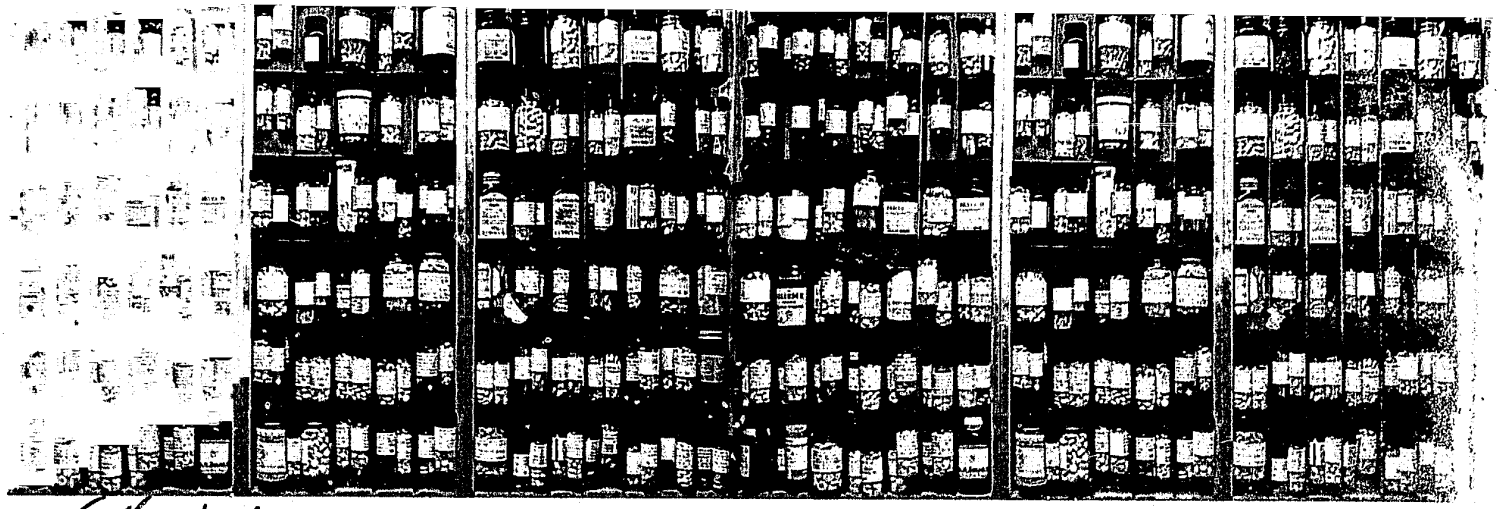

The Respectable Pushers

by Gary Thatcher
Staff Correspondent
Christian Science Monitor

They are doctors, pharmacists, and other professionals, often looked up to in their communities. The percentage of all those in the medical profession may be small, but they are peddling a cornucopia of illicit drugs.

It started in Baltimore when a motorcycle gang member sold "robins eggs" to an undercover police officer.

("Robins eggs" — tablets of phendimetrazine, a habit-forming diet pill that produces a "high" similar to amphetamines.)

The pills were not from some crude basement laboratory. They were manufactured by a legitimate pharmaceutical company, but were available only by prescription.

How did they end up on the streets of Baltimore? One gang member referred to "some doctor in upper Pennsylvania" as the supplier.

By checking sales records of drug manufacturers, police learned Dr. Robert H. Abbott, a 74-year-old osteopathic physician in Muncy, Pennsylvania, had been ordering unusually large quantities of the drug. But more evidence was needed to arrest him.

The spry, gray-haired physician unwittingly obliged, selling undercover agents more than 11,000 "robins eggs" during one month in 1975.

Dr. Abbott's arrest spoiled his plans for retirement. In a few more months he would have moved to Florida, with a comfortable bank roll built partly from sales of the drug. In the 14 months prior to his arrest, agents say he ordered 1.8 million pills, selling them for between $350,000 and $400,000.

A U.S. District Court jury convicted him of six counts of illegal drug distribution. He was sentenced to 15 years imprisonment and a $90,000 fine.

Dr. Abbott's case is not atypical of a problem authorities

Security Measures by a heroin dealer to avoid unwanted entry are shown in this photograph, taken after entry was gained to the premises.

Statistics, of course, can be the bane of any law enforcement effort. At the same time, if used well, they can be a valuable intelligence tool in themselves.

In Nevada, statistics have been used to isolate the separate and most serious problem areas. A look at the breakdown of the division's December 1975 caseload tells a story in itself: non-drug crimes, 6 cases; drug smuggling, 7 cases; controlled substances violations, 22 cases; and controlled subtances violations involving the use of prescriptions, 13 cases.

A further study of coroner's reports — perhaps a pioneer area of record keeping — shows that about 90 percent of the drug overdose deaths in Nevada resulted from pharmaceutically dispensed drugs, obtained legally or illegally, rather than from drugs sold on the street.

During a brief study period running from Nov. 9, 1975, to March 27, 1976, all overdose deaths in the state were examined. In that time, 21 men and 17 women died of overdoses, a total of 38. Of that total, 30 died of drugs obtained from licit sources and 8 of drugs obtained from illicit sources.

Barbiturates, Darvon and tranquilizers were the primary killers among licit drugs, while heroin accounted for six of the eight dead from illicit drugs.

Significant changes were also noted in comparing the drug arrests for 1974 to those for 1975. In the decrease column were marihuana, down 13 percent; opium, cocaine and derivatives, down 16 percent; and other dangerous drugs, down 33 percent. Showing an astounding increase were synthetic narcotics, up 214 percent.

To combat what obviously is the increasing problem of enforcing the portions of the Federal Controlled Substances Act dealing with the dispensation of drugs by physicians, pharmacists and hospitals, the Nevada Division of Investigation and Narcotics has added three compliance agents.

None of the three compliance officers are typical police narcotics agents. Instead, the division hired three registered pharmacists with eight to ten years of college and 40 years of experience between the three of them.

There were several reasons for the decisions to hire pharmacists. In investigating doctors and druggists, there were serious doubts that ordinary narcotics agents would be able to pick up the terminology and procedures of the medical trade. There also was the realization that registered pharmacists would know just what was going on, and it would be difficult for their fellow professionals to con them.

It also was necessary to counter the resistance of medical and pharmaceutical boards to the concept of investigations being conducted from outside their agencies. The use of registered pharmacists as investigators has helped alleviate this resistance.

The use of pharmacists as investigators has been working. Nine cases involving licit substances were closed during a recent six-month period. Eight more were turned over to the State Pharmaceutical Board. Ten remain under investigation or are pending court action.

