Morphine Maintenance

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THE SHREVEPORT CLINIC 1919-1923

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PREFACE

In 1965 the clinical development of methadone, a synthetic opiate, as a drug for maintenance ushered in a new era of drug treatment. Prior to 1965 (and dating back to 1923) drug treatment in the United States was largely institutional and emphasized total abstinence. Addicts went or were sent to prisons, hospitals, and self-help communal programs (such as Synanon or Daytop), and were expected to remain drug free when they left. Most did not, and it was a sad fact of institutional treatment that addicts could not or would not live up to the goals or objectives set for them by these institutions.

After 1965, an opiate (methadone, although designated as medicine, is still an opiate with strikingly similar effects as other opiates but somehow without the moral stigma) became available to outpatient clinics for maintenance of addicts. The drug was accepted because it was long-acting and easy to use in a clinical setting. There was also a theory, or more properly a rationale, for the use of methadone, that the synthetic opiate blocked the euphoric effects of other opiates. Methadone given in high doses would because of the high tolerances developed, "block" the effects of the highly diluted street heroin presently available in the United States. It does not, however, "block" undiluted, high-quality heroin. Clinical experiences in England where both heroin (pure) and methadone are used do not support the methadone theory. On the contrary, English addicts continue to get high on heroin while using methadone regularly (Judson 1973).

Methadone has been a boon to drug treatment programs. Used in a regular regimen, methadone allows addicts to give up drug-seeking as their life's work, to cut down on some of their more dangerous hustles, and helps them stay out of jail. Many go to work and join the "productive" bourgeoisie by starting bank accounts, buying cars, and making house payments. Methadone was a godsend in another way: it let society become a little more realistic about the addict. Drug programs that used methadone gave up the rather noble but grandiose objective (for addicts) of being drug free, and made a primitive bargain with their patients. If the addict went to work, or made an effort to go to work, and stayed out of

trouble with the police, then the clinic would give him *an opiate* regularly.

Having tried one opiate as a maintenance drug and found that it works pretty well, one could ask, "Why not try another?" Very well, why not heroin? Why not morphine? Traditionally, the arguments have been, "Well, they are both illegal, and besides we tried them back in the 1920s and found that they did not work."

We agree about the first—both heroin and morphine are illegal; but so was methadone until it was developed clinically. In fact, methadone still is illegal except as it is used under the strict guidelines set down for clinics. The reply to the second argument about the 1920s clinics is not so easy. On the one hand, the New York City clinic did not work. There were numerous problems—with large numbers of patients and few or no controls. (Both of these issues are discussed at length in Chapter 3.) It was so badly run that Ernest Bishop, a firm advocate of opiate maintenance, wrote in November 1919:

> We are in a very bad state here in New York. Conditions are probably worse than ever. I am told, and I believe it to be true, that more opiates are peddled than ever before. The Board of Health clinic has not been a success.

This, however, was only one of the clinics, and many of the others had far different experiences. Clinics in several other cities (Los Angeles, California; New Haven, Connecticut; Jacksonville, Florida; Alexandria and Shreveport, Louisiana) were run much more effectively and most reports were favorable if not praising. Unfortunately, the Narcotic Division of the Internal Revenue Service used the New York clinic as a negative model (perhaps to support an already established belief or policy) to justify closing all the clinics—even those which were run well and supported by their local communities. Most were closed within the first year or two of operation. The New York clinic was open only 11 months.

Following the closings of the clinics, there was surprisingly little written about them, hardly any of which used original source data. Charles Terry and Mildred Pellens in their marvelous book *The Opium Problem* (1928) were the first to discuss them at any length. They described five clinics (Jacksonville, Florida; Los Angeles, California; New Orleans and Shreveport, Louisiana; and New York City). Of the five, only one, the Shreveport clinic, was described in any detail. This was surprising, because Terry himself had been the director of the Jacksonville clinic. Even their treatment of Shreveport lacked depth and real detail, which was particularly surprising since there existed considerably more data about Shreveport than the others. Perhaps the authors were being too cautious, too careful, to show their "unbiased scholarship."

Since then, most writers have been content to rely upon Terry and Pellens or on the negative propaganda of the Narcotics Bureau (US Treasury Department 1953) with two exceptions—Alfred Lindesmith and David Musto. Lindesmith, in his book *The Addict and The Law* (1965), traced the yearly reports of the

Federal Bureau of Narcotics and Prohibition Units of the Internal Revenue Service and came to the conclusion that the clinics were closed when the Prohibition Unit took over the Narcotics Bureau and set a new policy as regards clinics. More recently, David Musto, in a painstakingly thorough documentation of the Narcotics Bureau's records and files, has come up with a critical presentation of the Narcotics Bureau's perspective of the clinics and their effort to close them. Also, in his book *The American Disease,* Musto presents new data from original sources that sketch the New Haven, Connecticut, clinic. Like many others, the New Haven clinic had been dismissed as being another failure. Musto found evidence that it was hardly that:

> The Police Department clinic operated from August 1918 until September 1920. . . . No scandal seems to have been associated with the clinic, doctors, pharmacists, or mode of operation, and, in fact, it received high commendation from Agents [of the Narcotic Division of the Internal Revenue Service] Forrer and Lewis in 1920. Its only fault lay in that it violated the Harrison Act by providing addiction maintenance [Musto 1973:178].

New Data

Both studies suggest that there were original data and materials that have not been used. Indeed, this turned out to be the case when Dr. Ester Blanc, a medical historian working for Scientific Analysis Corporation (a non-profit research corporation located in San Francisco), decided to explore the possibility of doing a large historical study of the methods of treating addiction. One of her first efforts was to interview Dr. Jacob Geiger, a famous public health officer. Dr. Geiger is an international figure in public health (he has received 43 different honors and awards from foreign governments, published more than 200 articles, taught at the Universities of Chicago and California, and was San Francisco's Public Health Director for 20 years. Geiger told Dr. Blanc that Dr. Willis P. Butler, the Director of the Shreveport clinic, was still living in Shreveport.[1]

Dr. Blanc and Martin Orlick wrote and telephoned Dr. Butler shortly thereafter, and found out that he possessed medical records of patients of the old clinic and numerous letters and reports which would help describe the clinic operations. He granted us permission to use this material, and two of the authors went to Shreveport to review the materials and interview Dr. Butler.

Acknowledgments

The original idea for the study came from Dr. George Challas of Scientific Analysis Corporation in San Francisco, California, at one of the many stimulated

[1] He also told Dr. Blanc that he ran a maintenance program for over 100 medical addicts in San Francisco during the 1930s, long after the Shreveport clinic closed, but that is another story.

and stimulating discussions held there. Dr. Ester Blanc of the University of California Medical School (with co-author Martin Orlick of Scientific Analysis Corporation) took up the idea after that, and did the original detective work to locate Dr. Willis P. Butler. Once found, Dr. Butler was most patient through all of our questions, and kind enough to give us permission to use his many records. Meme Clifford of Facts on File in New York diligently edited the first draft and helped to make it more readable.

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INTRODUCTION

Dr. Butler is a very gracious, charming, white-haired, 85-year-old man who likes to talk. He was pleased to recount the experiences of the clinic, and we interviewed him for approximately 34 hours over four days. All but ten hours were tape recorded. These interviews provided new information about the history and operation of the clinic.

The medical records provided by Dr. Butler consisted of a single page or cover sheet that summarized the patient. These records were in four different forms. The first was a narrative report that included the patient's name, address, sex, age, marital status, ethnicity, occupation, income, the reasons for initial addiction, length of addiction, the amount of drugs claimed, and the amount of drugs given. Actually, there were only ten examples of this form because once the clinic started full steam, a standardized form was developed. This second form incorporated the original data from the first form, plus other items such as the number of times previously treated, location of that treatment and the reason for the failure, etc. At the bottom of the form was a section for remarks which often included pertinent data about the patient—such things as his present condition, advisability of undergoing detoxification, when detoxification was undertaken, etc. The standardized form went through two other slight revisions that added several more items of data. Each form was also numbered and dated.

This data is available for 762 patients, or approximately two-thirds (62%) of the 1,237 patients that Terry and Pellens said attended the facility during its history. Reviewing these records, it is difficult to tell which are missing or excluded. Numbers for the records run consecutively and correspond with the dates appearing on the sheets. Low numbers appear during the first months, and high numbers toward the last months the clinic was open. The majority of patients appear during the first two years of the clinic's operation. The numbering system shows that 460 patients attended the clinic during the first year. This corresponds roughly with the 489 figure cited by Terry and Pellens; after that point, the correspondence between the numbering system and their data breaks down. Terry and Pellens say that 542 patients attended the clinic in

1920, and the numbering system shows only 378. Terry and Pellens' final total was 1,237, while the last numbered record was 762, dated January 23, 1923 (a month and a half before the clinic was closed).

Records also appear under every letter of the alphabet, and we were not able to detect any systematic exclusion. Both young and old addicts appear, rich as well as poor (a rich oil millionaire is listed, as is the mother of a city official and the owner of a large dry goods store). Persons given alias names (to protect their anonymity) appear just as those who did not use them.

The reasons for the discrepancy of the number system and Terry and Pellens' data has not been resolved to our satisfaction, nor has Dr. Butler been able to clarify the problem. Dr. Butler is a very meticulous man, and one would expect that records would have been kept current and up-to-date under his supervision. During the time the clinic operated, the records were reviewed at least six times (three committees of physicians and three full scale investigations by the Narcotic Division of the Internal Revenue Service), and there were never any problems with the records at these reviews.

It is our opinion (and we want to be careful to qualify it because we are doing a historical study and a lot can happen to records in 50 years) that these face sheets were *not* made for most transients or persons undergoing detoxification immediately after starting the clinic. *We expect that the records we examined are for long-term patients who were maintained for relatively long periods.* We also know that a separate registry of dosage and payments was kept by the clinic, and conjecture that perhaps Terry and Pellens used that for their count rather than the numbering system of the records.[2] These explanations seem reasonable. One could expect that detailed records would be kept for long-term patients, but not necessarily for persons who made one or two visits to the clinic. At the same time, no detailed record would be necessary for persons who underwent detoxification immediately, because they received opiates for only a short time. The records of dosage and price might have been adequate for short-term patients, and satisfied the various investigations.

As stated earlier, we do not know *exactly* who were included in the records, but that the numbering system appears to be consistent and reasonable. Until we know better, and we do not know that we ever shall, we will presume that the records are for relatively long-term patients. More than likely, most transients were excluded, as were persons undergoing immediate detoxification.

Medical records tell only part of the story of Shreveport. The real story of Shreveport comes from the man who ran the clinic, and, from public and private records of the time. Dr. Willis Butler was a product of Northern Louisiana and Shreveport. Born in Gibsland, Louisiana, in 1888, he moved to Shreveport when he was 11 years old. As a boy he was quite aware of the problems of addicts.

[2] This record was lost approximately 20 years ago when it was inadvertently destroyed with other records.

Working as a delivery boy for a pharmacist, he delivered drachma (half-ounce) bottles of morphine to customers. He graduated from high school in 1907 and went to Vanderbilt University the same year. His family was by no means rich, and he worked his way through medical school. Upon graduation in 1911, he was offered a teaching position at the university, but had to decline because he needed more money than the job offered. Returning home, he worked for a summer as a country doctor in one of the oil fields north of Shreveport. That same year he took a job as chemist and bacteriologist for the city's Board of Health. Five years later, he was selected by the Parish Physician and Coroner as a possible successor, and won his first election to those joint offices.

As Parish Physician and Coroner, he assumed responsibility for dealing with problems of public health. Dealing with the problems of addicts and addiction was only a small part of that job. At the same time that he supervised the clinic, he also ran a venereal disease clinic, supervised water and milk supplies, and cared for the mentally ill and prisoners in the county jail. The experience with the narcotics clinic, including its eventual closing, had little, if any, effect upon his professional life. During both 1920 and 1924, he successfully ran for re-election as Parish Physician. He held this position for 48 years.

After the clinic closed, Dr. Butler became interested in forensic pathology. During summers, he attended Cornell and Rockefeller Universities and worked with Dr. Milton Helpern in the New York City Coroner's Office. This eventually led to national recognition as he served in many national associations—the American Public Health Association, the National Association of Coroners, the American Society of Clinical Pathologists, the College of American Pathologists, and the American Academy of Forensic Sciences.

In Shreveport, Dr. Butler owned and operated two laboratories, served 12 four-year terms (48 years) as Parish Physician and Coroner, and was president of the Shreveport Medical Society and the Louisiana State Coroners' Association. He has earned and gained the esteem of both his colleagues and the townspeople. Dr. R. T. Lucas, a well-known pediatrician in Shreveport who has known Dr. Butler for over 50 years, said:

> Dr. Butler had the full confidence of the public, the medical and legal professions [when he ran the narcotics clinic] which he rightfully earned. There was, and is, no more respected a man in town than Dr. Willis P. Butler.

Today, Dr. Butler is an energetic and lively man, looking forward to a new working career. In 1961 he retired formally as Parish Physician but kept up his interests in his profession by serving as an expert witness (as a pathologist) in numerous criminal cases. Very recently, he has decided to return to work part-time. He was asked to supervise a new blood bank for Shreveport. According to his new employer, "He is the only man in town who could do the job." Shreveport still has a place for Dr. Butler. Despite all the difficulties and the struggles to keep the Shreveport clinic open, his reputation never suffered.

On the contrary, he seemed to grow taller with all the adversity. Certainly his reputation has grown—both locally and nationally.

Dr. Butler's story of the clinic is unusually balanced and objective. In general, the important features of the history of the clinic are supported by letters and documents from the period. Many were provided by Dr. Butler from his original files of materials—these include mimeographed reports of the clinic, letters, and records of the proceedings of the Shreveport Medical Society. These documents were supplemented by newspaper reports of many of the events of the history. The struggles of the clinic to stay open were important and timely news to Shreveport, and newspaper reports were detailed and extensive.

Unfortunately, time has taken its toll on the other actors in the Shreveport drama. All of the staff of the clinic are dead and none of the patients known to be alive. Ideally, we would have wanted other points of view and other recollections as well as Dr. Butler's, but this was not possible. Fifty years is, in the case of the clinic, a long time.

Very briefly, the form of this report will be as follows. In Chapter 1, we set the Shreveport stage and then describe the history of the clinic. Chapter 2 consists of an in-depth analysis of the 762 patients for whom we have records. This analysis is largely demographic, but it also reveals much of the functioning of the clinic. Chapter 3 deals with the specific methods and procedures of both the clinic and detoxification hospital. Finally, in a brief summary we attempt to relate our findings to some important contemporary issues, namely, the feasibility of drug maintenance.

1 | SHREVEPORT AND THE CLINIC -the 1920s

Shreveport is named after Captain Shreve, a riverboat captain who was instrumental in clearing the natural river raft that blocked the Red River until 1838. Captain Shreve devised a battering ram riverboat and spent five years freeing the river of a giant log jam. He began this monumental job in 1833, clearing 60 miles the first year. The next 60 miles was a much harder job; it took him four years to finish the second half.

