

Just a Phone Call Away

Portland, Oregon

In his forties, Alan Levine lost both legs to frostbite when he fell asleep drunk under an overpass in an Illinois snowstorm. Somehow he survived this and in time he migrated west, ending up in Portland, Oregon.

He was already a longtime heroin addict. Levine first used heroin at age twenty in New York and that first shot made him feel the way he wanted to feel the rest of his life—like the King of the World and the President of Everything.

All his life, Alan Levine loved drugs and the charge they gave him. But his lack of legs got in the way. He shuffled around on prosthetics. Usually, he procured dope from some house where he had a connection, or by wandering around the Old Town Chinatown neighborhood north of Portland's downtown, an arduous trek repeated three or four times a day. Levine hobbled along, driven by his addiction. Each time, he never knew what he was getting, or whether he would be robbed or arrested. He'd make it back to his motel, fix, and zone out until it was time to go look for more, surviving on panhandling and a monthly disability check.

In 1993, Levine returned to Portland after a year away. He heard that dealers had come to town who now delivered dope if you called in an order. Somehow Levine got their business card, though years later he couldn't remember precisely how. He had never known of a heroin dealer with a business card and a convenient number you could call.

With that card, well, Alan Levine might've just died and gone to heaven.

WAYNE BALDASSARE, MEANWHILE, WAS sure he was entering hell.

Baldassare was a cop who loved dope work. He'd been on the Portland Police Drugs and Vice Division since 1982. He loved the creativity the job required, that he had to use and care for informants. Each day was different: an undercover buy in the morning, a

search warrant in the afternoon. The job required imagination, because the dealers were themselves endlessly creative.

For years, heroin was the easiest drug to work because it was sold out of houses. You arrested a junkie. Terrified of withdrawing in jail, he'd tell you how a dope house worked. The junkie would bring an undercover officer to the dealer. Then you busted the place.

But in about 1991, Baldassare saw all that change. Young Mexican guys, clean-cut, courteous, and looking quite out of their element, were driving the town in old cars, delivering heroin. "All of a sudden you got a dispatch center taking orders and calling these delivery guys," he said. "It made it very hard to get a good case. You were looking at hours of surveillance for five or six small bags of dope."

The delivery drivers did tours of six months and then left. If they were arrested they were deported, not prosecuted, because they never carried large amounts of dope. The cases were always light. Baldassare first figured they were small-timers. Later he realized that, quite to the contrary, they had learned how drug investigations worked: prosecutors prized cases with large quantities of drugs. Crack and methamphetamine were the priorities then, each measured in kilos. As camouflage, these Mexican heroin guys used just-in-time supplying, like any global corporation, to ensure they had only tiny quantities in their cars or apartments. This, too, was sophistication Baldassare didn't see in the heroin underworld.

Soon these delivery drivers crowded into Portland. Heroin prices dropped and Baldassare watched the drivers get wise. They drove in circles to lose the officers following them. It took four or five officers to tail one car. Up to then, Portland hadn't much of an aerial police service. One officer owned a four-seat Cessna and charged the city for gas when he used it for police work, which wasn't often. Now the airplane was pressed into regular service, with a pilot and an observer watching the heroin delivery car on the street below. Baldassare was the observer. Peering through binoculars from above, he radioed locations to his colleagues on the ground.

It was grueling work and went on for hours. Baldassare was one of the few officers who could peer through binoculars from the plane, as it went around in circles, without getting airsick. As the drivers rooled around Portland all day making deliveries, Baldassare spent ten, twelve hours a day in the plane, watching from twenty-five hundred feet in the air, stopping only to refuel. This was before GPS, nor were there cell phones to track.

"It was line of sight," he said. "If you looked away, you could lose them. So you picked your times to look away. If your neck was getting a kink in it, you had to choose when to massage it."

Above downtown, Baldassare could follow a heroin car for a half circle of the plane, then lose it behind a building as the Cessna completed its circle, hoping to pick up on a new go-round. Cars easily got lost under Portland's dense canopy of trees.

Before long, the department had to expand its air force. An air force was a luxury most police departments the size of Portland's can't afford, but which this new heroin system made necessary. The city hired another two pilots. Finally, the department bought a new plane with full-length windows for easier surveillance.

THEIR BUSINESS CARD was yellow. It had a phone number and an eagle with a snake in its talons, the emblem on the flag of Mexico. That was all. No names. No slogan. Call anytime, Alan Levine was told. One night, he did.

