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N A N C Y C A M P B E L L

NANCY CAMPBELL: Can you tell me how you got to the University of Geneva for medical school?

BP: In 1950 I finished college at West Virginia State College, which is now West Virginia State University. I was a member of the Reserve Officers Training Corps, ROTC, during the Korean War. I was a premed, biological science, and German major, and I knew I was going to get drafted. I even stayed an extra year to finish ROTC because I had transferred to West Virginia State College from another school. You had to be there four years to do ROTC. Although I was premed, my degree was a bachelor of

science in education. I could either go into teaching and be a coach, because I was a basketball player, or I could end up going into the service. I knew I was going to get drafted even if I had taken one of those other jobs, so I took my commission and went into the 82nd Airborne Division and was a paratrooper officer for four years at Fort Bragg, North Carolina. The 82nd Airborne Division was a very elite division of the service.

As a matter of fact, I was the first black officer integrated to command white troops in our country. Then I got hurt in a car wreck. When I came out of the hospital for my injury, Truman had declared that the officer corps would be integrated. There had been integration in the services in Korea, where white officers commanded black troops. There were always white officers commanding black troops, and some black officers commanded black troops, but no black officers commanded white troops. By division order I was sent from the hospital from my division to this completely white unit. As the ranking first lieutenant, I should have been assigned as a battery commander, but instead they made me a battalion intelligence officer that was two ranks above my qualifications. Then I was retired from the Army for my disability from my injury. I was then thirty percent disabled. I received thirty percent of my pay for the rest of my life, which went from $80 at that time to today about $500.

Anyway, I had a friend who I had grown up with who was an all-American runner and a national cross-country champion and honor student for NYU and he couldn’t get into

medical school. Instead of giving up and not going, he applied, was accepted, and went to the University of Geneva, where he had a couple of Jewish friends who had also applied to the University of Geneva. He was graduating from the University of Geneva Medical School at the time I was coming out of the service. We had been inseparable growing up and he suggested that I apply to European schools.

NC: Where had you grown up?

BP: Originally I was from West Virginia, but my family moved to New York when I was 12. I then grew up in New York. My friend came to see me at Fort Bragg to celebrate getting out of medical school. I had been hurt, and was in the process of getting a medical retirement. So he said, well, you've had German. Maybe you should apply to the German medical schools. So I applied to the University of Heidelberg in Germany, and the University of Innsbruck in Austria. I was accepted to both schools. I was discharged from the service September the 30th, 1953. On October 5th, I took a boat train to Halifax, Nova Scotia, and on October 6th, was sailing for Europe on the Queen Mary to go to med school at the University of Heidelberg. My family helped me make passage on the Queen Mary, which could not come into New York because there was a tugboat strike in New York. In order to get the boat, I had to take a boat train from New York to Halifax, Nova Scotia. The Queen Mary had to go there because that was the closest port in the East where it could go into the harbor. The boat train took two and a half days to get up there. I took the Queen Mary and went to Europe and got off at Cherbourg and

then took the boat train into the Gare Saint-Lazare. I never will forget it. It was that September. Matter of fact, I had on a seersucker suit.

NC: Just like you do today.

BP: Yes, I had on a seersucker suit just like this. I was a very meticulous guy, like I still am today. When we got into Germany, I had fallen asleep in my cabin. I still had my Army raincoat on because it was cold. This German conductor came in with this German hat. He woke me up, and I was startled. All I could remember was the Second World War, and I almost panicked and started to fight him because I was startled when I woke up.

NC: How did you happen to go from the University of Heidelberg to the University of Geneva?

BP: I couldn't get my GI Bill at the German schools, so I had only my retirement pay, which was about $80 a month. That was 400 marks in 1953. I stayed at Heidelberg for a year, almost a year and a half. But I got married in 1952. My wife was a teacher, and I wanted her over there, so I figured I'd better find a way to get my GI bill and get the $160 that the GI Bill paid plus my retirement pay of $80 to make $240. Then she could come over, and we could have an apartment. The only way you could do that was either go to

an Italian school, a Swiss school, or a Dutch school. I said, what would be easier for me? Maybe I should try the Dutch school, make an application over there.

You go through the Ministry of Education in Holland. You don't go to the med school like you do here. The Ministry of Education accepts you for medical studies and they send you to one of the universities where there is a place available. So I made application, went over there and got an interview with the Ministry of Education. The guy who was the Deputy Minister of Education was from Nijmegen in Holland. I had on this Army raincoat with the 82nd Airborne All-American patch still there on my sleeve. He took me for having been one of the paratroopers because I had to show my discharge, and he saw that. He thought I was one of the paratroopers that had freed his town in Nijmegen. He admitted me to school and wanted to send me to Nijmegen. I told him no, there were no black paratroopers in the Second World War. The black paratroopers only started after the Second World War. We saw no combat, but he didn't know that. He said lots of my colleagues were buried there, and I would do fine there.

When I went over to Nijmegen, they really didn't have a place for me so I came back and reported that. He says, well, we've got a place for you at Utrecht. So I went to Utrecht. I sat in the class there for a day or two, and the Dutch was so difficult, even with my German. I just said no, this ain't for me, and went back to Heidelberg and was, you know, very despondent, wanting to be with my wife and so forth. Then I said, let me try Switzerland. Let me try the German part of Switzerland.

So I went down to Basel, and talked to the dean and was going to get admitted to Basel, or Zurich. The Schweitzer Deutsche was just as difficult as the Dutch was. I said, all right, what the hell am I doing here? So I called my friend and he said, maybe try Geneva, Beny. You'll do all right. You'll learn the language. It'll come easy for you, you'll go to class every day, and you'll end up speaking to anybody, and you'll learn the language. So I went down to Geneva. My friend had two friends who were still there in school, black guys named Charles E. Wilson and Charles Peter Felton, who were juniors in the med school. My friend said, go to Chuck, who was a fraternity brother in the black college fraternity, Alpha.

Chuck was in Alpha, and I had gone into Alpha, so we bonded that way. He says, I'll take you to the dean. He says no, better still, I'll take you to the registrar and when I give you the sign, you cry. He says, you'll see me, I'll give you the sign, and you start to cry. He says, Beny, you've got to do this. When we get to the registrar, she goes over my transcript and says, I don't know whether you can make it or not here. You have a D here in genetics. I had gotten that D because, if you cut this man's class, your grade was reduced to a D – I really had an A in genetics. You could only cut his class three times. I cut six times, and he gave me a D. She said, that's important for medicine, genetics. To make a long story short, my friend gave me the sign, and I said, I got to go and I don't know any other way. I heard later on that this lady, Mademoiselle Grosselin, had dated a Moor and was very partial to what was going on in the United States with prejudices

against blacks. She was very sympathetic to our cause. She saw me tearing, and she said, well, you have a good background, you were a soldier, you were a paratrooper. She says, we're going to admit you, and I don't know how you're going to make it, but I think you'll make it. I walked out of there the happiest guy in the world. I went back to Heidelberg, packed up my old car with my belongings, and came to Geneva and got a room. Then I went to Paris, and met my wife, who had come to Europe.

NC: So she spent a few years there with you?

BP: Yes, she spent two years there. My oldest daughters were born there. We had an apartment just like I dreamed. She enrolled in the school of music, and she was getting her masters in music. She had finished Fisk as a music major and was getting her masters. She didn't know French, but she had had French in high school. When you go to University of Geneva, and you're a foreign student and don't know French, they assign you to a French class. You have to take this test to see where you fit into what level of the French class. So she had had French. They said to her and me both, you haven't had, you have had, but still you will take this little test. They dictate to you a paragraph or two, and you have to write it. Then they grade that and according to what you get, they place you in beginning or right on up the line in terms of what class French you should be.

I got placed in the beginners' class. They have maybe 30 or 40 new students in different faculties – faculté de médecine, l'Ecole d'Interpret, faculté d'Engineering, etcetera. But you were all beginning to learn this, so you have a textbook and they would give all of us an assignment. When I would go home that night and read the assignment, I would memorize it. When you went back to class, the teacher would go from student to student, and you would read the next paragraph. When she would get to me, she would say Monsieur Primm, and I was supposed to go. I wouldn't have to look at the book. I would just go blah blah blah blah blah blah. I remember one day she looked at me, and I thought I had done something wrong. She said, Monsieur, after class, I want to see you. And I thought, what did I do wrong? My whole career counted on me knowing French.

