AT THE HEIGHT of its activities the ABA-AMA joint Committee received support briefly from a strong ally positioned directly on the Bureau's flank. Because of intense public interest in science and, above all in highly promoted "wars" on disease, the National Institutes of Health had become so popular with Congress that NIH spokesmen sometimes had to go to Capitol Hill and beg the lawmakers not to appropriate any more money for their research budgets. And occasionally even this unusual plea had no effect, for every constituency in the nation could be counted on to react enthusiastically when its elected spokesmen sent word of how diligently they had fought for more money to cure cancer, more support for Dr. Salk, or increased efforts to put an end to other human ailments. In 1958, led by three courageous doctors from career positions in the National Institute of Mental Health, the Institutes moved boldly into the drug-addiction field.

Supported by their chief, Dr. Robert Felix, who was one of the AMA members of the joint Committee, Dr. Kenneth Chapman and Dr. Robert B. Livingston, with cooperation from more conservative Dr. Harris Isbell (who had prepared the 1952 Council on Pharmacy and Chemistry report mentioned a few chapters back), organized a symposium on drug-addiction problems, under official sponsorship of the Department of Health, Education, and Welfare, which brought together, at Bethesda in March 1958, the most fairly balanced group of discussants ever assembled to consider this subject. Even Commissioner Anslinger participated in the initial arrangements, although he declined to attend the symposium itself when it became apparent that among the participants there would be outspoken critics of his Bureau.

 Nonetheless, tough penalists like Assistant Attorney General William F. Tompkins, co-author with Anslinger of the 1953 Bureau credo "The Traffic in Narcotics," and M. L. Harney, whose eloquence we have already sampled, did participate. In the same discussions, joining an assemblage of expert and moderate younger doctors from the Public Health Service, seniors like Dr. Lawrence Kolb and Dr. Walter Treadway, retired Assistant Surgeons General who had devoted their entire professional lives to the subject, made uninhibited contributions. The federal judiciary was represented by judge Diniock, another member of the ABA-AMA joint Committee. Related disciplines from chemistry through sociology had their spokesmen. In addition to Tompkins, the Department of justice also sent James V. Bennett, long-time Director of the federal Bureau of Prisons and one of the world's most eminent and humane penologists.
Since I have perhaps been less than charitable in portraying law-enforcement exponents and their roles in this story, let us pick from this symposium some moderate statements of the law-enforcement arguments. For it is not open to question that there is a significant place in drug-law enforcement for the policeman and, moreover, that through the years repressive efforts have indisputably had some beneficial effects in the United States. No doubt an undeterminable number of addicted persons simply cured themselves and gave up the use of drugs, just as many drinkers doubtless abandoned alcohol, when prohibition efforts against both were first launched in the twenties. It seems certain also that many potential drug abusers have been deterred—simply scared off—by our severe laws in the ensuing decades.

Rigorous control of manufacture and distribution through legitimate channels must be credited, in the case of opiates and cocaine at least, with almost total elimination of diversions from such sources into the black market. And putting aside the question of how they got onto the scene in the first place, so long as the nonaddicted, profit-motivated smugglers and peddlers continue to function, no one denies that they ought to be fought with all the repressive energy we can muster against them.

Thus Dr. Treadway mildly acknowledged the economic truth behind one of Commissioner Anslinger's points (addicts are "infectious" and "lepers"): It is known that addicted individuals, having acquired a supply, are very apt to dispose of part of it for a consideration, thus assuring their own future purchases. It is known also that these addicted peddlers, or addicted pushers as they are called, may assiduously endeavor to recruit new addicts, often for the same reasons. This kind of peddler is a very great hazard and danger to the community because of serving to create new addicts.

Dr. Kolb admitted that partial responsibility for the way the enforcement pattern emerged in its early days lay on his own profession: Although the first steps towards the indictment of physicians were started by law-enforcement officers, some physicians in strategic positions to influence public opinion gave powerful support to the law officers. It is possible that without this early and ill-considered action, the United States would have developed a sane policy which recognizes that addiction is primarily a medical problem, but also one which requires some police action to insure adequate control.

In presenting the case for repression, Assistant Attorney General Tompkins told the symposium, referring first to the Harrison Act: Throughout the years, the vigorous enforcement of this statute has markedly curbed illicit narcotic traffic and its application has met with the outspoken approval of a number of U.S. District Court judges. . . . I have
noticed in my travels around the country and in my conversations with Federal judges that the overwhelming majority of them feel very strongly on this problem of peddling dope.

