max: Well, it's sort of the same let-down as when you don't have heroin. You're edgy; you're uptight; you don't feel good. You go to the toilet a lot. You'll start throwing up. It comes out everywhere. Your eyes water; your nose runs. You throw up a lot. You can't sleep.

Watch out! [Rapidly passing car forces cameraman onto the sidewalk] I don't know how many days that goes on for on methadone, 'cause I've never done it all the way before.

[Door to the methadone clinic slams amidst shouting and cursing] Sid looks like he might be a little upset or something.

Philippe: [Ignoring Sid's shouts] How many times have you been on methadone detox?

Max: Oh, gee whiz. I don't know, 15 times over the years. Something like that. [Sid shouting even louder in the background] Maybe 20 times over the past five years.

But methadone works if you let it work for you. It will cut your habit down. You just have to be a little bit stronger than I am.

It's just that it's easy to get hooked on and they cut you down in 21 days, and that's really too fast.

Here – ask Harry. He's been on methadone for a year and a half. I'm gonna go see what's with Sid.

Harry: Yeah, I've been staying clean. I'm on 80 milligrams. The stuff works. On methadone you're just like normal. You wake up; you're not sick at all. I mean, hey, you feel normal. I can get up; smile; brush my teeth and eat; go to work – if I worked. I can do things I'm supposed to do: I can shave; change clothes; wash clothes.

On heroin you don't even feel like getting out of bed. You're so sick you'll go grab a gun and start robbin'. You gotta pull your gun out of the closet and put it in peoples' faces and hurt 'em.

I was tired and frustrated of that shit. On the methadone I'm just like normal.

Philippe: What happens when you chip [occasionally inject heroin] on methadone?

Harry: It's a waste of money. You won't even feel the heroin unless you do a whole bunch of it. You know who invented methadone?

Sid: [Hurrying over to us] We gotta get out of here [pointing to the agitated security guard in the doorway of the clinic]. King Kong over there has a hair up his ass.

[The security guard starts walking towards us]. C'mon, let's go – quick. The asshole thinks he owns this fucking place. [We scramble into the van carrying the camera equipment with the security guard cursing at us through the window].

Harry: [Inside the van] [embarrassed] I hope you can edit all that out? So I was tellin' you about who invented methadone.

Sid: [muttering out the window at the security guard who is slowly walking back to the clinic's entrance surveying the block for other loiterers] Fuckin' bastard.

Harry: I was saying that I heard that Hitler was behind methadone in the beginning. I don't know the whole story but I heard it used to be called "Adolphine" after Adolph Hitler.[4]

Philippe: [Driving away from the methadone clinic] Sid, what's the matter?

Sid: They breathalyzed me. I had too much alcohol on my breath . . . Just over the limit.

One fucking point over the limit. They didn't serve me.

Max: Did you lose your money?

Sid: Yeah. They would've given me a half a dose but the doctor isn't in now, so I woulda' had to wait a half hour. But I gotta get to work. I'm supposed to paint a sign today.

I lost $12! They used to fucking give the money back, you know? Now they say it's in the computer. Like they can't fucking erase the computer, you know?

Bullshit man, that's another scam of theirs. They're just legalized dope dealers. They could give a fuck less about people.

Harry: [Calmly] Well it must go to a main terminal.

Sid: No, somebody got a hair up their ass in there and decided they was gonna punish people for drinking.
[Everyone talking at once]

Jim [Anthropologist colleague driving the van]: That's biopower, Philippe!

Sid: [Interrupting] Look what they did to you [pointing to Harry] last month. They cut you way down; made you real sick for a while ...

Harry: [Angrily excited] That was for a whole week – just for drinking.

Max: [In a low awesome voice whispering to Philippe] At 80 milligrams! You don't know how wrong that is.

Sid: They got complete control of your fucking life.

Max: [Normal tone] That stuff is strong, man. It's stronger than heroin.

Sid: [Loud] That fucking bitch! That's why I'd never get on maintenance again. It's like being in prison. I can't stand that.