Anyway, I went up to her after class. My wife was also in the class. She says, I don't want you to come back anymore. You can imagine, I'm 26 years old, and I've got my wife there, and I've put all my eggs in this one basket, and she didn't want me to come back to the class anymore. How was I going to learn French? She says, you're going to be okay. She says, I want you to do something, she said, and then she kind of leaned forward to give me some confidence. She said, I want you to speak to everybody you can, anytime you can have an opportunity. I want you to go to class every day, she said, and don't be ashamed if you don't have the right verb or the whatever. You're going to be okay, she says. You'll see, she says, don't be discouraged. But you don't need to come here. My wife was furious because she had to continue. Six or seven months later I was

taking notes half in English, half in French. I never studied a word of formal French except for that week and a half in that woman's class.

NC: How did you become an anesthesiologist?

BP: I came back to the United States, did an internship at Meadowbrook Hospital on Long Island, which is now Nassau County General Hospital. I was the first resident that they ever had in anesthesia, the chief resident, and I won the internship of the year award. I finished my anesthesiology residency and passed my boards and had passed my New York State board one year after I started my internship. Foreign medical graduates were considered second-class physicians. When all of that was over, I took my boards, as soon as I was eligible, because I had to make some money because by then we had a kid.

NC: Can you tell me why you chose anesthesiology?

BP: In January 1960, when I started my residency after finishing in December '59 from Geneva, I wanted to do OB-GYN. Getting an OB-GYN residency was very, very difficult, and extremely difficult for a foreign medical graduate and a foreign medical graduate who happened to be black. You could go to Harlem Hospital or Lincoln Hospital if you could get in, but the competition was very keen. You've got to remember that when I wanted to apply to medical school in 1950, there were 5,000 black applicants to medical schools that year in the entire United States.

There was no admission to medical schools of blacks below the Mason-Dixon line to white medical schools. None. Two medical schools accepted blacks, Howard and Meharry. They accepted about 180. Around the country there were schools like NYU that'd accept two, Harvard maybe three, University of Michigan four. So when I graduated from medical school that year, there were only about 227 African Americans who had graduated from medical school.

A residency for a black guy was almost impossible if you hadn't gone to one of these schools. First they took the guys who went to Harvard or NYU or Michigan. A couple went to California, a couple may have gotten into Loma Linda University, but nothing below the Mason-Dixon line. The two guys who were in Geneva, one was from New Jersey, Chuck Wilson, and one was from Louisiana, Charles Peter Felton. The state of Louisiana paid his way to medical school because he was getting ready to apply to medical school at University of Louisiana, and they didn't want blacks to do that so they paid his way at Geneva so that he wouldn't. That's how bad racism was, it was rampant. Chuck Wilson was from New Jersey and he was on the GI Bill like I was on the GI Bill at Geneva. When people ask me, why did you go over there to medical school, that's what I tell them. I had no other way of getting to my goal.

I had always wanted to be a doctor from the time I was a little boy. My father was a funeral director and my mother was teacher and school principal. When I played with my

brother, he would play the funeral director, and I would play the doctor. We had a small little city that we built, and we would have accidents, and I'd say people got killed, and he'd come in and bury them. That's what we did. So he became a funeral director, and I became a doctor.

NC: Did you find anesthesiology interesting when you first encountered it?

BP: Actually, not really. I thought it was a new residency that I would be able to get admitted to without a lot of fanfare, instead of trying to go OB-GYN because I knew how racist it was. They just didn't want black guys really doing physical exams on white women. It was just that bad. When I finished my residency I took my exam for the state boards, and I passed the first time and got my license. I was one of the few guys that was licensed in my intern class. Then I could go work at other hospitals covering the emergency rooms with this license because we were only making about $3,600 a year, $300 a month.

Once I got my license, I went to work in different hospitals. I went to Good Samaritan Hospital in West Islip. I made $3 an hour. I worked 36 hours on and 12 hours off at my internship and residency. The 12 hours I had off I would go and work in the other hospital and it would make me $36. That was a lot of money then, and I saved up enough to buy a house for my wife and kids.

I remember at Good Samaritan this woman came in, and she had an acute abdomen. I covered the emergency room. I palpated her, and I knew right away she had a ruptured ectopic pregnancy. I went into the ER. She had a little vaginal bleeding, a little spotting, but an acute abdomen. So I said, she's going to have to be examined. The nurse called me out because she had said something to the nurse. She says, that nigger, I don't want that nigger to touch me, and her husband said that, too, so I said okay. I said, I tell you what, she's going to die because she's got a ruptured ectopic pregnancy. So I said, I'm going to go back to the quarters and sleep. You let her know that if she isn't seen soon, she's going to bleed to death. She's bleeding internally, so she's going to die. Anyway, she changed her mind. That was the kind of thing you ran into.

That was the kind of thing I ran into when I became a resident in anesthesia. People would be going for operations, and I'd go do the pre-op. They'd say, I don't want that nigger to put me to sleep. There was just that kind of prejudice on Long Island, where I did my residency. Things were not good.

NC: How did you handle that? How did you cope with that?

BP: I had encountered prejudice all the time in the service. When I went to jump school, when I went to the 82nd Airborne Division, there were black showers for black officers and white showers for white officers. You couldn't go into restaurants in 1950, '51, '52, '53. The civil rights movement hadn't started. All that hadn't gone on so racism was the

order of the day. There were whites that embraced me, but there were always whites that just hated black folk. We knew that. You had to be schizophrenic, in a way, because the only way I was going to get where I had to go was to be with white folks in terms of my residency in anesthesia and learning medicine. That's who controlled the hospitals so I did the best I could to cope with it. I had some bitterness, but I'd get over that anger very quickly because you'd have to do your work.

NC: What drew you to start working in Harlem?

BP: I started working in Harlem in 1963, three years after I finished my residency. There was a guy from Finland who was my junior resident in anesthesia. I taught him how to do anesthesia. He had come here from Finland, was married, was a heavy, heavy vodka drinker, and had three children. Even went on welfare while he was on because he had three children and he qualified even though he was on salary as a resident in anesthesia. When he was anticipating he was going to graduate, he got a job at North Shore General Hospital, which was in Nassau County. They needed an anesthesiologist, and I knew that, paying $30,000 a year. Though I was the top guy in my class and had trained him and Dr. Lutzberg, who was the woman who came afterwards, they both got jobs at that place, but I couldn't because I was black. The only way I could get a job was at Harlem Hospital, where the chief of anesthesia was a black guy, Herbie Cave. Everybody knew about me and I went there and was making $13,000 a year. I was very bitter about that.

Later on I became chief of anesthesia at Oyster Bay Hospital, which was an all-white hospital. People in Nassau County knew of this black guy who was an anesthesiologist that was so good at Nassau General because many of the doctors who were attendings at Nassau General Hospital were from Oyster Bay or North Shore or other places out there. So they would be surgeons who worked there as attending physicians, and when I was a resident I put their patients to sleep, because this was the public hospital in Nassau County. So they knew how good I was.

NC: At this point, Henry K. Beecher at Mass General was criticizing the field for anesthesia-related mortality. He was bit of a whistle-blower later in terms of informed consent but in the ’50s he was a whistle-blower among his colleagues in anesthesiology. He wrote two articles about excess mortality rates, anesthesia-related mortality. There was massive outcry from the field, criticizing Beecher for doing this. Would you have known about that at that time? Would that be something that you would remember?

BP: Sure, I knew Beecher, but I knew him from attending conferences on anesthesia in Boston. He was a renowned anesthesiologist. He was at the place where anesthesia was pioneered, at Mass General. That’s how I know him, from the history and I met him at conferences.

NC: In 1963 you went to Harlem Hospital. Were you no longer working at all these different places at that point?

BP: No. I did do some moonlighting, and I worked in a doctor's office in Wyandanch, New York, in a general practitioner's office. I did some house calls and covered him on the weekends to make extra money to pay for the house.

NC: When did you begin to get interested in drug addiction?

BP: When I was at Harlem Hospital.