Day after day, law enforcement gains a tighter grip on the illegal drug trade in Nevada, and yet, the more that grip tightens, the bigger the potential catch seems to be. In an agent's day of work, the need for interdiction becomes balanced by an awareness for the need to know more and more about the full scope of the problem.

Old assumptions and the failures of limited and fragmented intelligence operations fall by the wayside.

The image of five years ago that drugs were predominantly the problem of Las Vegas' low-income, primarily black west side no longer stands the test of experience.

The one-time insistence of local law enforcement authorities that there is no major drug traffic in Northern Nevada is a stand of the past.

Instead, law enforcement is finding that the average overdose victim is a white male between 17 and 19, and the public reads frequently of drug smugglers departing for federal prisons, after being caught flying loads of marihuana, usually a thousand pounds or more, into remote stretches of Nevada desert.

The term "drug pusher" in Nevada no longer means only some nefarious character on the streets; it also can mean a doctor, druggist, or member of a hospital staff.

Drug problems in Nevada are being solved. And yet with each solution comes an increasing awareness of the size of the problem.

across the country are grappling with — the diversion of legally manufactured drugs into the illegal street market.

The drugs — among them narcotics, amphetamines, barbiturates, tranquilizers, and other "psychoactive" (mind affecting) substances — are manufactured for use in medical treatment.

But because of their popularity among abusers, the U.S. Drug Enforcement Administration (DEA) estimates over 200 million doses are diverted from legal channels annually.

Some are lost through drugstore thefts and forged prescriptions or are stolen from truck shipments. But the largest single group of diverters — responsible for 100 million doses yearly, according to DEA estimates — is a relative handful of corrupt doctors, pharmacists, osteopaths, veterinarians, dentists, nurses, and other medical professionals.

The situation has called for a new thrust in narcotics law enforcement. The "respectable pusher" now is a major target of both state and federal anti-drug efforts.

Most experts say only about 1 or 2 percent of the 516,990 professionals permitted to handle dangerous drugs knowingly sell them to abusers or street-level dealers. But even one corrupt practitioner or pharmacist can put huge quantities of drugs into the illegal trade, they stress.

The hard evidence:

- In 1974, the Illinois Legislative Investigating Commission concluded "the fact that relatively few physicians are engaged in this illegal practice does not minimize the problem in the light of the fact that just two Chicago physicians, namely Dr. Payming Leu and Dr. Valeriano Suarez, issued thousands of illegal prescriptions from which they profited an aggregate of almost $2 million a year."

These two doctors are now out of business, but others have taken their place.

- Investigators checked the prescription files of just two Chicago pharmacies this summer, and discovered more than 122 prescriptions totaling 7,110 doses of powerful stimulants and narcotics, all written by one doctor on just one day. The average Illinois physician writes only 20 such prescriptions in an entire year, according to the Illinois Bureau of Investigation. Assuming the doctor worked an eight-hour day, he was writing one prescription for a dangerous drug every four minutes.
- Drug diversion is not confined to big cities like Chicago. In six months of investigating the problem, the Monitor found cases of corrupt medical professionals stretching from coal-mining towns of West Virginia to posh California suburbs, from small villages in Michigan to rural Alabama and Texas.

Most of these professionals were raking in large sums of money while fueling a national drug-abuse problem. The White House Domestic Council Task Force on Drug Abuse in its September, 1975, white paper, estimated around 5 percent of the adult U.S. population, about 7 to 8 million Americans, are engaged in "active nonmedical use" of barbiturates, tranquilizers, and amphetamines, with several hundred thousand using them in a "chronic, intensive manner." The problem "probably ranks with heroin use as a major social problem," the task force concluded.

Society pays for drug abuse through the street crime and shoplifting that finance drug habits. But it also foots the bill when drugs are diverted through state medicaid programs and the prepaid prescription plans offered by some companies and labor unions.

The U.S. Congress has been trying to stem abuse of prescription drugs since the passage of the Harrison Narcotic Act of 1914, when the sale of opiates was first regulated.

But the capstone of the effort came in 1970 when, engulfed

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in a media-spotlighted "drug crisis," lawmakers passed the Comprehensive Drug Abuse Prevention and Control Act.

The act allows DEA to regulate virtually every phase of the dangerous drug manufacturing and distribution system. For the more potent drugs, it can even dictate the thickness of warehouse walls where they are stored (eight inches of concrete with reinforced steel rods) and the order form needed to purchase them (three carbon copies with one forwarded to DEA headquarters).

Through these regulatory mechanisms, DEA officials claim diversion from factories and warehouses has been virtually eliminated — but at a price. Increased diversion at the retail level is the cost, they say. It is marked by a sharp rise in drugstore robberies and burglaries along with increased pressure on some doctors and druggists to cross the line from "professional" to "pusher."

Unfortunately, too many have yielded. Here are the major reasons:

1. **Greed.** Pharmacists and physicians have cheap and easy access to drugs which command top dollar on the street. For example, they pay only about $36 for 500 tablets of Knoll Pharmaceutical Company's Dilaudid, a synthetic narcotic similar to morphine. But the small white tablets sell for up to $20 apiece on the street.

Some corrupt professionals barter drugs or prescriptions for merchandise. Oklahoma officials report Dr. George Conrad Markert, a Stroud, Oklahoma, physician, wrote prescriptions in exchange for silver tableware and trays, then melted them down and made jewelry. He was convicted earlier this year of illegal drug distribution.

Some doctors make their living by operating "diet clinics" where they freely dispense or prescribe amphetamine tablets, even though the use of the drug for weight control is questionable.

2. **Lust.** Some pharmacists and physicians give pills or prescriptions in return for sexual favors. There is usually no shortage of drug abusers to accommodate them, especially prostitutes who take amphetamines to stay awake. Dr. Anthony LeBaron Foster, for example, was arrested in a Mobile, Alabama, motel room and pleaded guilty to "attempting to give away" drugs to a woman patient. Actually, she was an undercover agent.

3. **Salvaging a failing practice.** Drug peddling is a particular problem among older practitioners who outlive most of their patients and among younger doctors who lose patients through incompetence.

Accustomed to high incomes and sometimes deeply in debt, they find that writing prescriptions or dispensing pills is a quick and easy source of income. Word travels fast in the subculture of drug abusers. Some will travel hundreds of miles to buy drugs.

4. **Self-addiction.** Drug addiction is an "occupational disease" among some members of the health-care professions.