Give us twenty minutes, said the guy on the end of the line. To Levine's immense surprise, within fifteen minutes, a Mexican kid was knocking at his motel door. He was young and nervous and clean-cut. He looked like a farm boy. He spoke no English. But he had sixty dollars' worth of black tar heroin.

Levine had never forgotten the first rapturous feeling he got from heroin back in the 1960s. But through the years that followed, he also never felt that high again. Until, that is, he shot up black tar heroin that night. Levine called the number three times a day after that. The delivery guys changed often and he called them all Pedro. They were reliable. They arrived quickly. Now, instead of having to brave Old Town on his two fake legs, Alan Levine could sit in his motel room, aware that he was "just a phone call away from getting loaded."

The Mexicans were the only dealers Levine had encountered who never ran out of dope. In time, prices dropped to as little as five dollars a hit as these crews brought huge supplies of high-quality tar heroin to Portland and competed against each other. Yet he noticed that they never feuded. They gave him credit. They often gave him a little extra, a bid to keep him as a customer.

One night, one of these kids, a driver as Alan Levine remembers it, tried to scam him, offering eighteen balloons for a hundred dollars when the deal, already long established, was twenty-five balloons.

Levine objected. Let's see what the boss says, the boy said. Levine got in his car and followed the driver across Portland. They came to a house. Out came a man Levine years later determined to be Enrique Tejeda-Cienfuegos, but whom he came to know then as El Gato.

Tejeda-Cienfuegos was from the village of Aquiles Serdán, a few miles south of Xalisco. He and his four brothers ran a heroin franchise in Portland. Levine knew nothing of this. He only knew that the delivery kid was trying to screw him and he explained this to El Gato that night. The boy now produced the twenty-five bags of heroin, saying in Spanish that this is what he offered Levine the whole time and there'd been some misunderstanding. El Gato was apologetic and gave Levine those twenty-five bags of heroin for free. Levine never saw that driver again.

El Gato "was evidently powerful," Levine remembered, when I spoke with him in a motel room near downtown Portland one night many years later. I tracked Levine down through his ex-wife because by then I realized the history of heroin was best told by addicts, the older the better. I sat in a chair while he, legless, sat in his bed, smoking constantly. Cigarettes gave his voice a growl as grizzled as his face and a strange chop to his jaws that sounded, when he spoke, as if he were chomping on a juicy steak. Sure enough, he knew the story of the Xalisco Boys' arrival in Portland as well as anybody, even if he knew them only as a rotating series of Mexicans he called Pedro. When I showed him a mug shot, he definitely remembered El Gato.

"When he spoke, they acted," he said. "He had some status. He took a liking to me because I paid on time. After that, they'd come and say, 'Gato said to give you this; Gato said to give you that.' They called me Liver because I told them I had hepatitis C and I didn't want to share needles."

El Gato later gave Levine a Buck knife, perhaps feeling he could use some protection. Levine realized he was worlds away now from how heroin had operated for so long.

"You didn't have to leave your house. Dealing with those people was paradise. You could nickel-and-dime them, too, when they got there. They were eager for the green money."

Levine had never known any dealer to give away free drugs to get people hooked, or to keep addicts from getting clean—the kind of mythical pushers the government and the media had invented amid the "dope fiend" scare. Until he met the Xalisco Boys.

"This marketing technique *was* about that. They knew what they were doing. They were marketers."

Searching for the Holy Grail

Lexington, Kentucky

On New Year's Day 2013, I steered a rental car through the snow-covered rolling hills just north of Lexington. The land there is divided into horse farms, and black four-board fencing provides simple and clear outlines to the pastures. As my car loped hypnotically past these farms and trees laden with mistletoe, I came to a lonely two-lane county road known as CR 1977. CR 1977 rises over small hills, curves, and then deflates as the hills bottom out. The road cuts past a farm to the north, home to a dozen studs, stallions, and broodmares. It passes the Masterson Equestrian facility, a large park for horses.

Then it bends and reveals a collection of stern, tall brick buildings set well back from the road. The compound could pass for a nineteenth-century factory were it not for the towering stadium lights that clarify the situation. The Federal Medical Center, as it's now known, is home to seventeen hundred prison inmates.

I got out of my car. Prison officials had denied my request to see its innards. So 150 yards was as close as I was getting to one of the strangest monuments in the story of American opiate addiction. When it went up in 1935, this federal fortress was known as the Narcotic Farm. The Roosevelt administration deemed it a "New Deal for the Drug Addict."

Under the Harrison Act of 1914, thousands of addicts were convicted as criminals and streamed into prisons, where their drug seeking disrupted life in the institutions. The government built the Narcotic Farm to house them.