Although it is still definitely too early to determine what effect the Narcotic Control Act of 1956 will have on the traffic, there are indications that, where severe sentences are consistently imposed, many of the persistent traffickers have dropped out, or have been sent away to long prison terms and probably will not show up in the traffic again. . . . It is fair to say that the illicit narcotic traffic in the continental United States is approaching somewhat that condition in Hawaii in 1955 which was described in a letter from Judge McLaughlin. "Things are tough here-about for addicts these days as a result of judge Wigg and I seeing eye to eye regarding narcotic peddlers. After a few 10-year sentences, the boys folded up." . . .

When you consider that the illicit narcotics traffic is one of the pillars of organized crime in America, good enforcement, vigorous prosecution, and stern justice are an integral part of the solution. I feel certain that there is general agreement on these principles and I also feel very certain of this: That the American people want these principles observed and that they are certainly entitled to no less.

Even ebullient Mr. Harney came through with some good points, and not ungracefully. Referring to instances related by Dr. Kolb in which overzealous narcotics agents had interfered with the treatment of patients genuinely ill with such painful ailments as cancer, Mr. Harney said:

With one of the individuals particularly it's a matter of great distress that I should have to disagree with him in any respect, and that is with the venerated Dr. Kolb from whom I learned some of the first and best things that I have ever learned about the drug addiction problem. However, I know that some of my colleagues in the police profession here were greatly distressed at some of Dr. Kolb's observations. Those which Dr. Kolb mentioned from his personal knowledge illustrate one point that I ought to make with my colleagues in the law enforcement profession. That is, when you get into the business of enforcing the law in this area, you must proceed with great circumspection. One thing we all know, in law enforcement, as in medicine, when you make mistakes, the consequences are likely to be tragic.

The question as to whether or not narcotic addiction is a sin is something perhaps for the Pope to pass on for some of us. The question of whether or not situations connected with narcotic traffic or narcotic control are legal or illegal are for the legislatures, expressing the wisdom of the people, to decide. Some of us can have our personal exceptions, but when a program is laid down, we ought to carry it out in the best conscience, and see that it
is carried out. Anything verging on the side of foot-dragging should probably be designated by a worse name.

You can call this a habit or what you want, or differentiate it from or compare it to alcohol and so on, but I will still say as a simple policeman who has walked the streets with these addicts that this stuff is a poison, and that people who sell it sell poison. . . . And I think some of the medical people here who have tried to revive some of those fellows that got an overdose-who accidentally got some good heroin in those days of scarcities that law enforcement brings about-perhaps they recognize that they were dealing with a case of acute heroin poisoning.

Then came a spirited exchange between Harney and Kolb. Harney had referred to the London murder trial of Dr. John Bodkin Adams (which resulted in an acquittal) and to newspaper accounts that Adams had administered heroin to hundreds of people in such a way as to cause their deaths. Kolb challenged him:

I would like to know where his information about Dr. Adams comes from. Two distinguished enforcement people in the United States said that Adams killed 400 old people in Eastbourne by making addicts of them, and then giving them heroin until they died. That seems to me to be just fantastic. Knowing that it is almost impossible to kill an opiate addict by giving him more of the drug, and that is what was implied in the statement, I wrote to the British Ministry of Health for information about the Adams case.

This is the response which I received. "So far as the Adams case is concerned, there is no evidence whatever that he created 400 addicts or killed 400 people. Perhaps all this can be best covered by saying that no credence should be given to this sensational report . . . and, indeed, no writer in this country would be likely to venture to repeat these libels even for the purpose of refuting them. Nor is there any truth in the statement that the authorities were attracted to the situation by the high death rate at Eastbourne. . . . I have not been able to find in any official orts or scientific articles anything to substantiate the statements that Mr. Harney and my other two friends have made about the Adams case.

Harney replied that his knowledge of the Adams situation was largely confined to what had appeared in the American press, and then the following dialogue took place:

Kolb: My second question is: Does Mr. Harney believe that being a drug addict or the selling by a pusher to a drug addict is as serious a crime as murder, kidnapping or rape? That is what has been told to our Congress, and on that basis our Congress has passed one of the most tragic laws that ever got on any legal document anywhere.
Harney: There are a lot of murderers for whom I have more respect than dope peddlers. There are many people doing time for murder who are creatures of one horrible impulse to which they succumbed and for which they must live the rest of their life in remorse. For these people I have the greatest sympathy. As for the man who deliberately sets out to engage in narcotic traffic, you and I see a little different type, of course, doctor.