NC: Up to that point had you ever known anyone who had a drug or alcohol problem?

BP: You shied away from dealing with people like that. I mean, an addict was the scum of the earth.

NC: How did you begin to realize the extent of the problem?

BP: Because I handled emergency cases very well, they put me on the shift from 3:00 or 4:00 o'clock on Friday to Sunday morning. I was there during the weekend and that was my whole week's work. I was off the rest of the week, so I could do whatever I wanted to. Lots of emergency surgery came during my time there. All the time it was either indirectly or directly associated with substance abuse. One night this kid who had almost exsanguinated – bled to death - from a gunshot wound of the heart. We rushed him to the

OR and opened his chest, and I could see he had another scar on his chest. He was just semiconscious, and he had been in the hospital a year before with a stab wound in the heart. But he was an addict and his admission to the hospital was associated with his addiction. Once I got his old chart, I read this. I did a study and wrote a paper after I saw that 90 percent of the emergency surgery done at Harlem Hospital on the weekends was either directly or indirectly associated with narcotic addiction.

NC: Was that your first paper?

BP: Yes, that was my first. The dean up at Columbia, Mel Yahr, who was the dean at that time, found L-dopa and was a big guy in Parkinson's disease research, saw the paper. There was an affiliation between Columbia and Harlem at the time. When he saw the paper and called me and said, Dr. Primm, maybe you should do what you have suggested. What I had suggested was that, if a person comes in the hospital and has a surgical or medical diagnosis, no matter what it was, and also happens to have a problem with substance abuse, that that person should be seen and something done about the substance abuse while they were more vulnerable and reachable in the hospital setting. He thought that was a great idea.

He spoke to the chief of anesthesia at the hospital, Dr. Cave. I already had done some very innovative things at Harlem Hospital. The first time they had a resuscitation team, I started it. They never had even a cart for a code blue, when somebody has a failing heart

and you go to them. They didn't have anything like that going. I started all that at Harlem. So I was known as very innovative at the hospital and I was very friendly. I would get the student nurses to help me do all kinds of things, so I said, we should have a team of people that go in and see somebody who may have a surgical diagnosis or a medical diagnosis that also has a substance abuse problem, and talk to them about going into drug treatment, and get them into drug treatment.

NC: What did drug treatment consist of that the time?

BP: It wasn't much of anything. It was mostly therapeutic communities. I called this thing HOC, the Hospital Orientation Center, which had a staff of three people, me, a secretary, and another young fellow. We worked out of a closet, literally. That was my office. We set it up and started seeing people. We didn't have any place for people to go to get treatment. Therapeutic communities were just starting to get going. Phoenix House was going and there was Odyssey House, Exodus House, and the Addicts Rehabilitation Center. That was it in New York. They had limited space. Methadone was just starting in 1965 or '64 at Beth Israel Hospital downtown. If you were in Harlem, and you were addicted, and you wanted treatment, and you wanted to get on methadone, you had to go down to Beth Israel to be inducted, and stabilized. Then you were sent back up to Harlem, where they would dispense the medication.

So I was kind of a revolutionary. I said, why do black people have to leave Harlem, the center of addiction, where black doctors are here in great numbers, and we're all smart, just as good as white doctors? Why send them downtown to a hospital where it's very difficult for me to even practice medicine, and put them on a substance that they're going to have to be on for the rest of their lives, supposedly, and then send them back uptown for us to continue to refill their drug need? I said something's wrong with that. What are these white people doing, trying to enslave black folks and make us all into zombies?

NC: Did you think that at the time?

BP: Yes, I thought that. I'm kind of a revolutionary anyway. I said, what is this bullshit? I don't want this anymore. Dr. Trussell, who was the dean of the affiliation contract, they literally despised me because they thought I was going to ruin this whole thing that they had started that was going to save the world in terms of addiction.

Anyway, about a year later an institution was started up by a guy named Dr. Thomas Matthew. I was very well known by then to be interested in the addiction problem. Tom started up a thing called NEGRO, the National Economic Growth and Reconstruction Organization. NEGRO was to do healthcare, develop economic endeavors for black folk, to liberate us. Tom was a very prominent neurosurgeon, and I was known a very active and vocal anesthesiologist. He got me to come to work in the institution called Interfaith Hospital that he set up. I was going to do the anesthesia there, and he would do surgery,

and we also would do work about the addicted. We would bring addicts in, detoxify them, do therapy, and so forth. I had this experience already with the Harlem Hospital Orientation Center. So I was the guy who was in charge of the hospital, where I was director of professional services. This was in the middle 1960s, ’65, ’66, ’67. Then in ’68, Bobby Kennedy was killed. When he was assassinated, Nick Katzenbach, who was attorney general, and Burke Marshall, that whole group of Democrats, came back to New York looking for a candidate for the presidency of the United States. New York City Mayor Lindsay wanted to switch from Republican to Democrat. When Bobby was killed, Mayor Lindsay was trying to position himself to become the Democratic presidential candidate. The problem of addiction in New York City was rampant and he was the mayor. One of the weak spots in his administration was he didn’t know what to do about addiction. Beth Israel Hospital had a very closed methadone maintenance treatment program, which was supposedly the answer at the time. Riverside Hospital, the only hospital that was treating addicts, was closed because of its poor performance. It was on North Brothers Island.

Dr. Trussell was chosen by the governor of New York, who was Tom Dewey at the time, to investigate Riverside, which closed in 1962 or ’63. Once Dr. Trussell, who was at the Columbia School of Public Health, closed Riverside, he knew of the work of Dole and Nyswander down at Rockefeller. Dr. Nyswander was also at the Morris Bernstein Institute, at Manhattan General Hospital. Dr. Trussell knew that this work was being done and he wanted to do something because he had become commissioner after he headed up

this committee to investigate Riverside, found that it was a total failure and should be closed, recommended to Dewey that it should be closed, and it was closed. He knew something else had to be done. Trussell then became Commissioner of Health in the City of New York, and got Dole and Nyswander a $100,000 grant from a research foundation. That grant allowed them to continue their work with methadone maintenance at Beth Israel, and at Manhattan General, which then became the Morris Bernstein Institute.

They developed methadone maintenance and expanded the program even to Harlem Hospital, where there was a fellow that they trained named James Robertson, an M.D. He was an internist, a general practitioner, who ran the Harlem methadone maintenance treatment program. They would send patients who were inducted at the Morris Bernstein Institute or Manhattan General, and keep them there for a couple of weeks or so and stabilize them on methadone. Then they were medicated at Harlem. That bothered doctors at Harlem, too.

The whole Tuskegee thing came out about that time, too, and experimenting on black people. Racism was still rampant. We had all kinds of cockamamie ideas about what was going on. It was so racist that there were very few, if any, black doctors on the staff of Beth Israel, or very few black doctors on the staff of any white hospital in New York – there were hardly any at Cornell, New York Hospital. Presbyterian had maybe four or five, but that was it. They just didn't exist. We were all suspect. Being shut out and the racism toward us further exacerbated our feelings of distrust. These were real issues. If

you put yourself in the position where you had done all this studying, passed all your exams, one, two, three, and then it's the white boys who had gone to American schools, who took the exam with you, who didn't pass the first time, who you have to listen to. If they failed, but passed the New York State Board the next time, they could get reciprocity to go to another state to practice. As a foreign graduate, I had to go to that other state and take an exam even though I passed the first time with a high mark. I was very angry. I had been a paratrooper, had been a Johnny Armstrong all-American boy, doing everything right.

NC: Would it be fair to say that at some point you translated that anger and revolutionary spirit into starting your own institution?