The town itself was founded in 1837 on the site of an old Caddo Indian settlement on the Red River. The land around Shreveport is lush and fertile, and the town slowly became a thriving agricultural center. The population grew from 1700 in 1850 to 16,000 in 1900 on the basis of its agricultural production. In the next 20 years, the population nearly tripled to 44,000; World War I and the rich oil fields of the area were the reasons why.

According to the *Chronicles of Shreveport*, gas and oil were known to exist as early as 1870:

> The first intimation that there might be oil or gas in Caddo parish was given by a deep well drilled to supply water for an ice factory in Shreveport in 1870, but the intimation was so far in advance of any knowledge of the oil and gas industry in this part of the country, all the oil at that time being produced in Pennsylvania, that no attention was paid the discovery except to use the gas for lighting the plant. And that was due to the curiosity of a workman who struck a match to the "wind" coming out of the hole to be blown out. Instead, the "wind" ignited. It isn't of record how the fire was put out.

Thirty-five years later in 1905, three wells were drilled for natural gas. Shreveport piped it in the same year, and the following year the first crude oil was shipped to Port Arthur, Texas. Two years later, a Standard Oil Company charter was established, and a refinery pipe line was started. 1914 and World War I accelerated both gas and oil production; by 1930, 34 petroleum fields and 24 natural gas fields had been discovered.

Shreveport boomed with the oil. By the time the clinic started, Shreveport, a town of 44,000, had a symphony orchestra, a motion picture house, and an occasional opera in the Opera House. The 1923 symphony orchestra season included a feature performance by a young Russian violinist, Jascha Heifetz, on his first American tour. The town claimed two colleges, five banks, a state hospital, and a Federal Court House. The Louisiana Motor Car Company was mass-producing three or four cars a week that ran around town under the new street lights. Radio Station KWKH opened in 1921 and was the precursor of today's rock stations; KWKH was the first to play phonograph records over the air.

Socially, Shreveport was becoming less black (the black proportion of the population declined 10% between 1910 and 1920) and more racist. While black people immigrated north during the war years, the Ku Klux Klan surfaced again in Louisiana and Shreveport following the war. Loyalty cards were required of "loafers and idlers." These cards had to be signed and punched by an employer, and the holders had to produce them for police inspection. It was suggested by one newspaper that vagrants be arrested and forced to work to increase the labor pool.

Union oil field workers struck in November 1917 for an eight-hour day, an increase in wages, and recognition of bargaining rights. Oil companies resisted the last demand, and National Guardsmen were called by Governor Pleasant. Strike breakers were brought in from Texas, and oil production was resumed under martial law.

Huey Long, who practiced law in Shreveport during the twenties, took on the Standard Oil Company in the interest of independent companies. This was the beginning of many of his anti-corporation battles. In 1924, at age 30, he became a candidate for governor and ran third in his first attempt. At about the same time, he took on Governor Parker and lost in a libel suit; he received a suspended sentence and a $1 fine.

Prohibition was in full swing; both liquor and narcotics were feared and condemned. The Louisiana State Board of Health brought in an outside drug expert from New Jersey in 1918 who estimated that there were 18,000 addicts in Louisiana. He was successful in alarming the state legislators who enacted a new law in July 1918 that required official narcotic prescription blanks, civil commitment (which usually meant jail incarceration) and gave new powers to the Board of Health to make sure the laws were enforced.

The Clinic

In 1919 two important Supreme Court decisions were made that had a large impact on addicts and the ways they were being treated by doctors. In March of that year, on the very same day, the Supreme Court decided: (1) that the

Harrison Act *was* constitutional and (2) that doctors who maintained addicts were in violation of the Harrison Act. In the first case, the Supreme Court reversed an earlier District Court decision that dismissed an indictment against Dr. Charles Doremus. Doremus, of San Antonio, Texas, had been arrested in 1915 for providing a large supply (500 one-sixth gram tablets) of morphine to a known addict, a violation of the Harrison Act. When he appealed the arrest, the District Court decided that the Harrison Act as a revenue measure could not restrict the medical practice of Dr. Doremus. In other words, the way the law was used to prosecute Dr. Doremus was unconstitutional. The Federal government pursued the case to the Supreme Court, and in a five to four vote won a reversal of the decision of the District Court. They found Dr. Doremus in violation of the Harrison Act and thus affirmed the constitutionality of the act.

In the second decision, Dr. Webb's appeal of a Harrison Act indictment was denied because he had supplied morphine to an addict with the intention of maintaining his accustomed use. This decision established that the maintenance of an addict was against the law unless it was part of a *cure*. Maintenance, for decades before the decision, had been a common practice. In the event that a doctor could not successfully treat some illness or disease, doctors felt justified in relieving the accompanying pain and suffering. For the addict the relief was opiates.

Effects of these two decisions were immediate. Federal agents of the Narcotics Bureau of the Internal Revenue Service started immediate indictments against a small number of doctors in various cities throughout the United States. Often these were doctors who were known to cater and prescribe flagrantly to large numbers of addicts. Exactly 36 days after the decision was made, Federal agents in New York City, led by Major Daniel L. Porter, arrested six physicians, four druggists and 200 addicts for violation of the Harrison Act (*New York Times,* April 9, 1919). The basis for the indictments of physicians was the Supreme Court decision that addicts could not be maintained on opiates.

Both the decisions and the arrests that followed caused panic among large numbers of doctors because it was quite common for doctors to have a small number of patients to whom they regularly prescribed opiates. More often than not, these were patients who suffered some chronic or terminal illness and were being treated in good faith. But this practice now fell into question, and doctors were loathe to treat any addicts. This reticence was understandable; they were just as liable for indictment as those doctors who prescribed flagrantly. Doctors complained and sought advice. Addicts complained and sought help.

The "solution" of the emergencies caused by the Webb decision were "temporary" clinics or dispensaries to treat and "cure" addicts. Some sprang up spontaneously (as did the New Orleans clinic), but others seem to have been established at the instigation of Federal agents. Obviously, Federal agents had some clinic in mind when they made the New York arrests because two days

later a clinic was opened by the New York City Health Department (*New York Times,* April 10, 1919). The clinic must have been planned before the arrests were made. It opened very quickly and began to serve large numbers of addicts in a short period of time (12 addicts enrolled the first day, but the number jumped to 173 on the second day).

Federal agents anticipated that there would be trouble from both addicts and doctors when legal supplies of opiates were cut off. Addicts would be without supplies and could clamor or become involved in thefts. Doctors would complain on the behalf of their more affluent, established addicts. There were also other considerations. World War I had ended in November of the previous year, and there was a steady stream of returning soldiers from Europe. It was expected that many returning soldiers would be addicted in the course of treatment for war injuries. This had been the case after both the Civil and Spanish-American wars, and there was no reason to expect that soldiers from World War I would be different.

In other cities the same pattern developed. Doctors, druggists and addicts were arrested, and there was a clamor for some help or solution for the problems of both addicts and doctors. In Shreveport, Louisiana, at the same time (April 1919) narcotics agents came to town to begin investigations to enforce the new drug policy. They reviewed the records of druggists, contacted addict informers and solicited illegal prescriptions. Addicts were arrested and indictments against doctors were started through a grand jury. About the same time, petty thefts were said to increase, and it was thought that addicts were the cause.

One particularly well-known and esteemed doctor, Dr. R———, was one of several charged with violations of the Harrison Act by Federal narcotics agents. Federal District Attorney Phillip Mecom of Shreveport knew Dr. R——— very well and was convinced that he was not indiscriminately prescribing opiates to addicts. He was not as certain about the other doctors, but felt that something had to be done about the problem. Consequently indictments were not pursued with particular vigor, since local officials felt that they could handle the situation better without making charges. Two doctors, considered to be flagrant prescribers who dispensed opiates not out of sympathy or understanding for addicts but for profit, were asked to leave town; both left.

The first measure taken was a short-term prescribing procedure. The State Board of Health designated one physician to take over the job of prescribing for all the addicts in the town. Addicts got their prescriptions daily and had them filled at one official drug store. The job was too much for one doctor to handle, and addicts resented being required to go to both the doctor and a druggist every day to get the prescriptions and have them filled. Another objection came from the official pharmacist. He felt that addicts coming to his drug store daily would drive his regular customers away. This procedure lasted less than a month, when the doctor in charge of the procedure resigned.

Shortly after the doctor's resignation, Dr. Oscar Dowling, President of the Louisiana Board of Health, came to Shreveport on another matter. During the course of his visit, he asked his young friend and colleague Dr. Willis P. Butler, the Caddo Parish Physician and Coroner, to visit him at his hotel. Their conversation eventually turned to the problems of addicts and the unsuccessful prescribing program. Dr. Dowling, knowing that Dr. Butler had some experience treating addicts in the county jail (as part of his normal duties as Parish Physician) asked him to visit the New Orleans clinic and see what he could do for Shreveport. New Orleans, like Shreveport, had experienced a drug panic in March when the Webb Supreme Court decision was announced. Addicts affected by the panic appealed to Dr. Marion Swords, the Secretary of the Board of Health, and he then opened a new dispensing clinic. The principal method used by the clinic was direct dispensing to the addict, thus obviating the use of a commercial pharmacy. Its primary objectives were to provide temporary relief for addicts at a reasonable price, to cut down on rising theft committed by some addicts, and to drive the price of illegal opiates down so the illegal supplies might dry up (Swords 1920).

Dr. Butler went to New Orleans and visited the clinic for two days and returned with mixed impressions. He liked the basic idea of the clinic and its security, but he did not like the methods used:

> I saw right away that the clinic was trying to fool their patients off of drugs. They were mixing morphine in solution and reducing their dosage drastically. The addicts knew what they were doing because some of them were doubled up in pain. I knew enough about addicts, I had seen plenty of them in the county jail [the Parish Physician is responsible for all prison patients] to know that you shouldn't try to do that to them.
>
> I came back to Shreveport and made my report of what I saw. It was generally unfavorable as regards their methods, and I said that if I were going to do it, it would have to be my way. Well, they let me do it my way [Interview 1973].

The next thing Dr. Butler did was go to the Shreveport Medical Society and tell them of his plans for the dispensary. The Society, which consisted of over 100 doctor-members, approved the plan and passed a resolution that thenceforth they would *not* treat addicts, but would send them to the clinic for treatment. Dr. Butler agreed that neither he nor the clinic would interfere with their regular practice regarding the use of opiates to non-addicts, but that addicts would be treated only at the clinic.

On May 3, 1919, the clinic was opened at Schumpert Memorial Sanitarium, the largest hospital in Shreveport, under Dr. Butler's direct supervision. The day they opened, four patients came. The first patient was a 24-year-old waiter who had been addicted four years and was using 5 grains[3] of morphine a day. He was a new resident in Shreveport, having arrived three years earlier. Joe Sing, a 39-year-old Chinese restaurant worker, was the second patient. Mr. Sing had become addicted to opium in China before coming to the United States, and

[3] one grain = 64.8 milligrams = .0021 ounces.

when he came to the clinic he was using twelve grains of morphine. The first female patient was an attractive, young store clerk who had been addicted for five years when she arrived at the clinic. She was suffering from syphilis and was using 12 grains of morphine daily. The plan of treatment shown on her record was to treat her syphilis first, and then to reduce her morphine dosage gradually in preparation for detoxification.

On the second day the clinic was open, six patients arrived; and by the end of the first week, 23 patients had enrolled. The clinic grew slowly during the first month to 42 patients, and by the end of the second month, 60 patients. During the first month of the clinic's operation it was decided, upon the urgings of Oscar Dowling, to combine the narcotics clinic with a planned venereal disease clinic. At the time, Shreveport was experiencing a venereal disease epidemic. The new VD clinic would use a new form of treatment for syphilis developed in Germany. Previously, the syphilis treatment had been to use a preparation of mercury, and the new method used arsenic preparations called "606." Patients were given two or three injections of the new 606 over weekly intervals, and then a series of monthly Wasserman tests to determine the outcome. When three negative Wassermans were taken, the patient was considered cured. This new treatment was provided by the State Board of Health, as were funds for the staff. The VD clinic utilized the same facilities as the narcotics clinic, and the staff was the same. This proved a good thing for the addicts, as a large percentage (approximately two out of five) also suffered some venereal disease.

Gradually, as the numbers of patients increased, Dr. Butler and the staff realized that they needed a separate facility to conduct treatment of "cures." Patients usually could not be successfully detoxified in the out-patient clinic, and Dr. Butler felt that jails were no more successful, so an isolated hospital facility was planned. Toward the end of September 1919, space was provided at Charity Hospital to start the "cures." During September, one patient was detoxified, followed by five in October, and three in November. December was a bumper month for these treatments as 10 persons were treated. It would seem that they were preparing for the Christmas holidays.

By the end of the year 1919, the townspeople were well apprised of the clinic's work. During the ensuing eight months, 264 patients had enrolled at the clinic, and eighteen had been detoxified in the Charity Hospital facility. The clinic received good coverage in the local newspaper, and officials in the town were pleased with its operation.

Prior to the clinic's opening, a number of addicts had been arrested for theft and robbery—medical bags were being stolen, doctors' offices were being broken into, and numerous petty thefts were committed by addicts. These crimes dropped off dramatically after the clinic was operating. On January 7, 1920, an editorial appeared in the *Shreveport Journal,* one of the largest papers in town, that praised the work of the clinic and supported its continuation. The editorial

also suggests that there was some Federal pressure to close the clinic in the form of "reported withdrawal of government and state support." The editorial seems to have been written to forestall the closing of the clinic.

It is very likely there *were* some rumors to the effect that the narcotic clinics would be closed by the Narcotics Bureau because in December 1919, a major reorganization of the Federal Bureau of Narcotics took place. With passage of the Volstead Act (National Prohibition Act), the Prohibition Unit of the Internal Revenue Service was given the responsibility of enforcing the Harrison Act, and a month later (December 1919) a new organization was put into effect. The new arrangement put Prohibition agents in charge of policy making over narcotic agents (Lindesmith 1965). Prohibition, as the reader will recall, was a very vociferous, zealous movement, which had elements of a red scare (Musto 1973). Advocates of prohibition felt, not unlike other "true believers," that all the sins and evils of the world could be eradicated by prohibiting the use of liquor and drugs. Furthermore, they were very effective in convincing the public that opiates were as evil as liquor. This undoubtedly had a great effect upon the way doctors and the public viewed narcotic addicts.

The effects of the changes in the Narcotics Bureau were not felt immediately in Louisiana, but they were felt elsewhere. David Musto, in his excellent historical study *The American Disease* (1973), contends that a policy decision to close the clinics was made late in 1919 or early 1920. The New York clinic was used by the Treasury Department as a model of a failed clinic. The clinic served extremely large numbers; it was not uncommon during its peak period to serve 700-800 addicts every day. There were, to say the least, excesses in prescriptions. The upper limit for dosage was 15 grains, and many persons received that amount. Many addicts cheated, and there were several identification procedures used. None was really effective, which is perhaps understandable given the large numbers of patients attending one facility. It is interesting to note that most present-day methadone maintenance programs avoid these problems by keeping the numbers of patients attending a clinic relatively small (usually 100-200 patients).