It was a rare place—both a prison and a treatment center—that for forty years reflected the country's schizophrenic approach to opiates and drug addiction. During years when much of the country was segregated, blacks and whites, gays and straights, Latinos, Italians, Irish, Chinese, men, and women from across America shared a thousand acres in Kentucky—with only heroin in common. Many were serving

prison sentences; others, like beat writer William Burroughs, checked themselves in to kick the habit.

The Farm stressed outdoor work as addiction therapy. Inmates milked cows and raised tomatoes and wheat, and supplied the institution with food. There was a canning plant, a radio repair service, and a dental lab making false teeth. Administrators felt recreation was therapy. Addicts played basketball and tennis; the Farm had a golf course, a bowling alley, and basket-weaving classes.

In the 1940s, off in New York City, Charlie Parker turned swing jazz inside out. Hundreds of younger New York musicians worshipped the alto saxophonist and turned to heroin hoping to play more like Bird, who died addicted in 1955, his body and his art corroded by junk. Many of these musicians went to prison. A virtual generation of bebop's young punks in dark glasses came to the Farm: Sonny Rollins, Lee Morgan, Howard McGhee, Elvin Jones, Chet Baker, Tadd Dameron, Jackie McLean, Sonny Stitt, and many more. They jammed for hours, formed bands that were never recorded, and played shows for the Farm's inmates and Lexington hipsters who were allowed to attend. A Farm jazz band once played on *The Tonight Show* starring Johnny Carson.

I encountered the story of the Narcotic Farm as I sought to understand how, decades later, a Mexican village came to sell heroin across the country and in places where the drug had once been virtually unknown. The threads of these stories, I came to believe, ultimately connected.

For years the Farm was the world's foremost center of addiction research, for reasons that predated the institution itself. World War I had again demonstrated to doctors the merciful painkilling benefits the morphine molecule provided. Fresh, too, in their memory were heroin's first decades, which showed just as clearly that addiction too often bedeviled those who used opiates. Try as they might—with strategies as varied as farm work, group therapy, or prison—rehabilitation specialists never graduated much more than 10 percent of their addicts to true opiate freedom. The rest relapsed, slaves, it appeared, to the morphine molecule. This seemed a shame to scientists and physicians. Was mankind really doomed to not have it all? Couldn't it have heaven without hell? Couldn't the best scientists find a way of extracting the painkilling attributes from the molecule while discarding its miserable addictiveness?

In 1928, what would become known as the Committee on Problems of Drug Dependence (CPDD) brought together the country's best

researchers to do just that. John D. Rockefeller Jr. organized it using money his father had set aside. The CPDD promoted cooperation among drug researchers in government, academia, and industry. German science used this kind of collaboration to come up with some of the world's best drugs. But German drug supplies to America ceased during World War I. After the war, American scientists concluded that the country was vulnerable because U.S. drug research was random and haphazard.

The CPDD funded chemists and pharmacologists, academics and industrial scientists, toward the goal of finding a nonaddictive painkiller. Novocain, invented in 1905, avoided the need for addictive cocaine in dentistry. Why not a morphine substitute? Such a drug could cleanse doctors' image as clueless dealers of dangerous drugs that they'd earned by widely prescribing heroin in the early 1900s. Academics, meanwhile, hoped for a new era of modern scientific research applied to medicinal drugs. Law enforcement hoped a nonaddictive pain reliever would lessen the fallout from its attempts to rid the country of opium. Researchers called this drug the Holy Grail and the search for it would take the rest of the century and beyond.

The CPDD set up a laboratory at the University of Virginia to create these new drugs. Another lab formed at the University of Michigan, to test new drugs on animals. Now all that was needed was a place to test the new drugs on humans, a place where drug addicts were in ready and huge supply.

In 1935, the U.S. Narcotic Farm opened.

The Farm contained a section known as the Addiction Research Center (ARC). For decades, the ARC tested on inmates every major opiate that Committee-sponsored chemists produced: Dilaudid, Demerol, darvon, codeine, as well as Thorazine and many tranquilizers and sedatives. Experiments at the Farm showed that methadone lasted longer and spared junkies the severe highs and lows of heroin that spurred their frenzied attempts to score. Thus, they concluded, methadone could act as a replacement for heroin.

The ARC had a staff of psychiatrists, biochemists, physiologists, pharmacologists, lab technicians, and four guards. They studied every aspect of morphine's interaction with man. ARC research developed the first quantitative scales for measuring degrees of addiction, severity of withdrawal, and the addictiveness of many drugs. For four decades, heroin and morphine addicts with long sentences would volunteer for studies because they were given dope. After the studies ended, the

subjects were given a six-month rehabilitation to ensure they were no longer physically dependent.

