

# Methadone Today

The official newsletter of DONT-BY PATIENTS, FOR PATIENTS February 2004 Volume IX Number I

## An Interview With Dr. Vincent Dole - (Part 1)

by Odus Green

I would like to preface this article with some words of thanks for those who made it possible. First and foremost, many thanks go to Ms. Beth Francisco, Editor of *Methadone Today*, without whom this whole exercise would not have happened; to Ms. MaryAnn Hayes, Dr. Dole's secretary, who was gracious and kind to me; to all those fine folks on the "Methadone List" for the questions which they sent me; to Edward Breecher, who wrote the *Consumers Union Report on Licit and Illicit Drugs*, which provided a plethora of information while researching this article; and to Dr. Dole himself, who is one of the most humble men I have ever had the pleasure to know. Finally, to my lovely wife, Cindy, who puts up with my many hours locked away in my office, doing all types of advocacy work, as well as writing articles. - *Odus Green*

Dr. Vincent Dole--the name brings to mind a picture of a man in a white lab coat, glasses worn way down on the end of his nose, asking questions of one of the early volunteers in his experimental methadone program--a caring man who, along with Dr. Marie Nyswander, "invented" the concept of Methadone Maintenance (MM). He is a man who is very shy about taking any credit for his hard work and dedication.

There weren't many scientists in the 60s willing to work with opiate addicts. Even among those in the field of drug rehabilitation, opiates are looked upon as the most insidious of all drugs.

Dr. Dole was working on a study of obesity when he saw that some people craved food much as drug addicts craved drugs. This prompted him to read a book named *The Drug Addict as a Patient* by a psychiatrist, Dr. Marie Nyswander. Both were commissioned as officers in the Navy during WWII, both worked on diseases which were perceived as "a weakness of will" rather than a metabolic disorder. To this day, that particular perception still exists among most of the population of America! Despite this

perception, they continued to work with addicts throughout the rest of their careers. They were also partners in another venture that seems to have worked out very well. In 1965 they were married.

During the early part of their research, they were working with two patients in order to study the metabolic effects of opiates. These two patients were allowed to take as much IV morphine as they wanted. Accordingly, these patients were being "perfect patients" in every way. They were not at all shy, and were very cooperative with the researchers. Morphine became their whole lives; they sat passively in front of television awaiting their next shot. Although they were offered other activities, they declined them.

After the researchers were through with these studies, they were required by law to detoxify these two patients before discharging them out into the world. The approved method of detoxification then was to transfer a patient from his opiate of choice--in this case, morphine to methadone. The daily dose of methadone was then decreased slowly over a period of time until a zero dose is reached. So, as per the law, Drs. Dole and Nyswander placed their patients on methadone. However, instead of reducing the methadone right away, they decided to keep the patients on it for a length of time sufficient to run the same metabolic tests which had previously been run while the patients were on morphine.

After the patients were switched to methadone, a peculiar thing began to happen. Instead of laying around in their pajamas all day watching TV, the patients started asking for access to activities which required actual physical exertion on their part! This was very far removed from their behavior while on morphine. The eldest patient (34) asked for, and received, permission to paint which had been a hobby of his years ago. The younger patient (21) began to ask for permission to attend a night class, so he could earn his high-school equivalency diploma. He was allowed to **(Cont. p. 3)**

**The goal is NOT abstinence, the goal is to become functional. The data collected over the years has shown that abstinence is an unlikely goal. It is a terrible mistake to put someone in the position of either eventually becoming abstinent or becoming a failure.**

Dear Methadone Today,



I have never used drugs in my life but have observed my friend who had a heroin problem. I saw him try to quit many times, and the result was always failure. From the reading I have done, no matter what detoxification treatment was used on heroin addicts, the failure rate is 97%. This statistic alone should tell all of the politicians that programs for heroin addicts should be expanded—not reduced.

My friend is now in a METHADONE PROGRAM, and it was like WATCHING HIM COME BACK FROM THE DEAD to again lead a normal life.

I am appalled at the ignorance of the general public about drug addiction, and believe it or not, I am elated that Rush Limbaugh became an addict. It seems that a problem is more quickly addressed when someone famous is involved. -**Bob**

Dear Bob,

Thank you for your input. It is always good when a non addict notices the positive difference in a methadone patient. Methadone is truly a life-saving medication for opiate addicts. You are absolutely correct that other opioid addiction treatments have a very low success rate (all treatments except for opiate agonist treatment can be characterized as "detoxification treatment"). A slow methadone taper is statistically the most successful "detoxification" treatment\*, but this regimen still results in an 80-90% relapse rate, even when the patient is very motivated. There is no question that methadone maintenance treatment remains the gold standard for opiate addiction treatment. Those who criticize methadone treatment simply do not understand the nature of opiate addiction or opiate agonist treatment. The delivery system often leaves much to be desired, but the medication itself cannot be faulted.

One of the main reasons more non addicts do not see the beneficial effects of methadone treatment is that very few stable methadone patients are willing to reveal to their friends **(Cont p. 2)**

**Dear Bob (from p. 1).**

that they are on methadone--some do not even tell their immediate relatives. In fact, many non addicts have seen the positive difference methadone makes--they just don't realize that the difference is the result of methadone, because they have no idea that the individual is on methadone treatment.