Detoxification was also a problem for the New York clinic. New York communities were unwilling to accept addicts or the hospitals which were to treat them, and eventually addicts were sent to Riverside Hospital on North Brother Island (this was also used for treatment of juveniles in the 1950s). The clinic itself attempted gradual reduction and placed some of the patients in Riverside Hospital when beds were available. The main problem was illegal sources for the drug. Persons attending the clinic used both legal (from the clinic) and illegal drugs. Many of the patients detoxified at Riverside Hospital relapsed immediately or shortly after leaving the hospital (which is not unlike the present-day situation). The failures of the New York clinic were well known,

and the Narcotic Division seized upon the adverse publicity as justification for their anti-clinic policies.

The New York clinic was the first to close. Reports from the *New York Times* say the clinic closed on March 6, 1920, less than 11 months after it began. There was little, if any, resistance from the staff. Drs. Royal S. Copeland and S. Dana Hubbard both came to believe that ambulatory treatment should be abandoned for institutionalization (hospitals and jails) and strict law enforcement against illegal suppliers. Earlier in the history of the New York clinic, Drs. Copeland and Hubbard were enthusiastic about the prospect for ambulatory treatment, but they soon took the opposite line. Their clinic certainly was not run very well, so perhaps like many "drug experts" since then, they conveniently blamed the addicts for their own failure.

Dr. Copeland was not above playing to the newspapers for as much publicity as he could get out of the problem. Before the clinic opened, he estimated populations of 150,000 and 200,000 addicts in New York City. These were properly deflated during the clinic's operation; during the year the clinic opened, it reported only 7,400 addicts treated. Dr. Copeland went on to become Senator of New York State. He, like others who have followed him, used the publicity generated by addiction and the problem of treating addicts to further his larger career.

First Investigations

David Musto reports that the first full-scale investigation of the Shreveport clinic took place in March 1920. He reports the results of the investigation as follows:

> The investigation viewed the clinic as a means leading to institutional treatment believed to be curative. It was not presented nor perceived by the agents as a maintenance clinic. The strong support of enforcement and other public officials was impressive, and the agents "were very favorably impressed with the clinic, and also with Dr. Butler, who seems very efficient, and seems to have one idea of curing the addicts by treatment in the hospital" [Musto 1973:167].

Dr. Butler recalls an earlier visit by two agents who came to Shreveport to attempt to buy or procure illegal morphine:

> One day during the first year of the clinic, I got a call from some newspaper men down at City Hall who wanted me to make a statement about a press conference just held. Two narcotic agents came to town and attempted to buy narcotics, but could not get a drop. They said they wanted to make a public statement so held a press conference. I did not see either one of them but heard one was from New York.

The first anniversary passed with no further intimations of any enforced closing. During that year, the clinic had treated over 450 patients, of which 46 had been detoxified. The clinic was firmly endorsed by most of the public officials in Shreveport and this was demonstrated in August of that year (1920) when pressures for closure seemed imminent. Steps were being taken in New

Orleans to close the dispensary there. During August, several officials wrote letters of endorsement to Dr. Dowling and Dr. Butler. These included Federal Judge George Whitfield Jack, U.S. Marshall J. N. Kirkpatrick, Sheriff T. R. Hughes of Caddo Parish, and Shreveport Commissioner of Public Safety R. L. Stringfellow. The clinic, over the 15 months of its life, had substantial endorsement. Dr. Oscar Dowling sent Dr. Butler 22 letters that commended or praised the clinic and its operation. Dr. Dowling seemed proud of the clinic's record and continually sought some recognition of his role in its establishment.

Pressure to Close

The intimations of pressures to close the clinic became more apparent when Dr. Dowling wrote the following letter to Dr. Butler on September 27:

New Orleans, La.
September 27, 1920

Dear Doctor Butler,

Your letters of the 24th received this morning. I am glad your trip was enjoyable and helpful. It must have been very gratifying to you to have commendation of your dispensary [the narcotic clinic]. I hope that Col. Nutt [Levi Nutt, the head of the Narcotic Division] may come at an early date and go over the entire details of your work. . . .

I understand there is a very definite movement to have closed all the dispensaries giving ambulatory treatment, but of this I know too little to advise of the details, and I shall ask you to keep the matter to yourself until I know something more definite.

Very truly yours,
Oscar Dowling
President
Louisiana State Board of Health

Oscar Dowling had generally advocated the dispensaries in Louisiana as a reasonable and humane service. He most certainly was instrumental in suggesting a clinic operation to Dr. Butler and more than likely did the same for the clinic in Alexandria. During the first year of the dispensaries' operation he visited the Shreveport dispensary several times and offered it considerable support primarily through financing of the VD services. Relationships between Drs. Dowling and Butler were very cordial; both were graduates of Vanderbilt University Medical School.

Although there was considerable age difference between the two men, Dr. Butler considered him a close and valued friend. Dr. Dowling reciprocated these same sentiments.

After receiving the letter from Oscar Dowling, Dr. Butler met with the Shreveport Medical Society and told them there were some rumors that the clinic might be closed. They were, understandably, concerned about the fate of the clinic. The clinic had taken over most of the addict cases for doctors of the town. If the clinic should close, it would be very likely that some patients might return to their doctors. The Society appointed an investigation committee

composed of three doctors. On October 5, they reported their findings to the rest of the Society as follows:

> To the Shreveport Medical Society:
>
> . . . We were most favorably impressed by the conduct of the clinic including the details of complete records of all addicts coming under care, classification of addicts and treatment according to classification, the elimination of non-residents of Louisiana and careful treatment of curable cases UNDER RESTRAINT, the procuring of employment for addicts who are able to work while attending at the dispensary and for cured patients who wish to remain in Shreveport after recovery, are all of this work that strongly commend the conduct of this institution.
>
> It is significant that Dr. Butler's judicious and tactful conduct of the clinic has secured for him the unqualified support and cooperation of the Federal, State, Parish, and City authorities, and the State and City Boards of Health.
>
> In brief we wish to express our unqualified support and approval of the Shreveport Narcotic Clinic and its systematic and effective administration by Dr. Butler.
>
> *W. H. Billingsley, M.D.*
> *J. J. Frazier, M.D.*
> *J. G. Pori, M.D.*
> Committee

Levi Nutt visited Dr. Dowling in November; the visit had important effects upon Dowling's attitude toward the clinics. Dr. Dowling, up to that date, had been a staunch supporter of the Louisiana clinics, but Federal pressure to close them was persistent. David Musto has documented a threat of indictment by Prohibition Commissioner John Kramer against Dowling unless he closed the clinics. This threat was made by Kramer's general counsel during December 1920 (Musto 1973:166, 314). Dr. Dowling responded by requesting time to garner support against the clinic in his state. This was only the beginning of Dowling's troubles with the Narcotic Division; there would be more to come.

Meanwhile, the clinic was soliciting more support from the local community. U.S. Assistant District Attorney C. H. Blanchard and Commissioner Stringfellow both wrote letters to Oscar Dowling urging him to keep the clinic open. On November 16, the City Commission Council (the mayor and four commissioners) voted unanimously to support the clinic and urged state authorities not to disturb the clinic. The clinic was obviously getting solid backing from the community.

New Orleans and Alexandria Close

The next move by the Narcotic Division was an investigation of the New Orleans clinic. A report of the investigation was eventually sent by the narcotics agent in New Orleans to Governor John Parker. Along with other members of the State Board of Health, Governor Parker advocated and supported the work of the clinics. The narcotics agent's report on the New Orleans clinic was negative, but as Musto points out, the conclusions were unjustified.

> Examination of Truxton's report reveals that he found only a small percentage of faulty dispensing and his most substantial statistics, the number of residents with criminal

> records, was actually irrelevant to whether, if addicted, people with criminal records should receive narcotics until treatment in an institution was available [Musto 1973:166].

This report was the basis for a meeting held in February 1921 of the State Board, Governor Parker, the principals of the three dispensaries, agents of the Narcotic Division, and a special committee of the Board to investigate the New Orleans and Shreveport clinics. The clinic in Alexandria did not present any particular problems to the Board. They did not present the same defense as did the New Orleans and Shreveport clinics. The investigation committee of four Board members chaired by Dr. Thomas A. Roy made a compromise recommendation. They recommended that both clinics (New Orleans and Shreveport) be continued until a hospital could be established to treat "curable" addicts. When the hospital was established, the clinics would continue to provide services to the incurable, aged and infirm, and cases waiting to be cured.

Federal agents at the meeting singled out the New Orleans clinic for attack. Dr. Swords was accused of making money off addicts of the clinic, but the agents were reluctant to charge him. This was a common tactic of narcotic agents in their attempts to close the clinics and a tactic that generally worked. Dr. Swords denied the charges and Governor Parker supported Swords' stand. By this time, Dr. Dowling was fully in the camp of the Narcotic Division. Dr. Dowling and the Federal agents were adamant in their attack on the clinics, but the final decision was put off until March.

March came and the State Board of Health decided against the New Orleans clinic, most particularly Oscar Dowling. Dr. B. A. Ledbetter, a member of the investigating committee, contended that if the New Orleans clinic should be closed so should the other two. Two other doctors on the committee, Drs. Chamberlain and Roy, opposed this position because ". . . Federal Judge Jack favored the institution [Shreveport], especially since Dr. Willis P. Butler, in charge of the narcotic dispensary at Shreveport, had established a real hospital for treatment of drug addicts, renting a ten room house in which to treat them" (*Shreveport Times,* March 16, 1921). (The Shreveport clinic had anticipated the issue of a separate hospital and had rented a large house in downtown Shreveport to treat "curables.")

An impasse was anticipated, and Dr. Chamberlain of the Board introduced a resolution that *all* the clinics be closed: "We must bring this matter to a crisis, and might as well close all, and let the people howl" (*Shreveport Times,* March 16, 1921). This resolution was passed, and all three clinics were ordered closed.

During the Board meeting there was some discussion about utilizing city authority to authorize the continuation of the clinics, and this is what Dr. Butler did in Shreveport. Dr. Butler returned to Shreveport and got support from staff physicians of the T. E. Schumpert Memorial Hospital, the site of the dispensary, to continue the work of the clinic. Eighteen doctors voted

unanimously to continue the clinic on March 15, 1921. On March 23, 17 doctors from the staff of the North Louisiana Sanitarium made a similar resolution.

Second Opening

Dr. Butler complied only symbolically with the order of the State Board. The Louisiana State Board of Health Narcotic Dispensary and Institutional Treatment Department was closed, but the facility re-opened as the Public Health Hospital Institution and Out-Patient Service the same day. Dr. Butler sought legal advice from a District Attorney of Caddo Parish about the powers of his office as Parish Physician and Coroner to dispense narcotics, and was given legal authority to do so.

This move was unanimously endorsed by the City Council upon the suggestion of Mayor John McW. Ford, and the City Attorney was instructed to draw up a city ordinance to authorize the hospital. At the beginning of April 1921, the ordinance was passed by the City Council and became city law. The ordinance gave the hospital and out-patient service authority to treat narcotics and venereal disease cases, and specified funds to pay a portion of their costs. Operating as a city clinic, patients were treated in the clinic until February 1923.

More Investigations

Dr. Willis Butler was and is a soft-spoken, persistent man. His gentle and humorous manner is only one part of the man; the other is a staunch fighter. Confident of his clinical work and the full support of the community, Dr. Butler did not hesitate to fight for what he considered a much needed humane service. His fight was not without some threat to himself. He was a holdout who became an embarrassment to Oscar Dowling and the Narcotic Division. Dr. Dowling became so incensed with Dr. Butler that he issued his own threats of indictment: "He told me if it was the last thing he did, he would have me in Atlanta [the Federal prison]. Well, I hadn't left anything in Atlanta, and I wasn't about to go there." (In subsequent efforts at retaliation, Butler was investigated by two grand juries.)

During the next two years, agents from the Narcotic Division visited Shreveport on numerous occasions. Musto found evidence of two full-scale investigations and five or six visits by a single agent from the Kansas City office during this phase of the clinic's operation. Dr. Butler's recollection of these visits was:

> The government seemed to send agents into Shreveport continually, usually on the sly. Some I saw, some I only heard about. Mostly, they would come attempting to buy drugs from peddlers or get prescriptions from doctors. They were usually discouraged in this because there were no peddlers; and if you went to a doctor to get morphine, they would just tell you to go to my clinic. Both the patients and the doctors told me of these visits, once a newspaper reporter let me know what was going on.

Some agents were gentlemen and completely aboveboard. They came to see me, and I would show them the clinic records and tell them to go see all the officials in the town and ask about the clinic.

According to Musto, Colonel Nutt of the Narcotic Division ordered the second major investigation in October 1921. Musto, using records of the Narcotic Division, described the results of the investigation as follows:

Two agents, one of whom was Dr. B. R. Rhees, secretary of the recent Special Narcotic Committee of the Treasury, went to Shreveport. First they visited the drugstores. No prescriptions were found for narcotic addicts, a significant fact to the investigators; the reputable druggists of Shreveport unanimously praised Dr. Butler as "honest and sincere in his efforts to help the City of Shreveport." Then they visited three prominent doctors and again approval was unanimous—they were no longer bothered by drug addicts except an occasional visitor to the city. The physicians warned that "there would be serious objection to the clinic's discontinuance." The agents saw little if any opportunity for morphine to be improperly disposed of. Every grain was accounted for. One hundred twenty-nine patients had been declared incurable and were receiving maintenance supplies. Each incurable was so certified by three or more physicians.

Various officials were also interviewed. Federal District Judge Jack again affirmed his high opinion of the clinic, which now had been operating for over two years. He warned that he would vigorously oppose any steps taken toward a discontinuance of the clinic, because from his own knowledge it had lessened crime in the city. The city judge was even more outspoken than the federal judge in his praise of Dr. Butler. He particularly favored care of the incurable addict which enabled him to work and not be a charge on the city. Both the chief of police and sheriff said that crime, such as petty thievery which might be resorted to to pay for illicit drugs, had lessened since the inauguration of the clinic. The U.S. marshal was of the same opinion.

The agents discovered a political environment which they found unique among communities with clinics: "There is absolute cooperation between Dr. Butler, the Police Department, the City officials, and the Federal officials." They recommended that the clinic not be discontinued since it was "operating under the full sanction of officials charged with the preservation of peace and order in the City of Shreveport and the Parish of Caddo" [Musto 1973:168].

Dr. Butler recalls another large-scale investigation of the clinic that most likely did not appear in the records of the Internal Revenue Service because it was clearly an embarrassing incident.

I recall one incident vividly. One of the narcotics agents sent to investigate our dispensary turned out to be an addict himself.