As American science organized to search for the Holy Grail of a nonaddictive painkiller, the Farm made this research possible and kept hope alive. Researchers viewed their mission simply: to prevent another heroin; prevent another highly addictive drug unleashed on the country without proper study. With this, they justified experimentation on inmates. "The ARC saw itself as safeguarding public health on a global scale by preventing addictive compounds from destroying the lives of thousands," wrote Nancy Campbell, J. P. Olsen, and Luke Walden in *The Narcotic Farm*, a fascinating book on the institution.

The research at Lexington generated hundreds of scholarly articles and amounted to the only serious study of addiction in the world at the time. The World Health Organization relied on it for data. Addiction study emerged there as a scientific field, and ARC staff were the first to conceive of addiction as not a character failing, or a crime, but rather a chronic brain disorder. The ARC was shut down in the 1970s, when the U.S. Senate's Church Committee, investigating the Central Intelligence Agency, found that the ARC had done experiments with LSD on inmates at the behest of the CIA. With that, an era ended. The Farm was transformed into the prison and hospital that it is today.

But for forty years, all the drugs created in the CPDD's search for the Holy Grail were tested on inmates at the Narcotic Farm in Lexington, Kentucky.

Early on, the UVA laboratory's first director, Lyndon Small, synthesized a drug he called metopon. Metopon had some of morphine's painkilling attributes but was slightly less addictive. Metopon fell short of the idea the CPDD pursued. Yet it was taken as proof that a morphine-like painkiller that was not addictive—that elusive Holy Grail—might be found someday.

This goal urged on the next generations of drug researchers, and in time helped fire a cadre of revolutionaries seeking a better way to treat pain in America.

The Pain

THROUGH MOST OF THE twentieth century, doctors treating the terminally ill faced attitudes that seemed medieval when it came to opiates.

Doctors who prescribed the painkillers were treated as virtual outlaws. Parsimony described how drugs were distributed. Several doctors' signatures were often required even for small doses as dying people writhed in the most indecent pain. Treatments for pain came in strange concoctions. One was called the Brompton cocktail—a combo named for the English hospital where it was used: morphine, cocaine, Thorazine, honey, gin, and water—which read to me like a concoction some street junkie would come up with, but which I'm told was pretty effective.

In the 1970s, attitudes slowly began changing. In England, Cicely Saunders, a nurse and researcher, opened a hospice that treated terminal cancer patients with opiates. Under Saunders, St. Christopher's Hospice in London was the world's first to combine care for the dying with research and clinical trials. St. Christopher's was inspired by the idea that patients should be treated for pain without the drugs also destroying their personalities. Saunders's employee, Robert Twycross, began experiments that showed enormous benefits from using opiates on dying cancer patients. St. Christopher's promoted opiates, sometimes at high doses, to relieve the pain of the dying. Saunders and Twycross believed it inhumane to do otherwise. If people were soon to die, what did it matter if they were addicted? Wasn't pain relief and a dignified death more important? At St. Christopher's, dying patients were given opiates regularly, whether they were in pain or not.

The Queen honored Saunders with damehood.

Dame Cicely and Twycross worked hard to change minds, though this took longer in the United States, where decades of opiate demonization made doctors wary. Twycross once said that exiting a plane in New York City, he "could smell the fear of addiction in America."

In 1972, a British company called Napp Pharmaceuticals developed a controlled-release formula, known as Continus, that the company first put to use with an asthma medicine. One day Twycross suggested to some Napp reps that their company might use Continus to develop a timed-release morphine pill. Napp eventually did so, and this proved important to this story. It offered doctors a new tool for treating pain in dying patients. Napp, also, is owned by Purdue, the laxative manufacturer that Arthur Sackler and his brothers had purchased in the 1950s.

Meanwhile, a Swedish cancer physician named Jan Sjernerward was put in a position to change pain treatment worldwide. Sjernerward was made chief of the cancer program for the World Health Organization in Geneva in 1980. He'd spent time years before in a Kenyan hospital, where he witnessed acres of cancer patients dying in agony. The third world lacked the resources to treat cancer. With morphine, Sjernerward felt, patients could at least spend their last days pain-free. But doctors refused to use it, fearing addiction.

Now, as WHO's new cancer chief, Sjernerward remembered Kenya. He set about establishing norms for treating dying cancer patients with opiates, primarily morphine. Ten-milligram morphine pills cost a penny apiece. This would allow, Sjernerward believed, the same care the world over to people who were leaving life as to those who were entering it.