Long working hours and the easy availability of drugs are often cited as reasons. Some experts estimate that addiction among physicians is 30 to 100 times greater than in the general population. Addicted professionals may turn to diversion to support or finance their own habits.

Such cases are particularly pathetic. One young Albion, Michigan, dentist eventually lost his license to practice when his addiction to Demerol (a narcotic similar to morphine) was discovered. His office assistants quit their jobs after watching him jerk uncontrollably while drilling patients' teeth. A doctor sharing the same office building found him collapsed on the floor from the effects of the drug. Another physician treated an infection on his arm, the result of an injection with a dirty needle. But none of them ever reported his addiction to either law enforcement officers or the state or local dentistry society.

Worse still, four pharmacies in the area allegedly profited from his habit by selling him Demerol — in some instances for up to twice the normal retail price. The pharmacists were indicted for failing to report the transactions to DEA.

5. **Senility.** Some senile doctors and pharmacists have unwittingly yielded to the demands of drug abusers. In other cases, a nurse, medical receptionist, or family member has "taken over" the practice of a senile professional and allowed dangerous drugs to be diverted.

One elderly doctor in a small Alabama town was gaining a reputation as an easy mark for prescriptions. When undercover agents went to his office to make purchases, they found his wife writing and signing the doctor's prescriptions. This practitioner subsequently lost his right to prescribe dangerous drugs.

6. **Rationalization.** Some professionals justify selling to abusers, rationalizing that they will get drugs anyway, perhaps through street crime or prostitution.

But experts say a steady and easily accessible supply of drugs may delay entry into a treatment program aimed at ending a drug habit altogether.

Getting hard evidence of diversion is difficult. Although pharmacists are required by law to account for every dose of dangerous drugs they order, "suspicious" fires, robberies, or break-ins can destroy prescription files and cover shortages of pills.

Files can also be peppered with phony prescriptions, or

the quantities of drugs on legitimate prescriptions can be altered.

Catching drug-peddling doctors is even more difficult since they are allowed to prescribe or dispense drugs for medical reasons. Undercover agents who make purchases of drugs or prescriptions take risks by feigning illness or pain, because a doctor can then claim — perhaps truthfully — "I was only practicing medicine."

But sometimes undercover agents catch doctors in situations where this defense is impossible. For example, Dr. Joe F. Howell, a Birmingham, Alabama, physician, was arrested in a parking lot trading prescriptions for a "stolen" motorcycle. He was convicted of illegal distribution.

But most cases are not that clear-cut. Doctors who knowingly break the law are often aware of the legal constraints on narcotics agents. They simply refuse to sell to anyone they don't know well; or they demand that each customer give some reason for receiving a drug. In this manner, a physician can fulfill the letter if not the spirit of the law. And if a customer cannot think of a symptom, the doctor may even supply one.

One undercover agent says Dr. Charles Nonziato, a Trenton, New Jersey, physician, made several illegal sales of amphetamines to him — ostensibly to help him lose weight.

However, the agent says he repeatedly told the doctor, "I'm not taking these to lose weight. I'm taking them to stay awake." (Actually, he didn't take them at all. He saved them as evidence.)

Dr. Nonziato reportedly became annoyed with his answer, and snapped, "You're not supposed to say that. You're supposed to say you want to be skinny!"

Dr. Nonziato later pleaded guilty to misconduct charges before the New Jersey Board of Medical Examiners, and his license was revoked.

But the difficulties of getting evidence against a drug-peddling professional look pale beside the difficulties of prosecuting them.

"There is a double standard as far as prosecuting a professional is concerned," says James F. Hogan, chief of DEA's state and industry section. "You bring in a dope peddler off the street into court, and there's one way of handling the case. You bring in a doctor or pharmacist who's also a dope peddler and you have difficulty even getting a prosecutor to take the case."

Part of the reluctance of prosecutors is explained by the complex drug laws they have to master to take a diversion case to court.

"The first thing a prosecutor looks at is the fact that he's dealing with a professional person," says Robert Pingston, a detective sergeant with the Michigan State Police. He explains: "They don't want to take the time to try a very technical case. These cases are complex, whereas a street-sale case is pretty open and shut. A prosecutor would rather try 50 street junkies than one registrant [professional]."

There are other pressures on the prosecutor. He may have a social or political relationship with the professional. And if he is in a rural county where doctors' offices are few and far between, he knows that any doctor forced out of business could leave some families without easy access to medical care. And inconvenienced voters often have good memories when the prosecutor has to stand for re-election.

Consequently, many drug diversion cases never go to trial; the prosecutor "plea bargains," and the professional is allowed to plead guilty to lesser charges.

However, there is another alternative to formal court proceedings that can be quicker, easier, and have more of a deterrent effect on corrupt druggists and doctors than criminal proceedings. This is revocation or suspension of the professional's license to practice. The power is vested in regulatory boards in virtually every state.

Peter B. Bensinger, head of the U.S. Drug Enforcement Administration (DEA), says federal and state cleanup of the medical drug industry will increase unless it cleans its own house.

"There are too many high school kids going to their own funerals" caused by overdoses of barbiturates, amphetamines, tranquilizers, and other medical drugs, says the nation's top drug enforcement official.

Twenty doctors and 37 pharmacists in the San Francisco area were nabbed this summer by the DEA in the first of an all-out federal effort against illegal sales of prescription drugs. One has been convicted, several others await trial, and most have been disciplined.

But Mr. Bensinger is also telling the American Medical Association, retail and wholesale druggists, and pharmaceutical manufacturers in meetings this year that they must take steps against the errant few in their professions who have caused so much damage by large illegal sales of controlled narcotics.

"We can't do this regulatory job ourselves," he states. "I'm warning the professions that they better guard against [drug] diversion or else some doctors will end up in jail."

Public awareness of this problem is low, finds Mr. Bensinger. The professional associations can alert their members and work for reform in the states, he added.

"For the last three years, DEA has been adding experience and knowledge," he says. Here's how the DEA attack will work:

• DEA investigators of the medical drug industry will increase in number from 198 to 254. Five agents will work overseas for the first time.

• Special federal investigation units working at the state level will be expanded to five more states beyond the present nine. Eventually, 40 or more states will get federal backup using computer networks and undercover agents.

• New guidelines for U.S. attorneys who prosecute doctors and pharmacists will be issued by the Department of Justice. "We want to let prosecutors know that the drug problem is more than heroin addicts," says Mr. Bensinger.

• Complex state laws which govern drug sales, and licensing boards — and often stymie even state and local prosecutors — may be rewritten under the urging of DEA officials. A model law is being pushed.