He is all cleaned up and slick, and he minds papa when you have him in the hospital corridor. But the fellow who goes around, up and down the streets with our undercover boys, he is a pretty sad fellow. That is a situation I wouldn't put any human being into. And a person who for money, for blood money, puts a fellow human being in that position, he is worse than a great many murderers.

Kolb: In reference to this I want to point out again that there is only one reason to regulate heroin and other opiates. The reason is the physical dependence, because of which habitual users have severe withdrawal symptoms when the drugs are withheld. This is an important thing to protect people from, but the assumption that these drugs cause deterioration and crime is utterly unfounded. [Italics in original.] To send persons to the penitentiary for 10 or 15 years for possessing one heroin tablet, as some of the "educated judges" that Mr. Harney has talked about have done, is a tragic thing that must eventually end just as witch burning eventually ended. The witches are now treated in mental hospitals, but we needed laws for this just as we need laws to regulate addiction. Sickness is the paramount thing in both cases. . . .

We need sane narcotic laws, administered by people who know that their function is to enforce the laws and not to dictate what the laws should be. What is there about drug addiction that it should be made the worst possible crime in the United States? I think that any informed person who gives the matter any thought at all will find that any such assumption is unwarranted. I know that drug addiction has decreased through law enforcement, but I think it would have decreased to the same extent if we had the same sort of enforcement as they have in England and some of the other European countries. . . .

The story of the 1920's and the breach between the medical profession and federal agents was summarized by Dr. Kolb much as I have tried to unfold it in the preceding pages:

In point of fact, the slavery so easily acquired or imposed by a continued daily use of opiates is such a fearful thing that it does demand control measures beyond those needed for all other potentially harmful drugs. But what has happened in this country is the almost total failure to provide for the necessary and proper measures. On the basis of a very evident need to prevent and cure the slavery to opiates, there has built up in this country an
enormous mass of misinformation about their physical and moral effects. The collectors and disseminators of this misinformation have included sincere laymen and law enforcement officers aided to a considerable extent by otherwise competent physicians. For the most part, these people have exhibited the capacity to generate enthusiasm and zeal for the suppression of vice rather than the desire to obtain and spread proper knowledge of drug addiction.

The proposition that Communist China was intentionally fostering drug addiction in the United States drew this comment:

A Western power fought two wars against China to force her not to interfere with the opium trade. The Chinese have in the past and probably still are smuggling opium into other countries. In all of these cases, the motive has been money. It is a very recent American invention that opium is being used to weaken countries for the kill. It is well known that neither opium nor any of its derivatives, including morphine and heroin, have any such sinister, magical properties. Only in an atmosphere already clouded by propaganda and permeated with fear could the contrary and untenable idea take root and grow. The erroneous idea has flourished in this country and has helped to bring about the enactment of drastic, tragedy-producing narcotic legislation.

And on marijuana:

Marijuana is undoubtedly a potentially harmful intoxicant, but there is no sense in sending a person to the penitentiary for ten years for having one marijuana cigarette in his pocket, a cigarette that would surely have no more effect on him than one drink of whiskey. Such treatment is ridiculous, fantastic, and a disgrace to our civilization.

Dr. Chapman quoted guiding principles in the treatment of drug addiction from the World Health Organization as follows:

It should be very clearly understood that the maintenance of drug addiction is not treatment. Nevertheless, under certain circumstances complete withdrawal of the drug of addiction might be deferred. There are well-recognized, obvious medical conditions such as severe chronic or terminal illnesses, where continued administration of drugs is indicated. In addition, experience with the problems of addiction in several countries and newer knowledge of the psychology of addiction leads the medical profession to believe that in exceptional cases it is within the limits of pod medical practice to administer drugs over continuing periods of time.

Although expressing reservations about reviving "clinic" facilities on any large scale, Dr. Chapman concluded for himself and his colleagues:
We question the attitude of those few physicians who deny the addict benefit of current knowledge, and others not trained in medicine who aid and abet such physicians. Their attitude betrays a lack of understanding of the physiology and psychology of addiction. These individuals would not withhold or condone withholding antibiotics from anyone who has pneumonia. The excuse of these physicians is anachronistic and includes such statements as, "We do not want to coddle the addict; it will teach him a lesson."