Occasionally we used to confiscate illegal drugs from patients. In one instance a doctor came from New York City to be treated in the hospital and he had a jar, a handsome jar, with two or three ounces of morphine. He turned over the jar to the clinic. The custom was to keep such drugs in a safe until I could take them to the Federal District Attorney, Attorney Mecom that is. Before I took it and other confiscated drugs to the Attorney's office, I stopped by a druggist I knew to weigh it. I got a receipt for it and then took it to Mecom's office.

Well, this Federal agent came to town with two other state agents from New Orleans and went to see Mecom. And as it was their custom, the federal agent collected the confiscated drugs, but for some reason the agent returned the drugs temporarily to Mecom. Attorney Mecom told me of this, and I became a little suspicious. So just to cover myself, I went to the Attorney's office, got the drugs and had it weighed a second time. When the drugs were weighed a second time, 60 or 70 grains were missing. I had both receipts of the measures.

The next day the three agents came to my office to review my dispensary records.

> The review was a rather long job, and as noon approached I noticed that the Federal agent was getting very nervous and irritable. I began to suspect him of being an addict and kept him there in the office as long as I could. The longer he stayed, the more he perspired and became nervous. He was exhibiting obvious withdrawal symptoms.
>
> Finally, I just asked him, "How much morphine do you use?"
>
> He got very indignant at this question, saying that he would not stay there and be insulted. He left the office as mad as an old wet hen.
>
> After he left, I had some second thoughts about what I had done. I wondered if I hadn't torn my britches. So just to check I called the druggist to make sure of the amounts. He confirmed my figures. And then it wasn't any more than an hour or so when I got a call from the two agents accompanying the Federal agent. Agent I said that I was right about the Federal agent. He was an addict, but they did not know what to do about it.
>
> Well, I knew what to do. As coroner I had the right to arrest him. I went and got a warrant for his arrest, but before I could get to him, he had left town.
>
> He got away, but the next day we called Attorney General Palmer and told him of the incident. The next thing we heard was that the Federal agent was transferred to the Cincinnati, Ohio, office.

During 1921, the number of new patients gradually began to decline. Many more were coming to take treatment at the hospital than came to the clinic. This trend continued through the third year of the clinic. Patient records show only 55 new patients attending the dispensary during 1922.

Visitors came regularly to the clinic, and the clinic received a lot of favorable publicity. Dr. Butler published a description of the clinic in March 1922 issue of *American Medicine.* Both Ernest Bishop, a New York doctor and author of a popular book of the time *The Narcotic Drug Problem,* and Charles Terry, the Executive Director of the Public Health Association's Committee on Habit-Forming Drugs and eventual co-author of the classic *The Opium Problem* (1928), championed the clinic publicly. This publicity embarrassed the Narcotic Division, as Shreveport was the last of the clinics, and Federal agents could not find cause to close it down.

The Last Months

Perhaps out of desperation the Narcotic Division sent a "hatchet man" to Shreveport. This was H. H. Wouters who, with a group of Federal agents, proceeded to build a case against Dr. Butler and the clinic. They made two visits to Shreveport. During the first visit, Wouters reported that a group of citizens approached him about an illegal peddler who was said to be paying off one of the clinic's inspectors to stay in business. When Wouters approached District Attorney Mecom with this information, Mr. Mecom told him to go to the sheriff, Dr. Butler, and his investigators with this information. Wouters did not do this, but rather became suspicious of the authorities and reported this to his supervisor.

On the second visit, they proceeded to interview 50 of the clinic's 129 patients. The object of these interviews was to reveal that patients were simply drug addicts and not worthy of being maintained, did not work, and were

possibly criminal. A personal case was built against Dr. Butler. In the report, he is accused of making money out of the clinic and keeping a large staff from the proceeds (Musto 1973:170).

Wouters, except during the first visit, tried to avoid Dr. Butler and the clinic. The first meeting was heated; Wouters accused Dr. Butler and the clinic of treating prostitutes, and Dr. Butler denied this. (He later described Wouters as "ingratiating but sly.") The second meeting was like the first:

> During his [Wouter's] last visit here, the patients asked me about him because he was going around questioning them. Wouters was trying to get evidence on the clinic and patients on the sly. I confronted him with it, but he denied it. Eventually, he told one of the patients his intentions (trying to close down the clinic) and the patient told me. I went around to see Sheriff Hughes about it, and Hughes decided to get a local warrant to pick him up. We did not get to him in time. By the time we got to his hotel, he had left. He left a forwarding address in the Virgin Islands.

By this time, Dr. Butler was getting tired of all the battles to keep the clinic open. The numbers of patients had declined to approximately 100, and he was beginning to feel that it was taking too much of his time and effort and possibly was not worth it. Toward the end of January 1923, G. W. Cunningham, a Federal narcotics agent from Richmond, Virginia, was sent to Shreveport on a "diplomatic mission" to close the clinic (Musto 1973:172-173). He, with two other agents, talked with Judge Jack and Phillip Mecom. Judge Jack stopped by Dr. Butler's house that night and told him of the meeting. Phillip Mecom telephoned the next day and asked Dr. Butler to meet him in his office:

> Mecom said that Cunningham was giving him a lot of trouble about the dispensary. Shreveport was the last of the clinics and they wanted it closed. Mecom was taking my part, but Cunningham wanted him to prosecute me. Mecom said there was nothing to prosecute. A meeting was arranged for January 30th.

The meeting took place in the Federal Court House with District Attorney Mecom presiding. Dr. Butler was present with Cunningham and two other agents. After some discussion it was agreed that the clinic would close on February 10, 1923. Dr. Butler described the meeting later in a letter to the *Atlanta Georgian* newspaper as being amicable:

> No records were gone over, no patients, officials, or doctors were called and nothing was gone into except the closing of the dispensary. I have felt all along, and still do, that I am right, but rather than enter an endless controversy without reasonable hope of what I consider right to prevail I agreed to discontinue the so-called clinic.
>
> All was very harmonious, and I must say the Inspectors appeared to be very nice gentlemen, far different from Mr. Wouters. I was told that I am not in any way accused of wrong-doing or bad faith, but that the work that I am doing here caused trouble because other places contended that if Shreveport be allowed to have a "clinic," they should be allowed such a privilege.
>
> Mr. Cunningham read a part of Wouter's report in the conference. The addict's word was accepted by Wouters as truthful without corroboration, and without an investigation of facts that records, histories, and examination findings would reveal. For instance, several cases who have resided here for years were classed as not belonging here. Cases almost dead were called curable, so they report.

The dispensary closed on February 10, but the treatment (or detoxification) hospital remained open until March 1925. The clinic arranged for some of the approximately 100 patients left on the rolls of the dispensary to either take treatment in the hospital or be transferred to private physicians. After these arrangements were made, Dr. Butler was left with 21 incurables (aged and infirm) whom he treated as the Parish Physician.

The Final Charge

The meeting with Cunningham on January 30 was not the end of the matter by any means. A short time later, District Attorney Mecom informed Dr. Butler that Cunningham was pressing him to prosecute. Cunningham wanted Mecom to fine Dr. Butler $5,000 for violation of the Harrison Act. Dr. Butler never quite understood all the particulars of this action, but agreed to it in order to get the District Attorney "off the hook." Cunningham accused District Attorney Mecom of protecting Dr. Butler. Mecom made some complaint (Dr. Butler did not know the particulars), Dr. Butler gave him a $100 bank draft, and that was the last he heard of the charge. It would seem that the District Attorney charged him with something and fined him $100 to close the case.

Shortly after the clinic closed, Sidney Howard, a journalist and dramatist, visited Shreveport and the hospital for a week and wrote a popular eulogy to the clinic. Mr. Howard was favorably impressed with Dr. Butler, the clinic's operation, and the town's response. His re-creation of the clinic's operation in the June 1923 issue of *Hearst's International* magazine is one of the best on-the-spot accounts of the town's attitude toward the clinic. He noted that in the absence of the dispensary there already was a suspicion that an illegal supplier had already started operating in Shreveport in a new drug store.

This suspicion of a flourishing illegal supply was amplified in a newspaper investigation conducted by the *Shreveport Journal* in June 1923. Both illegal morphine and cocaine were said to be readily available from peddlers. This was a quite different situation from the period of the clinic's operation when little, if any, illegal supplies were available.

The Hospital "Cures" Continue

The treatment hospital and venereal disease clinic (which was always an active part of the out-patient services) remained open in the same building on Travis Street in downtown Shreveport. The hospital continued to treat persons who wanted to be detoxified until March 1925, with a temporary closing in the spring of 1924. From the period October 1919 to February 1923, approximately 350 patients were detoxified at the hospital. Following the closing of the clinic (from February 1923 to March 1925) another 50 persons were detoxified.

While business at the treatment hospital was slow, the venereal disease clinic was very active.

Dowling's Last Stand

Although the hospital seemed to gradually phase out its services over the next two years, there remained one more drama in Shreveport involving addicts, doctors, and Oscar Dowling. This occurred in February and March 1925, two years after the clinic had closed. It began with the newspaper announcing a meeting held between District Attorney Mecom, Oscar Dowling, and Federal and State narcotics agents. In the meeting, Dr. Dowling and the agents claimed that narcotics were being grossly over-prescribed in Shreveport. The *Shreveport Journal* of February 14, 1925, reported that Dr. Dowling claimed, "Outside of twelve doctors here, the remaining local physicians prescribed annually more drugs than all the doctors in the State of Louisiana including New Orleans." This statement seemed to charge all (except 12) of the doctors in Shreveport with over-prescribing.

This statement caused an uproar among local doctors. A special meeting of the Shreveport Medical Society was called by President Sanderson the same night that the statement appeared in the newspapers. The meeting was held to clarify Dr. Dowling's allegations.

During the special meeting, Dr. Dowling revised his statement to "less than twelve physicians (I could almost count them on the fingers of one hand) are writing prescriptions indiscriminately for an amount of morphine in excess of the requirements of the State Institutions or even more than the needs of the profession of the state for legislative purposes" (Shreveport Medical Society, March 1925). Many members resented the original statement that all but 12 physicians were prescribing indiscriminately and the way it was publicized in the newspapers. There were heated discussions between Dr. Dowling and the members not only about the allegations made but about the narcotics clinic as well. Dr. Butler recalls the meeting and his role in it:

> During the meeting, Dr. Dowling attempted to discredit the clinic and his role in its development in an effort to get the Medical Society to revoke its earlier endorsement. He said that he disapproved the clinic from the beginning and never endorsed it. This was a patent lie, and I stood up and told the society that if that were the case, one of us was lying because I had 22 letters where Dr. Dowling had praised the work of the clinic.
>
> I passed the letters around and called for a vote of censure (that would have expelled him from the Society). Any censure required all the members to approve it. All but one of the doctors at the meeting voted for censure, but it did not pass as a motion.
>
> At the same time, the Society did not retract its earlier endorsement of the clinic either.

The meeting ended with the passing of a motion of resentment against the way Dr. Dowling had publicized his charges. The motion also stated that Society

members "deplored the existing conditions and pledged our support in an effort to eradicate them" (Shreveport Medical Society, March 1925).

Two days later, a grand jury was called by District Attorney Mecom that lasted for two weeks. According to newspaper reports, 49 cases were heard (*Shreveport Journal,* February 27, 1925). Dr. Butler was one of a number of doctors (as Dr. Dowling said, fewer than 12) being considered for indictment. Dr. Butler recalls that he learned of his own case being considered by the grand jury through Huey Long.

> Yes, Huey lived in Shreveport then. He was the State Commissioner of Railroads at the time, I believe. I knew him pretty well at that time; we were members of the same church.
>
> Well, one afternoon I was going home and stopped in front of the court house building. Huey Long stopped me and in his big way said, "Why don't you tell your friends when you are in trouble?" I didn't know what trouble he was talking about, and then he told me that the grand jury was trying to indict me with some of the other doctors.
>
> I couldn't quite believe it, but later on that evening he called me and asked me to come down to his office. In his office was one of the members of the grand jury, a Mr. E——— and he said that the jury was meeting and I was among the cases presented. Oscar Dowling was questioning my prescribing records to my old patients, about 20 of them that I had had for years, but they hadn't come to me about it.
>
> The next day I got all my records together, took them to Sheriff Hughes, and in turn he gave them to District Attorney Mecom. Mecom presented the records to the jury, and the case was thrown out.
>
> Mr. E——— told me after the jury was over that the jury was doing their best to get a case against me before those records were produced.

The outcome of the jury proceedings resulted in 28 arrests—seven doctors were charged, six druggists, two illegal drug peddlers and 13 addicts. Both of the drug peddlers and seven of the addicts pleaded guilty to sales and possession. Dowling and the Federal agents, by their own admission, said that they were not interested in convicting doctors and druggists and, true to their word, they did not. Addicts, as is often the case, caught the brunt of the investigation and the charges.

After the grand jury investigation, Dr. Butler decided to close the detoxification hospital. This was done on March 15 (1925), and the venereal disease clinic was transferred to Charity Hospital the same day. During an April meeting of the Shreveport Medical Society, the records of both the clinic and the hospital were turned over to a committee of members for review. The review was made with a favorable report, and that was the end of the matter as far as Shreveport was concerned (Shreveport Medical Society, May 1925). Today, there are very few people in Shreveport who remember anything of the clinic and its stormy history. During two visits to that city, we only met one person, other than Dr. Butler, who had any recollection of the clinic and its operation. This was Dr. R. T. Lucas, a pediatrician in the town for 50 years.

2 | THE PATIENTS

During the era of the clinic, the public image or conception of addicts was that of the stereotypical dope fiend. Addicts were considered to be, on the whole, young, working-class criminals who used drugs primarily for some forbidden and mysterious pleasures. Reading newspapers of the time one is struck by the recurrence of words such as "decrepit" and "derelict." Moral, productive citizens (by implication, the middle classes) were thought to be above such drug use, and "good" people did not use opiates. People who did use opiates or cocaine were thought to be morally inferior, and so beneath human consideration. Shreveport addicts did not fit these stereotypes at all. In general, the patients attending the clinic cut across all class groups; they were middle-aged and relatively productive citizens who held steady jobs (when their physical condition allowed it). Like the larger society, some were more "productive" than others. The list of patients included among other prestigious occupations, four doctors, two ministers, two retired judges, an attorney, an architect, a newspaper editor, a musician from the symphony orchestra, a printer, two glass blowers, and members of rich oil families, etc. There were, as well, day laborers, carnival workers, domestic servants, and other traditional occupations of poor and working-class persons.

Dr. Butler was familiar with the public's misconceptions about his patients. He tells a story about his experience with a grand jury:

> I had been called to testify in front of a grand jury about the clinic. During the course of this testimony, several of the jury members made deprecating remarks about patients, and I felt that it was my duty to put them right about patients. As it happened, one of the windows of the jury room looked out on the tallest building in Shreveport. This building had been built by one of my patients. So I quietly told them so, "Gentlemen, do you see that building out the window there? It's the tallest building in town, isn't it? Well, that building was built by one of my patients." [He had been addicted to morphine for 40 years.] "And furthermore, two of Mr.——— ———, the United States District Attorney's predecessors were patients of my clinic, as are two ministers in town." My patients came from all classes, but few people knew that.