It is a hot, muggy morning in mid-June, and the mous-tachioed man in the double-knit clothes is shaking his head in amazement.

"I just couldn't believe it," he says, waving a prescription in the air.

"The doctor didn't even look at me. He just took the ten bucks and handed me the scrip."

At almost any drugstore, the "scrip" will get him 30 capsules of Eskatrol, a drug popular with abusers because of the euphoria-producing dextroamphetamine it contains. Called "ups" or "skis" on New Jersey streets, the capsules can be resold for up to $2 apiece.

Eskatrol is one of a host of "controlled substances" — abuse-prone drugs manufactured and distributed under tight federal restrictions. Nearly two billion doses of them are produced each year.

Over half a million doctors, pharmacists, and other medical professionals are registered to possess and distribute these drugs at the retail level. But a minority of them — most experts say only 1 to 2 percent — use their professional status to become "respectable pushers" of drugs, selling them for nonmedical reasons.

DEA estimates such corrupt physicians and pharmacists divert over 100 million doses of dangerous drugs into the illegal street market each year.

That's where the man garbed in double-knit clothes comes in.

He will carefully file the prescription for Eskatrol in a manila folder, adding to a growing sheaf of evidence that will be used against the doctor in a criminal trial and during disciplinary proceedings before the New Jersey Board of Medical Examiners.

The man is an undercover agent for the New Jersey Diversion Investigation Unit (DIU), one of nine special-police squads created with DEA and Law Enforcement Assistance Administration (LEAA) funds to combat drug peddling by physicians and pharmacists.

Other DIUs are in Alabama, California, Illinois, Massachusetts, Michigan, North Carolina, Pennsylvania, and Texas.

These units are unique state-federal partnerships — composed of one DEA agent, usually five to eight agents from the state police or attorney general's office, and one or more inspectors from the state pharmacy or medical licensing board.

Vested with some of the powers of all these agencies, the DIUs can prosecute in federal or state court or ask licensing boards to revoke or suspend a professional's right to practice.

Since the first three DIUs started operating in 1972, approximately 400 doctors, druggists, osteopaths, dentists, veterinarians, nurses, and other medical professionals have been arrested for mishandling dangerous drugs. Last year, when all 10 units were in gear, 175 professionals were arrested and 4,829,866 doses of drugs were seized along with 199 pounds of bulk powder and 21 gallons of liquid drugs.

Behind each of these arrests and seizures is a saga. Some are routine, simply involving undercover purchases of drugs with marked money. Others are bizarre, involving elaborate schemes designed to catch medical professionals acting in very unprofessional ways.

Most DIU agents assume undercover identities, often sporting the long hair and ragged clothing of street-level junkies.

But there are others who can sit quietly in a doctor's office without drawing a stare.

James M., for example, is a fiftyish, balding, bearded man who poses as a truck driver or musician. Christine N. (one of the few female agents the Monitor encountered on visits to five DIUs) has long, chestnut hair and poses as a college girl, office worker, or prostitute.

These agents and others like them lead double lives. They mingle in spots where drugs change hands — busy truck stops, crowded bars, and on inner-city street corners and in parks.

They are always on the alert for a name, an address, any clue that might lead them to doctors or druggists who are "pushing." Often, they cultivate informants in the subculture of abusers.

Finally, the agents make purchases directly from the physicians or druggists to obtain evidence. But there is a fine legal line between buying what a corrupt professional has to sell and entrapping honest doctors and druggists.

Since the first three DIUs started operating in 1972, approximately 400 doctors, druggists, osteopaths, dentists, veterinarians, nurses, and other medical professionals have been arrested for mishandling dangerous drugs.

To make certain their cases will hold up in court, DIU agents must convince a jury that drugs or prescriptions were clearly sold for nonmedical reasons.

The agent who approached Dr. Reed Albert Shankwiler, a Michigan osteopath, claims he used street jargon when asking for "speed" (amphetamines) and "downs" (depressants). Dr. Shankwiler, as the agent tells it, coyly placed a bottle of 1,000 sodium pentobarbital tablets ("downs") on a table, then told him to put $500 on another table and pick up the pills.

The agent who arrested Dr. Shankwiler says he smiled and reminded him that he had never actually given him the pills.

The ruse didn't work. A U.S. District Court Judge slapped a three-year sentence on Dr. Shankwiler (with 2½ years suspended) and fined him $5,000.

He subsequently lost his license to practice.

Other doctors are more cautious, and dispense pills only in small amounts. It would have been fairly easy for Dr. Donald H. Anderson, a Portland, Michigan, M.D., to claim there was a medical reason for selling a 30-day supply of pills to just one undercover agent. But seven agents were ready to testify they obtained barbiturates or amphetamines from him without even receiving a physical examination.

Dr. Anderson pleaded "no contest" to one count of a 10-count indictment, was fined $250 and given three years unsupervised probation by U.S. District Court Judge Noel P. Fox.

Another way to prove a doctor is "pushing" rather than prescribing is to ask for prescriptions for fictitious third persons. This tactic worked for Alabama DIU agents who recall how they submitted lists of phony names to Dr. Benjamin F. Koepke in his Decatur office and received prescriptions for each "person." He pleaded guilty to two counts of illegal drug sales, and his license to practice was revoked.

Other doctors go through a charade of performing a physical examination — setting up an alibi that they diagnosed some physical condition that required medication. Agents tell of being weighed while they were wearing heavy winter clothes and boots, or having their pulse checked while the stethoscope hung around a doctor's neck, not from his ears.

Some physicians — Richard W. Aspen of Barre, Massachusetts, for example — reportedly instruct their customers to go to several different pharmacies to get prescriptions filled. In this way, they avoid arousing the suspicions of a single pharmacist and make sure there is not too much evidence against them in a single drugstore's files.

One of Dr. Aspen's customers turned out to be an informant for the Massachusetts DIU. Convicted on 17 counts of violating state drug laws, the physician subsequently lost his license to practice.

Making a case against a pharmacist is somewhat easier than against a doctor. DIU agents have access to records of all dangerous drugs purchased by a pharmacy and can ask the pharmacist to account for the drugs ordered either by showing they are still in his inventory or presenting filled prescriptions.

But proving that drugs are diverted is not as simple as it may seem.

For years, an Illinois pharmacist pointed to five bottles on an upper shelf when inspectors asked to see the five bottles of cocaine that appeared on his inventory sheets. When an Illinois DIU agent finally checked them, he found they contained not cocaine but aspirin powder. Investigators say he was selling the cocaine without prescriptions.