They got you scared all the time. They threaten you: "Do this" and "Do that". And they fuck with you all the time. You know, fuckin' following the rules.

And then when they get a little hair up their ass about something, they gonna cut you down.

[Wagging his head and talking in an abrasive falsetto] "We're gonna cut you off."

That shit, is life and death, man.

Max: They just did it to me man. They been dropping me in just a few days. The last few mornings I been feeling really bad.

Philippe: What's your dose? How many milligrams are you on?

Max: They don't tell you how much they're giving you. But this guy I know at the clinic, he told me he started me at 40.

Then I asked for three raises. Three days in a row. So I must have been at 50 – between 50 and 60.

Now they're dropping me down and it's been a week and a half, and the last three days I could feel the difference – a lot!

I wake up at about 3:00; and I lay there; just waiting till 7 or 8:00. I could hardly walk this morning!

Harry: Yeah, I could see you, goin' into convulsions, seizures. That could kill a person.

Sid: [still shouting] It does! It has. I'm tellin' you. Our bodies just can't take it anymore.

THE BIRTH OF THE METHADONE CLINIC

Despite the federal government's solid commitment through the NIH to the biomedical disease model of addiction, the public health establishment at the federal level bows to pressure from more prohibitionist criminalizing discourses on addiction spearheaded by Republicans in Congress and law enforcement agencies. Promoters of methadone, consequently, defensively focus much of their energy to ensure that legal methadone destined for treatment is not diverted illegally to thrill seekers. They also have to monitor that methadone is not supplemented with other illegal drugs that intensify its latent or frustrating euphorigenic qualities. The result is a panoply of repressive federal, state, and local regulations on methadone treatment at specially licensed methadone clinics like the ones documented in the outreach handouts cited earlier and in the videotaped conversation just above.

Psychosocial treatment is subordinated to repression of criminal behavior at most methadone clinics. To prevent patients from re-selling their doses on the street, addicts are forced to come to their clinic in person every day (hence Primo's problem with tardiness at work when his clinic changed locations) to receive their liquid dose of methadone which they are then forced to swallow under the watchful eye of a dispenser. This requirement of daily attendance is probably the single most resented regulation of methadone treatment, and according to one study significantly interferes with treatment retention rates (Rhoades et al. 1998). Exceptionally compliant addicts are rewarded for good behavior with the privilege of "take-home doses." Run-of-the-mill addicts only receive eminently re-saleable "take-homes" on Sundays. Despite all these micro-logistical precautions, doses of liquid methadone smuggled out of clinics in throats and cheeks or as privileged take-homes can be purchased on the blocks surrounding large methadone clinics in most large cities.

The complicated micrologistics for overseeing the consumption of methadone in order to prevent illegal methadone ingestion and to discourage ongoing poly-substance abuse by recovering addicts has given birth to a culture of the methadone clinic. Most of the approximately 115,000 addicts on methadone maintenance in the United States during the 1990s were granted only limited "take-home" privileges. Consequently virtually every day they are forced to converge on methadone clinics to drink their medication in a supervised setting.

One of the explicit therapeutic goals of methadone maintenance treatment is to sever an opiate addict's social relationship to the criminal economy and to the street-based substance abuse community. Ironically,

however, for most patients, it accomplishes much the reverse. The ethnographic literature on methadone clinics from the 1970s confirms how the multi-million dollar, federally-subsidized institution of methadone clinics in the cities that initiated large maintenance programs created an active culture of "broken down, toothless garbage heads" (as Primo refers to his colleagues at the clinic he attends). The intense policing and disciplining of methadone combined with its frustrating euphorigenic qualities render it a drug of last resort for tired, elderly, heroin addicts no longer capable (or willing) to generate sufficient income in the underground economy. Symbolic interactionists, ethnomethodologists and other empirically descriptive ethnographers consistently document methadone addicts as being at the bottom of the status hierarchy of street-based drug abusers (Goldsmith et al. 1984; Hunt et al. 1985; Preble and Miller 1977; Agar 1977). Institutionally autonomous street-based addicts contrast themselves to "those lame methadone winos" (Preble and Miller 1977). Hence the term "righteous dope fiends" to identify heroin addicts who are determined to die as outlaws with their boots on (Sutter 1966; see also Finestone 1957; Preble and Casey 1969).

