The Alchemy of OxyContin: From Pain Relief to Drug Addiction

By PAUL TOUGH

Paula is taking me on a driving tour of Man, the tiny West Virginia town where she has spent her entire life. Because I don't know my way around the hollows and gullies and creeks that carve through these hills, Paula is at the wheel. And because Paula isn't a morning person, we've set out on our tour at midnight. It's dark; the only illumination comes from our headlights cutting through the mist that rolls down from the hills.

The tour Paula is leading isn't sanctioned by the local chamber of commerce; there are no stops at Civil War plaques or scenic vistas. It's a pillhead tour: an addict's-eye view of the radical changes that a single prescription drug, called OxyContin, has brought to the town of Man. OxyContin abuse started in remote communities like this one more than two years ago; more recently, it has spread beyond its origins in Appalachia and rural Maine to affect cities and suburbs across the eastern United States. I came to Man to try to understand how America's latest drug problem started, to see its roots and trace how it has spread.

"That's my best friend's trailer right there," Paula says, pointing out a comfortable-looking single-wide across the creek. "She's somebody that you couldn't look at and know she was an oxy addict. She was a cheerleader in junior high. She's married. You can't just look at somebody and tell."

A few years ago, Paula says, Man was like any small town in America: you could buy a variety of illegal drugs, as long as you knew the right person to talk to. Pot was big; there was occasionally some cocaine around and a few pills for recreational use. Fads would come and go. But these days, she says, the only drug for sale in Man is OxyContin, a narcotic painkiller that users crush -- to disable its patented time-release mechanism -- and then snort or inject for a powerful and immediate opiate high. Legally, it's sold only by prescription for the treatment of chronic pain. In practice it's available just about everywhere around here, immediately, for cash. The going rate is a dollar a milligram, or $40 for a 40-milligram pill.

Paula is a thoughtful, good-natured 24-year-old with wispy blond hair, serious eyes and faded jeans. She's fidgety; as she drives with one hand, she's rummaging through her handbag with the other, looking for her pack of Marlboro Lights. She finds them, removes one and stabs the dashboard lighter. "I'll show you some places over here," she says, as she turns her car off the main road, over a short bridge and down into a rough indentation that holds a couple dozen trailers and prefab homes. "This is Green Valley. We just call it the valley. It's a pretty good neighborhood," she says, then interrupts herself. "Well, except that's a dealer there."

She points to a trailer with a Chevy pickup out front and a light burning inside. I crane my neck to get a look at a real-life drug den, but the tour has already moved on. Paula is pointing out a trailer on the other side of the road: "That's a small-time dealer there, nothing big," she says. Then she points to another one, and then another: "That's a dealer. . . . That's a small-time dealer. . . . That's a dealer. . . . Her son's a dealer, but I don't know if he lives there. . . . He uses, that boy in there. . . . They use really, really big."

We're driving slowly around the circular dirt road that is the only path through Green Valley. The neighborhood doesn't feel dangerous -- no graffiti, no pit bulls, no broken bottles lying around. Still, Paula is pointing out criminal activity in every second home, peering through the front windshield and gesturing left and right: "They used to deal, too, but they don't no more. . . . They deal. . . . There's some dealers up through there, one or two, nothing big. . . . This boy that lives here deals. . . . They deal, in that trailer there."

The first time Paula did an oxy (as she calls the pills), in the summer of 1999, it didn't do much for her. "That first 10-milligram pill, I didn't really feel nothing off it," she says. "But the second time I did it, I did two 20's, and I was high." She liked the effect. "When you get that oxy buzz," she says, "it's a great feeling. You're happy. Your body don't hurt. Nothing can bring you down. It's a high to where you don't have to think about nothing. All your troubles go away. You just feel like everything is lifted off your shoulders."

What Paula calls "that oxy buzz" comes from OxyContin's only active ingredient: oxycodone, an opioid, or synthetic opiate, developed in a German laboratory in 1916. Chemically, it is a close relative of every other opium derivative and synthetic: heroin, morphine, codeine, fentanyl, methadone. The narcotic effects that Paula is describing are the exact same ones that have drawn people to opiates for centuries. And just as every opiate does, oxycodone creates a physical dependence in most of its users and a powerful addiction in some of them. "At first you do them to get high," Paula says, "and then after you're addicted to them you don't do them to get high; you do them to survive. You do them to feel normal." At her peak, she says, she was snorting four or five 80-milligram pills a day.