Data on the long-term patients show that two out of every five patients (39.8%) worked in either white collar (19.4%) or skilled (20.4%) occupations, with the highest percent holding semi-skilled jobs (33.5%). Only 6.4% worked in unskilled jobs. These data undoubtedly reflect the economic life of the community. Shreveport, during the time of the clinic, was a rich oil and agricultural center in northern Louisiana, and the people who lived there had plenty of opportunity for good employment.

The most recurrent occupation reported were waiter and waitress; one in ten (10.4%) gave that occupation. Professionals (doctors, lawyers, judges, etc.) made up 3.0%, and 1.8% said they owned their own businesses. Such businesses ranged from a small Chinese restaurant run by a 43-year-old Chinese man who had been addicted for 24 years, to the largest dry goods store in town. Of the 176 women for whom we have data, the majority reported occupations; only a little more than a third (35.2%) said they were housewives.

The following are brief descriptions of five selected patients to demonstrate the range of patient occupations and the extent of their addiction:

> Maude was a 48-year-old nurse who became addicted during the course of her treatment for gallstones. She was addicted 11 years to morphine and reported she took 11 grains a day. She attempted treatment 18 different times, failing each time.
>
> John was a 52-year-old physician who said he became addicted to morphine when he used it for his insomnia caused by overwork. He was addicted 15 years and received 5 grains of morphine a day from the clinic. The clinic staff did not advise detoxification, and the patient died of cancer during the first year he was attending the clinic.
>
> Charles was the editor of a small newspaper in a town near Shreveport. He was 61 years old when he came to the clinic, and was addicted when he was 41. His addiction was the result of medical treatment for rheumatism caused by gonorrhea. He attempted treatment 15 different times before coming to the clinic.
>
> Paul was a $30-a-week glass blower who became addicted when he was 31 years of age and had been so for four years when he applied at the clinic. He began to use morphine to treat his syphilitic rheumatism. He claimed that he used 10 grains a day, but received only 6 grains. The clinic cured his syphilis and detoxified him within the first year.
>
> Mrs. Dash was addicted by her husband, a doctor, when she became "insane" at age 30. She was addicted to morphine for 27 years and lived in Bossier City [a town across the river from Shreveport] during the full course of her addiction.

The mean age of the patients for whom there are records was 35 years. Unlike present populations of opiate users, there were few of the very young. The youngest was 18 years, and there were only 10 (1.3%) younger than 21 years. At the other extreme, there were 30 (3.9%) patients over 60 years; 14 of them were over 70 years of age. The oldest patient was a 82-year-old confederate war veteran who had been addicted 55 years. This veteran had been shot in the head during the Civil War, and was treated with morphine by an army doctor. He received morphine regularly from his family doctor, and when he came to the clinic, he was using 2 grains a day. The second oldest patient was an 80-year-old housewife who had been addicted for 30 years. She attributed her addiction to

asthma and rheumatism, and the clinic staff considered her a "pitiful, incurable case."

Men outnumbered women considerably; for every woman there were three men. This seems to be only slightly more than the present male to female ratio of 4:1. White patients were predominant; nine out of ten patients were white (91.1%). The numbers of black people were extremely small, given their large numbers (17,500 or 40%) living in Shreveport at the time; only 4.9% of 762 patients. Quite obviously opiates were *not* used by black people as they are today. According to the 1920 Shreveport census, there were 10 Orientals living in the town. Two of these ten attended the clinic; both were middle-aged men with long addictions (24 and 18 years).

Drugs Used by Patients

Unlike addicts attending a similar clinic in New York City at the same time, there were very few heroin users in Shreveport. Nearly all the Shreveport addicts used morphine (97.9%), with only four using heroin, and a smattering of paregoric (7), codeine and laudanum (2) users. Users tended to stick with one drug, as only five persons said they were addicted to two drugs (usually heroin and morphine). Persons would occasionally use another drug when they could not get their drug of choice, but there was nothing like the poly-drug use practiced today.

The principal method of use was subcutaneous and intravenous injection. Dr. Butler said but for a small number they were "all vein shooters by the time they got to the clinic. They could hit a vein a lot better than I could. They would take an eye dropper, needle, and cigarette paper and make a very efficient hypodermic." This seems little different from the presently used "works" or paraphernalia. Neither needles nor hypodermics were offered or provided to patients. It was up to them to provide their own. Some rudimentary sterile procedures were taught, but only a very few made any efforts to employ them.

Doses were large compared to present-day use. Upon entering the clinic, each addict was asked how much he was using at the time. These reports ranged from a quarter grain to 30 grains a day. The mean dosage reported was 10 grains a day, but a good number (9.1%) said they used more than 15 grains a day. At the other end of the spectrum, there were only 8 persons who reported using less than 1 grain. These were all persons who were taking opiates for some terminal illness. Male and younger patients tended to claim more drugs used than women and older patients.

Like addicts today, Shreveport patients attempted to get as much of their drug as they could. As a consequence, there was a good deal of bartering and negotiation between the clinic and the patient. The clinic usually set an upper limit of 10 or 12 grains, irrespective of how much the patient claimed. The

median dose according to records was 7½ grains, and Dr. Butler said there was little difficulty in stabilizing the dosage. He believed that the clinic should be honest and aboveboard with patients in every respect. Every patient was told his dosage, and there were no secret or surreptitious attempts to lower a patient's dosage while he was an outpatient. Some were encouraged and supported to lower their dosage, but it was done with the full knowledge of the patient. Detoxification was another thing. When patients entered the detoxification unit, it was understood that they would receive decreasing doses of a substitution drug or drugs. According to Dr. Butler, patients had little difficulty stabilizing their dosage, and there was little tendency to escalate dosage once they reached a certain level. Slight increases were allowed up to 10 or 12 grains, but seldom over these limits.

During the life of the clinic, there were *never* any problems with overdose: "I never found one we could give an overdose to, even if we had wanted to. I saw one man take 12 grains intravenously at one time. He stood up and said, 'There, that's just fine,' and went on about his business." Dr. Butler was also the Caddo Parish Coroner at the time, and said he would have known had any of his patients died from an overdose. He and his staff conducted approximately 100 autopsies on patients who had died, but he could *never* confirm overdose or any other pathological complications from the use of morphine.

Length of Addiction

For the most part, the majority of addicts at the clinic were long-term addicts. More than half (51.7%) reported that they had been addicted for six years or more, and a quarter (24.5%) said they had been addicted for 11 years or more. The longest was a 79-year-old preacher who had been addicted for 63 years. He was addicted by a physician after he had been struck by lightning and lost an eye. The shortest was a 52-year-old man being treated for cancer of the face who had been addicted only four weeks. The mean length of addiction was eight years.

As one would expect, length of addiction was associated with age. The older a patient, the more likely he was to have a long term addiction. Age of initial addiction usually occurred during the patient's twenties or thirties, but there were a few exceptions. One 46-year-old man said he had been addicted to paregoric at 3 years of age. A 36-year-old woman cotton picker said she was addicted to morphine at age 10.

Reasons for Addiction

Contrary to the position (propaganda may be a more accurate term) of the Narcotics Bureau of the Internal Revenue Service at the time which said that the

majority of addicts were addicted for non-medical reasons, the patients of the Shreveport clinic were usually addicted for medical reasons. Only 65 (8.6%) cited non-medical reasons for their addiction, most of whom had become addicted through friendship or association with other users or addicts. By far the majority (88.8%) cited some medical reason for their initial addiction.

Often the medical reason given was some venereal disease; more than a quarter (27.2%) cited syphilis or gonorrhea as the reason for initial addiction. This was usually accompanied by rheumatism, a recurrent secondary symptom of the original gonorrhea or syphilis. In those instances where the patient still had a venereal disease (there were large numbers), the clinic would treat the disease before it expected them to undergo detoxification.

The next most recurrent illnesses cited for initial addiction were respiratory conditions (11.8%) such as asthma and tuberculosis, followed by accidents and injuries (11.1%) and surgical operations (8.4%). It would seem that opiates were a common medical treatment for all these conditions prior to the 1920s, and doctors regularly prescribed them. Perhaps the most surprising of these are asthma and tuberculosis, but one must realize that the incidence of both was high during that period.

Another item of data on the third revision of the patients' cover sheets indicates the role of physicians in the addiction of patients. This was a question asked of 184 persons: "Was a doctor responsible for your addiction?" Of the 184 persons asked this question, more than half (53.1%) said that a doctor *was* responsible, while 41.3% said that a doctor *was not* responsible for their addiction. Unexpectedly, younger patients attributed their addiction to doctors more than older patients did; 63% of those 18-30 years of age attributed their addiction to doctors, while only 45% of those over 40 years did. We had expected, because of the relatively widespread prescription of opiates by doctors in the nineteenth century, that older patients would cite doctors more than younger patients, but this was not the case.

Reasons for the present addiction of patients (at the time of their addiction) were incorporated on the second revision of the face sheet, and were asked of 488 patients. The answers most often cited were "habit," venereal disease, rheumatism, and respiratory conditions. One in five patients (21.9%) attributed present addiction to "the habit," with 1 in 10 attributing venereal disease (12.9%), rheumatism (11.0%), or respiratory conditions (9.7%). The remaining answers were spread over a wide range of other diseases and conditions from cancer to "female troubles." Again age seemed to figure in these responses. Younger patients tended to cite "habit" and venereal diseases more than older patients. Perhaps the incidence of venereal disease was more prevalent among the young.

Chronic Cases

The clinic treated a number of patients with chronic and terminal illnesses. By agreement with local physicians, the clinic became responsible for all persons taking opiates in Shreveport and Caddo Parish. Because of the continuing threats of arrest by narcotics agents, many doctors were quite willing to give up the responsibility of prescribing narcotics to the clinic. Patients usually continued treatment with the doctor, but went to the clinic for the needed opiate. This is illustrated very well by the case record of Harvey Stacy, a 77-year-old resident of Oil City, who had cancer of the tongue. The record contained a letter from the family physician to Dr. Butler:

May 26, 1921
Shreveport, Louisiana

Dear W. P. Butler,

I am referring to you Dr. Harvey Stacy, aged 77, who is suffering with an inoperable cancer of the tongue, involving the floor of the mouth and both sides of his lower jaw. He requires morphine daily to alleviate the constant pain, and his financial condition is such that he cannot purchase it through a physician's prescription in the usual way.

I would respectfully recommend him to you as a worthy patient to put on the clinic, for say 5 grains a day.

Respectfully,
J. M. Ehlert, M.D.

After examination, the clinic considered the patient "uncurable"—he had been addicted for 1½ years—and maintained the man on 5 grains a day. There were other similar cases of long-term addicts who had chronic illnesses. The following selections yield a good cross-section of these cases:

Thomas was a 24-year-old, white factory worker who had been addicted for 8 years. He suffered from "chronic gonorrheal arthritis and tuberculosis of the bone." This diagnosis was ascertained by his family physician's certificate. He died 15 months after he entered the clinic.

Mrs. Evans was a 21-year-old housewife who had become addicted at age 13 years following an operation for gangrene. She was taking 3 grains a day. She died 4 months after she enrolled at the clinic.

Everett ran the local pool hall for which he earned $30 a week. He became addicted when both of his feet were amputated. He was 30 when he came to the clinic, and had been addicted for 9 years.

There was as well another group of chronically ill patients; these were patients who had been using opiates only a short time. In every case, they were persons who were suffering considerable pain, and the opiate was used to give them some relief.

Mrs. Jones was a 71-year-old widow who was receiving 1 grain of morphine a day for cancer of the liver (this diagnosis was certified by Drs. Hendricks, Lloyd and Parsons from Highland Hospital) and was bed-ridden. Clinic doctors would visit her each week and deliver her supply to her daughter.

Rodney was "confined to his bed with a severe case of pyothorax." He was 5'4" and weighed 75 lbs. when he was referred to the clinic. He had been taking ¼ grain of morphine for 3 months. He died in 1923.

T. R. Williams was paralyzed from the waist down. He had been addicted for two months and was taking 2 grains. Notation on the record said that he was "incurable, a very pitiful case."

Previous Treatment

Treatment and "cures" for addiction are not particularly unique to our present era. Cold Turkey, as used by Synanon and other therapeutic communities, was known as early as 1854. Substituting one drug for another, as methadone is used today, and gradual withdrawal of the second drug was first written about in 1880. Terry and Pellens in their classic book *The Opium Problem* list numerous treatment procedures that include hypnosis; substitution of such drugs as belladonna, hyoscene, and cocoa; gradual and abrupt withdrawal; and combinations of substitution and withdrawal. All of these methods are what we now call detoxification treatment. "Cure," and that broad, euphemistic term "rehabilitation," are words that should be used cautiously as regards addiction. At present, there are no effective "cures." Drug free rehabilitation programs are effective with only a very small percentage of addicts, and methadone maintenance is a substitution of one opiate for another.

Shreveport patients reported a broad experience with drug treatment. Nearly half (45.7%) of all the 762 patients reported participating in some treatment, and more than a quarter (26.6%) had been in treatment two or more times. Fourteen (1.8%) patients reported undergoing treatment seven or more times, and a 46-year-old, white-collar worker who had been addicted 21 years reported taking treatment 24 times. Another patient, a 36-year-old nurse, said she had been in treatment 18 times.

As expected, the longer a patient was addicted, the more likely he would go to treatment. Only 15% of 47 patients who had been addicted less than a year reported having gone to treatment, while 56% of those addicted more than 10 years said that they had been treated previously. Such treatment usually took place in a hospital and outside of Louisiana. Ft. Worth, Texas, Kansas City, Missouri, and Memphis, Tennessee, were the sites of many of these treatments. Nearly all of these treatments had failed as "cures," since all who came to the Shreveport clinic eventually had become readdicted after previous treatment. There were some "successes"; some patients were able to abstain (one stenographer did not use opiates for five years after her first "cure"), but half (52.1%) said that they had not been "cured." This seems to imply that they did not finish detoxification. Some were detoxified, but returned to opiates because of recurrent illnesses (14.0%) or new illnesses (5.2%).

Criminality

Present-day addicts in the United States by virtue of Federal, state, and local laws against illegal possession and sales of opiates and paraphernalia to use them, are criminal. Some, but not all, also commit criminal acts to get money to support their opiate habits. Few Shreveport addicts were criminal. As a regular precaution, most of the addicts were fingerprinted routinely. Persons of high status in Shreveport were often *not* fingerprinted. The businessman who owned the largest dry goods store in town was not fingerprinted, nor was the mother of the Commissioner of the Shreveport Department of Safety (Commissioner of Police). These fingerprints were sent to the Shreveport police, Leavenworth, Kansas, and New York State to determine the criminal records of the patients. At that time, there was no central FBI fingerprint identification file, and the largest files were in Leavenworth and New York State. According to Dr. Butler, 14 patients left the clinic and Shreveport after fingerprints were taken; these patients never returned, and the inquiries returned saying that they had criminal records.