Other DIU probes have found pharmacy files peppered with phony prescriptions. Some are obvious frauds, made out to deceased persons and bearing addresses of vacant lots or the public library. Others, at first glance, appear to be legitimate prescriptions signed by real doctors practicing in the area. Pennsylvania DIU agents interviewed 70 doctors in the Washington, Pennsylvania, area after finding their names in the files of a local drugstore. They claim the names of 43 doctors were used illegally to divert an estimated 10,000 doses of controlled drugs to abusers.

Pharmacist Walter Leon Walters was sentenced 11½ to 23 months in prison as a result of the investigation.

But the size of some purchases made by DIUs makes prescription forgery look like child's play. An Alabama pharmacist, Bennie Bryan Boozer, was arrested as he delivered 30,000 tablets of phendimetrazine (a diet pill which produces a "high") to agents on the campus of Jacksonville State University.

After the arrest, agents searched his house and found an additional 735,000 tablets of the drug and $35,210.47 in cash — including $3,200 in marked bills used earlier to buy 40,000 pills from the pharmacist's wife.

The arrest turned out to be a veritable bonanza for the Alabama DIU. A check of Mr. Boozer's records showed he had purchased nearly 3½ million of these tablets from a New York drug company in less than a year. A Florida drug distributor has been put out of business, and six other people have been arrested as a result of the ongoing investigation.

The Alabama DIU found other things besides bills can be marked. Their investigation of several apparent drug-overdose

deaths in Gadsden led them to a young man inside Sutherlin Drug Store, who took their money, walked over to pharmacist Lon Miller, and returned with pills. They were certain they had grounds to arrest the young intermediary, but they wanted more evidence against Mr. Miller.

Their solution — barter "stolen" tape decks for drugs. The seven tape players were secretly marked with fingernail polish, and when they turned up for sale in the drugstore, DIU agents made their arrests.

Pharmacist Miller pleaded guilty to one charge of illegal distribution of phendimetrazine and was sentenced to five years imprisonment with two years of special parole.

Another ruse that "respectable pushers" use is a staged burglary or robbery to cover a shortage of drugs. One pharmacist in Springfield, Massachusetts, even hired an arsonist to set fire to his drugstore.

At least one enterprising osteopath — Dr. John M. Brown of Berrien Springs, Michigan — found the tactic backfired, however, when it tipped police off to possible illegal activity. In May, 1973, he reported several hundred pills stolen in a break-in of his basement office. But the police who investigated saw that a mound of leaves outside a broken basement window was undisturbed, and there were no leaves tracked inside.

Nearly five months later, a Michigan DIU agent approached Dr. Brown and, without a physical examination, purchased 1,000 tablets of phendimetrazine — one of the drugs reported missing in the burglary.

Dr. Brown pleaded "no contest" to charges of dispensing the pills illegally, was fined $250, and given five years probation.

But catching the "respectable pushers" in the act is only half the battle.

James F. Hogan, chief of DEA's state and industry section, explains that "the DIUs have difficulty in getting a prosecutor to take a diversion case, because of the complexities of trying it." But when a case does finally get into court, there are problems with judges and juries, he points out. "Often a doctor or druggist is a long-standing member of the community. He might have even treated the judge or a juror, or known them socially. . . . And even if he is convicted, he doesn't get the prison time a normal dope peddler will get," Mr. Hogan explains.

The experience of the North Carolina DIU illustrates these problems. The unit made headlines in March, 1975, when it arrested 19 physicians in the Piedmont area.

Now, 16 months later, many are neither punished nor found innocent.

One grand jury in a rural county refused to indict a physician, presumably because he was one of the few practicing in the area, and loss of his services would have meant hardships for residents.

North Carolina district attorneys, who are elected, refused to prosecute three others.

Of the four who have been tried, one was found guilty, one was found innocent, and two others had charges dismissed when juries could not reach a verdict.

Three physicians pleaded guilty to lesser offenses, or voluntarily surrendered the permit that allows them to handle dangerous drugs instead of facing criminal charges.

The other eight are still awaiting trial. One passed on while waiting for a court date.

Speedy and effective justice looms as the major problem facing the DIUs. But there is some progress being made in this area.

Each DIU has held special prosecutor "schools" to alert district attorneys to the diversion problem and educate them in the nuances of drug and medical-practice laws.

The New Jersey DIU is even headed by a prosecutor, deputy attorney general Robert Weir. He directs the agents' activities, makes certain the evidence is adequate and legally obtained, and then takes the cases to court himself. So far, the unit has a perfect conviction record.

What is the future of the DIUs?

After federal funds run out (usually in about two years), the states are asked to assume the cost of the operation. Only one state (Florida) has declined such self-financing and disbanded its unit.

The White House Domestic Council in its September, 1975, white paper on drug abuse recommended continued expansion of the DIU program into other states. New Hampshire will probably be the next state to start one, with three or four others to follow during 1977. Mr. Hogan estimates 15 to 20 more DIUs are necessary.

But at a yearly cost of several hundred thousand dollars each, can the expense be justified?

Carl E. Cross, executive secretary of the Board of Pharmacy in Michigan (a state whose federal funds were exhausted in 1974 but which now pays the half-million dollar annual bill itself for its DIU) replies, "You have to ask, 'How serious is the problem?' How many lives does a pusher affect, whether he's on the street corner or in a professional office? . . . These 'trusted' people are turning around and using drugs against the public, and the public should realize that any money used to get them out of business is money well spent."

"Often a doctor or druggist is a long-standing member of the community. He might have even treated the judge or a juror, or known them socially.... And even if he is convicted, he doesn't get the prison time a normal dope peddler will get."

The computer doesn't know the language of San Francisco drug abusers, so when it prints out a list of their favorite drugs, it calls them secobarbital instead of "reds," pentobarbital instead of "yellow jackets," and secobarbital mixed with amobarbital instead of "rainbows."

Another popular drug, Ritalin, has no nickname.

According to the DAWN (Drug Abuse Warning Network) computer, these are the prescription drugs most frequently mentioned in the Bay Area's hospital emergency rooms, drug crisis centers, and morgues.

In Washington, D.C., another computer scans a list of nearly 15,000 doctors and druggists from the San Francisco Bay Area, searching for the ones who have ordered big amounts of these substances.

A woman sits at her desk in the national headquarters of the Drug Enforcement Administration poring over the printouts.

And from her research, a list of "targets" is drawn up for Project Dart.

In mid-January, 1976, agents of the California DIU started making illegal drug purchases from the doctors on the list.

As summer ends, nine doctors have been indicted for violating state or federal drug laws, and 21 pharmacists face civil prosecution. Ten other physicians and 16 pharmacists face disciplinary proceedings by state or federal agencies as a result of the probe.