The earliest reported cases of Oxycontin abuse were in rural Maine, rust-belt counties in western Pennsylvania and eastern Ohio and the Appalachian areas of Virginia, West Virginia and Kentucky. The problem traveled through these regions, as friends told friends and the word spread from town to town, county to county, up and down the Appalachians. There are a few defining characteristics that the first affected regions share: they're home to large populations of disabled and chronically ill people who are in need of pain relief; they're marked by high unemployment and a lack of economic opportunity; they're remote, far from the network of Interstates and metropolises through which heroin and cocaine travel; and they're areas where prescription drugs have been abused -- though in much smaller numbers -- in the past. "There's always been a certain degree of prescription drug abuse in this area," says Art Van Zee, a physician in Lee County, Va., "but there's never been anything like this. This is something that is very different and very new, and we don't understand all the reasons why. This is not just people who have long-term substance-abuse problems. In our region this is young teenagers, 13- and 14-year-olds, experimenting with recreational drug use and rapidly becoming addicted. Tens of thousands of opioid addicts are being created out there."

In Man, Paula said, it was like OxyContin came out of nowhere. One day no one had heard of oxys, and a month later, the pills had become a way of life for hundreds of locals. It became so easy to buy OxyContin in and around Man, Paula said, that until recently, she never really thought about the fact that everyone involved was breaking the law. "Buying pills never seemed illegal," she said. "It just didn't feel like it was wrong." There aren't lookouts involved, or secret passwords or elaborate drop sites: when Paula wants to buy an OxyContin pill, she simply drives to a dealer's house and knocks on the front door in broad daylight. If she knows the dealer well enough, she'll go on in and snort the pill there, just to be neighborly. If not, she'll hand over the cash, put the pill in her pocket and drive away. Sometimes she'll be the only person there; other times, there will be a dozen cars lined up out front.

The dealers have the benefit of a captive market: OxyContin, like any opioid, is very difficult to quit abusing. And given the pill's ubiquity here in Man, and the fact that the nearest rehab clinic is two hours away, this is an unusually hard place to quit using it. Nonetheless, Paula is trying. Six months ago, she and her best friend decided they were going to quit cold turkey. They took a couple of days off work, locked themselves in her friend's trailer and started to detox. "That was the worst three days of my life," Paula said. "Honestly, I prayed to God to let me die. That's how bad it is. Your stomach hurts, you get really bad headaches, you get diarrhea. You want to throw up. You get really depressed. If you can get past the third day or the fourth day, you're pretty much fine, but most

people don't make it." Paula and her friend didn't make it: at the end of the third day, they went out and got a pill.

A few months ago, OxyContin abuse was considered a regional problem, labeled "hillbilly heroin" and confined to areas far from the nation's population centers. This year, though, abuse of OxyContin has started to move away from its backwoods origins and into metropolitan areas on the East Coast, into the Deep South and parts of the Southwest and into suburban communities throughout the Eastern United States. In Miami-Dade County, there have been 11 overdose deaths so far this year in which oxycodone was the probable cause, according to the county medical examiner. There have been 11 more in Philadelphia, according to the medical examiner there. Police in Bridgeport, Conn., arrested a local doctor in July for prescribing tens of thousands of OxyContin tablets to patients, often, they say, without any medical examination at all. And in the suburbs of Boston, police say more than a dozen pharmacies have been held up by a gang of young men wearing baseball caps and bandannas, looking for OxyContin.

In many ways, the spread of Oxycontin abuse closely resembles another recent drug epidemic. In the early 1990's, the Medellin and Cali cartels controlled cocaine and heroin distribution in the United States. Cocaine was selling well, but there was a marketing problem with heroin: it could only be injected, and many people, even frequent drug abusers, are reluctant to stick needles in their arms.

The Colombians' solution to this problem was to increase the purity of the heroin they were bringing into the United States until it was potent enough to snort. They were then able to use their existing cocaine-trafficking network in the Eastern United States to get heroin onto the street in powder form. Cocaine users, who were used to the idea of buying and snorting a white powder, experimented and became addicted. As their tolerance increased, these new heroin snorters overcame their aversion to needles and soon turned into heroin injectors.

Similarly, there were plenty of oxycodone users in Appalachia before OxyContin came along. Many of the OxyContin addicts I spoke to in Kentucky and West Virginia used to snort or chew a mild oxycodone-based painkiller called Tylox. They said they found the pills somewhat euphoric and not very addictive -- each Tylox contains just 5 milligrams of oxycodone, along with 500 milligrams of acetaminophen. When OxyContin arrived on the scene, in pills containing 20, 40 and 80 milligrams of oxycodone, it marked a jump in purity similar to that of early-90's heroin -- and again, casual users started snorting, and then shooting, a powerful opioid.