There are on record self-reports by patients of criminality. On the second revision of the face sheet, patients were asked if they had an arrest or court record. Of the 489 persons answering this question, 7 out of 10 (70.1%) reported *no* police or arrest record; a quarter (26.0%) *did* report such records. The majority of these self-reports were for minor crimes such as drunkenness, gambling, etc. Several did report serious crimes such as robbery or burglary; one man said he had been arrested for suspicion of murder but was exonerated of that charge.

According to Dr. Butler, the clinic did not want "bums" or "loafers," and admission to the clinic was often refused to persons suspected of being criminal. Such persons were usually forced to leave town, which seems today a rather convenient and high-handed way to avoid the problem of addict crime. It also was a convenient way to pass on trouble to the next town, and in this day of at least some "civil liberties," it is not a recommended method. We do, however, have perhaps current counterparts to running people out of town. The new laws (1973) passed by the New York State legislature that specify mandatory life sentences for sale and possession of narcotics could drive many of New York's addicts to New Jersey or surrounding states. One can expect that the next step will be for New Jersey, Pennsylvania, and Connecticut to pass similarly harsh laws to avoid being considered havens for addicts.

Clinic staff also took precautions with cocaine users. Cocaine at that time was considered to be an extremely dangerous drug. We say at that time because, while the drug is illegal in most countries today, it is not considered dangerous by users. On the contrary, it is today a drug of high prestige, used by the wealthy and considered far less dangerous than opiates (especially as regards

physical withdrawal) or amphetamines. Cocaine is today the drug of the "jet-set."

The clinic staff asked patients, in the second revision of the cover sheet, if they used cocaine. Of the 480 persons asked this question, only 14.2% said they had ever used cocaine, and many were careful to say that it had been months or years ago. One might, given the extreme onus attached to the drug at the time, expect that patients held back or were less candid with the clinic staff about cocaine use.

The Southern Rural Addict

One of the continuing efforts of both researchers and clinicians in the field of addiction has been the search for some method to type addicts. Most often these efforts have been around psychological characteristics or functions of either individuals or the actions of the drug. These efforts have not been very successful; clinicians find most types of little use, and the addicts rarely fit the types.

Addicts have been designated at one time or another addictive personalities, escapists, double failures, sociopaths, and psychopaths; but the truth about present-day addicts is that they tend to elude all of the labels attached to them. This is most apparent in recent ethnographic investigations that study the addict in his own environment. On the street, in his own community, the addict appears to be quite different from descriptions that come out of jails, mental hospitals, or treatment programs. Patrick Hughes, in a study of a Chicago "copping area" found no particular psychopathology among addicts (Hughes et al. 1971). Edward Prebble and John Casey found that addicts on a New York street were *not* necessarily passive, withdrawn, or escapists as they have been described by researchers in institutions (Prebble and Casey 1969). Michael Agar, in an ethnographic study of Lexington Hospital, found that treatment staff would resort to their own white middle-class values or *a priori* theories in their dealings with addicts, and that addicts' own experiences did not necessarily fit these value systems or theories (Agar 1973).

If we are to truly understand and treat the behaviors of addicts, perhaps another approach is necessary—one that does not set the addict apart from the non-addict or society. In society, there are most certainly working typologies of people—typologies that categorize people according to wealth, social class, occupations, urban-rural, and geography. Poor people have different experiences from the rich; different class groups have different cultures; musicians are quite different from attorneys; Westerners and Southerners are different from each other and from Northerners. People know and use these typologies. Addicts may demonstrate similar differences. Rich addicts do not usually go to jail; different

classes use different drugs; large-scale drug dealers have different statuses from the run-of-the-mill hustlers—just to name some of the most obvious differences.

Geographic differences are another consideration as a typology. John Ball, in an article in *The Journal of Criminal Law, Criminology and Police Science* in 1965, was one of the first to notice the differences between Northern, big-city addicts and Southern, small-town addicts at Lexington Hospital. Very briefly, the Southern small town addicts were usually older, used doctors as a source for legal drugs, and used morphine. Northern, big-city addicts were younger minority members, went to illegal sources for their drugs, and used heroin. Our data supports Ball's "Southern type," and suggests that the model is at least 50 years old.

Another comparison supports the idea of geographic types. This is the comparison with data presented by S. Dana Hubbard describing the patients of

COMPARISONS OF DATA, NEW YORK CITY AND SHREVEPORT CLINICS

	New York City Clinic		*Shreveport Clinic*	
	Total Number	Percent	Total Number	Percent*
Sex				
Male	5,882	78.8	582	76.4
Female	1,582	21.2	176	23.1
Ethnicity				
White	6,429	86.2	694	91.5
Black	1,035	13.8	37	4.9
Other	–	–	2	0.3
Age				
15–30 years	5,103	68.5	299	39.2
31–40 years	1,921	25.7	261	34.2
41 and over	440	5.8	172	22.6
Stated Causes of Addiction				
Illness	1,994	26.7	562	74.1
Non-Medical	5,470	73.3	65	8.5
Length of Addiction				
Under 1 year	272	3.6	51	6.7
1–5 years	2,796	37.4	288	37.8
6–10 years	2,838	38.0	207	27.2
11–15 years	1,103	14.8	96	12.6
16 and over	461	6.2	87	11.4

*Sums may not equal 100% because "no answer" and "data unavailable" codes have been excluded from the tables.

the New York City clinic (which was operating at approximately the same time as the Shreveport clinic). Dr. Hubbard, in an article published in the *Monthly Bulletin of the Department of Health, City of New York* in 1920, presented data on the 7,464 patients who came to the clinic. This data is presented here to facilitate the comparisons.

Differences between patients of the two clinics are dramatic. New York patients were a good deal younger; more than three-quarters (78.2%) were under 30 years of age, while only 39.2% of the Shreveport clinic patients were that age. Breaking the numbers down further, we find that more than a quarter (27.8%) of the New York patients were under 19 years of age, while only 1.3% of the Shreveport patients were under 20 years. New York addicts obviously started their drug use much earlier than Shreveport addicts.

Differences in self-reports on the causes of initial addiction are equally dramatic. Shreveport addicts cited medical reasons for their addiction (74.1%), while New York addicts were largely addicted for non-medical reasons (73.3%) with most citing associations.

Another difference between the clinics was the type of drugs used by patients. While the Hubbard report of the New York clinic did not mention or discuss the drugs used, an earlier report written by Royal S. Copeland which appeared in *American Medicine* (1920) did. Dr. Copeland's study was not, however, of all the New York patients, but of the first 3,262 (or roughly half) of the total number who attended the clinic during its eleven months of operation. Comparing the two clinics, Shreveport addicts were predominantly morphine users (98.4%), while New York addicts were largely heroin users (66.5%). New York patients were also inclined to use combinations of drugs—more than a tenth (11.9%) said they were multiple drug users, while less than one percent (0.6%) of the Shreveport patients reported combinations of drugs.

COMPARISON OF DRUGS OF CHOICE, NEW YORK CITY AND SHREVEPORT CLINICS

	New York City Clinic		*Shreveport Clinic*	
	Total Number	Percent*	Total Number	Percent*
Drugs of Choice				
Morphine	690	21.1	746	98.4
Heroin	2,178	66.5	4	0.5
Cocaine	6	0.2	–	–
Combinations of Drugs	388	11.9	5	0.6
Other	–	–	5	0.6
Totals	3,262		760	

*Sums may not equal 100% because of rounding.

The pattern of heroin use by New York addicts appears to have been a relatively recent phenomenon at the time. According to a little known study conducted by W. A. Bloedorn (appearing in a 1917 *U.S. Naval Medical Bulletin*) of addicts admitted to a Bellevue Hospital drug program during the period 1905-1916 the use of heroin appeared suddenly to accelerate during and after 1914, while the use of morphine and cocaine declined. Up to 1910 there were *no* heroin addicts among admissions, but during the years 1911-1913 there was a sudden appearance of heroin addicts. In 1910 there appeared one heroin addict with a slow but gradual increase to 3 in 1911, 9 in 1912, and 21 in 1913. Suddenly the numbers jumped in 1914 to 146, which was a quarter (25.6%) of the 582 addicts admitted that year. Just two years later, in 1916, the majority were heroin users (81.5%). We expect that the first introduction of heroin was illegal and smuggled into the United States, but as it got around addicts began to request it from doctors. Heroin is more powerful and euphoric than morphine and New York addicts quickly learned this. Soon the majority were heroin users; by 1920 two out of every three addicts attending the New York clinic used heroin (66.5%) while only one in five used morphine (21.1%).

Heroin use did not, however, spread as quickly outside of New York. Dr. Pearce Bailey, a well known Army neuropsychiatrist who treated military addicts during World War I writing for the magazine *The New Republic* in 1916, made the following observation:

> The heroin habit is essentially a matter of city life, as in rural communities it does not exist as it does in New York. For example, the records of the State Hospital at Trenton, New Jersey, which recruits from a rural community, show that of the drug addicts who have gone there since the passage of the Harrison law, not one has been a taker of heroin and not one has acquired the habit through social usage [Bailey 1916].[4]

Clearly, the geographic typology New York urban as distinct from rural (which later became known as the Northern urban versus Southern small town) are very distinct and were established nearly 60 years ago. Data from the Shreveport and New York clinics support this.

War Veterans Patients

Both the Civil and Spanish-American Wars saw relatively large numbers of addicted veterans returning home. Army doctors in both wars used morphine extensively in treating war injury, and many of the injured became addicted. Indeed, the large numbers of addicts in the United States during the nineteenth century are often attributed to the Civil War. During the era of the clinics, it was anticipated that World War I would also contribute large numbers of addicted

[4] We learned of both the Bailey and the Bloedorn writings from David Musto through Meme Clifford.

veterans. These veterans would be coming home at an inopportune time—doctors would not be allowed to prescribe for them—and it was expected that there would be some demonstration or protest on their part.

Such protests and demonstrations did not take place in Shreveport. The numbers of addicted veterans were very small; only 19 out of 762 patients were war veterans, and of these 16 were from World War I. A quarter (4) of the 16 said they had been gassed in France and became addicted during treatment for the resulting respiratory ailments. One attributed his addiction to "shell shock." Another was an invalid after suffering gunshot wounds. This 31-year-old was using 20 grains a day when he came to the clinic and said he became addicted as the result of chronic amoebic dysentery before he was wounded. The clinic considered him "incurable" and maintained him on a steady dose of 12 grains a day. Two of the 16 responded very well to treatment. Both entered the treatment within 5 days of their arrival at the clinic and were discharged as successful "cures."

No special attention was given to veterans, as all patients but the obvious criminal were treated well. However, special concern for the veteran's benefit is illustrated by the fact that two were allowed to transfer from the clinics in New Orleans and Alexandria to Shreveport. One of these was a Spanish War veteran who was considered incurable and was maintained without being expected to take a cure. He was one of two Spanish-American veterans. The single Civil War veteran was the 82-year-old confederate soldier described earlier.

World War I veterans constituted only 2% of the clinic's long-term patients. If, as it has been said, one of the reasons that the clinics were opened was in anticipation of addicted veterans, then there were clearly not enough veteran addicts in Shreveport to justify a clinic. This might have been a contributing reason for the change in national policy to close the clinics. Veteran addicts did not show up as expected, but there were certainly enough non-veterans to justify keeping the clinics open.

3 METHODS OF TREATMENT

When doctors in Shreveport were threatened with possible indictment for treating addicts, they became understandably gun-shy. Addicts in the public stereotype were lumped together as "dope fiends;" and while doctors themselves might have subscribed to the same stereotypes, they also knew that there were addicts who did not fit society's image of them. Some addicts were rich and powerful; some were seriously ill, elderly, and infirm, who were taking morphine because it gave them some relief from constant suffering. Very clearly, it was *not* for the stereotypical addict, the dope fiend, that the clinic was established. According to Dr. Butler, the clinic was established "as a temporary stopgap to treat the aged and infirm." "Narcotics shy" doctors who did not know what to do with their rich patients, their chronically ill or elderly addicts, felt that the clinic could handle these patients for them, and so it did.

Maintenance was only one of the clinic's objectives, and not necessarily the primary one. The dispensary treated a wide range of illnesses. Addicts came to the clinic with much more than their addiction; many suffered from rheumatism and arthritis, respiratory conditions, and venereal diseases. The clinic felt that it was unrealistic to attempt a detoxification while an addict was ill, so the first thing given a new patient was a complete physical examination. The examination was made not only to establish the patient's addiction, but to determine his or her general health.

If, during the course of the examination, the patient was found to be ill, the patient was treated for the illness before anything else was expected of him. The dispensary was particularly sensitive to venereal diseases. After its first month of operation, it was both a narcotics and venereal disease (euphemistically called a "social disease") clinic. Wasserman tests were taken routinely; approximately two out of every five addicts (40%) were also treated for venereal diseases. But

this was only part of the treatment offered. The clinic had use of the facilities of two hospitals that treated a wide range of conditions.

The majority of patients fell into this category—persons who were *ill as well as addicted.* After treatment for the illness, the patient was prepared for detoxification. This preparation usually consisted of some gradual reduction in his or her morphine dosage. After reaching a certain dosage, the patient was placed in an isolated detoxification ward. All patients, unless chronically ill or very old, were expected to undergo detoxification, and considerable pressure was exerted on the patient in that direction. If, after a specified time, a patient resisted, he was dropped from the clinic. This usually meant that he had to leave town because he could and would be arrested by the clinic's inspectors; it was still an offense to be an addict. Addicts who attended the clinic and took treatment were tolerated; addicts who did not were not tolerated.

There was a second class of patients observable from the records of the clinic. These were the "healthy" addicts, i.e., persons suffering only from their addiction. This group was expected to undergo detoxification immediately. There were numerous records containing notations that treatment was started either immediately or three or four days after the person entered the clinic. These were often the youngest patients, who had been addicted for only a short time. Many resembled present-day addicts in that they had become addicted through their association with other users or addicts, rather than as a result of some illness or disease. Addiction without some physical basis was in most cases considered eminently treatable, and the clinic staff thought such persons had a good prognosis. This is a far different attitude than is generally held today. Today, addicts who use drugs for non-medical reasons are stigmatized as mentally ill or immoral, and their prognosis is negative to say the least.

The third and last group of patients were persons considered "incurable." These were either persons who suffered some chronic illness, or who had been using opiates for long periods (15, 20, or even 30 years) and were not expected to undergo successful detoxification. This negative prognosis was established after at least two physicians (sometimes three) had made independent examinations. Often patients came to the clinic with certificates from their own private physicians. In such instances, a second examination was made to corroborate the private physician's diagnosis.

Once such a diagnosis was made, the patient was maintained on a regular dosage, and there was no expectation that he should undergo treatment. This was the only category of patients maintained indefinitely; all others were expected to undergo treatment for their addiction. Roughly a third of all the patients were considered "incurable." Many were invalids or were suffering from terminal or incurable illnesses. Often the doctors of the clinic would make house calls to these patients because they could not get to the clinic. As could be expected, many of these patients died while enrolled at the clinic; more than 100 patients died during the history of the clinic.