Project Dart marked the first time that DEA used its two computer systems, DAWN and ARCOS (Automated Consummated Order System) to pinpoint where legally manufactured drugs were entering the illegal market.

There are plans for similar projects to be conducted periodically in other cities, says Kenneth Durrin, chief of DEA's Office of Compliance and Regulatory Affairs. Perhaps someday the DAWN and ARCOS computers will even "talk" to each other.

But Mr. Durrin admits that technological breakthroughs are "not the ultimate answer" to stopping the flow of an estimated 200 million doses of legally manufactured drugs into the hands of abusers each year.

In his view the "real answer" includes more affirmative action by the medical and pharmaceutical professions in stopping the "pushers" within their ranks. He estimates that this group alone diverts more than 100 million doses each year.

The other 100 million doses are obtained by persons who feign illnesses, forge prescriptions, steal from truck shipments, and hold up drugstores, says Mr. Durrin. Therefore, he continues, vigorous enforcement of drug laws must be coupled with more caution on the part of physicians and pharmacists who prescribe and dispense dangerous drugs.

A number of other experts across the country share his views. Here are specific recommendations on ways to control drug diversion, based on a six-month Monitor study of the problem:

- State legislatures should consider the use of "triplicate prescriptions" for most abused prescription drugs.

Three states — California, Illinois, and New York — already do this. They require doctors prescribing the drugs with the highest abuse potential — opiates, amphetamines, and the more powerful depressants — to use special pads that produce three copies of each prescription. One copy goes to the state government and is keypunched into a computer. Law enforcement authorities can then tell at a glance which doctors are writing inordinately high numbers of these prescriptions, and who is receiving them.

Lawrence Thompson, supervisor of the Illinois DIU, says the triplicate forms, printed on special paper, "absolutely cut out" forgery of prescriptions for these potent drugs. He calls them an invaluable law enforcement tool.

New York's handling of triplicate prescriptions was ruled unconstitutional by a U.S. Circuit Court because it invaded the privacy of the doctor-patient relationship. The decision is now on appeal to the U.S. Supreme Court.

But Illinois officials are confident their system will withstand a court challenge expected to be brought by the Illinois State Medical Society.

An American Medical Association (AMA) committee recommended in May, 1968, that all states adopt a triplicate prescription system for the most abused drugs.

- State and local pharmacy and medical societies should take a more active role in weeding out "pushers" from their ranks.

A typical response to this frequently heard suggestion comes from a spokesman for the Illinois State Medical Society, who argues, "The medical society is only an association. We can't do anything. We can't lift licenses."

But Dr. Robert C. Derbyshire, considered the country's top expert on medical discipline, says professional societies should act as additional "eyes and ears" for the state regulatory boards who do have the power to suspend or revoke licenses.

A few professional societies are moving in this direction.

The Wayne County, Michigan, Medical Society has a committee to review complaints of reckless prescribing and dispensing or drug abuse by physicians or pharmacists. When this body thinks it appropriate, complaints are referred

There are approximately 25,000 salesmen encouraging doctors to prescribe and dispense drugs — and only about 700 state and federal law enforcement agents are monitoring for possible illegal practices.

to the ethics committees of local pharmacy or medical societies.

The Camden County, New Jersey, Pharmacy Society goes a step further. It acts as a "clearing house" for complaints and refers some to either the state disciplinary board or to law enforcement officers.

Another recommendation made in 1968 by an AMA committee called for every state medical society to form a similar group to work with law enforcement officers on drug diversion. In most states, however, the committees never came into being.

- The AMA should do more within its own ranks to combat diversion.

The most important function that AMA — and perhaps only AMA — can perform is issuance of guidelines on the proper use of potent drugs. These rules would not only help honest physicians decide when to prescribe dangerous drugs, but could also be used to prosecute corrupt doctors.

The White House Domestic Council Task Force on Drug Abuse in 1975 called for a joint government-medical society committee to develop prescribing guidelines for amphetamines, barbiturates, narcotics, and other psychoactive (mind-affecting) drugs in its September, 1975, "white paper" report.

But the AMA prefers not to issue firm guidelines, according to spokesmen, instead relying on the courts to decide charges of unlawful prescribing on a "case-by-case basis."

However, a bevy of experts says that, now more than ever, organized medicine needs to take a firm stance on the proper use of psychoactive drugs.

Dr. Edgar W. Young, secretary of the Oklahoma State Board of Medical Examiners, notes that the line between proper medical practice and misprescribing of these substances is blurring.

"We're seeing a philosophical development of an unbelievable number of shades of gray . . . the issue is no longer black and white," he said in an interview in his Oklahoma City offices.

Some physicians now accept the view that "occasional use" of mind-affecting drugs is all right, he says, "such as the student who uses them to stay awake or calm nerves during exam time; or the guy who uses them in the morning to confront the day."

Lester Grinspoon and Peter Hedblom conclude in their book "The Speed Culture": "Physicians . . . are particularly apt to prescribe psychoactive drugs even when no definite indications for any drug treatment exist. . . . It is discouragingly clear that many physicians prescribe psychoactive drugs without making any attempt to achieve an adequate diagnosis and without taking even minimal testing or precautionary measures."

Paul D. Davis, an assistant dean at Cumberland Law School in Birmingham, Alabama, who has studied the diversion problem says, "The AMA should have the resources . . . to analyze where the problem areas are . . . and come out with guidelines on how to prescribe within the framework of legitimate medical practice."

The AMA has shown some concern about drug-peddling physicians and now is drafting a model state law which requires doctors to report their colleagues who engage in illegal drug transactions. A "model" state medical disciplinary act is also being prepared by AMA lawyers.

Further, an AMA committee now is evaluating the performance of state medical disciplinary boards and will make recommendations for improvement probably within the next year.

- State and local pharmaceutical societies need to set up telephone "chains" or "hotlines" to combat drug diversion.

Some county pharmaceutical groups already have telephone "chains" to alert each other to persons trying to have fraudulent prescriptions filled.

When a druggist receives a suspicious prescription, he refuses to fill it, then calls to warn other area pharmacists to be on the alert. They in turn pass the word along. Some telephone "chains" also include local or state police.

In Denver, a more formalized "Pharm-Alert" system works out of a central headquarters with a "hotline." Pharmacists can call in twice daily and learn of stolen or forged prescriptions or revocation of a physician's right to prescribe dangerous drugs.

- The American Pharmaceutical Association (APhA) should also be involved in the fight against diversion.