BIOPOWER IN ACTION

The repressive micro-logistics of methadone administration at clinics offers a graphic image of Foucault's concept of biopower unfolding in a very concrete setting: On any given day throughout the United States dispensers are cursing recalcitrant addicts, ordering them to open their mouths and move their tongues to make sure they have swallowed all of their "medication." As we experienced in the videotaped conversation outside the San Francisco methadone clinic security guards regularly patrol the block in front of clinics to chase away loiterers who might be reselling or buying smuggled methadone, or who might be selling methadone-enhancing substances. In short, there is a very intense policing, medical disciplining, and social dividing of bodies at the methadone clinic.

Methadone clinics, like most out-patient drug treatment programs, are required to submit their clients to random urine tests to verify poly-psychoactive substance consumption and continued illegal opiate use. Indeed, studies measuring continued consumption of illegal substances by methadone addicts offer figures that range from 16 to 60% (Caplehorn et al. 1993; GAO 1990). By strategically varying, supplementing, or destabilizing the effects of their dose with poly-drug consumption, methadone addicts can augment the otherwise marginal or only ambiguously pleasurable effects of methadone. Ethnographers working in the early years of

methadone maintenance noted that a significant number of addicts actually managed to enjoy the methadone high (Agar and Stephens 1975; Stephens and Weppner 1973). As noted in the fieldwork vignettes from East Harlem and Montreal, street addicts report that cocaine mixes well with methadone, especially at high doses (Hunt et al. 1984; Hunt et al. 1986; Rhoades et al. 1998; Strug 1985). Cocaine, in its smokeable base form known as crack, can be cheaply combined with methadone to approximate the *recherché* speedball effect: a contradictory roller-coaster high where the sedative effects of the opiate interact with the stimulating effects of cocaine (see Bourgois 1998). Valium is also said to enhance the otherwise often frustrating or subtle euphorigenic sedative effects of methadone. The most common substance abused by methadone addicts, however, continues to be fortified wine (Preble and Miller 1977; Valentine 1978). The appeal of combining cocaine, alcohol, and benzodiazepines with methadone can be particularly noxious for pregnant heroin addicts who are mandated into treatment, as poly-drug consumption is usually more detrimental to fetal development than heroin alone (Chavkin and Breitmart 1997).

An intense struggle unfolds inside methadone clinics over the dosage levels provided to addicts. Many addicts like Max in San Francisco want higher doses in order to "stay well" – or more surreptitiously in order to feel more strongly the usually frustratingly mild euphoric effects of a stable dose of methadone. Other addicts like Primo in New York want lower doses in the hope of becoming "drug free" – or more surreptitiously in order to be able to feel the euphoria of an occasional illegal supplementary consumption of a bag of street heroin.

Dosage levels are further complicated by the pharmacological fact that methadone is dangerous. Even heroin addicts with large addictions can be overdosed and killed when first prescribed methadone. By law they have to be started at low levels. Their dosages are then raised by 10 or 5 milligram increments depending upon the evolution of their "tolerance levels." Furthermore, individual metabolisms vary considerably, allowing patients to achieve different balances of forbidden euphorigenic feelings as Primo's case illustrates. He continues to "nod out" despite having been maintained at high dosages for several years. Similarly both Annie the transvestite from Canada, and Tito the street dealer in East Harlem stumbled about the streets throwing up after taking only relatively low doses of methadone yet having high tolerances to heroin. The most common scenario around dosage levels in maintenance clinics is the experience of Primo, whose dosage was raised every time he gave a "dirty urine" sample until, against his will, he was brought up to 120 milligrams, which is such a high level of dosage that his clinic must request special Federal/State authorization.

