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Contemporary Problems of Drug Abuse - V. Sunday Afternoon

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MR. FINLATOR: I would like to answer your question, if I can, by really avoiding it. I do not want to make it too easy for the government to put things under its control. I think we have too much control already. Let me give you a good example, if I may. Most of you will remember the banana peel bit in 1966 or 1967 when we got stories from the West Coast that you could take a banana peel, scrape it, do certain things with it, and smoke it and, man, you had a real high. The AP and UPI picked the story up, and it went all over the nation. I was head of the Bureau of Drug Abuse at the time. We bought 30 pounds of bananas, brought them into the laboratory, cooked them, steamed them, and smoked them. We did everything we could to those things for about 60 days, trying to arrive at a real conclusion. When we finally came to the real conclusion, the put-on was all over. We put out a nice press release which nobody picked up.

I think it should remain difficult to put drugs under control and I hope it will remain that way.

MR. ATKINS: We are beyond our time and I think this is a good place for us to conclude. Thank you, very much.

V. Sunday Afternoon

A. The Great Drug Education Game

MR. LEVIN: This afternoon we are going to focus on drug education. We are very fortunate to have with us the Executive Director of the National Coordinating Council on Drug Education, Peter Hammond.

MR. PETER G. HAMMOND: I did not pick the topic so I had to do some work to find out what the great drug education game is all about, and here are some of the things that I found.

You have been burned. Half your marihuana turns out to be oregano; throw that half away or use it on pizza and you lose half your stash. You get paranoid and flush five lids down the john; that will cost you $25 for the roto-rooter man. You inhale a still burning joint while trying to get the last hit; go to the freak clinic and pay $15. You are busted and must become an agent informer in order to save your own miserable hide; use that card to send the player of your choice to jail and you lose 5 ounces of dope plus all your friends. That is from "Feds and Heads," a Monopoly-style game of "pot" luck which has not been taken too seriously in drug education; for some very obvious reasons.
But we have another game that is called the "Junkie Game." The Junkie Game has been designed by the Haight-Ashbury Free Medical Clinic in San Francisco to give people a realistic appreciation of the bleak life of heroin addicts. The game has been developed as a realistic educational tool, a training device for socially relevant recreational experience. Two to seven players begin with a job, $500 in cash, possessions and pick up a heroin habit after first throwing the dice. Other aspects of the game include wisdom cards, hassle cards, hustle cards, and the center square — death — which puts you out of the game. If you get back to the starting point after a $20-a-day habit, you redeem your possessions, get your job back, become clean for good, and you win.

The "Junkie Game" costs $9 and, to me, it is further evidence of one of the phenomena I have recognized during the past 4 years in drug education — drug information has become very big business in the United States. It has captured the imagination of presidents, legislators, bureaucrats, school boards, publishers, film producers, and gadget makers. It has moved drugs into first place in our health education programs and has occupied the energies of at least seven different congressional committees and 13 federal government agencies. It has created commissions, task forces, councils, and conferences at Villanova, and has made instant experts out of thousands of people who never knew a thing about drug education. It has given a new lease on life to the export business. One of our "concerned filmmakers" has successfully sold over 2,000 prints of a drug education film at $250 each and, soon, with some dubbing, will make that same film available in French and Spanish.

There is only one thing that drug education has not done — it has not worked. I can find no evidence that our massive drug abuse education effort has worked. In fact, it has backfired on us and the full consequences have not yet been calculated. The National Education Association’s year-long study on drug education in America reported these findings this past summer: (1) The greater percentage of existing drug education programs are superficially or educationally poor; (2) Some of the programs, because of false statements made by misinformed or uninformed educators, could very well have contributed to the increase of drug usage in our society; (3) Much money is being wasted on poor materials and misinformation; (4) The use of false, poor, emotionally oriented and judgmental material is much more harmful than no material at all.

The key to the drug education game is having information; you can not play the game unless you have it. What we at the Coordinating
Council have been doing for the past 3 years is to evaluate some of the information. We discovered that, among other things, 84 per cent of existing drug abuse education films contain scientific or medical mis-statements about drugs and drug effects and that one-third of them contain so many errors that they should be classified as scientifically unacceptable. After systematically reviewing more than 220 films, our Council can barely recommend 16 per cent of them. The errors range from misstatements of fact and misleading innuendoes, from inaccurate portrayals of the drugs and their effects, to distortions of scientific data. The only thing they seem to do very well is show the proper administration of illegal drugs. In my research before coming here, I checked the use of films in the Philadelphia metropolitan area schools and found that over half of the films that are available for classroom instruction come from our list of scientifically unacceptable films.

The posters, the charts, the giveaways, the throwaways, the pamphlets, the dial wheels, the slide charts, and all the other general public drug education information literature are even much worse than the films. When our evaluation is complete at the end of this week, we are probably going to recommend about 10 pieces of literature from over 300 separate items that litter the countryside.

Our Council updates, through monthly supplements, a looseleaf reference notebook that covers 26 areas of drug information ranging from epidemiology to street drug analysis, from law enforcement to an underground drug digest, from alcohol to cannabis. We remind our readers that this publication, which we call Grassroots, operates under the assumption that one can trust most contemporary pieces of drug information to be valid and relevant almost as much as you can trust the drugs sold by your friendly street pusher to be potent, safe and unadulterated.

The misinformation situation has become so serious and widespread in the United States that one of the recommendations of the National Commission on Marihuana and Drug Abuse called for a moratorium on the production of new information materials. That is one of the recommendations that we made before the Commission, and I am pleased to announce that early this April about 10 to 15 of the major national groups in the country, including the National Education Association, the National Association of Secondary School Principals, and like organizations will be joining in calling for a moratorium on the production and distribution of drug education materials. Such a development will enable us to catch up on our evaluation and deter-
mine the kinds of new materials, if any, that may be necessary to rid ourselves of the existing misinformation.

As is usually the case when a big idea goes wrong in a very big way, there is a sequence of mistakes which must shoulder the blame for the failure. No one error, no one failure by itself, is at fault for the drug abuse education catastrophe. We have identified the following as contributing factors: (1) failure to question our intentions and assumptions; (2) failure to define the problem correctly; (3) failure to establish realistic goals; (4) failure to evaluate the validity of our messages and messengers; and (5) probably most important, failure to correct our mistakes.

Today the great drug education game continues and is still being perpetuated through invalid assumptions that range from “drugs are a youth problem” to “adults know what is right”; from “only illegal drugs are misused” to “abstinence is the best goal”; from “facts can change behavior” to “unless you have tried them you cannot talk about them.”

We have focused our entire education effort on indiscriminate dissemination of the so-called facts. We have confused information with education. The role played by facts in determining use is unclear, and teaching facts as the basis for decision making assumes that we use them in that process. However, information levels have not been shown to play a dominant role among the factors related to the different forms of drug use. The presentation of “just the facts” might well lead people to conclude that even powerful illicit substances produce pleasure and can be used with little risk.

We have clearly failed to understand the nature of the problem. We see certain drugs instead of certain issues; we see pat answers instead of probing questions; we see “them” instead of us; and we see a threat to our moral security instead of a challenge to our inventiveness. Nobody understands the drug problem well enough to try to solve it with education, and not enough people understand education well enough to deal with drug abuse. We rush to the media with advertising slogans and jingles from wornout heroes, but we forget that while advertising can shift brand preferences and create new markets, what it can do to manipulate values is still unknown.