While AMA studies medical discipline and works on model state disciplinary laws, its counterpart in the pharmacy profession does nothing of the sort. Indeed, it denies that drug diversion is a serious problem.

"I don't think we have a serious problem at all in regards to willful diversion," says APhA spokesman Ronald L. Williams. He adds, "If you have the feeling there's a big problem, there isn't."

Examination of the records of state pharmacy licensing boards reveals a different picture, however. Violation of drug laws was the largest single disciplinary problem among pharmacists during a typical year — June, 1973, to July, 1974.

But APhA has no educational or legislative program to deal with drug diversion. Most of its lobbying efforts have been directed at getting mandatory sentencing for persons

convicted of burglarizing or robbing a drugstore.

APhA does this in the face of claims by DEA that there are far fewer drugs on the illegal street market as a result of drugstore theft than as a result of illegal sales by corrupt pharmacists.

• Pharmaceutical manufacturing companies should change the ways in which they market drugs.

U.S. pharmaceutical companies are constantly urging the medical profession to prescribe drugs. Estimates on the promotional money spent by drug companies in 1974 range from $501 million to $909 million.

One method of promotion is to send sales representatives (called "detail men") to doctors' offices, armed with sales literature, fact sheets on the latest products, and free samples.

Studies have shown that "detail men" are often the physician's primary source of information on new drugs.

DEA's Kenneth Durrin estimates there are approximately 25,000 salesmen encouraging doctors to prescribe and dispense drugs — and only about 700 state and federal law enforcement agents are monitoring for possible illegal practices.

"That's quite a contrast," he notes.

The Monitor found two cases involving "detail men" who were themselves selling drugs illegally.

Another major source of physicians' information on drugs is advertisements in trade journals — which often feature bold colors, and sometimes overblown claims about the usefulness of the products.

These ads came under fire in an editorial in the New England Journal of Medicine, which charged that "physicians are encouraged to use these drugs as 'treatment of choice' for what are problems of everyday living — not traditional mental illnesses."

The editorial further charged that drug companies are pressing for their products to be used to treat problems "that might call for social action and psychologic insight as well as the time-honored virtues of endurance, patience, and self-reliance."

• Medical schools should place more stress on the ethical questions surrounding prescribing of abuse-prone drugs.

An article in the Feb. 5, 1973, Journal of the American Medical Association noted that "of particular concern for the future is the incidence of use of, and the attitude toward, psychotropic [mind-affecting] substances among medical students and physicians-in-training. These young men and women progress into the area of total, unsupervised responsibility for patient care, where impeccable judgement and unclouded thinking are the primary bulwarks protecting them from malpractice."

Yet interviews with medical students suggest that non-medical use of amphetamines in medical schools is widely practiced.

Dr. M. H. Crabb, secretary of the Federation of State Medical Boards, charges that nearly half the freshmen and sophomore medical students in the U.S. take drugs to stay awake during exam times or to help them cope with the stresses of their demanding curriculum.

Dr. Derbyshire says medical schools in general "haven't done a very good job" in confronting such ethical questions in the classroom — although he notes there has been some improvement in the past few years. But there is still a need for more ethics classes, he adds.

• Families and individuals should seriously question their own use of drugs.

If there was one common theme in the scores of interviews conducted for this series, it was that the American public is too reliant on drugs. The Social Security Administration says U.S. consumers spent $6.4 billion for prescription drugs in 1975.

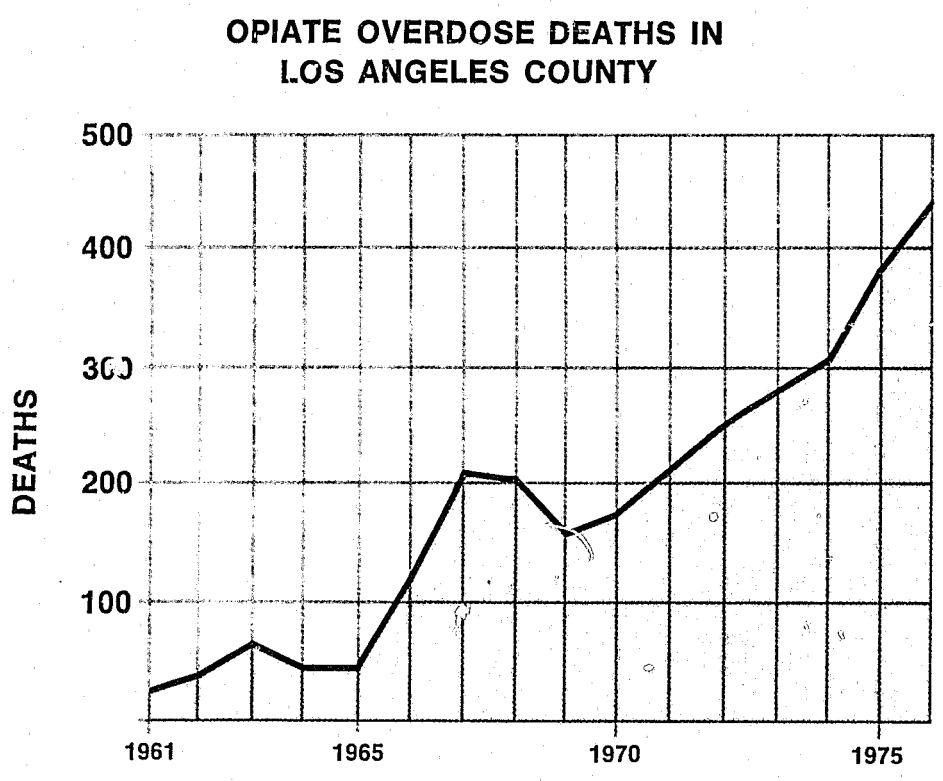
"In the long run, the solution to our drug-oriented society is a change in life-styles, a change in the demand for drugs," says the DEA's Mr. Durrin.

Dr. John C. Ballin, director of the AMA's department of drugs, stresses that public pressure for drugs is a major factor in a doctor's decision to prescribe.

Many patients feel cheated if they come away from an office visit without a prescription, explains Dr. Ballin. He adds: "I suppose doctors should resist this, but the pressure is constant, and insidiously the doctor yields."

Lynette Rich, a prosecutor in Manhattan's Special Narcotics Courts, says the common availability of drugs in the home — plus the example parents set for their children — is one of the root causes of drug abuse.

"How many kids start out abusing drugs by taking what their parents have in the medicine cabinet? And they don't think of this as drug abuse, because these drugs are available to a law-abiding citizen, where other drugs [such as heroin and marihuana] are patently illegal," she says.