BP: Exactly. Let me tell you what happened there. The Vera Institute of Justice, which was headed up by Herb Sturz, was very close to Lindsay. Herb was a backroom negotiator when it came to politics. Burke Marshall was that in the Ford Foundation. Dick Katzenbach was vice president of IBM. They were all Kennedy people who needed to bolster the candidacy of John Lindsay and shore him up in terms of his approach to doing something about the addiction problem in the city. They knew the success of the methadone program. There was no methadone program in Brooklyn, where the problem was up and going, and still none really established in Harlem, except at Harlem Hospital, where it was hard to get on it. There was one in the Bronx already, with Joyce Lowinson at Albert Einstein College of Medicine. But Harlem was really the center of addiction

and there was nothing there. So they said, we need to start some drug treatment programs in Brooklyn and Harlem. They used the Model Cities initiative money. They got some money through Bert Brown, who was then at the National Institute of Mental Health. They spoke to Lois Chatham, who worked at the National Institute of Mental Health, to start a program in Brooklyn that would expand to treat 5,000 addicts, 2,500 in Brooklyn and 2,500 a little later in Harlem. Through the model cities program, a star-studded board of directors, and the Vera Institute of Justice, they found a way for Lindsay to take care of his addiction problem in the City of New York. They needed somebody to go into the black communities to explain the need for drug treatment programs and in particular to explain the need to expand methadone maintenance treatment, the Dole and Nyswander thing.

Well, there was this guy at the Harlem hospital named Beny Primm who had been very outspoken and had taken over some buildings in Harlem. I had taken over some abandoned buildings and a state building. By night I smuggled in beds, sheets, and medical equipment, and set up a detoxification center right on 125th Street in Harlem. I went underground through a garage, up into the building, and took the building. I set up detox right in this building, a whole hospital setting unbeknownst to the people who owned the building, which really belonged to the state. They didn't know what to do. I started treating addicts there the next day, detoxifying them, because there was no program in Harlem. They knew that here was this active guy who the community might

believe in, and so they asked me to consult on their program that they wanted to start. So I did.

NC: At that point did you believe in methadone maintenance?

BP: I thought methadone was good, but you could go from methadone to abstinence. I didn't think you had to be on methadone ad infinitum, to stay on it for the rest of your life. I thought you could use it as a tool to get people into treatment, and start doing psychotherapy, and whatever else you needed to do to provide services that would then turn them around, so they would not necessarily be doing the criminal behavior and all that stuff.

I got chosen as a consultant to this program to go out and talk to residents in Brooklyn and I did. When the program was getting ready to get started, they needed somebody to direct it. I was running a detox center at Interfaith and doing all kind of revolutionary stuff in Harlem, so I knew the street people and was dealing with them. A lot of them were addicts. I had taken over offices in downtown New York, social service offices. I'd become known as a guy who was responsible, not the violent kind of a revolutionary type, but outspoken and really telling the truth. It's a wonder I never got put in jail or got beat up by the cops. It was amazing how I was treated, really.

After consulting with this program and talking about the need, the people in Brooklyn finally said, well, you can establish it in a model cities area. They got the building and said, well, Beny, what about you running the program? I said, you kidding me? I didn't run no methadone program. Why would I want to run a methadone program – put people on stuff for the rest of their lives. I was just dismissive of it. Then they said, you can run it like you want. This will be good research for you. Harvard will do the legal part to see the impact that your program will make on the criminal activity of these people. You'll have Jim Vornberg from Harvard doing the criminal evaluation. You'll have Herb Kleber at Yale to do the medical evaluation. Lukoff at Columbia will do the social. You'll have three evaluations. It was beginning to look pretty good to me but I said, no, I don't want that. They said, listen, why don't you give it a thought? I said no, I don't want that, I'm doing what I'm doing, and you all go ahead. But they kept coming back to me. They said, what would it take to get you to do this? I said, I don't want anything, I don't want to do it. They said, well, we'll pay you what you're making now and more. You don't have to be going to all these different hospitals doing anesthesia and hustling here and there. You can direct your mind to doing this research. We'll offer you $40,000 a year.

In my anesthesia practice, after I paid off my nurse anesthetist, I was clearing about $28,000, maybe. It was beginning to sound pretty good. No call schedule, no malpractice insurance, and I don't have to wear what these people in anesthesia wore. I was chief of anesthesia at Whitestone Hospital and the first year I was there they took 10 percent of whatever I made. Next year 15 percent. That year they were going to take 20

percent of whatever my gross was. I'm saying, what am I doing here? These guys are just taking my money for me to be here at the hospital doing work that they need to get done. This is ridiculous, a rip-off.

So then Herb says, Beny, you've got to do this. We'll pay you $45,000 a year and all your expenses if you run this program because we think you're the guy. I said okay, I'll do it. I'll do the medical but I don't want any bullshit with the administration. They had a guy, a lawyer, to do the administrative part.

NC: So that's how ARTC got started.

BP: Yes, we had $1.4 million or something like that through the Vera Institute of Justice and the City of New York Model Cities program. That's how the money flowed. Then I was in the papers. Dr. Dole said the ARTC thing was a 10-ton airplane with a one-horsepower motor that would never fly. I was the one-horsepower motor.

NC: Why was Dole so skeptical?

BP: They knew that I had been not a proponent of classical methadone maintenance. I started talking about neoclassical methadone maintenance and ways to do methadone to abstinence. They were variations on the theme as far as I was concerned. There's no set way to do anything, but they were unalterably opposed and rightfully so. They had put a

lot of research and time into this, and I could understand that. Fran Gearing at Columbia, and Trussell, who was by then the Commissioner of Health to the City of New York, were backing them. This guy Primm was up there making problems and was now going to start a program in Brooklyn. There were some scathing articles about me in The New York Times. They said I was killing people, giving children methadone, and manipulating the doses. They said people were dying from overdoses. All this was in the paper. They were tarring and feathering me.

NC: How did you handle that? How did you respond to that?

BP: I said, these people are just mean white people, the devil, not nice people.

NC: So were you able to get that program up and going pretty quickly, though, despite the obstacles?

BP: Yes, it started in October of 1969. As a doctor, as an anesthesiologist, I always said you've got to know the science behind this stuff. I said, I just can't be going out here running a methadone program, and they won't let me come over to Beth Israel and learn what they did. They won't share their information with me, so I said, I've got to find a way to learn about this from a medical scientific point of view. I made an arrangement to go to the Addiction Research Center in Lexington. I went down to spend two weeks in 1968 with Don Jasinski.

NC: They didn't like methadone at the ARC. They didn't like methadone maintenance. They had done initial studies on the drug after the Second World War, but they did not like Dole and Nyswander's maintenance approach at all.

BP: Well, that's true. That's true. But they allowed me to come, probably because they had heard these things about me in New York. I said, let me go and learn from these white boys at the research center how to really do this thing. Plus they were not in favor of maintenance but they wanted to use it in whatever way they want to use it. So I spent two weeks with Don Jasinski, Chuck Gorodetsky, Frank Fraser and Bill Martin. They all said, okay, come on in, we'll teach you a little something. I went down there, and they were very nice to me.

NC: What did you make of that place?

BP: I thought it was wonderful. This was a very select group of guys. So I went there, and I lived at a hotel and went over there every day, just like I was going to work. I talked to the patients and the prisoners about methadone. Learned to see how it worked once when you gave it and all that. Chuck Gorodetzky really took a liking to me. They thought I was this crazy black guy from New York. They were very admiring of my spunk and we all became very good friends. We're very, very good friends now.

NC: Did you learn a lot from them?

BP: Yes, and then I heard about Jerry Jaffe out there in Chicago, running a program. He had been up at Einstein, did his residence, and then went out to the Illinois Drug Abuse Program. I thought that substance abuse should have all these modalities. Why should we just have people on methadone maintenance ad infinitum all their lives? We could have methadone maintenance and switch them over. They could go into a TC once they detox, and maybe they'd end up being drug free. So I heard about this guy out there, and I called him up and went out there. Jerry kind of looked at me like, what do you want to know this for? He was very frank with me. He didn't know where I was coming from.

We became very, very close. I stayed out there about two weeks. He had Safari House, and he had another place in a hospital where he was doing detox, and he was doing TC, and switching people from methadone maintenance to drug free. They were doing exceptionally well. I really admired him. He and Ed Senay taught me more about maintenance and the mixing of modalities. When I got back to New York, I said, this is what I'm going to do. I'm going to do it like Jerry Jaffe did in Chicago.

NC: Was Jerry dealing with a lot of black people at IDAP?

BP: Matt Wright, who was Jerry's right-hand guy, was an ex-addict. He ran Safari House. Then there was Joey Joya and David Deitch out there with him. That was it for black guys... I went out there just at the beginning, just before I went into ARTC.