Operation Intercept produced some heroin addicts and some speed freaks when pot became scarce. Our current experience with the national “turn-in-the-pusher” hotline has undermined the services of existing community hotline programs. The banning of TV advertising has been one of the factors that has increased the use of nicotine
because of the use of other advertising gimmickry, and will, most probably, work the same result with drugs if the foes of over-the-counter advertising have their way.

The list is endless, but the procedure is the same. Public hysteria fed by misinformation has pushed us to short-term action solutions and the well publicized rush to act has too often only worsened the situation it was meant to correct. Drug education has to deal with all of these problems — after all, that is what education is all about — the sorting out, interpretation, and accommodation of the confusion that exists in the world. However, without realistic goals, the task is impossible. Abstinence cannot work until we outlaw curiosity or until people are willing to learn vicariously. On the other hand, teaching people how to use drugs is, at the present time, socially undesirable. The options available in between, in my judgment, are much more realistic and functional, and present the new light for drug use education and information.

Although there have been some shifts in the traditional information campaigns that we have witnessed over the past few years, most new efforts, as the result of an infusion of government funding, still depend too heavily on information about drugs. They have, however, begun, in some way, to incorporate drug relevant issues and have attempted to focus on behavior and attitudes. Unfortunately, the trend is compartmentalized. It has been kept within drug education as it stands in the traditional health curriculum, rather than spreading out — discussing morphine addiction in history class, examining epidemiology in math class, tracing traffic routes in geography class, or analyzing the content of street drugs in chemistry class. The intransigence of school administrators and the rigidity of school curricula in general, coupled with the general failure of American educational institutions to provide relevance and meaning to the learning process, suggest the urgent need for a new setting for drug education.

The new kind of drug education should not neglect information about drugs, but should assume that information does not influence behavior until it is processed by an individual in terms of his own experience, feelings, and life style. More meaning should be placed on the functions of drug use rather than on its psychological or physiological effects. The new approach should abandon charts, films, and ecstatic testimonials for rap sessions, role-playing and alternative behavior, and should focus on the family as a unit.

With any new focus, we are going to need a new setting, and I would suggest something other than a structured classroom. The
teacher should be every participant, the students should be every participant, and the subject might from time to time be drugs. With a new setting, we are going to need some new ideas, and these will necessarily vary from community to community, but the goals should be simple, uncomplicated, direct, and attainable — something like learning to listen or learning to express oneself. If we feel a compulsion to focus on drugs, cleaning out misinformation in the school or in the public library has some innovative merits.

For a community where experimentation is inevitable, we should probably focus on interpreting initial drug experiences. That is a critical point in the drug cycle with which neither education, treatment, nor law enforcement deals. All of our experiences and knowledge about drugs and drug effects are hidden from the experimenter. He is inevitably left to peer cheers and to other traditional attitudinal influences. He is not prepared or equipped to sort feeling from expectation or reality from anticipation. Yet, while his decision at that juncture will determine his drug behavior for years to come, we do not, now, bother to reach him because we have not yet bothered to create the mechanisms.

One thing is clear, and that is that there is much we need to know about realistic drug education goals. I do not pretend to have the answers, but one thing is clear — we must stop dealing with drug information and focus on human needs. Our efforts to reduce the casualty rates from the misuse of drugs would be enhanced overnight if we could substitute what we think we know about drugs for what we do know about human behavior.

In time, our civilization will perish and our great-great-grandson, the archaeologist, will be digging in our ruins. Buried there along with computers, weapons, and the rest, he will find tons and tons of papers with words printed in all languages. Many of these words will be about drugs — words like modality, rap, cyclasazine, score, lid, bust, coordinate and hotline, needle, poison, O'Dale, BNDD, SADAP, LEAA, NIMH, ASA, conference, seminar, and law — and he will conclude that we were a people addicted to words. We were all word freaks. We got up every day, every hour, with more words. He will wonder at the strangeness of a people who could talk so much and do so little to help each other.

I understand that I now have a few minutes for questions. There is one admonition. I know that you believe you understood what you think I said, but I am not sure you realize that what you heard is not what I meant.
PARTICIPANT: I wonder about the availability of the information that you handle, and what it would cost. You mentioned Grassroots, which I believe costs $96 a year. Is not that expensive for drug information?

MR. HAMMOND: No, it is inexpensive, if you look at the publication. It is a two-volume binder which contains 26 categories of information and is updated monthly. It is essentially our review and evaluation of all of the articles, reviews, and publications that appear on a regular basis, with some information services so that it is useful to you. It is published in cooperation with the Student Association for the Study of Hallucinogens (SASH) in Wisconsin. The American Bar Association and the American Medical Association are both members of our Council. We have a newsletter called The National Drug Reporter, which comes out on a biweekly basis and contains most of the information found in Grassroots in capsule version. Subscription to that newsletter is $9 and I would recommend it to those of you who are specifically interested in the field.

PARTICIPANT: I am interested in the study you said you did of the films used in Philadelphia area schools. You said half of them were found to be unacceptable. Were any of the other half in the recommended category?

MR. HAMMOND: We have essentially four categories of films. We have a recommended category and a restricted category within which are films that contain either conceptual inaccuracies or scientific misstatements that are not too serious. Most of the films in the Philadelphia area fall within that category as well as our third category, the scientifically unacceptable.

The final category of films includes those aimed at minority groups. Out of the 220 films that are available, only seven of them were made for Black audiences, which gives you an idea where everyone's head is. Interestingly enough, our review panel rejected all seven films as being very biased, very racist, and for perpetuating some incredibly invalid assumptions about drugs. It is always a Black male; he is always using heroin; it is always Trashcan Alley; and there are no positive role models for the young people who view the film.

We publish a report called Drug Abuse Films. It is a comprehensive review of 220 films which also explains how to use them. One creative way to use films in medical schools is to show one of the unacceptable ones and ask the students to identify all the errors in it.
PARTICIPANT: What about rap sessions and the drug education game that you mentioned?

MR. HAMMOND: I think the game is middle class. We are opting for and have tried, at least in the State of New Jersey, an en masse parade of ex-addicts before you, as part of the game. Have you ever seen an ugly ex-addict? He is usually a very tall, articulate, well-spoken individual who talks to people with acne and C's on their report cards and who just broke up with their best friends. He stands up in front of them saying, "Hey, drugs have ruined my life." There is really no evidence of that, and he probably gets $200 for the rap. If you put an ex-addict into a one-to-one situation, it does not take long for any student, middle class or otherwise, to cut through all the garbage he has been feeding him.

PARTICIPANT: How does the government output compare with private industry?

MR. HAMMOND: The government effort is improving considerably. As you know, Dr. Jaffe, who heads the Special Action Office for Drug Abuse Prevention, has, at least, made an attempt to avoid some of the conflicting information that has been characteristic of the government efforts during the past 5 to 10 years of our epidemic of drug interest. The quality of information is improving. In terms of volume, it is not as high as that in the private sector. In terms of what the drug companies are putting out, the information is in the mediocre category. I have never seen anything really exciting from our review of the literature, but some effort and money has been put into telling you to stay away from certain kinds of drugs.

MR. LEVIN: I attended the National District Attorneys Association convention in Chicago last year and Peter Hammond's presentation was the only one that left an impression on me. Thank you very much, Peter, for giving us a fine perspective on drug education.