It was these incurables who created the clinic's problems with the Federal government. The Webb decision specifically stated that:

> An order purporting to be a prescription issued to an addict or habitual user of narcotics, not in the course of professional treatment but for the purpose of providing the user with narcotics sufficient to keep him comfortable by maintaining his customary use, is not a prescription within the meaning or intent of the [Harrison] Act; and the person filling such an order, as well as the person issuing it, may be charged with violation of the law.

It was difficult to establish whether or not the maintenance of those chronically ill fell within this negative definition of professional treatment (it was not maintaining a customary dosage). Strictly speaking, the patients were being kept comfortable by maintenance of a customary dosage, but they were also being given morphine to relieve their pain and suffering. The latter had been a common medical practice and remains so today. Doctors considered it part of professional treatment, but it was difficult at that time to determine just how the Federal Narcotics Division would interpret the practice. The definition, or rather the lack of definition, put doctors in a quandary about whether to treat such patients. The clinic got doctors off the hook but put itself in the same kind of jeopardy.

Controls

Very early in the clinic's history, it was realized that there had to be strict accounting for dispensing and certain controls on the addicts attending. Dr. Butler was and is a meticulous man, so he was aware that the clinic was going to have to keep detailed records of the drugs dispensed. Two procedures were developed, one for persons coming to the clinic regularly and another for patients who had to somehow be treated specially. For the first, a registry was set up. Each day the patient came to the clinic, his dosage and the money he paid were recorded with his signature witnessed by the dispenser.

For special cases, i.e., persons who were ill or bedridden, a special form was devised that was numbered serially. These forms were, like the registry, strictly controlled; each form served as a receipt for the dose, payment, and person receiving the drug. These records were kept diligently and reviewed periodically by local officials, narcotics agents, and various inspection committees. Throughout the history of the clinic, these records were never faulted or questioned through various reviews, some of which were very intense and critical.

Not unlike today, addicts during the 1920s were subject to control. Shreveport was not an exception. More than once Dr. Butler has said that "vagabonds and loafers" were not tolerated, but this is probably extreme. Patients were watched closely by two inspectors: John Hudson and Teddy

Voight. Their primary concerns were that patients had a regular address, worked, did not sell their drug supplies or get in trouble with the police. Persons who did not comply were not allowed to attend the clinic. Addresses of patients who were not already known by the clinic staff were checked by the inspectors regularly; so were jobs, but the inspectors were careful not to jeopardize the patient's relationship with his employer—this was stressed by clinic officials and apparently worked, judging from the variety of professionals who were patients.

The inspectors' jobs were not, however, simply to control the patients. In fact, a good deal of their work was to assist them. Both men were well known in town and assisted a number of patients to obtain jobs, housing, and other necessities. Dr. Butler was pleasantly surprised with the sympathy of John Hudson who, as well as being his inspector, was also on the police force.

Captain Hudson (the title was honorific as is often the custom in the South) was perhaps the character on the staff. He seems to have played his policeman's role with considerable flourish and style. He was known as being fearless and somewhat ferocious when it came to offenders. Before joining the clinic staff, he had been instrumental in capturing a well known bank robber from Oklahoma in a dramatic shoot-out in Oil City, one of the boom towns just north of Shreveport. Sidney Howard, in his article for *Hearst's International* (June 1923), described him firsthand as being colorful:

> He would lend personality to any city hall. Longer ago than most men remember, a Mexican made a swipe at him with one of those curved Greaser knives. The blade slipped neatly between his ribs and amputated a considerable segment of Captain John's heart. It never phased him. It only added to his general prestige and reputation for the remarkable. Right now, today, he can still increase that reputation and prestige by swimming an icy river in pursuit of a fugitive who has stolen the only boat.

Unofficially, Hudson was Shreveport's narcotics agent. He knew all the addict-patients, and was quick to spot any unusual dealings among them. He held a tight rein on patients suspected of breaking the clinic rules. The other side of his nature was startling to Dr. Butler; Hudson could also be gentle and sensitive when the situation called for it.

Another method of control used was fingerprinting. During the first year, the clinic attracted a large number of persons from outside Shreveport, and many were suspected of being criminal or having criminal records. Fingerprints were taken to control this group (this was discussed earlier). After the first batch of prints were made, 14 persons dropped out of the clinic and left town. When the reports were returned, all were known to the authorities, and some were wanted on warrants. Fingerprinting was continued routinely after that.

Morphine Maintenance

The clinic was open four days a week (Monday, Tuesday, Thursday, and Saturday) from 8:30 to 10:00 in the morning and 4:30 to 6:00 in the evening.

There was, however, a certain flexibility about the operation. Patients with good reasons could come other times, and bedridden patients were visited by the clinic staff.

There were no efforts to supervise injections. Addicts were given their supplies of morphine in solution, labeled with the amount and the cost, and expected to take it on their own. Most patients knew very well how best to use the drug, but a few who had difficulty were given some instructions. Patients, according to Dr. Butler, managed their supplies quite well. Clinic staff were fair but firm. Once a dosage was established, there was little negotiation between patients and staff. Escalating tolerance was not a particular problem; after a few weeks, patients would remain at a stable dose called a "drug balance." If the addict was not making some preparation for detoxification, he was kept at the same dosage. Patients were not expected to reduce their dosage unless they were preparing themselves for detoxification. Incurables were kept on the same dosage for long periods with little fluctuation. There was little relationship between the length of addiction and the size of dose. Often, it was the young, short-term addict who used the most drugs.

Patients did not show any obvious signs of sedation or euphoria at the clinic. Like other non-addicts, some were active and lively while others were rather lethargic. While it was true that many experienced severe illnesses, most patients' attitudes were cheerful and hopeful. For a short while during the first year, a group of patients formed a patient group that met regularly to discuss their common problems. This group was instrumental in bringing a number of illegal peddlers to the attention of the investigators. They were obviously making an effort to police the town and keep their good thing going.

Clinic staff did not notice any particular negative effects with the use of morphine. On the contrary, morphine was considered to be rather benign in its effects on users, unlike the myriad misunderstandings which surround the issue of opiate effects today.

Detoxification

Detoxification, called treatment or "cure" by the staff, was begun by the clinic in September 1919, five months after the clinic was opened. It is not clear how this treatment began, but we expect that it was suggested by Dr. Dowling. Dr. Dowling served on the AMA and American Public Health Association drug committees, and was probably aware of the treatment policies being forced on the AMA by the Federal Narcotics Bureau. During the summer of 1919, the Federal Bureau of Narcotics declared that addiction was curable and that it should be done in hospitals and not outpatient clinics. This policy was part of the recommendations of the AMA drug committee and was eventually accepted as AMA policy (Kramer 1973). Dr. Dowling was, at that time, in close contact

with the clinic and with Dr. Butler, so one would expect that he would relay information on such drug policies.

This treatment was undertaken first at the Charity Hospital, a state hospital in Shreveport, and then in a separate "hospital" rented by the clinic in 1921. The move out of the Charity Hospital to the separate facility resulted from the suggestion of the State Board of Health to establish a separate hospital to treat addicts in the February 1921 meeting that closed the Alexandria and New Orleans clinics. It was obviously a survival tactic, both to satisfy requirements of the state and to get out of the state hospital. Dr. Dowling had jurisdiction over the state hospital.

The techniques used by Dr. Butler and his staff worked very well. The specific method was not particularly unique. Dosages were reduced initially in the clinic; and when patients went to the hospital, they were given substitute drugs (usually oral opiates with various sedatives of the day) which were reduced over a four- or five-day regimen. This was a common treatment method of the day, and not particularly different from present-day detoxification procedures. Today, doctors use methadone (a synthetic opiate) in combination with other tranquilizers and sedatives, and reduce the dose over a four- to seven-day period.

The unique feature of the treatment was the confidence and training of the staff. A strict isolation and control procedure was established which worked quite effectively. Patients were searched thoroughly before entering treatment, and no visitors were allowed during the stay. Attendants were present in the hospital 24 hours a day to protect security of the procedures.

Upon entering treatment, each patient had to sign an agreement that if he could not endure the withdrawal in the hospital, the staff could place him in jail for a period during the dose reduction. This was done to assure a complete withdrawal in the event that the patient decided to change his mind. Actually, the jail was used only rarely, but the *threat* of incarceration was used regularly to let the patient know the steadfast intent of the treatment staff.

Patients were expected to stay in treatment for at least two weeks, and sometimes as long as a month. Detoxification took place within the first week. The procedure worked very well, and most patients were successfully withdrawn by the fifth day, although most did not realize it so soon. Patients usually expected that the processes would be more difficult and longer than they actually were. The remainder of the time was spent in convalescence. Some of the poorer or more disadvantaged patients were given an additional convalescent period in the county work farm (actually a county jail). This was a voluntary arrangement, with the patient being allowed to leave whenever he wanted to, but some were encouraged to stay as long as they could.

After detoxification, there was little in the way of follow-up. Patients were required to deposit $25 (in weekly installments) with the clinic prior to undergoing detoxification. This was returned to them upon release so that each

patient would leave treatment with some money (poor patients who were not able to deposit $25 were given direct financial assistance). Once a patient left the treatment facility, there were no formal arrangements to see him or her again. Some patients came back to visit or wrote to the staff, but there were no formal procedures to find out how patients adjusted.

Some patients were known to relapse, but it was Dr. Butler's impression that the majority did not do so while the clinic was operating. Several reasons are given for this. Opiates were scarce; there was little, if any, black market while the clinic operated (this is supported by newspaper investigations), and there were no *other* legal supplies. Very few relapsed patients returned to the clinic. It was, however, a known policy that an addict could *not* come back unless he had some physical reason (recurrent illness) for his relapse. Another reason given was that inspectors at the clinic did not find any obvious relapse cases in the town. Shreveport was at the time a relatively small city, and the inspectors were efficient. Relapsed patients would have had to leave town to avoid detection. One could expect that some did just that.

Relapse is very much a part of the modern addiction process. Addicts now tend to relapse at phenomenally high rates (O'Donnell 1965). Some of this is obviously intentional. Addicts often use detoxification as a service or a haven in times of trouble rather than as it is usually intended by staff of treatment programs. They seem to use treatment programs as part of a survival tactic; if you will, part of an extensive repertoire of survival. Shreveport addicts, as reported in the previous chapter, experienced a lot of treatment before they came to the clinic, and had done their share of relapsing. One could expect that many would also relapse after taking treatment at the clinic.

We expect that perhaps the relapse rate for Shreveport addicts was higher than Dr. Butler's impression. There is some evidence to support this. In February 1925, two years after the clinic closed, Dr. Oscar Dowling with Federal agents conducted a large investigation that resulted in the arrest of two peddlers, 13 addicts, seven doctors, and six druggists. Although it is not known whether any of these addicts attended the clinic, one could expect that some had. It would also appear from the number of addicts arrested, that the addict population was sizable (*Shreveport Journal,* March 3, 1925). By Shreveport standards, this was a large number of arrests—far more than was experienced in 1919 before the clinic opened.

FUNCTIONING OF THE CLINIC

Staff and Financing

The clinic was essentially a part-time operation, and operated after the first month as both a narcotic and venereal disease clinic. State money was available for the VD clinic, so the narcotics clinic rode on its financial coattails. There were approximately 15 persons, give or take two or three, who worked in the

combined clinics. Dr. Butler supervised, and was assisted by Dr. Paul (who was also the assistant coroner). A third doctor, Dr. Boyce, was brought in periodically to conduct physical examinations. The rest of the staff consisted of a chief and assistant clerk, a pharmacist and dispenser, a superintendent nurse, guards, attendants, and inspectors. The inspectors, Captain John Hudson and Teddy Voight, were not paid by the clinic, but were contributed by the city government.

Morphine was bought by the clinic for 2¢-3¢ a grain and sold to the patients for 6¢. This was less than both the pharmacists' (10¢-15¢) and the peddlers' (50¢-$1) prices. There were no other fees or charges at the dispensary. Detoxification at the Charity Hospital before March 1921 was free. After 1921, when the clinic and treatment hospital were moved, there were fees charged for detoxification for those who could afford it.

State financial support for the clinic was indirect. There was money for the VD clinic, which paid the salaries of most of the staff. The Police Jury of Shreveport (the city government) contributed approximately $400 each month to both clinics. This, with the relatively small amount resulting from the sale of morphine, was used to supplement or pay salaries. When the dispensary was closed in 1923, the State Board of Health agreed to pay $100 for each patient detoxified at the hospital.

At one time, agents of the Narcotics Division claimed that the director of the clinic was making money off the clinic. This was one of many wild claims that was easily disproved. After the clinic and treatment hospital were closed, Dr. Butler asked the Commissioner of the Shreveport Department of Accounts and Finance to make an accounting of his salary and expenses during the years the clinic operated.

Both clinic and hospital were open a month and a half short of six years (the clinic was open three years and nine months), and Dr. Butler's total salary was $6,000, with $3,854 for expenses. The results obtained by averaging these two figures over the six years are $1,000 salary and $642 expenses per year. Even in the 1920s, this was not very much money; in fact, one of the patients reported a monthly income higher than the two *yearly* averages.

	Clinic		*Hospital*	
Years	*Salary*	*Expenses*	*Salary*	*Expenses*
1919	None	None	None	None
1920	None	None	None	None
1921	$1,350	$460	None	$ 489
1922	1,800	407	None	524
1923	150	None	$ 900	1,660
1924			1,350	314
1925			450	
Totals	$3,300	$867	$2,700	$2,987

4 | COMMUNITY SUPPORT

Dr. Butler's elected post, held for 48 years (twelve four-year terms) as Parish Physician and Coroner was a particularly good base from which to run the clinic. The position gave him rather broad powers to control the addicts who came to his clinic. With a warrant, he could arrest any peddler or addict who came to his attention. Under state law, drunkenness was an offense, and drunkenness included the use of narcotics. He used this power from time to time, but with considerable discretion. His experience with addicts in jail made him realize that incarceration did them little good, and he was inclined to be much more humane in his dealings. His patients knew of his powers, however, and he occasionally had a patient "arrested or run out of town" if he violated laws or rules of the clinic.

The post also put him in close relationships with the local government, the police, and the judiciary—with Mayor Ford, Sheriff Hughes, Judge Jack, and District Attorney Mecom. His principal office was in the County Court House, and he saw many of the people who later supported him regularly, some almost daily during the normal course of his work. Many he had known since childhood, and they knew him always to be fair and honest with others. Dr. Lucas, who has known him for over 50 years, said he was one of the most respected men in town during the time the clinic was open. People in Shreveport still think of him in those terms.

Among his peers, the physicians in town, he was held in the same high esteem. He was always an active member of the Shreveport Medical Society and held numerous offices, including the presidency of the Society. He owned and ran a laboratory that many doctors used regularly; he saw them often professionally.