Judge Ploscowe tried to wave the olive branch:

One of the problems is whether we must accept either point of view as completely accounting for reality. I think part of the trouble here has been an attempt to say either/or. Nobody in his right mind would cut out law enforcement. The problem is where lies the domain of medicine? Apparently there is some desire to eliminate medicine altogether and turn the thing over completely to law enforcement, or vice versa. Here is the basic issue: where are the respective domains of medicine and of law enforcement?

Then followed Dr. Isbell, sounding a cautionary note:

The clinical field of addiction has always been plagued by extravagant claims made for new withdrawal treatments. Every potent new type of central nervous system drug, each new hormone and each new vitamin is certain to be reported to be a "cure" for addiction. The fixation on withdrawal treatments is due to the failure of many physicians who, unmindful of the psychiatric components of addiction, mistakenly believe that the- "addict will be cured" only if he can be relieved of his drug. . . . Himmelsbach found that small amounts of opiates were the best treatment of the withdrawal symptoms.

The Himmelsbach referred to is Dr. Clifton K., another Public Health Service colleague and another "great" in the field of addiction research; and it would be amiss to acknowledge the eminence of these men without also mentioning Dr. Nathan B. Eddy, who told the symposium, among other things:

Dilaudid was introduced with the claim that it was relatively nonaddicting. An outstanding physician was quoted in the popular press as saying that it was more powerful than morphine and as harmless as water. . . . Dr. Isbell,- I believe, rates Dilaudid as approximately on a par with heroin in addiction potential. Both heroin and Dilaudid are undoubtedly valuable drugs medicinally. They could be used in place of morphine. But I think we can stand the ban on heroin if it will in any manner help the situation with respect to illicit traffic.
I started my first experiment on morphine tolerance 36 years ago. I'm getting near the end of the road. We haven't reached the goal that has been before us for so many years and very probably I'm not going to reach that goal. But I'm not willing to admit that the goals can't be reached. I think there ought to be a safer analgesic than any we now have, and I believe that one day we are going to find it.

Dr. Himmelsbach himself thereupon entered the discussion:

We were all very young officers in the Service and very young in this field. . . We had plenty of patients who were rather heavily addicted. They came to us with a quite strong physical dependence and very little else wrong with them. . . . In those days physicians paid almost exclusive attention to the treatment of withdrawal. When they spoke of treating drug addiction, that is what they had in mind and were concerned about. This accounts for the amount of time we had to spend in working on withdrawal treatments and trying to learn whether or not they had any value. The surprising thing to us was to discover that the doctor had at his command the best available medicine. It was found that the morphine abstinent syndrome could be substantially mitigated by the careful use of morphine itself. Following Dr. Kolb's suggestion, it was easy to develop a fairly satisfactory means of gradually separating the man from the drug. We found no one whom we couldn't take off under the methods that were developed in those days, and most patients seemed to us healthier at the end of withdrawal from even heroic levels of drug use.

Some of judge Dimock's observations are:

Sometimes I try to find out how these people got started on the drug. Here again they always tell me what they think I would like to hear. In fact, one of our probation officers told me that when she asked some young girl addict how she got started that the answer depended upon what story had been in the daily news the day before. I find no evidence that the use of narcotics leads to the commission of crimes of violence. [Italics in original]...

Whether the mandatory prison sentences do any good, I don't know. Of course, no judge likes to have his discretion interfered with; and yet I don't think that I am entirely unreasonable in objecting to the necessity of having to send a harebrained saxophone player away for 10 years for having a pack of marijuana cigarettes in his pocket.

Statistics came in for a drubbing from an eminent sociologist, Professor Isidor Chein:

The great bulk of available data is based on arrests. Unfortunately, the number of arrests is far from a simple function of the number of users. It
depends on the amount of police activity. It depends on the adaptability of possessors to the existing possibilities of detection, and the rate at which law enforcement officials can accommodate themselves to current skills and techniques of evading detection. It depends on the kind of police activity. Thus, if the police are concentrating on the primary sources of distribution, we may expect that the relative number of arrests will go down—simply because it is a more complex and difficult job to get at the primary sources and takes more man-hours of police energy. Contrariwise, if the police are concentrating on the consumer end of the business, the number of arrests will go up. The easiest way to produce a large number of arrests is to concentrate on the known addicts at large in the community. Statistics don't lie; but the people who take seriously estimates of incidents on the basis of presently available statistics are surely not statisticians.