B. The Drug Scene: What We Never Learned in Law and Medical School

MR. LEVIN: We thought that the most appropriate discussion with which to close this conference would be one concerning what actually is being done, now, in medical and law schools relative to the drug problem. This panel is comprised of people we consider to be the most prominent doctors, lawyers, and judges in the United States presently dealing with the drug abuse problem. Judge Paul Dandridge,
one of the most knowledgeable judges in the United States on the problems of drug abuse will preside. He has worked with the therapeutic community and is a member of the Governor's Council on Drug Abuse. It is my pleasure to introduce Judge Paul A. Dandridge.

THE HONORABLE PAUL A. DANDRIDGE: Thank you, Peter. Good afternoon.

The question, what did we learn about drugs in medical and law school can be answered very simply — nothing. This panel will try to explain how we have acquired knowledge, if we have acquired it. What we can do is suggest ways of learning and recommend how they may be implemented in your schools. I would hope that you will have more questions of this panel than I have heard of any other.

Dr. Fort, to my extreme left (and that may not be symbolic of his usual stance) is a medical doctor specializing in public health and social change. He is also a Professor at the School of Criminology of the University of California at Berkeley. He is founder and leader of the National Center for Solving Special Social and Health Problems in San Francisco, which works on crime, suicide, sexual and drug problems, and administers methadone. He is the author of *The Pleasure Seekers: The Drug Crisis, Youth and Society; Alcohol: America's Biggest Drug Problem*, and is co-author of *The New Sexuality*. He is a former consultant to the World Health Organization, United Nations, Peace Corps, and OEO.

DR. JOEL FORT: This panel may be distinguished by having at least one non-establishment anti-bureaucrat on it — me. I came here because I did not like much that took place when I went to medical school. I did not come to talk to the press or to talk to anybody else but you, the medical and law students. The main mistake I made in medical school was not realizing how much I could do to change things.

I would like to suggest that you, out of concern for drug abuse in America, and hopefully out of concern for the right of the non-smoker to breath clean air, refrain from smoking in this room for the rest of this presentation. As you know, our biggest drug abuse problems in America come from alcohol and tobacco. We show very little concern about that and, in fact, often consume too much of those drugs, at drug conferences.

I would like to commend the AMA, the ABA, and the pharmaceutical industry for taking a small step into the 20th century by co-sponsoring this meeting. I hope they take further steps to increase
their social consciousness and to help us solve some problems rather than creating more.

In medical school we learned little about drugs beyond pharmacology. Although I have not gone to law school, I have had extensive experience with the law, both as a litigant carrying through a constitutional challenge in California that freed public employees to participate in politics, and as an expert witness in many drug and sex cases. It is my impression that you learn very little about the drug scene in law school. Certainly, both law and medical students learn little about moral values, or the hypocrisy and corruption of both legal and medical practice and the society as a whole.

We talk glibly about drugs and the drug problem but seldom do we understand what we are talking about. The word “drug,” as certainly all medical students know — and I think probably most law students — includes everything from aspirin and penicillin to the mind-altering drugs which begin, not with marihuana, but with alcohol and tobacco, our most widely used and abused drugs. As good Americans, we deal with widespread, illegal possession of alcohol and tobacco by those underage through hypocrisy — we ignore the fact that it is happening and generally begin our discussions of the drug abuse problem with consideration of the other more political and sensationalized mind altering substances. The true psychoactive drug context ranges from A (alcohol) to H (heroin) and includes, of course, pot, acid, speed and a host of other substances.

What is drug abuse? For some, it is any illegal use, including in that terribly inaccurate definition, alcohol and tobacco use by those under the age of 18 or 21. For others, it is someone they do not like who uses a drug of which they disapprove, particularly if that person does not visit barber shops regularly or work a traditional 40-hour week. But, actually, any drug can be used once or occasionally. Some use may be regular with only a segment of that abuse, meaning excessive use that damages health, social, or vocational functionings.

About 10 years ago I began to take off on the term that we have all heard — “hard drugs” — as a way of defining the problem. Some self-appointed expert will stand before a group — he has traditionally been the drug policeman or a politician — and drop “hard drugs” out of the side of his mouth. We react with a knee jerk, horror response, ready to march on our capitols and demand new criminal laws. Of course, that is, in part, because we crave oversimplified pseudo-solutions in America, and the politicians, most of whom are lawyers, pander to that. They tell us that the solution is to pass a law or elect them to
office. That concept of "hard drugs" has been embedded in our minds, and certainly in the minds of the older generation. Let us, therefore, define it.

I think both the Birch Society and the Communist Party would agree that death is a hard phenomenon. So, any drug that is involved, significantly, in producing death or disability should be called "hard." Thus, we get to the million deaths produced each year by alcohol and tobacco and by a wide range of other drugs. Psychosis is another hard effect, and leads us to alcohol, amphetamines, LSD, occasionally marihuana, and occasionally other drugs. Certainly we include addiction as a hard effect and that brings us not only to narcotics but to alcohol, and sedatives such as barbiturates, Doriden, Miltown, and Quaalude.

To quote the President, let me make perfectly clear (a statement you would expect from somebody who never makes anything clear) what my moral and scientific position is on "hard drugs." I hope that all medical and law students, indeed all people, would share my position and would advocate the reduction or elimination of all unnecessary death, disability, psychosis, or addiction, whether it comes from a drug considered good for business, bad for business, used by those people over there, used by us, or whatever. But, that certainly has not been our position.

People use drugs for many different reasons, but, basically, because drug use is institutionalized in our society. We are taught to use drugs for every pain, problem, or trouble. Fortunately, more people have joined in the condemnation of advertising of alcohol, tobacco, and pills, something which I have been crusading against for a good many years. But advertising is not the only culprit. Beyond that there is the role model example children are shown by adults as they grow up. We take for granted that when we relate to another human being the best way to deal with the situation is to hold a glass of alcohol in our hand, have either a dried tobacco plant or a dried plant we call marihuana in our mouth, or drop a pill. We seldom turn on to the warmth and character of another human being or feel that we can enjoy ourselves or deal with difficulty or tension without using a chemical. Doctors, of course, contribute to that by their massive overprescribing of drugs, as does the pharmaceutical industry by its massive overproduction.

I cannot cover everything I would have liked to because of the time limitations involved and I would urge you to read my book, The Pleasure Seekers, if you want a more comprehensive view. It is now being used for instruction in many law and medical schools.
Most federal and state drug programs are total failures, regardless of the image building that we hear from the speech-writers of the compliant political psychiatrists in the drug bureaucracy. A recent book described those who got us into the Vietnam War as the best and the brightest. If that was, indeed, the case, those who lead our federal and state drug efforts are frequently the worst and the dullest.

Operation Golden Flow — national urine testing, assembly line methadone maintenance programs, harsher penalties, and increased government control are measures our federal leaders tell us will solve the drug problem. The implication is that heroin addiction is the only drug problem, and that all we have to do is use this combination of urine and methadone, perhaps mixing them together, and we will solve not only the drug problem, but all the criminal problems in America (hopefully, including wiretapping and burglary).

One solution to such a situation would be to hold the people who have been totally ineffective and detrimental accountable — accountability is lacking in our institutions. After being held accountable, a step forward would be for them to resign. I certainly think Nixon and Jaffe should both resign, because they have both been very soft on drugs. We have never had more use of increasingly dangerous drugs by more people than when they have been in control. They have to be held responsible for the increase because they have been in charge.