As the conversation and events videotaped outside the San Francisco methadone clinic demonstrate, it only takes a few minutes inside (or outside) a methadone clinic to realize that what the scientific biomedical treatment community refers to as "effective methadone dosage" level has little to do with technocratic pharmacological logics and much more to do with naked power relations. Dosage is determined by a struggle over pleasure, pain, and compliant social control. For example: 1) Max, who was suffering from methadone withdrawal symptoms, had been on a blind dose since inadvertently becoming addicted to methadone in the hospital; he begged for a higher dosage, but was unwilling to pay for it and instead was rapidly detoxed; in response he spent what money he had on street heroin. 2) Sid failed his alcohol breathalyzer test and was refused his 40 milligram dose (after paying for it). 3) Harry, at 80 milligrams, had his dose lowered for a week for failing to follow the clinic's rules limiting alcohol consumption. Given Harry's high dosage addiction it is not coincidental that he was the only person who at least partially defended the clinic's administrative computerized tracking system. ("Well it must go to a main terminal"). He was also embarrassed for the sake of the clinic when we filmed our flight from the aggressive security guard. ("I hope you can edit all that out.") Six months later when Harry died, grotesquely bloated from liver disease, his heroin addict friends (Sid, Max etc.) were convinced that the rapidity and the painfulness of his decay was caused by the high daily dose of methadone he had been consuming over the last two years.

DISCIPLINING THE DOSAGE: BIOMEDICINE'S POWER/KNOWLEDGE NEXUS

Just as the birth of the methadone clinic offers a graphic example of bio-politics in action around the state-mediated struggle to create disciplined and addicted – but heroin-free – subjects, so too the literatures on methadone in the field of substance abuse treatment and research offer a classic case study of Foucault's understanding of the disciplinary impact of the power/knowledge nexus. Relative dosage levels emerge as the central focus of the biomedical scientific debate on methadone's effectiveness. Indeed, much of the discussion is reduced to a technocratic concern with finding the adequate dosage level.

Large, epidemiological surveys of methadone treatment clinics consistently produce anomalistic data that one would think might question the scientific coherence of methadone treatment. The disconcerting empirical outcomes of methadone treatment, however, are successfully explained away as caused by "inadequate dosages" (GAO 1990; D'Aunno and

Vaughn 1992; Dole 1989; Dole and Nyswander 1982). The literature describes dosage level as a purely pharmacologically-determined objective variable. It is oblivious to the fact that recalcitrant addicts like Max, Sid, and Harry in San Francisco or Primo in New York are violently physically disciplined – if not fully controlled – at the capillary brain synapse level by manipulations in their dosage levels. As our ethnographic vignettes document, methadone addicts who fail to obey clinic rules (i.e., stay sober, make payments, arrive on time etc.) are purposely sent either into paroxysms of debilitating whole body pain (i.e., Max, Harry, and Sid), or else into drooling oblivion (i.e., Primo) by punitive decreases or increases in their dosage levels. Instead, the power/knowledge logic of biomedicine frames these conflicts strictly in terms of a technocratic search for the correct dosage. In the literature no mention is ever made of the types of concerns and rages expressed on video as we fled from the San Francisco methadone clinic. The technocratic search for determining the appropriate dosage level obscures the repressive fact that addicts like Max, Sid, and Harry are terrified of being thrown into violent withdrawal symptoms by a sudden decision of the clinic doctor or the nurse dispenser. Similarly, the dosage debate erases any scientific documentation of the humiliation experienced by Primo and his 12 year-old son when Primo, who had been raised against his will to 120 milligrams, nodded and drooled into his pizza in the midst of an intensely personal conversation with his son.

Not surprisingly, in epidemiological studies the single most significantly correlated variable for compliance among methadone addicts is a high dose level (D'Aunno and Vaughn 1992). The literature, however, avoids the obvious explanation for why there should be such a strong correlation between high dosage level and patient compliance. It is just accepted as a pharmacological fact which is as neutral and as precise as might be the correct dose of antibiotics for a blood infection (cf. Maremanni et al. 1994). Researchers are so uncritically immersed in the disciplining parameters of their biomedical framework that they fail to recognize that it is the painfully physiologically addictive properties of methadone that reduce even the most oppositional outlaw street addicts (like Primo in East Harlem or more broken-down Harry in San Francisco) into stable patients once their bodies have built up a large enough physical dependence on methadone to make it too physically painful for them to misbehave.