Although heroin and OxyContin have a similar unhappy effect on the lives of people addicted to them, there is a critical and simple difference between the two: heroin is illegal; OxyContin, when used as directed, is legal. More than that: the pill is government-approved. It is made by Purdue Pharma, a successful and well-regarded pharmaceutical company headquartered in Stamford, Conn. It is prescribed to a million patients for the treatment of chronic pain, and it is closely regulated at every stage of its manufacture and distribution by the Food and Drug Administration and the Drug Enforcement Administration.

This fact has meant a major conceptual shift for law-enforcement officials, who are used to combating narcotics produced by international drug lords, not international corporations. Terry Woodworth, the deputy director of the D.E.A.'s office of diversion control, says the spread of OxyContin has posed a challenge to the D.E.A.'s traditional methods: "Instead of using the normal law-enforcement techniques -- like going to the source and attempting to eradicate or destroy the criminal organization producing the drug and immobilize its distribution networks and seize all its assets -- you have a very different situation in a legitimate industry, in that your manufacture and distribution is legal."

Scott Walker, the director of Layne House, a drug treatment facility in Prestonsburg, Ky., puts it more

concisely: "You don't have the Coast Guard chasing OxyContin ships," he says. "This isn't something you can stop at the border. It's growing from within."

Part of what makes the spread of OxyContin abuse so difficult to track, let alone to stop, is that the drug moves not physically but conceptually. When crack cocaine spread from the big cities on either coast toward the center of the country, it traveled gradually, along Interstates, city by city. OxyContin abuse pops up suddenly, in unexpected locations: Kenai, Alaska; Tucson; West Palm Beach, Fla. At the Gateway Rehabilitation Center in Aliquippa, Pa., a suburb of Pittsburgh, Jay, a recovering OxyContin addict and a former small-time dealer, offered an explanation for OxyContin's sudden geographical shifts. "It's the idea that passes on," he told me. "That's how it spreads. There aren't mules running the drug across the country. It's dealt by word of mouth. I call a friend in Colorado and explain it to him: 'Hey, I've got this crazy pill, an OC 80, an OC 40. You've got to go to the doctor and get it. Tell him your back hurts.'"

Jay is 26, a college graduate and former nurse. He started doing oxys in 1999, and his consumption quickly rose to 240 milligrams a day. He was clean when we met and trying to stay that way. But when he talked about the drug's potential as a small business, he couldn't help getting excited. "I could go to California or Las Vegas and say, 'Hey, I was getting OC's prescribed to me in Pennsylvania; I'm going to get them in Las Vegas,'" he said. "And then if I wanted to sell them, I could sell them there. I'd start out and sell them for 10 bucks apiece. Get people hooked on them, then sell them for 50 bucks apiece. It's experienced word of mouth. I've experienced the drug, therefore I know how to describe it to you."

Unlike heroin, Jay explained, OxyContin doesn't require investment or muscle or manpower to move across the country. OxyContin abuse is a a contagious idea -- a meme, if you will. Because OxyContin, the medicine, is readily available in pharmacies everywhere, all it takes to bring OxyContin, the drug, to a new place is a persuasive talker like Jay. A powerful recreational narcotic can now travel halfway across the country in the course of a phone call.

In order to understand the particular dilemma of OxyContin, you need to understand the long-fought war among doctors over pain and addiction. For centuries, opium and its derivatives have been considered a double-edged sword -- the most effective painkiller on earth and also the most addictive substance. For most of the 20th century, opiates were considered too dangerous to use in all but the most critical pain treatments. The assumption was that their medical use would inevitably lead to addiction. In the late 1980's, for the first time, public and medical opinion began to swing decisively in the other direction. Patient advocates and pharmaceutical companies, bolstered by studies showing that there were vast numbers of cancer patients whose pain was being undertreated, encouraged the medical community to rethink its approach to opioids, especially in the management of cancer pain. Their campaign was persuasive. Between 1990 and 1994, morphine consumption in the United States rose by 75 percent, and in 1994, the Department of Health and Human Services issued new clinical guidelines encouraging the use of opioids in the treatment of cancer pain.

Purdue Pharma was a leading player in the pro-opioid campaign. The company contributed generously to patient-advocacy organizations, including the American Pain Foundation, the National Foundation for the Treatment of Pain and the American Chronic Pain Association, and underwrote dozens of scientific studies on the effectiveness of opioids in the treatment of pain. In 1985, the company began marketing MS Contin, a time-release morphine pill that was used to treat cancer pain. As attitudes on opioids shifted, Purdue began to promote MS Contin for noncancer pain as well.