I would like to say a word about our biggest growth industry in America today — drug careerism. There are probably more people working in drug treatment, drug education, and drug research, and attending drug meetings than there are drug abusers in America. Although it perhaps does not exceed the gross national product of General Motors, it certainly is a growth industry in which some of you may well have stock.

We are prisoners of mythologies; we are following outmoded traditions and rules. We have anachronistic organizations such as the AMA and the ABA supposedly guiding us, or testifying in our behalf, and, in the case of medical and law schools, we attend outmoded and obsolescent educational institutions.

Drugs have been overglamorized and oversensationalized on both their good and evil sides. Although I was probably the first to become involved in the decriminalization effort and in stressing a public health approach, it is not my view that everyone should use drugs or that drugs are good — when I use the term “drugs,” I include alcohol, tobacco, pills, and marihuana. Rather, my view is that the expectations of good about all these drugs have been almost as exaggerated as the
expectations of evil. Unfortunately, there is no drug including alcohol or marihuana, that will make an ignoramus into a genius, will solve school or family problems, or will rebuild neighborhoods. One of the reasons why I have simultaneously crusaded for decriminalization of private drug use and for moving the society beyond drugs is that I see a reverse relationship between dealing with oppression, with injustice, and with every uncomfortable situation through a chemical on one hand, and attacking the roots of discontent in bringing about the long overdue revitalization of our institutions on the other. So, let us try to evolve an independent position that gets away from the ridiculous polarities between those who advocate pot in every chicken, and those who call for the death penalty for the first offense and castration for the second.

My view is that pleasure is desirable and since we are in Philadelphia, we might reaffirm the Declaration of Independence that guarantees us life, liberty, and the pursuit of happiness. But, as far as drugs are concerned, they are, at best, one of many sources of pleasure and meaning in life and their effect rests not on the magical property of the drug but on the personality, characteristic, and mood of the user. However, there are many other sources of pleasure and meaning in life and one of the solutions to the many drug problems, therefore, is to provide a wide range of alternatives, including making medical and law schools mind expanding experiences rather than ones which disillusion and make cynical an increasing number of people.

Several of us were involved in an initiative effort to decriminalize the personal use of marihuana in California in 1972. I plan to continue that, as well as legislative efforts, and also seek to decriminalize private sexual behavior between consenting adults. I recommend involvement in those or similar efforts in your own states. Most of all, I recommend a confrontation with what I have long seen as the core problem of America, one I call "institutional pollution" — the bureaucratic-political-diplomatic process with its crises of mediocrity and senility. Congress is the best example, our largest and most expensive rest home in America, and the state legislatures are not far behind. Institutional pollution is one of the chief alienating factors in American society and no one can hope to understand drug use or abuse unless they recognize that it is symptomatic or barometric of that pollution, and of affluence, poverty, racism, and a variety of other things present in American society. We attack only the branches. As Thoreau once said, "there are a thousand people hacking away at the branches of evil for every one striking at the roots," and our leaders and our mass
media keep us looking at those branches, keep us from understanding what the roots are, and, therefore, make the problem much worse.

We need to confront the new barbarians in our society. The least able are governing us as they did in ancient Rome. We need to stress the positive alternatives in social action. We need to demythologize drugs, and we need to become more and more aware of the point I started with — that one person with courage can constitute a majority. Let us not continue to ask for those people “over there,” the politicians, the bureaucrats, the administrators, to solve these problems for us. We need a brick-by-brick rebuilding of our society which only you and I can accomplish. I hope that you will join in that effort.

Thank you very much.

JUDGE DANDRIDGE: We will now hear from Judge Richette. Judge Richette is a graduate of the University of Pennsylvania and of Yale Law School. She worked for the District Attorney’s office for some 10 years as Chief of the Family Court Division, and in the Juvenile Court. She has been in private practice and became a judge in 1971. She is the author of The Throwaway Children, and has been very active in drug affairs.

THE HONORABLE LISA A. RICHTETTE: Doctor Fort, I want to thank you for a refreshing and provocative presentation. I had not thought of myself as a hod carrier carrying those bricks, but maybe that is what I have been for the past 14 months.

I am assigned to the Major Trial Division of the Court of Common Pleas and have been there for 14 months. That is the place where all of the junk, the bile, the blood is deposited — all those cases that are used, politically, to terrorize this community. The whole sentencing process in this country has been politicized.

When our Chief Executive takes to the White House doorstep and gets on the air to talk in terms of penalties and soft-headed judges as part of a mass political program to bring an increasingly militaristic approach to the solution of human problems to this country, the lesser-level would-be Nixons — and we have a district attorney who fits that category superbly — take to issuing similar statements. That often makes it difficult for judges who come from the kind of law background that I come from. My background has always been people-oriented. I wrote The Throwaway Children as a brief for the human rights and the dignity of a whole class of people who I consider to be throwaway people. When I walked into the Major Trial Division, I realized that what I was confronted with were throwaway children grown up — nothing more than that.
I agree with Jim Markham, who wrote an excellent article in *The New York Times, Heroin and Hunger May Not A Mugger Make*, in his premise that you just do not explain crime by equating it with drug addiction. The problem of drug addiction is an outgrowth of many things that happen to people in very early years.

It is all very well to say that we ought to decriminalize addiction, but what happens when you have someone in front of you who has been found guilty, either by you or by a jury, of having committed a felony — let us say an armed robbery — and he is then ordered to have a presentence or a psychiatric report. Assume he is 19, 20 or 21 years old, because that is the age of most of the people who come before me. The report comes back and you find that you are faced with a person who has a severe addiction. My alternatives as a Judge are: (1) to put the person on probation — which is an almost meaningless gesture because of the vast numbers of cases each probation officer has to handle; (2) to send him to a penitentiary where he is not going to get any kind of personal attention, either for his drug addiction or for anything else that happens to be wrong with his life; or (3) place him in a therapeutic community that ostensibly is going to focus on the addiction but in the process of doing that will do a lot of other things in terms of changing the person's human value system and orientation, and so forth.

That is the struggle that I face every day — the prosecutor's demand for a jail sentence v. my own convictions, which are inevitably propped up by psychiatric and probation reports that are valid. (The district attorney's office has even taken to cross-examining psychiatrists who make recommendations as to their credentials. I will not permit them to do that because the doctors are employed by our court system and in a sense that would be an attempt to impeach our own people.)

So that is the hard decision and it takes a great deal of courage and integrity to do what you think is right. We have had, in Philadelphia, a Judicial Merit Commission which scrutinized all of our sentences. The district attorney and his first assistant systematically tried to get those of use whose sentencing practices with respect to drug addicts disagree with their views, declared unqualified. They did not succeed in my case, and they will not succeed because as long as I wear that black robe I am not, and will not be, a rubber stamp for a prosecutor's blind desire to punish.

What we need in our criminal justice system are the largest kinds of alternatives Dr. Fort was talking about. There are some people who are so troubled and who are so violent that they cannot be placed in one of the community-based drug programs in which I happen to
believe very deeply. I had the embarrassment of hearing a district attorney tell a young man from Gaudenzia House that the program there was “neonazi” and that was the reason why he was not going to support a sentencing recommendation. To the contrary, it is not neonazi. It is a way of reaching people that is far less nazistic than what goes on in our state prisons. What we need are more secure hospital settings where people who have these very special problems can go and get adequate therapy.