Some of the most revealing large-scale studies of dosage levels at methadone clinics have been conducted by a social worker at the University of Chicago, who receives multi-million dollar federal grants to distribute a relatively simple, self-descriptive questionnaire to random national samples of hundreds of different methadone clinics. The responses demon-

strate that average dosage levels fluctuate wildly across the nation. In other words the statistics reveal that there is no biologically coherent rhyme or reason to the way methadone is prescribed across the United States. Most clinics administer an average dose that is considerably lower than the dose that is considered by treatment researchers to be the minimum necessary dosage for effectively maintaining clients in compliant treatment (i.e., under 60 milligrams). A full 25% of the clinics surveyed set an upper maximum dose limit 10 milligrams below the 60 milligram minimum (D'Aunno and Vaughn 1992: 256).

The apparent biomedical dosage inadequacy of most methadone maintenance treatment clinics is, once again, an expression of the competition of contradictory discourses: the criminalizing and healthist versions of biopower that dominate in law enforcement, and popular culture, versus the "addiction-is-a-disease" model that prevails in the biomedical establishment and emphasizes the pharmacological control of bodies. This contradiction is reflected in the imposition by the legislature of repressive legal regulations that discourage high dosage prescriptions of methadone despite the emphatic consensus of federally-funded drug researchers that the biggest problem with most methadone clinics is the inadequately low doses they administer. Federal law requires clinic doctors to obtain special permission to prescribe more than 100 milligrams of methadone and further limits the rights of addicts with 100 milligram habits from having access to "take home" doses (Dole and Nyswander 1982; Newman 1987). High doses, of course, are especially susceptible to profitable diversionary resale since most individuals consuming methadone for the first time only need 20 milligrams to experience euphoria – complete with stumbling, nodding and drooling as the cases of Annie, the Canadian transvestite and Tito, the East Harlem heroin seller illustrate. At the same time because of federal pressure for "adequate doses" to produce compliant (i.e., thoroughly addicted) patients, more clinics are increasing dosage levels to the maximum level allowed (D'Aunno et al. 1997). Dissatisfaction by doctors over average low dosage levels at clinics across the country is confirmed repeatedly in the most prestigious medical journals. They regularly run editorials calling for less federal regulation to enable more accurate and higher dosage levels (cf. Cooper 1989; D'Aunno and Vaughn 1992; Dole 1989; Dole and Nyswander 1982). In contrast, federal publications such as a 1990 report by the Government Accounting Office call for greater central government supervision, but also ironically in the name of ensuring more accurate, higher doses – precisely what the doctors who protest Federal regulations also want (GAO 1990).

These convoluted political and moral tensions, anxieties and internal inconsistencies over dosage levels often manifest themselves at the clinic level with clients being denied access to information on their dosage level. In fact, clients are at best politely ignored when they report dramatically negative physical symptoms in response to dosage changes – hence, Max's description of his withdrawal experience outside the San Francisco clinic. Treatment scientists assert that patients should not "have a consultative influence on the determination of their dosage" (D'Aunno and Vaughn 1992). Detoxification clinics which tend to be more moralistic and healthist usually prescribe the lowest average dose levels and they are the least likely to allow addicts to know their dosage for fear of being manipulated into prescribing excessively high doses that might produce euphoria or might provide opportunities for smuggling out underground economy doses in cheeks or jowls. Significantly, these pro-abstinence clinics are "the least influenced by government regulation" (D'Aunno and Vaughn 1992: 257).[5] Federal regulation, although heavily concerned with criminalizing substance abuse, promotes control and compliance through the biomedical venue of prescribing high doses for long – even unlimited – periods of time (Maremmani et al. 1994).