I was looking for models to duplicate. I hadn't been working in addiction, and these guys had been working in addiction, with addicts. What did I know about addicts except for when they were on the operating table? At Interfaith Hospital, I was bringing them in, detoxifying them, keeping them for two weeks, and letting them go through therapy. It was like a revolving door. I did it for about two years or so before I went over to ARTC from '66, '67, and '68. In '69 I started ARTC. But in 1970, '71, I was at a conference in Washington. I was in the back of the room because I want to slip out. I wasn't going to stay. Some guy comes in the back of the room and says, Dr. Jaffe is looking for you. It was a Secret Service guy. It scared me. He said, Dr. Jaffe wants to see you, so I saw Jerry, who says, I want you to go to Vietnam with me.

NC: Tell me about your trip to Vietnam.

BP: Jerry said, we're going to go over there because the President wants me to look at the drug problem. I'd like you to go with me. I said, I can't do that, you kidding me? Go to 'Nam? I said, I'm a retired Army officer and I missed combat. I don't want to get killed. He said, you're not going to get killed. He talked me into it, so I said okay and went home and told my wife. She says, Beny, you're crazy with this drug stuff. Please

don't do this. I said, I think I have to do it. She says, I don't want you to do it. We've got kids, you've done your Army time, and now you're working with these addicts, too. I'm afraid. I said, well, don't be. I think I'm going to be all right.

They brought me to Washington to orient me to the whole trip. They brought my wife down to Washington the week before we went. They'd chosen who was going to accompany us on the trip. Seth Rosenberg was Jerry's assistant. Jeffrey Donfeld was on the domestic policy council. Me and Jerry and a couple of bodyguards on the plane. We took the first free radical assay testing machine, EMIT, over there with us on the plane. The plane was a very private 747. My wife was to be on the plane with us, and we were going to drop her off in New York on the tarmac. This is what happened. We kept on to Alaska and stopped in Anchorage. They checked people coming back, their belongings, and they had dogs sniff out drugs in their belongings in Anchorage. We knew what we were going to be facing when we got over there because people were shipping drugs back home in their belongings. We flew from there to Taiwan, and from there to Hong Kong, and from Hong Kong to Saigon.

We did the whole thing in Vietnam, set up drug testing, called it the Pee House of the Harvest Moon. We had troughs where the guys would come in and pee, and waited while we observed them and tested their urine. Up to the rank of major, if they were positive we kept them and sent them to treatment.

NC: How long were you there in Vietnam? What exactly did you do during the trip?

BP: We were there about three weeks. We set up the testing program and set up treatment places in Vietnam, at the front lines, too. I remember once we were in a plane, me, General Bernstein, and Jerry. They started vomiting, they got sick. The plane motors went out, when we were in enemy territory. Thought we were going to crash. I said, here I am in this damn place, and didn't even have a chute. I said, what am I doing here? I had friends who were colonels who were over there in combat, who were in the 82nd with me.

Anyway, we flew up to the front. They got sick, and Jerry had to go to the hospital, so he was in the hospital for about ten days. So I had to run the whole thing by myself. We became very, very close. I had to talk to the generals and command them. I had the honorific rank of a major general in order to command them so that I would be able to get things done.

When we left Vietnam they asked me what would I like. I said, I'd like a couple of my friends to meet me in Hawaii. Guys who were in combat. They sent two of my friends who were classmates – they were colonels – to meet me at Admiral Nimitz's house in Hawaii for four days. They had R&R, rec and recuperation, and the house was stocked with steaks and liquor and everything we wanted. It was just wonderful. They didn't know how they even got there. I really learned what power was in this country.

I was treated like a white boy. I hate to put it like that, I mean, I hate to put...

NC: Better than most white boys, I think.

BP: Yeah. We were hobnobbing with the President. We came back and met at San Clemente with the President. We're sitting around the table like this. There I am, a black revolutionary in Harlem, taking over buildings, an ex-paratrooper type, now sitting with the President of the United States and telling him about substance abuse. He says, you guys got to write a book. I smoked a pipe then, and I think he got a little bit afraid because he didn't recognize it was a pipe until I put it on the table. Then he was more comfortable. There are pictures of all this, by the way. I have pictures of all of this stuff.

After that, when we came back, Jerry was the drug czar and he said, Beny, I want you to continue to come down. I said, Jerry, I've got to run my program. He says, you'll fly down here every day and fly back to New York and just help set up the office. And that's what I did.

NC: How did you work out having your home in New York?

BP: We would fly down in the morning, get up, go get the 7:00 o'clock shuttle, or the 8:00 o'clock shuttle, be in Washington at 9:00, at my desk at 9:15 in the old executive

office building. I did that for a year, year and a half about two or three times a week for the Special Action Office of Drug Abuse Prevention. They'd bring my wife down. My first job was to train all the people in the United States, at the Army facilities and the VA hospitals, so that they would be able to assess soldiers coming back from Vietnam and to treat them right. So I would go to all the posts and train people all around the country. I brought them into Washington and trained them. I have pictures of all of these guys that I trained. We sent one team to Vietnam.

NC: Was it about then that you started to be involved with CPDD?

BP: '72. Lee Robins and I were the first two minorities, she as a woman and me as a black, on the Committee on Problems with Drug Dependence. That's when people like Hans Kosterlitz, John Hughes, and Eric Simon would come to this meeting. The committee was criticized for even funding Kosterlitz, who found enkephalin. What gets me is how this thing has evolved. I see kids around here in shorts and T-shirts at the plenary. That's why you see me like this. I'll never change. But it's okay, they're still doing the work.

Have you read Stephen Jay Epstein's book, *Agency of Fear*, which was terribly critical of the CPDD? We were terribly vilified. I don't want to lose that history because that's important in building up to what's happened. What has happened now to enkephalins and endorphins has changed the field into this whole brain science thing.

NC: Do you remember what happened the first time you attended a CPDD meeting in 1972?

BP: I made a speech: "Methadone Is No Answer." I still have the speech. It's not only methadone. You have to do something else with methadone. I had come to that conclusion back then. I left SAODAP maybe a year before Jaffe did, but I was still consulting when he would call on me. Later I was on a NIDA advisory committee and then on the ADAMHA advisory committee.

NC: What were those committees up to when you were on them?

BP: Each department has an advisory committee. I was on the FDA advisory committee for a while that dealt with drugs and drugs of abuse. Then I became a member of the NIDA advisory committee in the 1980s.

NC: How did the Urban Resource Institute (URI) come about?

BP: URI is an offshoot of ARTC. I began to see all different social dislocations in the community that needed attention and said, you can't get the grants through the Addiction Research and Treatment Corporation. In New York State they just didn't want to give you a grant to do stuff on battered women or the developmental disabled under the name of

addiction. So we needed another corporation. We set up another private nonprofit corporation to do other stuff. There we do an alcoholism program, we do a developmental disabled program, we do AIDS education, we do a transportation program for people who are developmentally disabled. We also have intermediate care facilities for the severely disabled. We set that up in 1983 or '84.

NC: Returning to Washington and your work at the federal level, tell me, didn't you work for Carlton Turner?

BP: Yes, I did. Carlton had me as a consultant to his office. He was President Reagan's advisor on substance abuse. He was the so-called drug czar. The first real drug czar was William Bennett, because that was a cabinet post. Carlton had that kind of a role before, but he was not considered the drug czar because it wasn't a cabinet post until later. I used to consult with Carlton all the time. How I got introduced to Carlton was that I was on the Advisory Committee to the Food and Drug Administration. They had an advisory committee on drugs that had the potential to be addictive. I had been on that committee and had gone down to the University of Mississippi to the marijuana farm. A lot of work was being done there on marijuana by Dr. K. Foley and others. Before Carlton became the drug czar he had worked in the laboratory at the University of Mississippi. Every genus and species of marijuana is grown there so that they test the potency of marijuana. They look at tetrahydrocannabinoids and cannabinols and everything that comes out of marijuana.

NC: What had your work had to do with marijuana?