Support for the clinic was not by any means automatic. Shreveport had its share of skeptics and prejudiced citizens. The dope fiend stereotype of the addict was at its height; addicts were generally considered second-class citizens

and somehow beneath human consideration. Dr. Butler continually came up against persons who held these images of addicts and believed that addicts did not deserve help. One such person was the Shreveport Commissioner of Public Safety, who was an early critic of the clinic. Dr. Butler tells an interesting story about this man:

> One day, I guess it was during the first few months the dispensary was open, I was talking with the Commissioner of Public Safety and a couple of prominent businessmen in town, and the Commissioner started to criticize my clinic in front of the other gentlemen. He said that they were a no-good bunch and did not deserve any help or treatment. He concluded his statements by saying that if he had his way, he would run the whole lot into the river.
>
> Well, I was bothered by this because he was criticizing me in front of these other gentlemen. When the other men left, I asked the Commissioner if I could speak to him in private. We went into his office, and I asked him if he really meant what he said about running all the patients into the river.
>
> He said he did, and so I told him, "I'm going to violate the confidence of one of my patients now because I did not like what you said in front of those other gentlemen. I want you to know that your mother is one of those patients that you would like to drive into the river."
>
> That really took him back. His mother was a 75-year-old lady who suffered terribly from asthma. She had been addicted for over 20 years, and her own son never knew it. We got to talking about her after that, and he said he never suspected it. He noticed that she had been spending a lot of money that last couple of years, but he never knew why.
>
> After that, there wasn't anything the Commissioner wouldn't do for our clinic. I took him up on his offer of help. I got one of our investigators from him.

Dr. Butler did not consider himself a politician in the usual sense of the term; he considered himself a physician and scientist first, and a politician because his job required that he be elected. His political life was unusually benign. Elections for his office were usually uncontested by any serious candidate. As a matter of course, he was accepted as being the best man for the job.

He recalls only one unpleasant political incident. This occurred in 1928 when a well-known doctor in town, Dr. S———, tried to get an old addict patient of the clinic to sign a statement that Dr. Butler had readdicted him to morphine after the clinic closed. Dr. S——— offered money to the man, and then threatened to have him arrested for being an addict if he did not sign the statement. The doctor said he wanted to publicize the statement to discredit Dr. Butler before his re-election for Parish Physician.

The old patient did not sign the statement, but went to Dr. Butler instead. He told Dr. Butler of the approach, and signed a statement, with a witness, describing it for Dr. Butler. A few days later, Dr. Butler met Dr. S——— on the street and told him of the patient's visit. Dr. S——— did not deny it, but claimed "that everything was fair in love, war or politics" (notarized statement, July 27, 1928).

5 | CONCLUSION

Reading history, one is continually reminded that knowledge is not particularly unique to our generation, era, or century. Men seem to continually forget their own technology and culture, and attempt over and over to re-invent the wheel. This is particularly true of present-day knowledge of the effects of opiates and treatment for addiction. Any doubts of this are easily dispelled by reading or re-reading Charles Terry's and Mildred Pellens' *The Opium Problem* (1928). Published more than 45 years ago, it is literally a compendium of all the present knowledge of opiates, addiction, and effective treatment. Any new compendium would show only minor revisions or additions. John Ball, a scrupulous researcher in his own right, wrote in the foreword to the new edition that it was "remarkable and somewhat surprising" that the work of Terry and Pellens is still so relevant.

More remarkable still is the fact that we do not utilize the knowledge, and even repudiate it. For nearly forty years, the narcotics policies of the United States, diligently supervised by the Federal Bureau of Narcotics, grossly exaggerated the effects of opiates, and denied the value of any kind of drug maintenance. Instead of using the knowledge we had about reasonably effective treatment, we simply incarcerate or institutionalize addicts. The results are staggering—increasing black markets, epidemic use, and criminalization of the addict.

The Shreveport experience illustrates these wrongheaded policies very well. The town was told to tackle its drug problem (to control drug prescription and treat addicts), did it well, and then was told that it was breaking the law and could not continue. Dr. Butler and the staff of the clinic developed workable treatment strategies to the satisfaction of addicts, local physicians, town officials, the police, and visiting experts. Everyone agreed that the clinic was run well and contained the problem in Shreveport—everyone but the policymakers of the Narcotics Division of the Prohibition Unit.

Unfortunately for Shreveport, its addicts and hundreds of thousands more over the next 40 years, the policy against maintenance and outpatient treatment

was made hastily and arbitrarily. Narcotics agents stacked the deck. They planted their own drug experts in medical committees, surveyed those favoring their policies, and used the worst examples as clinic models (Musto 1973; Kramer 1972). New York State had the worst clinics in the nation, but no consideration was given to clinics that were run well and seemed to work. Once the policy was made, narcotics agents enforced it vigorously. They closed down the good clinics with the bad, and ran roughshod over state and local governments. Doctors and officials who did not comply with their edicts were threatened with federal prosecution. Shreveport, in the end, but after a good fight, had to give in to the pressure.

Although Shreveport lost in the short run, they eventually were vindicated by history. Opiate (methadone) maintenance in the same kind of outpatient clinic was begun anew in 1966, and is now accepted treatment for addicts. Presently there are approximately 40,000 addicts being treated in over 450 programs. The vindication was very slow in coming. It took us over 40 years to realize that jails and hospitals could not do much for the addict. Shreveport was, as Charles Terry said, years ahead of its time (Musto 1973:175).

Another lesson to be learned from the Shreveport experience is that morphine used in a close clinic setting is a relatively good maintenance drug. From time to time in recent years, morphine (and heroin) has been considered half-heartedly as a maintenance drug. During 1971, the Vera Institute of Justice, a non-profit organization concerned with criminal justice issues, proposed a heroin clinic for methadone dropouts in New York City. In collaboration with doctors from the Yale Medical School, they formulated a detailed plan that is still being considered. The proposal lacked the support of New York City's Mayor John Lindsay. Heroin maintenance, unlike methadone, is very much a political issue in New York City, and one that Mayor Lindsay has chosen to skirt.

Among drug experts, who are usually very well "established," there have been similar reactions. When Dr. Joel Fort, from Fort Help in San Francisco, suggested at the Fourth National Conference on Methadone Treatment (1972) a limited clinical experiment with heroin, there was an uproar of criticism. Most of this came from persons in methadone programs who somehow felt threatened by the idea. In itself, the proposal was very modest and seemed to expect and predict failure. It was made in the spirit of trying it just to show everyone that it would not work.

The last halfway serious effort in the United States was made by Drs. Marie Nyswander and Vincent Dole at Rockefeller University in 1965. They maintained two addicts on morphine for three weeks, but gave up the idea. Dr. Nyswander described the experience in Nat Hentoff's book about her, *A Doctor Among the Addicts:*

> Well, we started the [two] addicts on morphine, a quarter of a grain four times a day. In three weeks, in order to keep them comfortable, we had to go up to eight shots a day

> of an increased dosage, a total of ten grains a day. Obviously, it was going to be impractical to devise a maintenance program on morphine. Also, on morphine the patients were rendered practically immobile. Much of the time they sat passively, in bathrobes, in front of a television set. They didn't respond to any of the other activities offered them. They just sat there waiting for the next shot . . . [Hentoff 1968].

Obviously the experiment was too small and too short in duration. Over time, the addicts might have been stabilized. Some of the inactivity of the patients could probably be attributed to the hospital setting. There was little expected of them, and there is little one can really do in a hospital that is not make-work or contrived. In any event, Drs. Nyswander and Dole preferred the observed effects of oral methadone, and went on to develop methadone maintenance. That, in itself, was a major achievement.

Dr. Butler's experience at Shreveport was much larger and longer—at least 760 patients over four years. Patients were not in a hospital, with the usual restrictions of that kind of setting, but living in their own community. It was also his experience that maintenance patients could be stabilized on a steady dose when "drug balance" was reached. This, naturally, varied from patient to patient, but the average dose was 7½ grains. Patients also worked and were, like non-addicts of the town, relatively productive. The clinic expected them to work and support themselves, so they did. Lethargy or inactivity was not a particular problem. There were more things to do than sit around waiting for their next shot. In fact, there were very few problems with the use of morphine. The program experienced *no overdoses,* and only a few complications from the repeated injections.

The reasons for the success of the clinic probably resulted from attitudes of the staff. They accepted the drug as necessary for some patients (not all; the majority were expected to detoxify), but set certain limits on its use. Dosage was limited, and patients were expected to live up to certain standards—to work and stay out of trouble. Not surprisingly, the patients responded by being reasonable.

This argument for morphine as a maintenance drug does not in any way indicate opposition to methadone. Quite the contrary, methadone has proved to be a very good maintenance drug and a mainstay in any drug treatment program. However, we do believe that since we have made one opiate available for maintenance, we might consider others as well. The time is past when everyone reacted hysterically to the idea of giving opiates to addicts; we have been doing just that on a large scale for nearly six years. Rather than limit maintenance to one drug, we think it is time to bring in the other opiates and try them in new ways.

The Shreveport experience supports the use of morphine. And since so many urban addicts prefer heroin, it should also be considered. If nothing else, they could be offered, as the New York Vera project proposed, to addicts who have not responded to methadone. Perhaps, morphine could be offered to addicts who use that drug on the streets. There are, to be sure, large numbers of

morphine addicts still in the South. It might be used in several ways—by injection, orally, or in combination with other opiates (as the British do). It might also serve to lure addicts into treatment programs. After a certain time, they could be transferred to methadone or helped to become eventually drug free.

Self-injection and the idea that drugs should be controlled and supervised very strictly are recurrent issues as regards morphine and heroin as maintenance drugs. Many "drug experts" believe that self-injection should be avoided whenever possible. Some have claimed that most addiction is "needle addiction." Most certainly there are needle addicts, but they are a minority among addicts. Most addicts manage repeated injections quite well on the street. Some get infections and hepatitis, some have collapsed veins, but the majority do not. Both of these, "needle addiction" and problems of injection, should be handled on an individual basis. If an addict has difficulty with injection, then he should be given help. Since the majority of addicts manage quite well under the present (illegal maintenance) system, it would be safe to say most would manage equally as well under a legal system.

The argument against needles and injection is much too paternalistic. It is similar to our attitudes toward welfare and the ways people spend welfare money. No one tells the retired army sergeant how to spend his retirement check, but the welfare mother is told how to spend her meager checks. If a welfare mother should want a glass of beer or wine, why shouldn't she as well as the army sergeant buy it with the money she gets? Drug programs should not attempt to treat or control every aspect of an addict's life. Such an attitude is unrealistic. Since most addicts are going to use drugs anyway—they have phenomenal survival powers in the face of all the obstacles put in their way—we might reconcile our paternalism to let them use the drug as they will. Drug programs can maintain control without dictating precise procedures of use.

Strict control is another manifestation of the same paternalism. The Vera Heroin Maintenance Project, mentioned earlier, proposed that addicts would receive *every* injection in the clinic. This plan seems unreasonable and unworkable. Programs cannot expect addicts to stay at a clinic all day, every day, or to return every four or five hours, except under coercion. Addicts may come for a while but they will soon drop out. Very few addicts would stand still that long for legal heroin. Most have more to do than spend so much time at a clinic.

The Shreveport clinic gave most of the patients two- and three-day supplies, and allowed them to regulate their own use and injections. They gave their patients some credit for intelligence and self-control, and the method worked well. They did not expect to control every aspect of the patients' drug use, and yet they controlled the legal supplies and cut off the illegal supplies.

Certain controls are perhaps a necessity. We do not take the position of Dr.

Thomas Szasz, who says that in a free society we do not need control over opiates. We obviously do *not* have a free society (despite all our proclamations); Federal, state, and local governments are continually regulating more and more aspects of life. If we had a free society and were less emotional about opiates, perhaps we would *not* need controls. Being irrational and emotional about opiates, we will undoubtedly have controls. But controls should be reasonable and workable. Very definitely they should be different from our present controls which are not workable. Addicts could be given daily supplies or, as in the British system, pick up their daily supplies at a pharmacy. There is bound to be some leakage, but if the dosage is monitored closely, this could be minimized.

Obviously, the largest problem would be illegal supplies. Fifty-five years of harsh laws and haphazard enforcement has had little effect upon illegal supplies. Only during World War II when there were strict trade controls was there any drop in illegal supplies. The police would have to become much more efficient than they are to cut these supplies. Illegal supplies in such cities as New York and Los Angeles cannot be controlled without special efforts, and they would have to be different from those used today. During the year that the New York City Health Department clinic operated (1919), it had little if any effect upon the illegal market. In fact, it may have contributed to illegal supplies.

Small cities, out of direct illegal supply lines, would have more success. If the illegal supplies are relatively small, it is conceivable that legal drugs might drive the price of illegal drugs down and make it less profitable to sell. Non-addicts can still provide a demand for illegal drugs, but the demand from addicts would be cut. It seems unlikely that illegal supplies will ever, under any system short of the most restrictive conditions, be eradicated. To do that would require more stringent efforts than any reasonable civil liberties would allow. If we seized and searched every passenger and every item of trade coming into the United States, we might eradicate the black market, but we would also have little freedom. Realistically, we probably cannot expect to cut all black markets; we could, however, cut some.

The Shreveport experience demonstrates what could be done under a legal maintenance system very well; black market drugs were practically nonexistent while the clinic operated. Narcotics agents tried several times to secure drugs without success (Musto 1973). What was done in Shreveport could very well be a model for many small cities in America. Obviously, such big cities as New York, Los Angeles, and Chicago, with larger illegal supplies, would have to develop special programs and strategies. Illegal supplies are too widespread in such cities to expect an opiate maintenance clinic or clinics to undermine their operation. Small cities with limited illegal supplies are another matter; illegal supplies would be far easier to control there.

The history of the Shreveport clinic tells us a great deal about the nature and treatment of opiate addiction. The Shreveport staff found no particular innate

psychological maladies in their addict-patients. Nor did they find any deleterious effects from maintaining addicts on large doses of morphine for long periods. These addicts were able to live, work, and lead quite normal and productive lives while being maintained. They were found to respond well to treatment when regarded as responsible human beings, rather than irresponsible, disturbed criminals as they often are today. Now, clearly, there have been some changes in the nature of opiate addiction and addicts. But historical evidence inevitably leads to the question, "Were laws and policies changed to fit addicts, or did addicts change under the laws and policies?" From what we have learned in Shreveport, and from what Terry, Pellens, and Musto have discovered about the history of opiate addiction, we must conclude that the laws and policies are more the cause than the effect.

In a more abstract sense, it seems that the response of a community or society to a social phenomenon such as addiction is not necessarily based on sober assessments of that phenomenon, but instead on emotional and irrational perceptions of something almost unrelated.

Then, as now, one is hard pressed to uncover any pattern or reason in societal decisions about behaviors it will tolerate and which it will punish. Indeed, the differences between the productive, citizen-addicts of Shreveport in the 1920s and the maligned, criminal addicts of today appear to be a function of our morals, laws, and treatments rather than of addicts themselves.

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