In addition to the dramatic statistics on ineffective dosage levels at clinics all across the United States (D'Aunno and Vaughn 1992; GAO 1990), the epidemiological and survey literature also confronts the medical illogic of the surprisingly unpleasant side effects of methadone consumption. For example, one study reveals that 80% of a random sample of 246 addicts complained of a wide range of some dozen different types of complications caused by methadone ingestion. The primary ones were "sexual dysfunction," "constipation," and "muscle and bone aches." A considerable number of patients suffered from "psychological distress," "impotence," and "libido abnormalities;" others experienced more routine "nausea," "vomiting," and "appetite abnormalities" (see review by Goldsmith et al. 1984; and see discussion by Rosenbaum and Murphy 1987b). Significantly, once again, studies documenting the negative side effects of methadone almost inevitably conclude that the long list of complaints made by the majority of addicted methadone consumers is "related to dosage acclimatization" problems. Once again the power/knowledge nexus manages to focus the problematic dimensions of methadone as a treatment modality onto the technical question of adequate dosage level. Most importantly, addicts are held responsible for causing these dosage inconsistencies by continuing surreptitiously to consume other euphorigenic drugs which exacerbate methadone's unpleasant range of side effects.

THE MEDICAL PRESCRIPTION OF HEROIN IN SWITZERLAND

Given that the side effects of methadone are dramatically more unpleasant than those of heroin (Uchtenhagen 1997) one wonders why methadone "cures" while heroin "sickens". Foucault's insights into the ways illegalities shape delinquency and his documentation of how the modern prison has failed to curb crime since the first day of its inception sheds insight into how it has been possible for methadone to have such a mediocre clinical treatment record for so many years yet continues to be considered the most effective treatment modality available for heroin. Foucault argues that prisons were not meant to eliminate criminal behavior, otherwise they would have long since disappeared since they produce recidivism and criminal subcultures. Instead prisons, like methadone clinics, distinguish, divide, and distribute illegalities, thereby differentiating them in various manageable forms (Foucault 1979; Rabinow 1998).

Oblivious to Foucault's critiques of state-sponsored medicalized control, Swiss substance abuse prevention researchers dedicated themselves very pragmatically to studying the internationally taboo question of whether heroin works better than methadone as a treatment modality. They launched a large pilot program for the medical prescription of heroin to stabilize chronic heroin addicts. Fully subscribing to the positivist natural science model of evidence-based epidemiological clinical trials that measure objective health outcomes, the Swiss conducted a large double-blind study involving 1,146 randomly selected heroin addicts whom they alternately treated with heroin, methadone, and morphine, both intravenously and orally (Uchtenhagen 1997). The side effects of methadone were so much worse than those of morphine and heroin that the biggest administrative problem of the study was the high attrition rates of the control subjects who were prescribed methadone instead of heroin or morphine (Uchtenhagen 1997). The research documented statistically that addicts who were medically prescribed heroin became more socially functional according to the classic biomedical and criminological indexes that measure health status as well as social compliance: mortality, hospitalization, psychological distress, criminal activity, legal employment, abstinence from the consumption of illegal drugs, etc. (Uchtenhagen 1997). Compared to the addicts placed on methadone or morphine maintenance, those who consumed medically prescribed heroin were healthier, "less depressed;" "less anxious;" and "less prone to delirium." They were also "better housed," "more employed," used "less welfare," and "decreased their street contacts more" as well as their "sensations of

automatism." Those prescribed heroin also used less illegal heroin and cocaine. Most dramatically, medically-stabilized heroin addicts decreased their participation in crime sevenfold.