BP: I had not done any work on marijuana. I had gone to Vietnam and I was known as a guy who worked in substance abuse. So I got appointed to this committee. I had some background in pharmacology because when I had graduated from medical school in Geneva, I had gotten my *Certificat de Fin d'Etudes Medicaux*, which said that I had finished medical school. That is equal to the M.D. degree, but what happens in Swiss schools, in order to get your doctorate in medicine, you have to do a thesis and you have to do it in a specialty. You stay around another six or eight months, and I did mine in pharmacology. Then you get a Doctorat aux Medecin.

NC: What was Carlton Turner like to work for?

BP: He constantly wanted my input in terms of policy and ways to go at the federal level. He wanted my presence because of my recognition in the black community. With me at his side, it made a way for him to be more accepted. He used me, but I didn't mind being used. You've got to be used in politics. But you use them, too, you know. That's important to me.

He was good to work with. He was a good Southern boy, and Southern whites and blacks have a synergy. There's racism, we know that. But black women used to nurse their

babies. Strom Thurmond had an affair with the maid that worked in his house and had a child by her. Not only were white southerners very closely related to blacks despite racism always being there. All her life she kept the secret and he even gave her money to go to college. So Carlton was just another good Southern guy. He was stymied by the administration when he was at the White House. He couldn't get much done. He couldn't get done all the things he thought was necessary, though we tried.

NC: What would you say he was trying to do in terms of substance abuse and drug policy?

BP: Status quo, keep things conservative. He pandered to the conservative side and he was controlled by them, really. He was safe for that administration, and he did some good stuff, but he mostly did nothing. He was a nice guy, a nice family guy.

NC: What led you to your appointment to the Presidential Commission on HIV/AIDS?

BP: I was on two presidential commissions. The first one was the Human Immunodeficiency Virus Epidemic Commission. I was appointed to in 1988 during the Reagan administration. That came about because of my consulting work with Carlton Turner. Being on the FDA Advisory Committee, and having gotten known by the Republican administration, when I went to Vietnam during the Nixon administration, led to my being appointed to the Human Immunodeficiency Virus Epidemic Committee

formed in late 1987. They had a black on the committee, Woodrow (Woody) Meyers, and he became argumentative with the chairman and, of course, he was very critical of what the administration was doing. He got kicked off the committee and so did the chairman. I got a call that they wanted to talk to me. Bert Lee III, MD, at that time the president's physician and Yale classmate, called me. He had been aware of my work here in New York on substance abuse. They had problems with what they were going to do with substance abusers who had HIV. They thought I was a likely guy to be able to do something about that. I had been speaking about this strange lymphadenopathy, this associated virus that my patients had and he had gotten wind of that. He made a recommendation that I join the Human Immunodeficiency Virus Epidemic Committee.

NC: Do you recall, Dr. Primm, when you first started seeing HIV in your patients?

BP: Probably around 1983, I had a patient that had pan-lymphadenopathy in my Harlem clinic, and I tried to get this patient to have a biopsy. His mandible lymph nodes kept getting larger and larger, and he wouldn't get a biopsy. He kept getting sicker and sicker and he later died of an opportunistic infection, pneumocystis carinii pneumonia. I began to talk about this problem in every medical conference that I attended, and how this was causing devastation in the black community, particularly among drug users. I had no idea that they were spreading this disease to other individuals. I began to read about it and I began to learn about what Luc Montagnier was doing at the University of Paris, and what the researcher Robert Gallo was doing here at the National Institutes of Health.

I began to think about what to do with addicts. I never associated it with injection drug use, I just knew that addicts had this and that I thought it might be sexually transmitted. I had an increase in tuberculosis among my patient population and so forth. In 1984 when they first identified the virus, I had an interest in it, and I would talk about it to the newspapers. That's how I got known. So when they needed to replace Woody Meyers, Bert Lee had read about some of the stuff I had done here in New York—I had been quoted a couple of times in *The New York Times*—and he recommended that I come on the commission. He talked to me and said that the president would like for me to come out to California and join this commission. I consented to do that and went out to the first meeting in Los Angeles at a hotel at the airport. I was there representing what to do with persons who became infected with HIV who happened to be substance abusers. I was to help to write the chapter in the book to advise the president about what to do about this problem.

We went around to multiple cities throughout the United States. I remember we met in San Francisco, it was a very charged meeting. Then there was a very charged meeting in Miami and New York. Then there was ACT UP, the AIDs Coalition to Unleash Power. They were a group that was very radical. They would disrupt the meetings that we would have in different cities, these town hall meetings. I got so that I said there was no need for this, and I would go down and talk to them. They had such respect for me from having worked in substance abuse and taken over buildings in Harlem years and years ago. They

trusted me and they would cool out, and allow us to go on with the meeting. For these very conservative people on the advisory committee, they were mesmerized by my ability to do that. I can remember in Miami, the Haitians were going to take over the meeting and they did. I spoke French, so I cooled them out and they had their meeting with me on the sidewalk, and the meeting was able to take place and go forward and we were able to satisfy lots of their demands. I would talk to them. I became that kind of a person with that advisory commission to the president. There were a lot of bigwigs on that commission—there was Cardinal O'Connor, who was cardinal here in New York; there was Bill Bennett's father; there was Admiral Watkins. It was a star-studded group of people. I became pretty well known and I helped to write the chapter.

We came out with recommendations to the president in 1988. Of course, Bert Lee was a classmate of George Herbert Walker Bush at Yale, and they were friends. He was one of Reagan's physicians. He liked me. I was the only black at that time on the commission. So that's how I got introduced first to HIV and AIDs.

When Bush was thinking of running for president, he had a problem with the whole addiction situation. They didn't like what was going on there, and so I got a call to come to Washington to meet the vice president of the United States and to choose four or five people to come with me and talk to him about what he should do for substance abuse in case he became president. Some of the people who were on the staff of President Reagan's HIV Epidemic Commission had recommended me to Vice President Bush

because I knew something about substance abuse. I chose four or five people and we went there and spent two-and-a-half hours with the vice president talking about what we thought he should do if he became president. Indeed, he became president. So I had been an adviser to the National Institute on Drug Abuse and an adviser to the Alcohol, Drug Abuse, and Mental Health Administration and had been making suggestions there also simultaneously. There was an overlap. Now we've got these three different things through which I had been known: one, the marijuana farm and the drug abuse situation with Carlton Turner; two, the President's Advisory Commission; and, three, they had my resume there to become the ambassador to Haiti. I had gone to 'Nam and I had done some really good things and I was a black guy and they needed black representation. So when my resume went over the White House to be vetted for the ambassadorial post in Haiti, I had even gone to Haiti to look at the situation. My wife was also very sick at the time, and once I had looked at it, I didn't really want to go, but the ambassadorial post was awfully attractive. The White House personnel office saw my resume and decided that this guy doesn't need to be going to Haiti, he needs to be serving on the President's Advisory Committee for HIV. So I did that.

Then when George Bush became president, he invited me to come down on the boat, to come down to Mississippi with him, and I did. Three or four weeks later, I get a call from Bob Trachtenburg to come down and meet with him and Fred Goodwin. They said, Beny, you're on the advisory committee, but the President wants you to do something else. I said, no no no no no, I'm fine where I am, I just want to run my program now and be

cool. I had just finished doing a thing with the Presidential Advisory Committee on the Human Immunodeficiency Virus epidemic. They said, no, there's something that we want you to do. We want you to do what you have been advocating all along. In the advisory committees we can't have a decent meeting because of you always suggesting this, suggesting that, suggesting the other. So we want you to do this job as the Director of the Office of Treatment Improvement. We want you to head it up and get it started. You don't have any competition. This is the job. The President wants you to do this and we want you do to this, and that's that. I said, but you don't pay enough money for me. They said, you don't have to come here as an employee. We'll pay your company for you to be here. I said, wow.

And that's what they did. When Mr. Bush was getting elected and having the Republican National Convention in New Orleans, they asked me to come and be on the boat with him coming down the Mississippi into New Orleans. He was going to choose his Vice President, Dan Quayle, that day, and I knew him. I didn't know that it was going to be Dan Quayle, but I knew that was what was going to happen. So I got on the boat north of New Orleans in the Mississippi and came down the river with him and then into New Orleans. Saw him, and he waved and talked to me. Then I didn't see him anymore.

NC: Tell us what the Office of Treatment Improvement was.