Dr. Russell Portenoy is chairman of pain medicine and palliative care at Beth Israel Medical Center in New York City, and the co-author of a groundbreaking 1986 study that supported the long-term use of opioids to treat noncancer pain. "Between 1986 and 1997, within the community of pain specialists,

there was increasing attention on the role of opioids," Portenoy says, "but there was relatively little diffusion of that idea to family doctors and other nonspecialists." That began to change, Portenoy says, with the F.D.A.'s approval of OxyContin in 1995. "There was a sea change that occurred with the release of this drug," Portenoy says. For the first time, general practitioners began to prescribe strong, long-acting opioids to treat chronic noncancer pain. Portenoy says the change was due to four factors that came together at about the same time. "The reasons were partly cultural -- the attitudes of the medical and regulatory communities had been gradually shifting for a decade. They were partly medical -- studies had been coming out showing that patients with low back pain, chronic headaches and neuropathic pain might benefit from long-term opioid therapy. They were partly pharmacological -- OxyContin made it easier and more convenient for patients to receive long-term opioid therapy. And they were finally related to marketing, because Purdue Pharma was the first company to advertise an opioid pill to general practitioners in mainstream medical journals."

In addition to those doctor-directed ads in magazines like The Journal of the American Medical Association, the company began an innovative indirect-marketing campaign just before OxyContin's release. Because of F.D.A. regulations on the marketing of narcotics, the company was unable to use direct-to-consumer advertising, as other pharmaceutical companies were beginning to do for antidepressants and prescription allergy medications. So Purdue decided to concentrate on what they call "nonbranded education." Just as Nike advertises the concept of sports instead of shoes, so Purdue would market the concept of pain relief to consumers, but not OxyContin. In 1994, the company launched Partners Against Pain, a public-education program that at first concentrated on cancer pain and later expanded to include other forms of long-term pain. Through videos, patient pain journals and an elaborate Web site, Purdue promoted three ideas to doctors and patients: that pain was much more widespread than had previously been thought; that it was treatable; and that in many cases it could, and should, be treated with opioids. Partners Against Pain didn't promote OxyContin specifically; the company's marketers knew that simply expanding the total market would also increase their bottom line.

OxyContin was seen by many doctors as the solution to the long rift between pain specialists and addiction specialists. Purdue Pharma believed that OxyContin's time-release function would mean a much lower risk of addiction than other opioid medications. According to a principle known as the "rate hypothesis," the rate at which an opioid enters the brain determines its euphoric effect, and also its addiction potential. This is why injecting a narcotic produces a more powerful high, and addiction risk, than snorting it or swallowing it. Because OxyContin, taken whole, provides a steady flow of oxycodone over an extended period, the high it produces is diminished, as is the risk of addiction.

Before OxyContin, narcotic painkillers were prescribed mostly by oncologists and pain specialists. Purdue believed that OxyContin's time-release safeguards made it appropriate for use by a much broader array of medical professionals. The company began promoting OxyContin to family doctors and local pharmacists nationwide through a network of hundreds of field reps who emphasized, in their office visits, the idea that OxyContin presented a lower addiction risk than other opioid medicines.

Over the next few years, sales of OxyContin exploded. OxyContin prescriptions have more or less doubled in number each year since its release; the company's revenues from the pill jumped to $1.14 billion in 2000 from $55 million in 1996. Last year, doctors wrote more than six and a half million OxyContin prescriptions, and OxyContin ranked as the 18th best-selling prescription drug in the country (as measured by retail sales) and the No. 1 opioid painkiller. The company grew along with its main product's sales; between 1998 and 2000, the Purdue work force expanded to nearly 3,000 employees from 1,600.

Purdue's attempt to expand the opioid marketplace beyond cancer patients was also remarkably

successful. Five years ago, cancer patients were still the main market for long-acting opioids, but oncologists accounted for only 3 percent of the OxyContin prescribed last year. The largest single group of OxyContin prescribers is now family physicians, who account for 21 percent of the total.

According to Portenoy, this change in the number and kinds of doctors prescribing OxyContin is fundamentally linked to the spread of OxyContin abuse. "It's not the drug, per se," Portenoy says. "It's rapidly expanding access, plus the reality of doctors prescribing it who may not have the skill set required to prescribe it responsibly."