I just want to close by saying that simplistic solutions to complicated human problems always mask an underlying antihumanity. Throughout history, those who have advocated simple and “ultimate” solutions have always been against man. Today, they focus on drugs, which are only a symbol of the kinds of boredom, misery and despair that people who never get near a law school or medical school feel in this country — people of the slums, the people of the ghettos. (Incidentally, I do not see very many Blacks or Puerto Ricans in this audience. Maybe they have just given up even coming to symposia.) What we have to focus on is on the social, institutional, and individual pathologies that underlie the drug problem. In other words, we have to get back to those old basics of poverty, racism, lost economic and educational opportunities, disintegrating families, and, above all, a collapsing criminal justice system. All of these problems seem to be very uninteresting to our national leaders. In fact, at the same time we hear severe, draconian penalties called for, we see a severe reduction in educational, social welfare, and other programs, on the grounds that they are inefficient. It is the same old problem; people have to understand that the solution does not lie in a voltage of electricity that passes through a human body but in a whole new way of how we look at people.

You ended, Dr. Fort, with a quote from Thoreau. I have a quote from Maeterlinck that I think says what Thoreau was saying. He said, “For every person who would push humanity forward, there are a thousand who would hold it back.” When there are only a few people trying, in their own ineffectual and imperfect ways, to push humanity forward, it is too easy for the “politicization” process to continue and to make thousands of people confused and disturbed about what is happening.

I feel very strongly that what we need are educated, courageous, and independent judges.

JUDGE DANDRIDGE: Let me add that Judge Richette is one of our most humane and understanding judges.
The next speaker is Dr. Schnoll, a medical doctor who has had a residency in neurology and is now working on his Ph.D. in pharmacology. He has been the Medical Coordinator at a number of rock festivals, has a number of publications to his credit, and is called upon by many of us in Philadelphia when we need help.

DR. SIDNEY H. SCHNOLL: The focus of this particular panel is on education and I would like to talk about the education we receive in medical and law schools. I think one of the prime things that is taught us is to emulate those who teach. Most of the time that teachers spend in the classroom is spent teaching students to be just as they are, to act the way they do, to look the way they do, and to uphold "the profession."

When I started in medical school, I thought I was going to get an education in medicine. When I finished the students in my class were asked what they had missed. The bulk of them replied that they would have preferred courses in how to set up a practice, medical liability, investment — all things which were important to managing their own personal life but which have nothing to do with taking care of the people a doctor is supposed to care for.

Look at what doctors do in emergency rooms with people who come in with an alcoholic problem. They are shoved in a corner, they are thrown to the side, they are looked down upon. That is what we are taught to emulate.

If my teachers had spent as much time teaching me to be a human being as they did telling me to cut my hair, I would be a great person today. But they totally missed the point. They said that I was not living up to the image of a physician. I still do not know what that image is, but from what I see most of the time, it appears to be pretty bad. I see physicians who do not extend themselves, do not reach out, and do not do the things necessary to treat people.

As a neurologist, many of the patients I saw were sent as consultations and their charts were sent along with them. If any of you ever have a chance to go to a hospital and look at some medical charts, you will see how physicians abdicate their responsibility. It is done very simply with three letters, P.R.N. That means that the nurse can administer a medication as she sees fit, and that the doctor is not to be interrupted, especially at night when he is sleeping — he does not want to know that his patient has a headache, can not sleep, or is having a problem. If he does not want to know about it, why did he go into medicine? The drug companies have certainly taught us, as
we have heard so many times this weekend, that there is a drug for every problem and the P.R.N. order is a solution.

I think the most important thing you have to decide is whether you want to be molded in their image or in your own image.

JUDGE DANDRIDGE: Thank you. Batting clean up is one Bernie L. Segal. I met Bernie when he was practicing law in Philadelphia as a defense attorney. He decided that he would leave his firm in Philadelphia for a short period and go to California, where he is presently an Associate Professor of Law at Golden Gate University Law School in San Francisco. He has lectured at the University of Pennsylvania, has co-authored a number of works with Tony Amsterdam, and has published a number of his own. I think that he is a topflight defense lawyer. I speak from some knowledge, having lost a number of battles with him when I was a prosecutor and winning very few.

MR. BERNARD L. SEGAL: I have no kind words for you this afternoon. In my judgment, the conference is a fiasco. Most of you are just hip liberals; you came here, most of you, because you were concerned about drugs and narcotics. What in the name of hell have any of you done here except to sit and sop up the alleged expertise of the panels, this one included? This was supposed to be your conference. It was put together brilliantly by Peter and the staff that worked with him. But the thing which a staff cannot put together in a conference is the catalytic reaction of the audience. As a matter of fact, you are not even an audience; you are merely participants. Because of your hip liberalism, you want to express your sympathy, your identity, your empathy with the problems. You have sat and you have applauded. It took a black man to remind you of the problems of getting black people involved. I do not know what else the staff could have done. Despite their superb efforts, you have had nothing to say.

You applaud when Dr. Fort makes remarks about the past failures of the AMA and the ABA. All of you have been in medical school or law school long enough to know about those things. What have you done there and what do you propose now? You are sitting out there now utterly cowed, waiting for us to tell you about what is missing from your education. I know what I missed in my education.

What troubles me, and why I started the way I did, is that I am afraid you in law and medical schools are waiting for one colleague, perhaps, to say something and that will jerk your mind and make you think, "Oh, yes, we are rather passive, are we not?" Perhaps we have
induced this passivity in you, but I do demur. I do think the conference has been organized superbly, but I respect your right to disagree and I hope that others will stand up and tell us all the things you need to know from the conference staff and from us.

I have a feeling that you sit in law school, those of you I know best, and talk about search and seizure cases and never ask why in the name of hell we are even devoting police energy to that area. You sit there in medical school and you get the occasional lecture about the law affecting narcotics and drugs, yet, how many of you have ever questioned the medical knowledge of the legislators and lawyers who rob you of some of your sworn obligation to treat people humanely?

Half of you, I suspect, are now saying, “Well, I know that when I get out I am going to do something about the problem.” I doubt you very much, because if you are not rising up here now at this conference and telling those of us who are here now and those who read the symposium as published by the *Villanova Law Review*, then, I think you will learn nothing. I was very shocked, for instance, that you sat here very interestingly listening to the report delivered by the Director of the National Commission on Marihuana and Drug Abuse as if you were hearing the truth. The truth is not what the Commission said. The truth was that even before the Commission’s report was complete the President of the United States, who had not read it, said that he would not follow it if it did not say what he wanted.

You assure yourselves, my medical colleagues, that you would really like to do something different about the drug situation, but you have abdicated to the lawyers. We lawyers assumed wrongfully that we were the ones with the expertise to deal with the laws of narcotics and drugs. Then we abdicated to the law enforcement people. As was pointed out by some of my colleagues here, it is the tenth-grade dropout who represents the bulk of law enforcement in America. They represent the largest amount of uncontrolled discretion in the criminal system. We abandon all to them.

I say to you at this juncture that now is your chance to reassume your role of running this conference. Tell us what you really need to be educated about in law school and in medical school.

C. General Discussion

PARTICIPANT: I have a question for Mr. Segal. How do you handle the situation, in a juvenile case, of an individual who has been declared deprived and who may want to go home, but you have different and competing institutions trying to get hold of him?
MR. SEGAL: That is really a question as to how you rationalize morality. It is a good question that ought to be raised in law school—what is the morality of what we are doing?