He met Vittorio Ventafridda, who ran a foundation in Milan that was the first in Italy to provide pain treatment to terminally ill patients. Lunching with Sjernerward one day in the cafeteria of WHO's Geneva headquarters, Ventafridda wrote out on a napkin simple principles for treating dying patients with opiates. It was a ladder of treatment. Increasingly powerful drugs, including opiates combined with non-opiates, should be used if pain did not subside. This was a radical idea at the time.

Sjernerward later gathered most of the world's few experts in pain treatment—sixteen in all—in a medieval castle in Milan to shape a world health policy, and brought that napkin with him.

The ladder that Ventafridda outlined at lunch that day enshrined the idea that opiates should be used to deal with terminally ill patients on whom nonopiates did not work. This was a humane approach, particularly in countries where few had access to cancer treatment. WHO published a book in more than twenty languages laying out simple pain treatment steps, which came to be known as the WHO Ladder. Within it, morphine was deemed "an essential drug" in cancer pain relief.

WHO went further. It claimed freedom from pain as a universal human right. The Ladder was accompanied by a concept relevant to our story that moved public and medical opinion. It was this: If a patient said he was in pain, doctors should believe him and prescribe accordingly. This attitude grew from a patients' rights movement that sprung in part from the Nuremberg Trials, where Nazi doctors were found to be experimenters who disregarded patients' autonomy, and later from the 1960s counterculture that suspected the motives of all established institutions, medicine included.

With the WHO Ladder, doctors' concern over the use of opium-derived drugs began to ease. They were, after all, remarkably effective at knocking down pain, which was now a human right. Worldwide morphine consumption began to climb, rising thirtyfold between 1980 and 2011.

But a strange thing happened. Use didn't rise in the developing world, which might reasonably be viewed as the region in most acute pain. Instead, the wealthiest countries, with 20 percent of the world's population, came to consume almost all—more than 90 percent—of the world's morphine. This was due to prejudice against opiates and regulations on their use in poor countries, on which the WHO Ladder apparently had little effect. An opiphobia ruled these countries, and still does, as patients are allowed to die in grotesque agony rather than be provided the relief that opium-based painkillers offer. India, a major opium producer, has minute per capita consumption of morphine (0.12 milligrams per capita a year in 2011), due mostly to a government bureaucracy that taxes the drug heavily.

In 1985, members of the International Association for the Study of Pain met in Buenos Aires. While there, the pain specialists visited a hospital where a neurosurgeon told them that opiates were allowed only for those undergoing surgery. He was forced every year to perform a thousand cordotomies for those with chronic pain—severing the pain and temperature nerves in a patient's spine.

"It was appalling. That was more than all the cordotomies done annually in the U.S. and Europe," said Dr. John Loeser, who was on the tour from his multidisciplinary pain clinic at the University of Washington.

Experiences like these scared doctors who were interested in pain management. Also on tour that year was Dr. Kathleen Foley, from New York's Memorial Sloan Kettering Cancer Center. Foley began her career in the 1970s, during the last years of the opiate dark ages, when doctors used these drugs under only the most controlled circumstances.

By the 1980s, Foley, a devout Catholic, had become a voice for these dying cancer patients, and an advocate for treating their pain with opiates. In 1981, she transformed pain treatment for cancer patients at Sloan Kettering, bringing together researchers to study pain and clinicians to provide pain treatment—the first pain group of its kind.

As time went on, Foley, however, took her advocacy of opiate treatment a step further. Opiates should not be confined to just cancer or postsurgical patients, she believed. They should also be used, she argued, to treat patients with pain that did not grow from a disease, injury, or surgery; pain that was chronic but equally life mangling—bad lower backs, knee pain, and others.

As I followed my story, I came to realize that this idea, alighting on the realities of American medicine and medical marketing of the 1980s and 1990s, eventually connected to why, years later, men from a small town in Mexico could sell so much heroin in parts of the country that had never seen it before.

In 1984, a young doctor came to Sloan Kettering for a fellowship under Foley. Russell Portenoy had grown up in Yonkers and developed an interest in biology as a child. A dapper and articulate man, Portenoy attended Cornell University, then medical school at the University of Maryland. He did a neurology residency at Albert Einstein College of Medicine.