Purdue's field reps were the first wave of OxyContin apostles, spreading word of the pill's effectiveness door to door -- doctor by doctor, pharmacist by pharmacist. But Purdue's officially sanctioned word-of-mouth marketing campaign was followed by another, unsanctioned one. This time the news was that the miracle pill had an Achilles' heel, that its time-release matrix could be eliminated completely in a matter of seconds by the simple act of crushing the pill with a spoon, a lighter, even a thumbnail, and that the resulting powder, when snorted or mixed with water and injected, produced a very potent high. The apostles this time were not Purdue's field reps but casual drug abusers throughout the Eastern United States. And just like Purdue's, their marketing campaign was enormously successful.

In a steel-mill suburb northwest of Pittsburgh, the leader of the second wave of OxyContin apostles was Curt, a young man who in 1998, at the age of 23, found himself kicked out of the Air Force and living back in his hometown. He worked the midnight shift running cranes at the mill, and he dealt a little marijuana during the day. He was part of a "drug community," as he calls it, 20 or so people who worked together, hung out together, went to parties and concerts and smoked a lot of pot. Every couple of months someone would land a prescription for Percocet or Vicodin, and they'd sell the pills to friends for $5 apiece, a cheap and mild high.

In April 1999, someone in his circle was prescribed OxyContin. Curt assumed that it was just like any other pain pill. "Everybody thought at first that they were like a Percocet," Curt says. "Nobody understood how many milligrams were really in these things. People were selling them like an expensive Percocet" -- for $10, in other words, instead of $5 -- and swallowing them whole. At a party, Curt figured out the trick of crushing the pill and snorting the powder, and he quickly spread the word. "I showed a lot of people," Curt says. "At first they were like, 'You're crazy.' But then they'd do it, and that would be it. People tell me now, Yeah, you're the one who showed me how to snort this thing."

Oxys quickly became very popular in Curt's circle of friends, and Curt found a comfortable niche for himself between supply and demand. "I knew people all over the county that were getting prescriptions," he says. "They'd call me and say, I'm getting OC's now and I want to get rid of them. They knew there was money there, but they didn't know who to sell to. They usually gave me a heck of a deal. I'd get them all for maybe $10" per 40-milligram pill. "I'd sell them for $20, so for every one I sold, I made one. And then I'd give them their money and the next month I'd get their scrip again." At that rate, he could make $900 off a 90-pill bottle. But he wasn't in it for the profit; he was in it for the pills. "I didn't need money," he explains. "I worked at the mill. I was always doing it just for the free drugs."

Before long, he had 10 people giving him their pills to sell, mostly women in their 30's and 40's on welfare or disability. (Patients on Medicaid pay just a dollar for a $250 OxyContin prescription.) "It's so weird the people that got into this," Curt says. "Some of them were innocent mothers. I had one that was in her 60's. She never did drugs. She'd sell every last one of her pills, and it would pay for all her other medication." Curt would keep careful track of which day of the month each of his suppliers filled her prescription. "A lot of times I would drive them to the pharmacy," he says. "I'd always get a couple

of pills for that."

One of the most valuable -and closely guarded -- resources in the local OxyContin economy was a doctor who was willing to write an OxyContin prescription without asking too many questions. "It's a slow process, breaking a doctor in," Curt explains. "You've got to know how to work him. I'd say: 'I can't take the Vicodins and the Percocets because they're hurting my stomach. Do they have anything that's, like, time released?' The doctor goes, 'Oh, you know what, they've got this new stuff called OxyContin.' And I'd say: 'Oh, yeah? Wow, how's that work?"' Some local doctors, Curt says, knew exactly what was going on, but they needed the business. One started handing out monthlong OxyContin prescriptions every two weeks.

On the demand end, Curt had between 25 and 50 steady customers. "I had a cell phone at that time, so I was doing a lot of driving," he says. "People would gather at their houses, and they'd bring all their friends over, 10 of them that'd use it. They'd all gather when they knew I was coming, because they wanted the pill immediately."

Curt has been in recovery for a few months now; since he got out of rehab, he's been cut off from almost all his old friends, and he fills his spare time fixing up his sister's house, fishing and reading up on psychology, which he plans to begin studying this fall. He's a man of boundless energy and focus, and he has taken to the 12-step process with an unusual intensity; in his first 60 days clean, he told me, he attended 138 Narcotics Anonymous meetings. That same energy served him well back in his oxy days, when he was cutting steel at the mill all night and driving around making pickups and deliveries all day. The pills themselves, he says, helped him keep going. "I could go get two hours of sleep, wake up, do a pill and continue on from there," he says.