The Swiss document concludes matter-of-factly that medically prescribed heroin is a better treatment modality than methadone or morphine. Their research design includes no qualitative component and is exclusively composed of rigorously quantified statistical correlations. The findings not only contradict the legal and moral discourses of the US medical establishment and law enforcement institutions but also contradict the very core of the U.S. biomedical understanding of the pharmacological mechanism that defines methadone as an agonist block to heroin-induced pleasure sensations inside the brain's synapses. The Swiss addicts were allowed to complement their treatment medication with other psychoactive drugs and Table 6 of the final report documents that methadone (by a factor of 257%!) was the drug that was most frequently voluntarily combined with intravenous heroin by study participants in the clinic. Even when participants had the choice of augmenting their base prescription of intravenous heroin with unlimited quantities of heroin, morphine, cocaine or methadone in either injectable, oral, or smokeable form, a plurality chose oral methadone as a supplement to heroin. Most significantly those addicts who achieved stable employment were the ones who most frequently requested a supplement of oral methadone to complement their stable prescription of heroin in order to limit the number of times per day they had to interrupt their work schedule to inject. This offers a dramatic contrast to the U.S. biomedical treatment model's understanding of methadone which asserts that it is pharmacologically incompatible with heroin, and that most problems with methadone treatment can be attributed to inadequate dosage levels. The homologous biomedical Swiss model comes to precisely the opposite conclusion: Low doses of methadone in combination with heroin are the most effective way to rehabilitate formerly hard-core, anti-social addicts.

ENGAGING FOUCAULT WITH HARM/RISK REDUCTION

In 1997 the Swiss government conducted a referendum in which well over 60 percent of the population voted to legalize the medical prescription of heroin. It is ironic that Switzerland, historically the cradle of Calvinism, should be the first country in the industrialized world officially to abandon the criminal repression of heroin. Does this contradict the interpretation that a Calvinist-Puritanical morality that identifies pleasure with sinfulness and idleness (Weber 1958) motivates government drug policy to

criminalize the pursuit of pleasure? Or is the Swiss championing of the medical prescription of heroin the ultimate expression of an efficient and highly technified biopower in pragmatic practice? Indeed, the medical prescription of heroin can be understood as an extraordinarily effective method of social control – far more efficient than the prescription of methadone. It is easier to integrate stabilized, mildly euphoric heroin addicts into the lowest-tiers of the legal labor force than it is to bully frustrated, depressed, oppositional methadone addicts into social compliance. Within the biomedical paradigm of finding technological magic-bullet solutions to complicated chronic social problems, the pharmacology of heroin allows for greater social engineering at a much cheaper cost. It is precisely the unambiguously euphoric effects of heroin, combined with its relative lack of negative side effects, that makes heroin such an effective agent of biopower once it is directly administered by the state through medical treatment clinics.

It would be tempting to conclude somewhat sanctimoniously with the foucaultian insight that disciplinary power is omnipresent – if not omnipotent – no matter what discourse happens to dominate treatment or criminal justice policy. Indeed, mixing foucaultian metaphors, disciplinary power can be understood literally and figuratively to be as capillary-like as the medicines that are used to rehabilitate the unruly bodies of self-destructive street addicts. This article, however, began with a promise to break with much of the tradition of second generation foucaultian scholarship and instead to heed Foucault's personal example along with his more humble call for "specific intellectuals" to take political positions on the "technico-scientific" practical details at the interstices of the public policies that discipline citizens' lives (Rabinow ed. 1984: 71). Otherwise, Foucault's theoretical understanding of the way power permeates truth, knowledge and even oppositionality, leads to paralysis. The ethnographic method is well suited to the challenge of politically engaging Foucault's critical insights and rendering them concretely relevant. Consequently, the technocratic – even bio-moral – question of what combination of drugs, laws and medical/health discourses might produce less social suffering on the street needs to be taken seriously.

In this practical vein, the risk/harm reduction paradigm represents an interstice between the state and the medical apparatuses where specific foucaultian critiques of drug policy can become concrete. The first step is to suggest that according to a wide range of quantifiable measurements heroin appears to be a less harmful and more socially useful drug than methadone. More precisely, the drug combination that the Swiss study stumbled upon – i.e., low doses of methadone supplemented by

strategic injections of pharmaceutically pure heroin – can be identified as an especially effective magic-bullet-like potion for stabilizing heroin addicts who want to enter the labor market. Ironically, once again, this directly contradicts the U.S. biomedical establishment's understanding for why methadone is effective in drug treatment as an opiate agonist which by its pharmacological definition is supposed to be incompatible with heroin consumption.