Portenoy worked among Sloan Kettering cancer patients for almost two years. During the 1980s and 1990s, he and Foley helped midwife a new specialty in American medicine. Palliative care—treating the pain and stress of the seriously ill—grew from a variety of influences: the hospice movement of Cicely Saunders and the idea, then surprisingly uncommon in medicine, that death should be dignified. Palliative care involved far more than just drugs. It included psychological, spiritual, and family counseling. The new discipline gave Russell Portenoy "the talking points I needed to mold my work life," he once wrote. As an emerging discipline, palliative care appealed to a bright young doctor interested in staking out his own ideas. Comforting the seriously ill and dying touched on the altruistic reasons why anyone would enter medical school in the first place.

What's more, it challenged him. Just knowing a symptom didn't mean he understood the patient. Portenoy wrote later that he found himself forced to study the profound psychosocial and spiritual impact of advanced illness. He was forced to learn, for example, how to tell a family of a loved one's life-threatening illness. Palliative care, he came to

believe, was guided by moral issues of patient autonomy and respect for cultural and individual differences. Decisions were made with the input of the patient and family. This was very different from how medicine had treated serious illness and pain. Watching people struggle with pain, and talking to families who faced the loss of a loved one, gave Portenoy a touch of idealism, a bit of the crusader pushing up against conventional wisdom.

IN FACT, THE 1980s were good years for a young doctor with pain as his focus doing battle with conventional wisdom. Researchers had come to new understandings of how pain happened in the brain. The work of Cicely Saunders in England was dissolving the old bugaboos about the prohibition on using opiates in the United States. Medical advances were extending the lives of cancer patients in some cases from months to years. These treatments were themselves painful, and thus many more patients required attention for their pain.

In 1984, Purdue Frederick produced one solution. It released MS Contin, a timed-release morphine pill—the product of that conversation Robert Twycross had with the Napp Pharmaceuticals reps in England years before. MS Contin was intended for cancer and postoperative patients.

In Salt Lake City, a doctor named Lynn Webster had been studying new techniques for acute pain at Holy Cross Hospital. One day in 1989, a woman named Dorothy had surgery on her lung. During surgery Webster inserted in Dorothy's back an epidural catheter with an injection of pain medicine. Through the catheter Webster gave her small, continuous doses of opiate anesthetics. Epidurals had been used in labor and delivery, but new research showed epidurals could be used for other things. They could, Webster reasoned, allow him to gain more localized pain control with less medication than the typical intravenous or muscular injections.

In fact, Dorothy left surgery awake and coherent, unlike typical post-op patients, who were prostrate and completely sedated. Word spread through the hospital. She asked for coffee, stood up, and raised her arms—to the shock of hospital staff. "Nobody's done this before at the hospital. All these doctors and nurses are standing in the doorway," remembered Marsha Stanton, a nurse who worked with Webster at the time. "She drinks her coffee and she's fine. She's not nauseated, which usually they are."

Webster, and then others, energized by new possibilities, began treating more patients with this kind of pain control.

To Russell Portenoy, these were revolutionary times. It was cruel not to give pain-relieving opiate drugs to dying cancer patients or those emerging from surgery. Soon this was no longer a controversial opinion in America. Terminal patients no longer had to die in agony. The pendulum was swinging toward more humane pain treatment.

It thrilled him, Portenoy said later, to be able to relieve the crippling pain he saw in patients. He viewed pain management as "a white-hot" profession, made possible by pharmaceutical companies' innovations. Their powerful new pain relievers seemed far less addictive because through their timed-release formulas they eased relief out to the patient over many hours.

Now, to the patient crushed by pain, "the pain-management specialist who knows what he or she is doing can go in there and find a way to offer something that—it doesn't provide comfort, it provides hope," he said later. "I believe in drugs. I think pharmaceuticals are a great gift to humankind."

Pain and the Pro Wrestler

Seattle, Washington

John Bonica was born in Sicily, grew up in Brooklyn, and began lifting weights at age eleven. In college in Long Island and New York, he was a star collegiate wrestler. He earned his way through college and medical school as a pro wrestler. This career continued after he joined the U.S. Army before World War II. When a higher-up told him that pro wrestling was unbecoming of an officer, he donned a mask to hide his identity and became the Masked Marvel, touring with carnivals and wrestling as many as twenty people in a day. He met his future wife, Emma, at a pro wrestling match.

Pro wrestling also proved important to his future work. It partly disabled Bonica and bequeathed him lifelong chronic pain from torn hip joints, shoulder injuries, multiple rib fractures, and excruciating cauliflower ears "like two baseballs" that required plastic surgery.

"Working 15 to 18 hours a day," he told *People* magazine in 1977, kept the pain at bay.