As a practicing lawyer, I am concerned with the interest of my client. I am also a change-oriented person and I cannot accept that I have solved anything or done anything just because I have protected my client's interest. What I have to do is to recognize that if I earn my living this way, I must give that a certain amount of committed energy to effect a change process. What lawyers have to do, what the district attorneys that Lisa Richette has to deal with have to do, instead of getting up and trying to enforce certain laws is to say, "We confess error. It is morally and legally wrong." That is what the proper lawyer will do.

JUDGE RICHETTE: I wanted to talk about the problems of representing juveniles. What Judge Dandridge did not say was that I had been a Clinical Professor of Law at the Villanova Law School. We had an excellent program at the Law School which Dean O'Brien is continuing and supporting—are you, Dean?

DEAN O'BRIEN: Yes, I am, Lisa.

JUDGE RICHETTE: We sought to take third-year law students into Delaware County to represent juveniles for whom no legal services were available. The question you asked is one question that had to be confronted by each of the participants in this program. All I could do then was to help each person to find a proper solution for himself. I think you must never equivocate and never accept the rhetoric of rehabilitation; never accept at face value what some probation officer or some psychiatrist says that institution or this foster home is going to provide.

What we did was to attempt to involve every juvenile in the decision about where he would go. We would take them out to an institution and have them walk around and talk to other people there. If the Court would not allow that child to get out of detention, we would be absolutely opposed and would take an appeal. Some of the students even went out and found alternatives to institutionalization. They went out and spent the time and effort to find foster homes for the kids.

PARTICIPANT: I have been involved in a clinical program. One thing we do not get is a discussion by students of what is actually
happening. We do not get a chance to sit down and reflect, morally, on the alternatives.

PARTICIPANT: I would like to raise a point with Dr. Schnoll about the role of medical education. It seems that both doctors and lawyers are taught to be very paternalistic and part of your accusation, I am afraid, is part of the same paternalistic mode that we are taught to take on. Why should a drug not be P.R.N.’d for the patient? If the patient is informed of what the drug does, why should the patient not be allowed to take it P.R.N.? Why must the doctor be informed about every headache in the middle of the night? Why should the patient not have the right to decide what his doctor knows about him, even if he is in a hospital?

PARTICIPANT: Following that, what about people who choose drugs as their alternative, as their meaningful experience? In some cases, they do not want to become vegetables, and in others they do. We should let them make a decision. After all, it is their life.

PARTICIPANT: How many doctors tell their patients what the drugs do to them?

PARTICIPANT: In my school, the pharmacist tells the patient what the side effects are.

PARTICIPANT: How many do it in practice?

PARTICIPANT: Very, very few.

Turning back to Dr. Schnoll, I would like to point out that, of all the specialties in medicine, neurology is the one least associated with care of the patient. When you do find out he has a headache, do you see him every day? I question your right to accuse other doctors of being lax in daily care.

DR. SCHNOLL: You all have brought up a great many very interesting points. I am not going to try to defend neurology, because I do not think neurology is the greatest profession in the world. That is why I do not practice it anymore.

When I was talking about the P.R.N. use of medication by physicians, I was talking about its indiscriminate use. When I was in medical school, I was taught by the internist on the service that when I wrote orders, I should always include a P.R.N. order for a headache medication, a P.R.N. order for a sleep medication, and a P.R.N. order for a laxative. That is still being taught, by example, to many medical students in this country. That is indiscriminate use of the P.R.N. type
of medication. The doctor does not know if the patient is constipated and, even if he is, the constipation could be caused by a bowel cancer. The doctor should check, but he does not. The fact is that if you looked at the charts in almost any hospital you will find that some charts will have as many as 12 to 13 P.R.N. medications on them.

Now, certainly, there are some medications that can be given P.R.N., but that is not what I am talking about. I am talking about indiscriminate and excessive use. When that happens, the physician is abdicating his responsibility to find out what is wrong and help the patient.

Someone else brought up the point about the use of drugs to get high for an experience. I was not talking about that. I was talking about what we were trained to do in medical school, and that is something entirely different.

Physicians do abdicate their responsibilities to the patients, they avoid them and give them as little time as possible. Giving a drug to someone who has a severe psychological problem means that the doctor does not have to deal with the problem, he can stay away from it.

DR. FORT: For those who were not fortunate enough to go to medical school, P.R.N. means as needed.

PARTICIPANT: My question is how many doctors actually tell the patients what medication they are going to get and what it is going to do to them?

PARTICIPANT: None. That is another part of the paternalistic role that doctors are really encouraged to play in medical school. They know what is right for the patient better than he does. Therefore, he does not explain what a drug is or what is wrong.

JUDGE RICHETTE: It is not so much paternalism as authoritarianism. To what extent can medicine, the law, and all the authoritarian control systems superimpose their own judgments for individual judgments? I think it is a very important philosophical question which is being raised and can not be avoided.

DR. FORT: I see it as a much broader and somewhat different issue. How often does a lawyer explain to people the range of possibilities available to them in the system that we call administration of justice — the different dispositions, the plea bargaining, the adversary system, the deal-making, the whole range? How often does a doctor explain to people the implications of methadone maintenance, of antabuse, or of psychoanalytic therapy? How often does the self-help
program describe what is involved in the kind of commitment it expects people to make and the devices that are used as part of that? While it does involve authoritarianism, I think it is much more than maternal and paternal.

One other thing I wanted to discuss is that for us to get to medical school or law school, and for us to survive that process, requires a marked degree of overconformity. I have doubts, myself, whether I would do it again. I was always a rebel. I do not know how I got through medical school. I guess it was in part because after the first year, which was a total waste of memorization and regurgitation, I really enjoyed what I was doing and found it to be a tremendously exciting thing, despite the fact that it took a year or a year and a half longer than necessary. The point is, we are indoctrinated into overconformity, into passivity. Our whole acculturation is geared to keep us under the control of the least able people, who learn how to manipulate us, how to use image building to replace reality, and how to divert us from the sources of our discontents.

We have to confront all of that, beginning where we are. For example, why is curriculum not shortened? Why do you need to spend 4 years in medical school or 3 years in law school? The reason why there are not more Blacks, Puerto Ricans and women here is not because the people who planned the meeting did not want them, it is because your medical schools and law schools do not admit them.

JUDGE RICHETTE: I have been involved in the movement to humanize the legal profession and it is not easy because there is great resistance on the part of professors, degreeholders, and chairholders who feel very threatened by the influx of a whole new philosophy.

PARTICIPANT: I think that one major thing that is lacking in medical and law schools which reflects on the education they offer is responsible and receptive admissions policies. I speak as a veteran of seventeen medical school rejections, with a husband who has a record of 26 medical school rejections because he failed organic chemistry the first time although he got an “A” the second time.

Sometimes, of course, rejection can be a good thing because it may force you to find something else. I found law. I found a dean who looked at my degree in chemistry, looked at my law school admissions test scores, and looked at my sex. They were looking for women and I was admitted. It was a good year for women, and we are very grateful.

Anyway, I think the problem with the medical and the legal profession lies with the admissions committees. They get hung up on hair,
and they get hung up on beards. The great emphasis on grades results
in the admission of brilliant students who do not know how to talk to
people and who care only about their grades. Their attitude carries
over into their professional lives with the result that we end up with
a lot of professionals, people who are supposed to treat the problems
of others, who do not care about the people with whom they deal.
That is not going to change until the admissions criteria change.
I do not think it takes brilliant people to be doctors; you do not have
to be a chemist or a biochemist. It takes people who really care, and
we do not have nearly enough of those.