BP: The Office of Treatment Improvement was in the ADAMHA, the Alcohol, Drug

Abuse, and Mental Health Administration. There was an Office of Prevention and the Office of Treatment Improvement, OTI, under ADAMHA. Then ADAMHA evolved into SAMHSA, which had the Center for Substance Abuse Treatment (CSAT) and the Center for Substance Abuse Prevention (CSAP) and the Center for Mental Health Services (CMHS).

NC: Did you sense a rift between substance abuse research and treatment at that time?

BP: Yes. I had problems with that break of research and treatment. I did not want to get involved in an intramural kind of war like what went on. I think there was some resentment on the part of NIDA that some of their funds were taken away to form OTI. When the NIMH moved from the ADAMHA over into NIH, there was this elitism that was created that prevention was not really science, and science was everything that had to be under NIH, and NIMH was science, and so forth and so on.

NC: Are you saying that there was an elitism created at NIDA by that split?

BP: It was always there, I probably always felt something like that, but it became more apparent during that period of time. I could see us being together. I thought it would destroy substance abuse as we knew it. Of course I still had influence at NIDA because of my associations with the College of Problems of Drug Dependence (CPDD) and the people who ran NIDA, and the fact that I'm a member of the American College of

Neuropsychopharmacology. Goodwin and company, people like that, liked me. To tell you the truth, I think it helped to have a little color around for them, too. Even though there were certain areas I was locked out of, that I was not that privy to, they were pretty accepting of me. It allowed me to bring along people, who were even more capable than I am in terms of their own preparation for the kind of research that goes on, which has been a godsend for the field. That's sort of my role. I know also that my role also is to get some things done politically. I'm very happy with what I've done in this field. I saw a need for young, white or black, didn't matter to me because my Army experience was such that, if we got something going, I don't care what you are. I see all my relationships like that. With Jerry Jaffe, it's like he's my brother, there ain't no white boy or Jew. He's my brother, his kids are like my kids. My kids are like his kids. They're all successful, they're just good kids. Jim Anthony is like a son to me. I've been a champion of women's involvement in this field. I look at Maxine Stitzer, Loretta Finnegan, Joyce Lowinson, Karol Kaltenbach, and Mary Jeanne Kreek, and all of the women that I know who have done so much in this field and I champion their causes.

NC: What did directing the Office of Treatment Improvement enable you to do?

BP: I made the changes that I always wanted to make. I was able to talk about comprehensiveness and that methadone should have this, this, this, this, and drug abuse should have this, this, this, and this. That was implemented. I'm just ecstatic about that. It revolutionized drug treatment. I was able to get representation from Native Americans,

Hispanics, and blacks involved in choosing grantees and on the different committees. I talked about integrating HIV identification and care for those people in substance abuse programs. They had to go together. At that time we already had a way to find seropositivity in the population. We had tests to do that. Tests were being done and the people in my program were finding that 20, 30, 40 percent of them were HIV-infected. So when I went to Washington for OTI, it was on my mind that you gotta do something about HIV among substance abusers, or you're not going to be able to do anything about this problem. It had to be integrated into the treatment process. I began to talk about comprehensiveness. I began to talk about the "supermarket of services." In other words, if you had a drug treatment program, you had to have all these other things as well. You had to have comprehensive care. If you just did methadone and didn't do anything else about the person's social dislocations, you weren't going to do anything about the disease and most of them will become recidivists. I had become pretty convinced that you had to do comprehensive care, and that's the only care that the federal government should be funding in drug treatment programs. I thought that I should be a spokesperson and make sure that's done while I was down there and able to influence substance abuse treatment and how it would go in our nation. That's what I did.

I became more and more involved with AIDS. Then the president's advisory book came out and I was mentioned therein as having contributed to it. So my HIV work just mushroomed. I was being asked to speak about HIV and its impact in the African American community all over the country. I would get people interested in it in different

parts of the country and people would start to do something about it. I became nationally known as doing something about this problem.

In 1998 after being an adviser to the CDC and speaking all over the place about this disease, they called together about fourteen African Americans to Atlanta to tell us how the problem had been burgeoning among African Americans in the country, and how bad it was. After the first day, they had told us all the data, the epidemiology, and I was meeting with some of the group that night just sitting in the bar and we talked about how negligent the CDC had been in not making this a public thing. If these numbers had been in white folk, this whole country would have been in an uproar. We needed to try to force them to do what we thought was necessary to combat the further spread of this disease among African Americans and Latinos. There weren't any Latinos with us, but we included them anyway. We decided that night to take over the meeting the next day. I had been pretty experienced in seeing people take over meetings and buildings to try to get people to do what I thought was right. We had become a little bit more sophisticated than in the earlier things I had done. We began that night to write a paper that we were going to put on the chairs of all the other invitees to say that we wanted to call a National Health Emergency for this problem of HIV in African Americans and Latinos. We went out to Kinko's and early that morning, we had a paper on the chairs of everybody who was going to be at the meeting. We chose someone who was going to take over the meeting. It was Reverend Yvette Flunder from Oakland, California. But Yvette didn't come down on time, and I was there on time. So everybody said, "Well, Dr. Primm, you're the senior

person here, you take over since she's not here." Yvette was a fiery, well spoken black woman, and a really great minister. So I took over the meeting and I demanded that the CDC call a National Health Emergency. We demanded to see the director of the CDC, and said she should be here talking to us and the meeting shouldn't go on without it. We said, "We're going to run the meeting and tell you all what to do for our people." Naturally, that didn't go over very well but it went over well enough. The director of the center for HIV and STDs was Helene Gayle (now president of CARE and chairman of the President's Advisory Commission on AIDS under the current administration). She had been a mentee of mine. I was an adviser to the Student National Medical Association, and she was president of the SNMA at the time that they had had to declare bankruptcy. I helped her get out of bankruptcy and I was like a father to her. She understood what we were trying to do. That day and the next day, she and the director of the CDC were supposed to be going to Washington to speak to the Appropriations Committee to renew the grant for CDC. Our demand that they show up at this meeting and speak to us—and if they didn't we were going to be even more disruptive—they consented to our demand and came to the meeting, both she and the director of the CDC. But then they had to leave because they had to catch a plane.

I immediately knew what I had to do. I thought, I know what I gotta do now. If they're going to leave, and go to Washington to go before the Appropriations Committee, I gotta get to Washington as well, so that when they testify before congress, before the committee, then I have to get some people in Congress to ask them some questions about

why they have been so negligent in not notifying the African American community beforehand about the problem that has really gotten out of hand. So when they flew to Washington, I flew to Washington and I met with Congressman Lou Stokes, who was a member of the Appropriations Committee, and I met with Congressman Nita Lowey, who was also a member of the Appropriations Committee. I got Lou's legislative aide to get him to ask the questions concerning the negligence of the CDC. He had no idea of the numbers, which were astronomical compared to whites and others. He was very concerned and of course made a very passionate interrogation of both Helene and the director of the CDC. They were asked questions about why the numbers were so great and why they hadn't done something to focus more specifically on that population.

Let me tell you how the thirteen of us got to the CDC in the first place. There were people working in the Division of HIV and STDs and Tuberculosis who were black folk who would call people like ourselves, activists like Deborah Fraser –Howze and me in the field, and let us know what was going on so we had an idea, but we had no idea it was so bad. To show you how bad things were, there were people who saw the data and the epidemiological reports and had become alarmed. The top people were so afraid that they would be accused of stigmatizing black folk that they were reluctant to do anything. That happens all the time at the federal government. They were reluctant to do anything that may be something else added to black folks' burden.