Watching his wife go through searing pain in childbirth in 1943 set Bonica on his career as an anesthesiologist. He trained hundreds of anesthesiologists in the U.S. Army Medical Corps. After the war, he became chief anesthesiologist at Tacoma General Hospital and wrote a classic textbook, *The Management of Pain*.

Bonica opened America's first pain clinic when he was appointed chief of anesthesia at the University of Washington School of Medicine in 1960. Pain could only be salved, Bonica believed, when many disciplines within medicine, and beyond, were applied. The clinic pioneered an approach to pain that had patients see as many as fourteen specialists, who would then work out a therapy that a patient would be asked to follow in his daily life. Bonica's multidisciplinary approach was complicated and required a lot of the patient, but was often effective.

Bonica retired in 1977. His successors, Drs. Bill Fordyce and John Loeser, expanded the Center for Pain Relief at the UW medical school.

The clinic used occupational and physical therapists, psychologists, social workers, and others to treat pain. Patients spent three weeks in the clinic and left with medical and life strategies for controlling pain, such as exercise and diet—a bio-psycho-social approach, in the term Loeser coined.

"We were trying to teach [patients] that they were the ones who controlled whether they were well or not well," Loeser said. "The patient has to do the work. Chronic pain is more than something going wrong inside the person's body. It always has social and psychological factors playing a role. Physicians have traditionally ignored such things."

The UW pain clinic set itself against trends in medical marketing. Those Valium ads that years before insisted that one pill could solve a patient's problems were wrong, researchers at UW believed, at least where pain was concerned. Pain was complicated.

But "there is a philosophy among many patients—I'm entitled to be free of pain," said Loeser. "People are entitled to health care. Health care should be a human right. Pain management must be a part of health care. But they are not entitled to pain relief. The physician may not be capable of providing them with pain relief. Some problems are not readily solvable. A patient is entitled to reasonable attempts to relieve the pain by reasonable means. You're not entitled to pain relief any more than you're entitled to happiness."

"But usually the patient says, 'I come to you, the doctor. Fix me.' They treat themselves like an automobile. People become believers in the philosophy that all I need is to go to my doctor and my doctor will tell me what the problem is. That attitude has been fostered by the medical community and Big Pharma. The population wants to be fixed overnight. This is the issue we addressed with chronic pain patients. They have to learn it's their body, their pain, their health. The work is done by them."

Bonica's protégés at the University of Washington were suggesting a comprehensive approach to treating pain, in which opiates played only a small role. By the early 1990s, hundreds of clinics in America followed the UW model. Yet, almost from the beginning, insurance companies balked. In time, they stopped funding crucial parts of multidisciplinary treatment that weren't strictly medical: physical, occupational, and psychological therapy, in particular. Loeser and his staff battled them incessantly. He would show the companies that the patients became healthier, and this saved the companies money in the long run. "But the people making the funding decisions have nothing whatsoever to

do with health," Loeser said. "They were more and more restrictive in what they would pay for."

Thus doctors were increasingly deprived of some crucial tools to treat that pain just as patients were taught to believe that they had a right to pain relief.

The Man Comes

Los Angeles, California

The Man had come out of the west dusty and wizened.

His grandfather, whose name he bore but whom he never knew, had two women, two families—one in Phoenix, the other in New Mexico. His father's half brother, whom he never knew, was murdered by Pablo Acosta, a weed smuggler and the first Mexican drug lord.

In 1939, the Man's father moved the family from New Mexico to California. The agricultural town of Brawley in California's Imperial Valley was a pit stop for Depression migrants taking the southern route into the Golden State. His parents worked on the Brawley farm of a relative, and during this time the Man was born. They then moved to Fresno, where his father became a farm labor contractor.

His parents separated when he was thirteen. He went with his mother to Van Nuys in the San Fernando Valley of Los Angeles. They found a house in the Van Nuys barrio, a place without sidewalks or much police presence. This being the 1950s, Mexican Americans, in the Valley's sea of white people, rarely ventured out of their barrios unless it was to go to work. Families in Barrio Van Nuys owned their homes. The men were employed in the lower rungs of the movie industry or as city and county workers, paving roads, landscaping public buildings. They hung out after work at the neighborhood store and drank beer under pepper trees.

The Man dropped out of Van Nuys High, got his diploma at a continuation school. By then he was also trafficking—cutting up pounds of weed and selling joints in the neighborhood. When pills—whites, reds, bennies—became the fashion, he drove to Tijuana, stayed all weekend, bought jars of them, and tripled his money back in Van Nuys. He liked to think that he was something of a shot caller among his generation. He was nineteen. About then he started using heroin. Many of the young men in Barrio Van Nuys used it and most of them died young.