MR. SEGAL: May I make a comment which, though not
directly in line with your point, is relevant to the overall problem
we both are talking about. It is a travesty of law school structure
today that you are only taught the rules, and you have no idea about
the people. At least the doctors sometimes see a patient. I do not mean
that we should turn over the lives and property of people to unskilled
second or third year law students, but I mean that we should talk about
the lawyer's role, and, as best we can, live it in the context of the
law school.

Why am I a professor? I am not a "professor." If I want to
call you by your first name, you call me by my first name. I will have
your respect. I either know my course or I do not. I come down off
the podium and take my coat off if I want to. As far as I am con-
cerned, you can put your feet up, if that is cool with you, as long as we
think and try to relate as human beings.

PARTICIPANT: I want to ask Judge Dandridge a question.
You sit in the courtroom and listen to those D.A.'s come in and tell
you about the penalties they want and you put people away. Why do
you do it?

JUDGE DANDRIDGE: I will try to answer the question. I
think the percentage of people I put away runs around 3 to 5 per cent.
We still have laws, I am sworn to uphold them, and there are certain
situations in which I will not put people back on the street. If I think
it is necessary, I will put them in jail. If you do not want me to make
that decision, put me out of office.

There are certain judges and certain people who believe everybody
who comes before them for certain crimes should go to jail. That is
nonsense. However, there is a certain percentage of people that come
before a judge who will go to jail for either a limited or prolonged
period of time. You put me in the position to make that decision, and I make it to the best of my ability. Some people will go to jail; most people will not.

PARTICIPANT: Judge Richette, are you aware that in our methadone program here in Philadelphia, there is no provision for rehabilitation; that the methadone maintenance program which was funded by the federal and state governments is aimed at recidivism?

JUDGE RICHETTE: I have very strong views about methadone and they have been made very clear to people. I do not know about the current methadone maintenance program but I have had any number of people who have come in accused of crime, who were on methadone maintenance and getting their methadone regularly. I am sure that they were not getting other therapy, because they told me so.

JUDGE DANDRIDGE: You are absolutely correct about the old regulations. The new regulations, which have just come into effect, require that any center providing methadone must also provide a variety of other treatments. Those regulations will become fully effective soon.

DR. SCHNOLL: I would like to say something as long as we are on the topic of methadone. I do not know if most of you are aware that we have gone to a great deal of effort trying to make sure that the people who work in our programs are qualified. We try to train our counselors and social workers, but we never try to train the physician who has a very large impact on the program, or the psychiatrist who works in the program.

I have heard it said that the psychiatrists who work in methadone programs are usually people who can not make it in private practice, could not make it in any of the state mental institutions and, therefore, wound up in methadone. I do not know if that is true of the psychiatrists, but I think it is true of some of the physicians who work in the programs part-time and have no concept about the drug that they are administering. If we are going to have some input, I think we should make a major effort to make sure that anyone who works in the rehabilitation or treatment of any of the addictive diseases knows what he is doing and is trained in the area of his so-called expertise.

DR. FORT: I want to say something on that point, too. Ninety-nine per cent of the people working in drug treatment programs today, particularly methadone maintenance programs, had no contact with heroin addicts or any other drug abusers prior to the past 2 or 3
years. They are basically trained in traditional Freudian psychotherapy and its application to affluent, white middle class women who do not get well too quickly and never pay their bills. By simply renaming that method "community mental health," it has been made applicable to drug abuse, racial conflicts, poverty, sexuality, and a variety of other things. That is why our methadone programs and other so-called mental health programs do so poorly. We need to have staff people who know what they are doing. Most importantly, methadone should not be presented with the commitment that the recipient will eventually be able to get free of it as well as free of heroin. While we should have a rule that there have to be comprehensive services offered in addition to mere maintenance, we also must guard against putting more time, energy, and personnel into methadone than we do into the wide range of possible alternatives.

What we need lies not in our curriculum or our practices, but in something much more fundamental. We must work out ways to stop branding people as criminals for their private behavior — sexual, drug, gambling, or whatever — and we must work out ways to prevent them from becoming ill in the first place. Even if medicine were far more effective than it is now, we should still be placing 90 per cent of our emphasis on prevention. Both of our systems, the so-called administration of justice and the so-called delivery of health services, are terribly inefficient. They need to be renovated with stress placed upon decriminalization and preventive medicine.

PARTICIPANT: I am a social worker and an R.N. I work at the methadone clinic in the Wilmington Medical Center in Wilmington, Delaware. While we have a small program, we have extremely dedicated physicians who are not there just for their paychecks. Our psychiatrists and psychologists are also dedicated. We have been learning the hard way — every day we learn something new. Everybody else knows more about it than we do, but, because of our interest, kindness and love for people, we have an excellent program.

I am glad to see this group of young people who are at least interested enough to come to listen. Hopefully, when you begin your practice, you will not lose your idealism as I have seen happen with every new intern and resident because of the great pressures that they are placed under.

I have a great deal of faith in the young people today. I can not say that our entire medical community in Wilmington is receptive to the drug addict. Fortunately, we have a few who are concerned; the rest of them treat them like the plague. Like the alcoholic, they do not like them in their practice because they are a nuisance. Maybe with
this group and their colleagues, we will have a medical community that will begin to take interest. The problem is here to stay and we have to work with it, we have to fight it.

PARTICIPANT: I would like to speak for one moment as a pharmacologist rather than as a journalist attending this symposium. The problem with drugs in our country is that the physicians do not know anything about them. The Dean of the Philadelphia College of Pharmacy and Science told the AAAS meeting which was held in Washington before the Christmas holidays that half of the prescriptions written for barbiturates in this country were written for non-valid medical reasons. The reason for that is the abbreviation of the medical student's course in pharmacology. Most medical students in this country are offered a course in pharmacology for 6 months during their sophomore year, which is sometimes taught by a Ph.D. who has never seen a patient. They are then expected to go into practice and know a great deal about drugs. Any continuing education generally comes from a detail man, a salesman from a pharmaceutical house, who is neither a pharmacist nor a medical doctor.

The problem today is not that one drug is being given, but that many drugs are being given at the same time. Drug interactions and the attendant problems present the real drug problem with which we must cope today.

PARTICIPANT: I would like to address a question to Dr. Fort. Doctor, you talked a little about cynicism. I would like to know how, in the light of everything we have heard at this conference, a professional, be he a lawyer or a physician, can avoid cynicism and believe that he could actually work to change things?

DR. FORT: You are quite correct that I did touch on cynicism, but I do not believe I expressed it in terms of my personal values. What I talked about was the moral corruption and hypocrisy which I think pervade our society. Oscar Wilde defined a cynic very well as one who knows the price of everything and the value of nothing. I have not become a cynic. I believe a lot of the things I say are born not of cynicism but of realism. I think that the first step toward social change is to be able to point out that the emperor has on no clothes; and that the second step is, then, to reclothe the emperor, not to be satisfied simply with pointing out the absurdity.

I do not know how one can completely avoid cynicism or pessimism; to attempt to explain that would, I think, be pseudoscientific. The answer depends upon one's own life experiences and character. In my own life, I have found that I have been able, through a variety of
things, some of which were forced upon me, to make a dent, to make some significant changes. The national effort to change our whole approach to drug and sex problems has certainly made some impact. Change is not a result of any one person's effort, but one person can provide a foundation and, depending upon his energy level, and his initiative, he may be able to take his cause to millions of people through radio, TV, and articles, such as those I have written in *Playboy* magazine (which, I might add, have been read by more doctors and lawyers than the 30 or 40 I have written in professional magazines).