So we had an in, and we were being informed by interested people about these kinds of

situations. Had we not had that, we never would have been able to be effective to get Congress to do what they did. Later on, I had gone to the Congressional Black Caucus because through Lou Stokes, who was chairman of the Health Advisory Committee of the Congressional Black Caucus, I was able to make a speech that spring to them. They became up in arms about it and in speaking to them, I challenged David Satcher, who was the Surgeon General. I hated to do that as David and I had been very good friends for years when he was president of Meheary. I demanded that the Secretary of HHS, who was Donna Shalala, do something about HIV at the time, and do it not only because it was right to do so but because of these numbers. It was shameful. They couldn't get a national health emergency called because that would have created some kind of response that they only do when there is a major epidemic. So it went back and forth and then Maxine Waters became enamored with this whole problem and got most of the women in the Congressional Black Caucus to go along with her. With me and Deborah Fraser-Howze here in New York, they came up with having a town hall meeting in Washington and invite activists like ourselves from around the country to come to Washington and be demonstrative and have a meeting at the Rayburn building to discuss what should be done about this. Eleanor Holmes Norton and of course Maxine Waters, Barbara Lee, Dr. Donna Christensen from the Virgin Islands, were all extremely active to bring this to the fore and to demand that President Clinton declare an emergency in the African American community. They got to the president and we had the meeting in Washington. We bussed people down to Washington from New York and from Philadelphia and from Richmond and Baltimore, and had a major all-day meeting with members of the Congressional

Black Caucus with a lot of fanfare and certainly a press conference. The president was notified and ended up declaring not a health emergency but that it was a problem in communities of color, not only the African American community but that it was a major problem in our nation. He ended up appropriating 156 million dollars to do something about the problem. I ended up being the spokesperson because I guess I had the grayest hair and a well-known name.

NC: Were you still working for the federal government then? How long were you at the Office of Treatment Improvement (OTI)?

BP: I was at OTI about two years, and then it became CSAT [Center for Substance Abuse Treatment]. I was the first director of CSAT. I left in the spring of 1993. Clinton was elected in November of ’92 and I stayed after his election. I was still director until the spring of the next year. So by 1998, I had left CSAT, which stayed head-less for a while, and then Lisa Scheckel, who had been my deputy, was acting director of CSAT. I never had a government check. I was on loan from my corporation to the federal government and the government paid the Addiction Research and Treatment Corporation (it wasn’t mine because it’s a nonprofit, but I had started it and that’s where I had worked). When I left, I went right back to my job as executive director of ARTC.

NC: What federal roles did you play after that? When did your work with the next presidential commission start?

BP: After all that stuff with the Clinton administration in 1998, getting him to declare that there was a problem and to give us the money, I became a member of the Advisory Committee to the CDC and was one of the first members of the Joint Advisory Commission to the CDC at HRSA [Health Resources and Services Administration]. The Joint Advisory Commission came out of what I called the Linkage Initiative. I sponsored a conference that brought together all of the different acronyms in the federal government—representatives from HRSA, SAMHSA, and the CDC—that had anything to do with HIV and AIDs. Orrin Hatch was a sponsor of this Linkage Initiative with me, and Fred Goodwin, who was then head of ADAMHA.

Then I got a call from Secretary Sullivan about serving on the Advisory Commission on HIV and AIDs of President George Bush. Lou was co-chairman of the advisory commission and I had worked under him during the George Herbert Walker Bush administration. He was secretary of HHS and he knew about my work on HIV and thought I would be a good member of the president's advisory commission. Dr. Coburn, who was then a senator, was co-chair, so I went and became a member of the commission. I was appointed and immediately served on the subcommittee of treatment and domestic committee. There were two committees, one was the domestic committee and the other was the international committee. I was assigned to the treatment and domestic committee. I had quite an ample voice on almost every issue. Normally, you are appointed for three years, but when my three years were up, they felt very strongly that

my contributions had been such that they wanted me to stay over and I was held over for another two years. I was on that commission longer than any other single person. I have now been off the committee now for about a year and a half.

NC: What do you feel you were able to accomplish on that committee?

BP: I began to have great influence in terms of focus not only on the African American community but also the Puerto Rican community in Puerto Rico, who still have yet inadequate help for their HIV problem. It's rampant, especially among injection drug users. My pet peeve was also about testing in the prison system, and getting people tested and knowing their status and getting treated early. That took on a very important focus for the administration.

I insisted that that testing be universal and trying to stop people from having to go through such rigamarole just to get tested, in terms of consent forms and so forth. If you try to get people to sign consents, it scares them that they are consenting to be tested and so forth.

To make treatment available to everyone who tests positive. In my own program, for example, I make sure that if you have to have a yearly physical in my drug treatment program, that viral load is done on each person yearly. If you are being treated by us, naturally, we do the viral load. But you may not be being treated by us, but you're HIV

positive and you're being treated elsewhere. But we can monitor how well your treatment is being done by looking at your viral load. Those people whose load is still high and are in treatment are contagious in the community. That's why the disease continues to spread so widely in the African American community. It's not only injection drug users but those people who are HIV positive, who get on treatment and who may not be following their treatment as they should. As a consequence they still have viral load and are still heavily contagious. I think people should—when they are tested and are found to be positive--shouldn't wait until the viral load is 250. You ought to be treating these people when the viral load is 500 or less because they'll do better. There are new studies out that indicate that. Treatment outcome is a hell of a lot better if you begin to treat people with HAART [Highly Active Anti Retroviral Therapy] when their CD4 count are higher than normally believed. In Africa, of course, you don't have the money, so they wait until the CD4 count is 250. Well, people's immune system is pretty battered by that time. I think we ought to begin to treat people when CD4 counts are 500.

NC: At your program, ARTC, have you been able to put into practice the kind of drug treatment and HIV treatment that you see as ideal.

BP: Yes, I have. I have comprehensive care, as illustrated by what I call my "supermarket of services." I have a supermarket shopping cart with all the things that I offer and should be offered for comprehensive care for the treatment of addiction. I'm a proponent of that being done in all substance abuse treatment programs. Unless you do that, your outcome

is not going to be as successful as it would be if you did that.

NC: Would you consider that one of your major contributions to the field of addiction? Is that what you would want to be remembered for?

BP: Absolutely.

NC: What else would you want to add to the list of your contributions to the field of addiction? What else would be on that list?

BP: If you are using medically assisted addiction treatment, using methadone or buprenorphine, that you include other ancillary services. That's the comprehensiveness but also develop vocational services along with this. I have a Culinary Arts Academy, for example, where I train people to work in kitchens, hotels, schools, and so forth for 14 weeks and give them a certificate if they pass the standard test. Then they have a certificate that they can go and get a job so they finally have something other than themselves to offer up to people. I have people now who have graduated doing catering work for other companies. I think that to me is demonstrative. I also have an artist-in-residence, and we're doing art therapy. We're integrating it into our treatment process. I have my developmentally disabled patients and drug abuse treatment patients doing artwork so that as they are completing a piece of art, they are also helping themselves realize that a process may be slow but if you work on it, you can complete your rehab and

complete your artwork. It takes time and it creates patience and it creates an understanding of this disease, that this is not something that you can get rid of overnight. That has been a contribution that I'm trying to make and I'm demonstrating it in my own program.

This is a chronic re-occurring disorder, addiction. You may ameliorate it, you may reduce it, but there's always the possibility that it can be rekindled by just going into a neighborhood where drugs are being sold. It doesn't have to be. Certainly, you can become abstinent but for me, a goal of abstinence is a goal to failure in treating the addicted. You can achieve abstinence but you have to be ever careful monitoring your temptation. I have characterized addiction as a chronic, relapsing disorder.

NC: Often, the definition of addiction as a "chronic, relapsing disorder" contains the word "brain." Do you see addiction as a "chronic, relapsing brain disorder"?

BP: My focus has been more on the social than it has been on neurology, on the brain situation. However, I think if you have become so programmed by the use of drugs, that your brain has become accustomed to that feeling and chemical change, that indeed there are brain changes that may be irreversible when you take exogenous substances. The irreversibility of that makes you always liable to suggestions. That's why people shouldn't necessarily go back to the neighborhood where copping takes place, because all of a sudden that triggers something in the brain that changes their focus on abstinence to

an uncontrollable compulsion to get involved again. They end up starting all over again. So I'm under the impression from my years of being involved in this that there are brain changes. And those changes are in many cases irreversible and permanent. That may be why the explanation by Dole and Nyswander in terms of methadone is so important to be considered. It's now established. I do think that the brain is involved in this whole situation, and that these changes take place with short and long term use. You and I know if you have postoperative pain and you have not had drugs before, we long remember the immediate relief that you get when you are administered a narcotic. I do. Though the pain is not removed, your perception of the pain is different. It makes changes in perception in the brain when you get the drug, and you never forget that.

END AUDIO