He became a steamfitter later, and had other jobs, two marriages, and children, but mostly he was, as he put it years later, a "drug merchant." He

liked to see himself as sticking it to the Establishment, living outside the law. He served several prison terms; it usually took less than forty-eight hours of freedom before he was shooting up again. Not much mattered to him but the drug. He bought houses for his family, his kids. Mostly, though, money was to be used to get more dope. About the only other thing that held his interest for so many years was gambling on NFL games.

What bedeviled him was a reliable source of heroin supply. His sources had always been difficult to maintain. People were always going to jail, or he was. Or they died. Either way, it was always a battle to find consistently good-quality heroin in large amounts.

In the 1970s, he met a guy, a relative of a lieutenant of Ernesto "Don Neto" Fonseca. Fonseca was a grizzled Mexican drug kingpin who later gained infamy, and a life prison term, for his part in organizing the Sinaloa drug cartel. Fonseca's nephew, Rafael Caro Quintero, joined him behind bars for arranging the torture killing of DEA agent Enrique "Kiki" Camarena in 1985.

The Man and his contact took the train down to Mexico to buy a kilo from Fonseca. They met the legendary capo in the hotel he built in downtown Culiacán, the sweltering capital of Sinaloa, the birthplace of Mexican trafficking.

"I'm gonna give you this kilo and see what you guys can do with it up there," Fonseca told them. "I'd like to open a market up there. You guys do right and I'll keep supplying you."

For four months, they did Don Neto right and he kept sending them kilos. Then they were arrested and the Fonseca connection disappeared. The Man found other sources in Mexicali, which didn't last long either.

But all that was years ago.

When I met him, the Man was slowed by a liver problem. His eyelids often hung at half-mast. Years of trafficking, gambling, and spiking his veins had sapped him, in his seventies, of any real mirth. He never read novels, only nonfiction. His laugh issued from him as a dry chuckle, thin as cardboard.

But when he was in his late fifties, he had happened on a scheme that would, in his eyes, make his life worthwhile. It involved bringing black tar heroin to new people and places east of the Mississippi River. He had blown into these cities across America like a wind, a different name in every town, in old used cars that were gray or beige. He left behind a drug that would change these places, and bring misery to thousands of families.

Through the 1990s, that drug, in turn, transformed the small Mexican town of Xalisco, Nayarit, a place he would come to view as

his own, where he would buy property and keep a woman. He was a contemporary of David Tejeda, whom he knew, though not well. Tejeda was among the pioneers to ignite the first stage of the Xalisco heroin expansion in the early 1990s. The Man began the second, in 1998. So, after I tracked him down, I visited him often and listened to him talk about the past. He held the answer, I came to realize, to how black tar heroin crossed the Mississippi River to stay.

He liked to think himself a hero to the young men from the small town of Xalisco, Nayarit, whom he recruited and taught to retail the drug. "I'd have fathers and mothers come ask me for work for their sons, knowing exactly what they were going to do, exactly what I did," he said one day in the living room of his Central Valley home. "These are people who are dirt poor. They see all these other young kids with new trucks, building houses, mothers and fathers driving around in a half-nice pickup. Then the kid's bugging them, 'I want to go up north.'"

Initially, the market they sold to was older addicts like him—the heroin underworld that had survived since the 1970s, when the drug was last popular. But as it happened, illicit use of another drug—a pharmaceutical called OxyContin—was creating a vast new market for heroin among middle- and upper-class white people. Folks with money. When he heard about OxyContin, he began to follow it, knowing that if he did, he would soon have a market.

The relentless Xalisco retail delivery system evolved as it fed on this ever-growing base of customers addicted to OxyContin in America and on the deep frustration of young, landless working-class men in Mexico. These men did not form a cartel. They could not. The envidia—small-town jealousy—and the wild-bronco attitudes that rule Mexican ranchos prevented grand organizations from forming. "Families cannot work together," the Man told me. "We're real envious of each other."

But precisely because they could not, their heroin system became pernicious and successful. It aroused the entrepreneurial spirit of rancheros, young and driven, as it harnessed a cheap and addictive product to the power of small-scale free-market capitalism. The system marked a radical departure in the way Mexican traffickers sold and profited from dope, and it challenged U.S. law enforcement.

"We didn't start the heroin-dealing business. We just used a different method," the Man said. "We weren't a cartel. We were all different cells. Everybody's their own group. There's the boss of each little group. They all work individually. There's some heavy dudes, some who are mediocre and some who are trying to make it. Some go bust. Some got a lot."