More important, however, than arguing over the relative effectiveness of the precise balance of milligrams of one opiate versus another is the political and intellectual urgency of debunking the power/knowledge dead-end that has confined discussions of drug treatment effectiveness to technical debates over dosage titrations. The bio-politics of methadone revolve around a political economy of human dignity that is both cultural and economic. It is no coincidence that virtually every single ethnographic description or conversation cited in this text articulates methadone consumption with the central problem of employment and income generation: from Primo's almost caricatural case of unsuccessfully negotiating sobriety and stable employment at the margins of New York's legal labor market, to the more violently tenuous attempts of Annie the Canadian transvestite and Tito the East Harlem heroin seller to consume cocaine in order to render themselves fit to continue working at the entry levels of the underground economy. Less dramatically, at the San Francisco methadone clinic Max's status of being unemployed forced him to endure painful withdrawal symptoms for two extra hours each morning. Sid, on the other hand, when he failed the breathalyzer test at that same clinic had to forgo waiting for the doctor to prescribe him a half dose of methadone in order to return to his sign-painting job on time.

From a less economically-oriented political economy perspective, the search for cultural respect emerges as another central facet complicating methadone's acceptability on the street. Indeed, virtually all the ethnographic accounts from the first decades of methadone studies identify the drug's unsatisfactory location in street-based status hierarchies. More intimately, the research from the 1980s cites the unpleasant physical and emotional effects and context of methadone consumption at user-unfriendly clinics. In this polarized context, medicalized heroin, precisely because of the pleasure it provides to its consumers, offers the opportunity of metamorphosing a larger percentage of depressed self-destructive, often-violent street-relegated outlaws into relatively reliable, low wage laborers – or at worst into harmless, complacent, inexpensive beneficiaries of public sector largess.

We need to de-exoticize how we think about drugs. The dramatic social transformation of heroin from drug to medicine in the Swiss experiments was accomplished merely by the juridical act of legalizing – or at least medicalizing – heroin-cum-methadone addiction. Perhaps, more important from a humanitarian risk reduction perspective, medicalized heroin would also certainly result in dramatic reductions in HIV, hepatitis, abscesses, tuberculosis and other new epidemics of self-administered social suffering which plague inner cities. The most significant effect would be a massive reduction in the numbers of incarcerated inner-city youth – the most dramatic outcome of U.S. drug and social welfare policy at the close of the twentieth century.

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NOTES

1. Of course I respected Primo's request to make no mention of his methadone addiction in my book. Surprisingly, given the often painful material presented in the book, this was the only major fact that any of the characters who previewed *In Search of Respect: Selling Crack in El Barrio* asked me to omit from the text. It illustrates the profound stigmatization of methadone in street culture. Three years later when I asked Primo why he was willing to be part of this current article on methadone he laughed politely:

   Methadone sucks. I hate it. Plus, I like helping you out with my stories – you know that. I mean it might help some knucklehead out there not to do wrong.

   Also, [long pause] I don't mean to disrespect you Felipe – but nobody really reads the shit you write – at least not nobody I know.

2. The president of Primo's union local (32B-32J) of the Service Employees International was the highest-paid labor leader in the nation in the mid-1990s with an annual salary of $412,000. (Daily News p. 70, by Dave Saltonstall. April 11, 1995.)
3. See Smart 1984 for a discussion of the interface between British medical and criminal discourses on drugs.
4. In fact, methadone's evil conspiracy creation story is even more dramatic in real life. Methadone was invented by IG Farbinindustrie, the chemical conglomerate that is better known for having been the prime employer of slave laborers at Auschwitz during the Hollocaust. Their product was seized as a spoil of war by the United States and first marketed by Eli-Lilly Pharmaceuticals under the trade name "Dolophine" not "Adolphine" (www.drugtext.nl/library/books/methadone).
5. The more morally repressive, low-dose, "ineffective" clinics also treat the highest proportions of African American addicts. Surprisingly, this correlation is not explored empirically or theoretically in the epidemiological literature despite the proxy measurement it provides on differential access to biomedical facilities by race due to government regulation.

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