You can reach a vast number of people. We err in thinking in all or nothing terms. If we each say to ourselves, "How do I change the whole country by tomorrow morning?" we have set it up in such a way as to give ourselves a copout, an excuse for doing nothing. What I meant by the brick-by-brick concept I mentioned earlier is that we should start with our own families, our own agencies, our own schools, our own classes, the organizations of which we are a part, and we should try there to change outmoded procedures, confront abuses of authority, try to make the institutions human and relevant to what is going on in society. We must find others who share our vision of what needs to be done, and then gradually change it.

I am reminded of the anecdote about some men who were laying bricks. A passerby asked several of them what they were doing. The first one said, "I am laying bricks." The second one said, "I am building a wall," and the third one said, "I am building a cathedral." I think that if we can keep that concept in mind, if enough of us are laying bricks, wherever we are, we will, together, build a cathedral in our society. That is how we can effect change. We can no longer expect Democrats, Republicans, liberals, conservatives, lectern-pounders like myself, my wife, or anyone else, to change the system. It has to be all of us and the sooner we realize it, the better off we will be. That the process, even if we do not succeed, is what makes our lives meaningful.

JUDGE RICHETTE: It strikes me that the only reason you can say you are a cynic is because you are a white male. You have never had to live in an oppressive situation. You have never really had to struggle for human acceptance. I have always been involved with people who have been oppressed, and they are not cynical. Black people in this country have an enormous amount of energy and they do not use it to rationalize their own inactivity.

I think that, in addition to everything Dr. Fort said, what we need is to work — constructive work, even for a very small change-producing project, and work with other people. I think that out of joint effort comes a force that is greater than the individual component.
Perhaps what the people in this audience ought to do, apart from thinking of the dreariness and blackness of their educational process, is to set up their own educational systems. Who says that the only way one can learn how to be a lawyer is by ingesting what Villanova or the University of Pennsylvania Law Schools think you need to know? You must take responsibility for your own education, and you must get involved on every level with people around you.

JUDGE DANDRIDGE: Let me say two things. I think you have struck on something that is very vital. One of the ways we are going to bring about the changes that we really want in our system is to take over the system. I say “we” and there is a generation gap between us, but you are going to have to deal with the whole political process. Start by electing your committeeman. Then, from your committeeman, move to electing your ward leader, your legislator, and then your governors and your mayors. But you do not do that. For the most part, you talk a good game, but when it comes down to the nitty-gritty work, electing people and voting, you do not do it.

PARTICIPANT: You are talking about power and the power is in the industrial complex, not in the government. It is not in political parties.

JUDGE DANDRIDGE: As long as you say that and do not try to do something about it, they will control, but once you put people into office who are going to be responsive to you, not to the chemical companies and the large manufacturers, things will happen.

PARTICIPANT: Getting back to drugs, I can remember when Dr. Schnoll lectured to my medical school class. He specifically talked about the drugs that we have been discussing here. It was basically the same cut-and-dried lecture that we got about adverse effects. I do not think our class was really that well informed, and I am wondering where and how the subject can be presented more specifically. We can talk generalizations, but where, specifically, can you really teach us how to deal with people and what to do?

MR. SEGAL: That is exactly the thrust of what I said. Nobody can teach you. You are looking for the expert. Go meet people, bring people into your life. Forget about your role as a lawyer or doctor. Try to be a humble individual human being in the presence of some guy strung out in a clinic or in a detention center. Do not worry about expertise as the answer for it.

You have to take the initiative yourself. If you want some people to help, to lend guidance along the way, to share the experience, you will find them all around you, but you have to ask.
PARTICIPANT: The people that want to get involved are going to, but in a class of 200 there may only be about 10 people who get involved. The people who have M.D.'s, those in a position to help in a methadone maintenance program, are not doing a thing. I want to know how we may generate the interest necessary to motivate them.

DR. FORT: There are two areas in which there is great natural interest, sex and drugs. You will have no trouble getting a sufficient number of students who want to have a special curriculum, and that is what you should have. It should not be run by either the pharmacology or psychiatry departments. Both of those disciplines are relatively irrelevant to problems of human sexuality and drug use and misuse in American society.

Each of you should go back to your law and medical schools and help to establish a special curriculum on human sexuality and a special curriculum on mind-altering drugs, ones with student involvement and student leadership. You should enlist the aid of people from all disciplines, not just from the medical ones. You should get them from sociology, criminology, and local programs which have nothing to do with academics or government.

DR. SCHNOLL: I do not think a special curriculum is necessary. With respect to that "bland" lecture I gave to your class, the following year I was not asked to give it. I guess it was much too heavy for the administration to take.

What I have heard here is a lot of rhetoric. I am involved in a free clinic in Philadelphia. How many students from Jefferson show up down there and participate? I sent a letter to every resident and intern on the entire Jefferson house staff — 200 new physicians — and got one volunteer to come to the clinic.

You are talking about something that people do not seem to want to do, they only want to talk about it. If you want to do something, you have got to go out and do it.

We started the free clinic. We did not ask where it was so that we could go help. We started it. It was just that simple. If you want something you have to get up and do it. Nobody is going to wait around for you to come to them.

JUDGE DANDRIDGE: Let me add that I think it is absolutely important that those of you who want change in your school or in your life be active in bringing about that change. Sitting back and just talking is not going to get anything done.

PARTICIPANT: I am an educator, not a doctor or a lawyer. I work at the Albert Einstein Mental Health Service. Lisa Richette
spoke to some of my students in our drug program and did a wonderful job. We had lawyers, doctors, street people, teachers, every imaginable discipline, and every imaginable kind of person in that program and gave them contact with the people with whom they are going to be working in the drug problem area.

I saw in the brochure that this was to be an interdisciplinary meeting. How many disciplines are represented in this group? There are two professions that dominate. I would hope that, in the sense of your own power, you will be able to structure the next conference of this sort in a way that will put you in contact with the workings of many different disciplines, minds, and groups of people. I think that with a broader base, a conference like this would produce more constructive suggestions as to how to deal with the problems it confronts.

PARTICIPANT: I am a first-year medical student. I was confused when I got to medical school, because I was expecting to see people who were really involved with others. The people in my class sat around and did nothing until somebody told them that their spring vacation was coming at an inappropriate time and that they were going to have 4 days of classes in between exams and then 4 more days of classes before the vacation. They got up and roared about it. But, when somebody wanted to change a new class we have which is called Medicine in Society, and which is supposed to be doing a bit of what we have been talking about here, the only thing my classmates wanted to do was boycott the final exam because they thought the class was a farce and should be thrown out.

We are talking a lot here, are hearing what we want to hear and are applauding it. But what are we doing?

JUDGE RICHETTE: Do not make the error of thinking that people can be instantly mobilized into hasty and perhaps ill-conceived action. It takes a long time and we do not know what seeds are being planted here today. I, for one, feel that there is great hope and strength in this room, and that many of the things we have talked about will get done.

JUDGE DANDRIDGE: It is time to wind up our discussion. On behalf of the panelists this afternoon, let me say that we enjoyed you. We hope that you have enjoyed us. Thank you very much.†

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