Approximately 43% Of County Deaths
Occur in the City of Los Angeles

and the one-spoon seller or the marihuana user to the major supplier and his agents. The second phase of this new enforcement effort began in April 1971 when the Los Angeles Police Department established liaison with the Drug Enforcement Administration, California Bureau of Narcotic Enforcement, and the Los Angeles County Sheriff's Office. These principal agencies became a part of the Narcotics Intelligence Network (NIN). The purpose of NIN was to provide up-to-date information on major narcotics suppliers in order to preclude unnecessary duplication of effort and waste resulting from an absence of one agency knowing what another was doing. The sharing of intelligence information on major suppliers has resulted in significant improvement in narcotics investigations. Of course, the system relies heavily on the sharing of accurate information and the prompt opening and closing of cases. The system has been successful for everyone except the major supplier.

California duplicated this same intelligence network in 1974. Member agencies of the California Narcotic Intelligence Network share information on major suppliers within the state. The system is being expanded to include some jurisdictions in Nevada and Arizona. This approach to narcotics intelligence has benefited many agencies within the state.

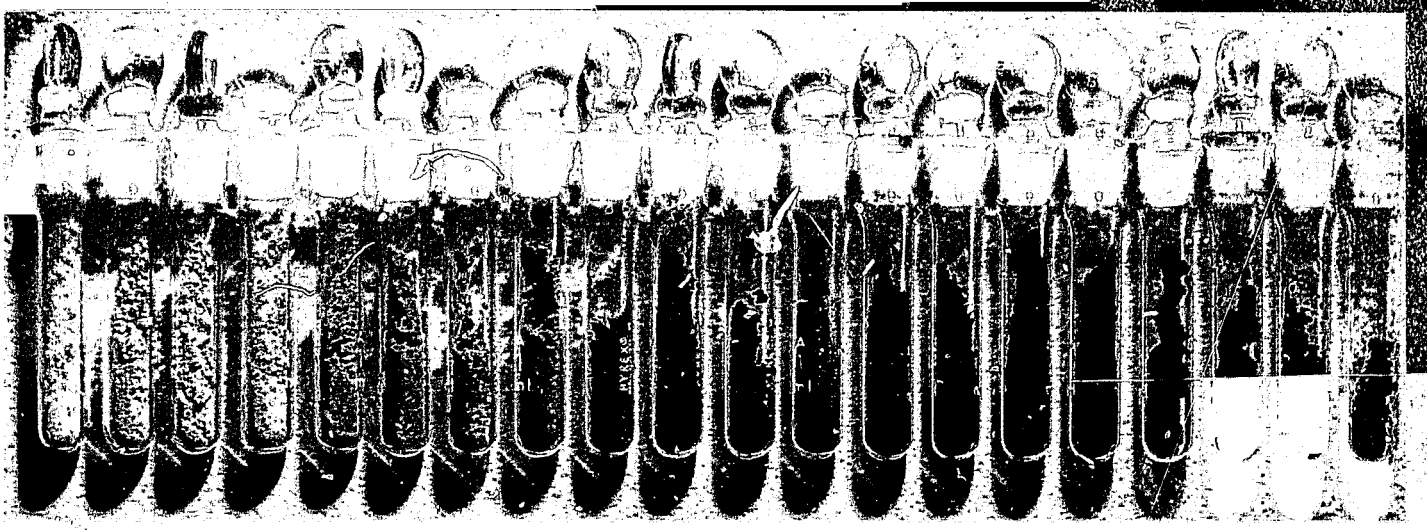
In addition to the multi-jurisdictional approach to intelligence gathering, an enforcement task force has been created within NIN. This task force utilizes the talents of local, state, and federal agencies toward the successful interdiction of narcotics and the successful prosecution of major violators. Individuals involved in the sale of thousands of pounds of narcotics, who previously were able to escape from the grasp of local enforcement agencies, have found the task force to be a tough opponent.

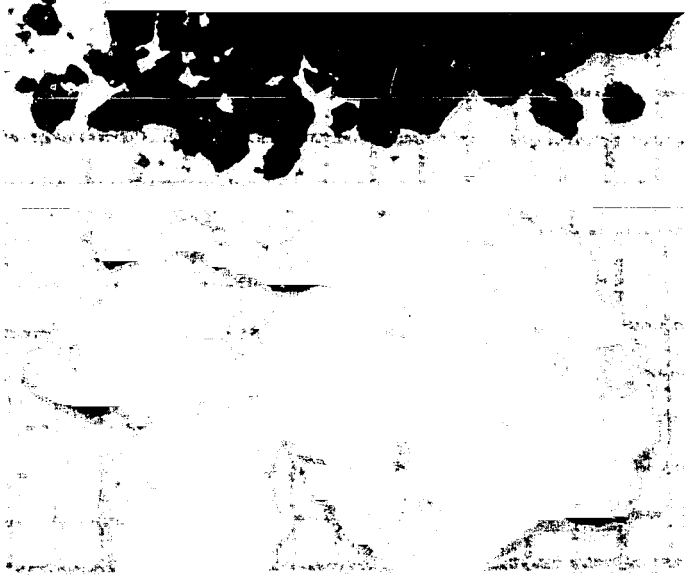
Independently of the NIN system, my department has worked with various school officials to stem the flow of narcotics into local campuses. There exists a need for narcotics enforcement and education at the high school and junior high school level. For example, a federal study indicated that marihuana use among 12-17 year olds nearly doubled between 1972 and 1974. Fifty-five percent of the three million high school seniors in 1975 experimented with dangerous drugs and nearly 66 percent thought that marihuana should be legalized or decriminalized. Within the City of Los Angeles, we found through a survey that nearly twice as many students at the high school and junior high level admitted marihuana usage in 1974 as admitted use in 1971. Prior surveys had indicated a decrease in use.

One program which was initiated by my department to prevent the spread of heroin addiction is called the Contagion Program. Under this program, persons that may potentially become infected by drug users are contacted and counseled. This program is primarily directed at the close friends and family members of a drug user. Through followup interviews we have determined that the program has been effective as well as received in a positive manner.

While our past successes can give us personal pride in the effort we have expended to eradicate this menace to society, much remains to be done. The drug problem is still out of control. Its control in the future will depend upon the national, state, and local cooperative enforcement policy which is currently enjoyed by member agencies in the Western Region. We will have to strive to improve our intelligence system and our intelligence gathering capability.

Most of all, any future success must be predicated upon the generation of a public attitude which acknowledges dope for what it is — the most debilitating threat to the individual youth of this nation today.





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