Prison Director Bennett avowed that for thirty years he had been convinced "that the way to make our prisons more effective as crime deterrents was to get the narcotic addicts out of these largely punitive institutions," and continued:

The Bureau of Narcotics currently estimates that there are approximately 43,000 persons addicted to opium, morphine, marijuana and the synthetic drugs or 1 in 4,000 of the general population. To put this estimate in perspective we can compare it with the number of chronic alcoholics—which is generally agreed to be approximately 5 million. . . .

The case of the "average" Federal narcotics law violator can be illustrated by the following case history--selected almost at random from our case files: R. G. is a 30-year-old Negro who is serving five years for sale of a few grains of heroin to an informer. He comes from a large Eastern city, was reared by a father who had frequent psychotic breaks and a stepmother who rejected him. He completed two years of high school and is the father of an illegitimate 7-year-old child. He began to experiment with the use of marijuana during his late teens. At 19 he began to use heroin, and shortly thereafter was placed on probation for three years for forging a narcotics prescription. After one year he violated probation by returning to the use of drugs. He was committed to Lexington on a 4-year commitment, was granted parole after serving more than two years and was returned after a few months as a violator. He had again relapsed into the use of drugs. While in the hospital he was a volunteer in research projects dealing with problems of addiction.

He was again committed to Lexington on his current commitment and again he was described as cooperative, pleasant and dependable. Three months after his conditional release in the summer of 1957, he was again using drugs and a few weeks later was returned to custody as a violator. In addition to the charges involving narcotics he has a history of several arrests and convictions for, petty offenses. This man is a typical example of
the current crop of narcotic violators. Change his name and modify the
descriptive data only slightly and the circumstances will fit hundreds of
commitments received in Federal institutions during the past ten years. . . .

In quite recent years the role of the hospitals, insofar as the treatment of
prisoner-patients is concerned, has of necessity become a more limited one
because so large a proportion of the convicted addicts have been committed
for such long terms as to make them unresponsive to treatment. They are so
discouraged, defeated and embittered by the long sentences they will not
coopoperate in self-improvement. Thus, in the space of a quarter of a century
we have apparently made a full circle in our approach to the needs of the
convicted addict. The problem seems well on its way once again to
becoming a "prison" problem. I confess we face this prospect with a feeling
of discouragement and a sense of futility.

Another important consideration to be taken into account in determining
penalties and prosecution policies is how much of a menace the addict may
be to others than himself and his own kind. It has been pretty well
established that the drug user does not commit serious crimes of violence
aggravated assault, bank robbery, kidnapping and major crimes of that
type. I know from my own experience that the "junkie" is not considered
reliable by other prisoners. They shy away from him, do not take him in on
any criminal plans for fear that he will "squeal" when deprived of narcotics.
They look upon him as a "chicken," who has only enough courage to snatch
pocketbooks, forge a small check, act as a pimp or a prostitute. There are
no real desperados who use drugs or will team up with anyone who does.

Prisons, both state and Federal, in the years immediately ahead will be
faced inevitably with the problems of narcotic offenders, addict and
nonaddict alike, who are weighed down by the hopelessness and the bitter
futility of sentences which seemingly stretch into infinity. What can the
institution offer the man serving 30, 50, or 80 years with no prospect for
parole or hope of his sentence? Now, I am not saying, mind you, that
severe penalties are not necessary for certain types of these cases. I believe
they are. But like judge Dimock, I think that each case has got to be
considered on its individual merits and the person committed according to
the character and quality of his offense.

As institutional officials confront the dangers of escape, contraband, and
other hazards which are present as the result of a new concentration of
narcotic law violators with long sentences in institutions housing other
offense groups, there will be a natural tendency for many institutional
programs to become more restrictive in character. Some of the benefits of a
more relaxed institutional climate which has been developed over the past
decade may well be lost in the process. The hopeful prisoner will naturally
suffer as a result, custodial costs will mount, and other rehabilitative activities will be handicapped.

Still another real concern is the costs which accrue from the requirement that long-term institutional care be provided for the narcotic violator. . . . Assuming no increase in costs and only the anticipated increases in population which result from the longer terms of imprisonment imposed, the bill to the taxpayer five years from now may well be at the seven million dollar mark. This is obviously a heavy price to pay for a program which cannot hope to provide much more than custodial care. We must therefore face up to the question as to whether funds would be better spent on some form of community supervision and care of addicts. In this connection it must be remembered that the addict released from prison is doubly stigmatized. He must face not only the hostility and the suspicion which the community reserves for the "ex-con," but he is also an "untouchable" because he has used drugs.