It was only a couple of months after OxyContin arrived in town that Curt and most of his customers realized they were addicted. At first, they were happy just to take a pill whenever one was around, for fun, but soon they found themselves experiencing severe withdrawal symptoms if they didn't have a pill every day. Everyone's tolerance built up quickly -- one week they were able to get by on a 20 a day, the next week they'd need a 40, and a couple of weeks later, it had to be an 80. "No one knew what was going on," Curt says. "These are a bunch of pot smokers, drinkers, just mellow people. This drug just took us by storm. A whole community, at least a hundred people I know around here. They're all into the addiction. These are guys I used to smoke pot with and drink beer with in the woods. I grew up with them all, having parties and that. And now there's not one of them -- not one of them -- that don't use pills."

Purdue Pharma wasn't aware of significant problems with OxyContin abuse until April 2000, when a front-page article in The Bangor Daily News, claiming that OxyContin "is quickly becoming the recreational drug of choice in Maine," landed on the desk of Purdue's senior medical director, Dr. J. David Haddox. In the summer of 2000, the company formed a response team, made up of medical personnel, public relations specialists and two of the company's top executives, which has guided the company's OxyContin campaign ever since.

It's fair to say that in public relations terms, Purdue's reaction to the OxyContin problem has been less than successful. As recently as six months ago, the company had a considerable supply of good will in the media, the government and the affected communities; it is now facing 12 separate potential class-action suits from former patients, as well as one from the attorney general of West Virginia; formerly sympathetic community leaders in Appalachia and Maine have grown increasingly skeptical of the company's approach; and in separate Congressional testimony, Attorney General John Ashcroft called OxyContin a "very, very dangerous drug," and Donnie Marshall, then head of the D.E.A., said in May that unless he received "more cooperation" from Purdue, he was "seriously considering rolling back the quotas that D.E.A. sets . . . to the 1996 level," which would have meant a

95 percent cut in production.

Purdue's P.R. problems seem rooted in the company's deep-seated belief in the inherent safety of and public need for its product. It is an article of faith for the company that illegal traffic in its drug is the work of "bad guys" and "professionals," in Haddox's words. In fact, Purdue says that its internal data indicate that the levels of OxyContin abuse in the country are no greater than expected. "We have had increased numbers in the last year or so," I was told by Robert Reder, Purdue's vice president of medical affairs and worldwide drug safety, "but our estimation is that they're commensurate with the distribution of the drug." The abuse situation, according to Reder's numbers, is normal. (Government statistics indicate that as of 1999, 221,000 Americans had abused OxyContin.) The real victims, the company says, are their "legitimate patients," who would be denied OxyContin if its distribution were restricted.

In March, Purdue announced a 10-point plan to combat OxyContin abuse. The plan includes tamper-resistant prescription pads for doctors, antidiversion brochures and educational seminars for doctors and pharmacists in affected areas, an initiative to combat smuggling of OxyContin from Mexico and Canada and a donation of $100,000 to a Virginia group for a study of prescription-monitoring programs. To Purdue, the plan is generous and well focused; to people in the communities where abuse is widespread, it seems like a way for the company to avoid the real problem. I spoke several times this spring and summer to Debbie Trent, a professional counselor in Gilbert, W. Va., who runs the local antidrug community group called STOP (Strong Through Our Plan). In our first conversation, she was scrupulously cautious and polite when she spoke about Purdue Pharma, saying, "I don't want STOP to be seen as fighting OxyContin." During STOP's first few months, Haddox addressed her group twice.

When we spoke in April, though, Trent told me that she had come to believe that the company's 10-point plan was addressing the wrong problems -- prescription fraud and international smuggling, for example, when what Gilbert really needed was a way to get immediate treatment for its many addicts. "I read about the tamper-proof prescription pads and I think, Give me a break!" she said. "That seems like such a little thing. It seems so minute in comparison to the scope of the problem. It's almost intentionally missing the point. Rather than prescription pads, I would like to see something done in rehab, something where they're making an effort to help these folks get better."

Similar sentiments were expressed in Maine in July, when Purdue announced its latest solution to the OxyContin problem: a $100,000 grant to start a "mini-M.B.A." program in high schools. This fall, Purdue will send 20 teachers from some of the most affected counties in Appalachia and Maine to New York for training by the National Foundation for Teaching Entrepreneurship. When they return to their schools, they will teach students how to formulate a business plan and invest in the stock market. The idea is to "provide these kids with a sense of hope," according to a Purdue spokesperson. A Maine school administrator was quoted in The Boston Globe asking why the company "wouldn't have come up here and asked us what we want"; if anyone had, she said, she would have asked for money for the treatment of addicts rather than entrepreneurial training.

Again and again, Purdue has apparently been blindsided by criticism. At a news conference in Alabama attended by parents whose teenage children had died from OxyContin overdoses, Gov. Don Siegelman interrupted a Purdue doctor who was going point by point through Purdue's 10-point plan. "I find this very offensive, and I want you to stop," he said as the doctor stood open-mouthed in front of the television cameras. "We've had enough public relations and enough sugar-coating of this issue and quite frankly, as governor, I am fed up." In March, Haddox had what he thought was a cordial and cooperative meeting with Attorney General Darrell V. McGraw of West Virginia to discuss the company's plan to combat drug abuse. Less than three months later, McGraw filed a lawsuit against Purdue, charging the company with "highly coercive and inappropriate tactics to attempt to get

physicians and pharmacists to prescribe OxyContin and to fill prescriptions for OxyContin, often when it was not called for," and seeking millions of dollars in compensation for state medical costs.

In the meantime, the lack of co-ordination between Purdue and the government agencies that regulate it has had serious repercussions in affected communities, as local police, small-town mayors and individual doctors and pharmacies have been forced to make up their own policies on the fly. Six states -- Florida, Maine, Vermont, West Virginia, Ohio and South Carolina -- have introduced regulations making it harder for Medicaid recipients to receive OxyContin. After the recent spate of pharmacy robberies near Boston, dozens of drug stores in Massachusetts pulled OxyContin from their shelves -- only to be ordered by the state pharmacy board to begin carrying the drug again. In the small town of Pulaski, Va., the police have instituted a program in which patients picking up OxyContin prescriptions from local pharmacies must give their fingerprints, a development that has alarmed civil liberties advocates. Doctors in many states, sometimes fearing reprisals from the D.E.A., have refused to prescribe OxyContin even to patients clearly in need.

Purdue's executives see the company as an unwitting victim of criminal activity -- not unlike Johnson & Johnson in 1982, when seven people were killed by Extra-Strength Tylenol tablets that had been laced with cyanide. The company's critics prefer to compare Purdue to tobacco companies and handgun manufacturers, who are increasingly likely to be found liable for deaths caused by their products. Clearly, the company failed to anticipate the growing chorus of public sentiment against it. And as OxyContin incidents move closer to Washington and New York, pressure may increase on the D.E.A. and the F.D.A. to take regulatory action against Purdue.

When I returned to the Gateway rehabilitation Center outside Pittsburgh earlier this month, I got a clearer sense of the way in which OxyContin is taking hold in urban and suburban America. I also learned about an unexpected secondary effect of OxyContin abuse: in cities like Pittsburgh, the crackdown on OxyContin is resulting in a sharp rise in heroin abuse.

I sat for an afternoon in a glassed-in conference room, looking out on Gateway's parking lot and groomed grounds, and talked with Andy and B., two addicts and former low-level dealers. Before trying OxyContin, they had used their share of recreational drugs, but they didn't consider themselves part of a hard-core drug community. Aside from the track marks on his arms, B., 21, looked like every disaffected college kid in America. He was a professional sloucher, dressed in an orange T-shirt, Army shorts and sneakers, with a mop of brown hair. Andy wore a sparse goatee, a hooded Ecko sweatshirt and a baseball cap with a Japanese character on it. I asked him what it meant, and he said he didn't know.

B. began using OxyContin in 1998, when a friend told him about the pills. He soon started dealing to support his habit, buying pills from a dozen or so people and then selling them from his apartment to friends and friends of friends. His sources were all legitimate pain patients, sick with cancer, carpal tunnel syndrome, lupus or chronic back problems. But, as B. explained, they would often supplement their OxyContin prescriptions with something weaker and cheaper, like Vicodin, then sell the OxyContin and struggle through the month on Vicodin. "Some of them were old sick ladies who've never done drugs," B. said. "They didn't understand what oxy can do to people. They just knew they were getting $20 for each pill -- $1,800 a month off something they can do without. They just wanted that money."

Andy laughed. "Old people are supposed to keep young people off drugs," he said.

B. described for me the casual feel of his drug deals. For the first several months that he was selling OxyContin, he said, everything was friendly when he'd go to pick up pills from his suppliers. "Most of them would say, 'Hi, honey, come on in.' You go into their house and sit down and have something to

drink and talk for a while and see how their family's doing, and they see how mine's doing. They were nice people. I don't think they think of themselves as drug dealers." Nonetheless, B. said, his suppliers kept most of the profits; he'd generally buy their pills for $20 apiece and then sell them for $25.

About six months ago, B. said, as the police and news media began to sound the alarm about OxyContin abuse, local doctors grew anxious. Many switched their patients to harder-to-abuse fentanyl patches and morphine, and B. lost most of his connections. The supply dried up, prices rose and people started ripping each other off.