Mr. Bennett concluded his observations as follows:

My own view is that the problem of narcotic addiction must ultimately and properly be defined as a health problem not as a problem of morals, or a problem of crime. The past twenty-five years have, I feel, demonstrated amply that neither the punitive approach nor hospitalization alone provides the answer. . . . A practical solution to this most difficult problem cannot be found in actions based upon fear or motivated by vengeance. It is to be hoped that the day is not too far distant when reasonable men who share in the responsibilities for finding solutions, whether they come from the field of law enforcement, administration of justice, or public health, may take the opportunity to reevaluate our present methods in the light of objective facts and chart new patterns for the future.

Then the symposium heard an articulate psychiatrist, Professor S. Bemard Wortis:

I am sure all of you realize that addiction is the only disease the only disease-with proven physiological and mental disturbances in which the physician in the United States of America is restrained by the threat of law from furnishing the patient sufficient comfort that he may engage in a useful profession or occupation. This restraint is lacking in many other countries, with no apparent serious public harm. Now medicine and physicians see addiction in one perspective. The law and some law enforcing agencies see it in a different perspective and with their special prejudices. And the public is periodically fed exaggerated, fearful perspectives of the drug addict as a heinous, aggressive criminal.

The public has been-led to believe by many dramatic headlines and lurid news stories, that opiates, by themselves, apart from the physiological
phenomenon of physical dependence, directly incite the drug user to violent, aggressive assaultive criminal acts and sexual crimes. Nothing could be farther from the facts; for opiates calm the user, create a pleasant dreamy state, and depress sexual drive. . . . The most impartial students of this facet of drug addiction have clear evidence that no significant percentage of addicts commit violent crimes while under the influence of drugs.

As has been said here before, alcoholism, and certainly driving under the effects of alcohol, is a much more serious public health matter. For example, at Bellevue Hospital, we see approximately 10,000 alcoholics a year and many with delirium tremens which is a serious complication. Many of them die. You all know from studies of driving accidents in many States that the alcoholic who is behind the wheel is a serious killer. Yet our press does not crucify the sick alcoholic as it does the sick addict. All of this, of course, must quite naturally raise the question of whether the confirmed drug addict should have a means of obtaining his drug legally so that he will not have to engage in criminal acts to raise the money needed for the drug, needed to avert the pain of withdrawal.

I have once again taken my readers through a long course of quoted material for two important reasons. First, this good-natured and for the most part high-minded exchange of views, which took place in the spring of 1958, was the nearest thing to an honest confrontation between Commissioner Anslinger's law-enforcement forces and their critics that has ever taken place. I reproduced these excerpts for their content. They give authority to many of my own arguments, and I submit that the forces of reason fairly swept the field.

But a second purpose was to provide a full insight into the not-so-funny remainder of the story. When the participants took leave of one another, many felt, with satisfaction, that their deliberations had indeed illuminated the subject, and that the proceedings, which were to be published forthwith by the National Institutes of Health, would become a useful reference and might eventually contribute to a revamping of attitudes and policies.

But they reckoned without Mr. Anslinger. Remember that the sponsors and many of the participants were federal employees - Public Health Service doctors answerable to the Surgeon General and above him to the Secretary of Health, Education, and Welfare, Prison Bureau officials answerable to the Attorney General, and Anslinger's own Treasury men. And every one of the federal government participants who had expressed views out of line with the Narcotics Bureau position found himself under some kind of pressure and attack. Men at the top like the Surgeon General, Dr. Felix, and Mr. Bennett were chastised indirectly - a word dropped at Cabinet meetings or excoriating remarks from members of the Anslinger claque in Congress. Even judge Dimock, invulnerable as a life-appointed federal judge and ordinarily accorded the respect due his office, found himself being rudely criticized. And for some of the less secure participants the blows that fell were meaner and more telling - letters of censure for their presumption in daring
to question policies of the Bureau, calculated to land in their personnel dossiers and which in the arcane workings of such things may well have damaged their careers.

Nor was that all. The NIH doctors who had organized the symposium and were preparing its papers and discussions for publication ran into a bulldozing campaign to suppress it. For five years, under three HEW secretaries, the edited transcript remained locked up by an informal "secret" classification. When it finally went to the printer in May 1963, other events which we have yet to recount had greatly altered the picture-among them the resignation gently extracted from Commissioner Anslinger himself by President Kennedy and his Attorney General brother.