A friend told him that shooting heroin was just like shooting OxyContin, only cheaper. He'd never imagined that he might take heroin, but the expense of OxyContin was killing him. "I was spending a hundred bucks a day on oxy," B. said. "That's why I switched to heroin. You get really high off two bags, which is 30 bucks a day. That's a big savings."

Andy agreed. It took him only a month and a half to go from using OxyContin for the first time to shooting heroin, he said. "I've always said that I'd never ever touch heroin. But then oxys came along and that's the same thing, just cleaner. And that got me into shooting dope. If I'd never touched OxyContin, I wouldn't have done heroin."

In Pittsburgh and its suburbs, Andy and B.'s stories aren't unique. Gateway's doctors report a sharp increase in admissions of young heroin addicts who started out on OxyContin. "Ninety percent of my friends that were addicted to oxys are now addicted to heroin," B. said. "I know probably 30 or 40 heroin IV drug users now because of OxyContin."

OxyContin entered the lives of casual drug users as a Trojan horse, disguised as something it is not. It has never become a popular drug among existing heroin or crack addicts, who already have a cheaper and at least as intoxicating mechanism for getting high. OxyContin does the most damage when it enters a community of casual drug users -- Curt's pot smokers and beer drinkers -- who think of pain pills as just another interesting diversion for a Saturday night. In networks like Curt's or Paula's, before OxyContin, no one ever did heroin or crack; those were seen as an entirely different category of drug: something that will take over your life.

When you hold it in your hand, an OxyContin pill doesn't seem any different than a Tylox or a Percocet or any of the mild narcotic preparations that have for years seeped out of the pharmaceutical pipeline and into the lives of casual drug users. What B. and Andy and Paula and Curt failed to realize is that despite appearances, OxyContin actually belongs on the other side of the drug divide; it might look like a casual Saturday-night drug, but it's a take-over-your-life drug. Rehab centers across the country are filling up with young people who discovered that fact too late.

To Art Van Zee, the doctor who has seen his small community in western Virginia "devastated" by OxyContin abuse, the answer to the crisis is to take OxyContin off the market. Van Zee is circulating a petition asking the F.D.A. and Purdue to withdraw the pill until a safer formulation can be found. "The bottom line is, there's much more harm being created by this drug being available than good," he says. "There are very good medicines available that are equally effective. We can certainly meet people's pain needs without OxyContin."

But for many people, "drug communities" like Curt's are not worthy of a whole lot of official sympathy or regulatory concern -- especially not when their interests are considered next to those of patients in pain, who are using OxyContin the way it is meant to be used and whose lives have been improved as a result. For doctors who have seen their patients transformed by OxyContin, there is something mystifying, even infuriating, about the suggestion that it should be withdrawn or even restricted, just

because a bunch of kids in Kentucky didn't know what they were snorting.

"There is no question that increasing opioid consumption for legitimate medical purposes is going to lead to some increase in the rates of addiction," Portenoy of Beth Israel says. "But the fact is, the trade-off is worth it. At the moment, the attitude is that if one housewife in Alabama becomes addicted, then the drug must be pulled and the company shut down. But we're talking about millions of people whose lives can be brought back from total disability by the proper use of opioids. Any actions taken by law enforcement or the regulatory community that increase the stigma associated with these drugs, or increase the fear of physicians in prescribing these drugs, is going to exacerbate an already terrible condition and hurt patients."

The 10th point in Purdue Pharma's 10-point plan to reduce OxyContin abuse is reformulation. The company says that it is spending millions of dollars to create a new version of OxyContin, or perhaps a whole new medication, that would have all the benefits of OxyContin and none of its dangers. Of all the initiatives under way, this is the one that has received the most attention and created the most hope in Appalachia and other affected areas.

In some interviews, Purdue's representatives sound downright enthusiastic about this idea. Earlier this month, they put a price tag -- $50 million -- on the project for the first time. But when pressed, Haddox admits that what Purdue's scientists are looking for is a "holy grail," a drug that will activate the receptors in the brain that control pain relief and leave alone those that control euphoria. And this isn't a new initiative, it turns out, but one that the company has been working on for many years. Scientists and doctors as far back as Hippocrates have tried to find a way to separate the benefits of opiates from their dangers.

There are often suggestions from Purdue that this reformulation may take "a few years"; it's also entirely possible that it will never happen. Opioids, including OxyContin, may remain the double-edged sword they have always been. And regulators may simply decide to accept a certain amount of unintentional damage in the treatment of pain, and leave local police chiefs and drug counselors -- as well as individual addicts -- to find solutions to the OxyContin problem on their own.