We certainly hope that Rush Limbaugh's admission that he is addicted to opiates leads to greater public understanding of drug addiction, specifically opiate addiction, and results in the addressing of various related societal/governmental problems. But over the years--and especially within the last 10 years or so, the media has reported on many public figures that are/have become addicted to opiates and/or other drugs--particularly prescription opiates. Just off the top of our heads, we can think of a couple of movie actors, a television actor, the wife of a prominent politician, and rock and pop musicians. The problem is that such revelations do not necessarily lead to greater public understanding of drug addiction--in fact, revelations of celebrity addictions sometimes serves to perpetuate ignorant attitudes, given the stereotype of many celebrities as being hedonistic and spoiled. But perhaps, Rush Limbaugh's admission will have a different effect on the public, given his image as an extremely conservative and straightlaced individual.

*\*Buprenorphine, another opioid, is also used to "detoxify" opiate addicts, by way of a slow taper. Researchers had hypothesized that buprenorphine would be easier to withdraw from than methadone, but research thus far indicates that the success rate of a buprenorphine taper is no higher than a methadone taper (the success rate is about the same).*

## Loner Group--An Alternative to Meetings

"Narcotics Anonymous Loner Group" is organized for drug addicts who live in areas that do not have regular NA meetings. The "Loner Group" holds bi-monthly "meeting[s] by mail." The "meeting by mail" is actually a newsletter members receive that consists of letters and stories from members. Thus, members get a similar experience to real in-person NA meetings, as they have the opportunity to both share their own thoughts and stories, as well as read the thoughts and stories shared by other members of the group.

Please understand that **Methadone Today** is not recommending or endorsing the "Loner Group"--this notice is being included in **Methadone Today**, as some readers who wish to participate in a twelve step group, such as Narcotics Anonymous, may be interested in "meeting by mail".

As we have reported in previous issues of **Methadone Today**, Narcotics Anonymous has a dim view of methadone treatment. NA does not permit methadone patients to share at their meetings: they do not let attendees who are actively using "drugs of abuse" share at meetings, and for all intents and purposes, they view legitimately prescribed methadone as a "drug of abuse" (and therefore, methadone patients are not considered "clean"). This also means that NA will not honor "clean time" if an addict is in methadone treatment. So, a methadone patient who has been in methadone treatment and has abstained from illicit drugs for five years is not and has not been "clean" for that time, as far as NA is concerned.

NA's position on methadone treatment is at odds with the current understanding of opiate addiction as a disease. The fact is that methadone patients are not addicted to the medication, so clearly, they should not be singled out as not being "truly clean". Moreover, it is disturbing that NA officials venture to "play doctor" and determine whether methadone treatment is a legitimate opiate addiction treatment. Incredibly,

NA makes a distinction between the prescribing of methadone for the treatment of opiate addiction and the prescribing of methadone or other opioids for the treatment of pain. NA does not penalize addicts taking methadone for pain relief purposes.

For this reason, we suggest that methadone patients who are interested in attending twelve step meetings find a methadone anonymous/awareness group or an Alcoholics Anonymous group. Technically, AA is for individuals suffering from alcohol addiction, but it is also open to people who are addicted to drugs and alcohol. Unlike NA, AA does not have a position on methadone treatment or any other drug or alcohol addiction treatment.\*\* MA groups are similar to NA, except that they do not discriminate against methadone patients. On the other hand, we realize that MA groups or even AA groups are not available everywhere--and many opiate addicts feel awkward attending AA meetings where many people may not understand opiate addiction. Thus, we are providing the following contact information for any readers that may be interested in the "Narcotics Anonymous Loner Group": *Loner Group, P.O. Box 9999, Van Nuys, CA 91409-9099; or on the internet at [www.na.org](http://www.na.org).*

*\*Methadone Today takes strong exception to the term "clean". Terms like "clean" and "dirty" are inaccurate and serve to stigmatize opiate addicts. For instance, these terms carry a moral connotation--"dirty" may be interpreted as being morally impure. These terms are completely inappropriate when discussing a medical condition, including opiate addiction. If Narcotics Anonymous is at all interested in persuading the public that drug addiction is a medical disease and not a moral deficiency, they should drop erroneous terms like "clean".*

*\*\*Local groups or chapters of NA or AA may have rules or practices that are at odds with the national organization, even though they are technically supposed to abide by the rules and guidelines put in place by the national/parent organization. For example, some NA groups may allow methadone patients to share at meetings. Of course, local groups and individual members may also express opinions and attitudes that differ from the organization's official position. For example, some members of an NA group may say that methadone patients are "clean" or "in recovery", or members of an AA group may express the misinformed opinion that methadone patients are not really in recovery.*

## Dr. Vincent Dole--Father of MMT is a humble Humanitarian

I spent the better part of the morning talking to Dr. Dole, and could have talked all day long. He is a very interesting and articulate man, and I am proud to have met him.

Once we realized we were both in the Navy, we swapped sea stories for a couple of hours. It was difficult to stick with the work at hand; he was so filled with knowledge, I kept getting sidetracked.

To illustrate just how humble the man is, I will tell a story: We were sharing our Navy adventures when he told me he was working for them at Rockefeller during the war, "doing some research." He didn't elucidate; I had to drag it out of him. What type of research, you ask? Well, he was among the ones who pioneered the administration of plasma to wounded soldiers in the field! This undoubtedly saved tens of thousands of lives in the war years alone, not to mention the years since with methadone. This, to him, is just a day's work.

We can be proud to say he actually thinks it is WE (patient advocates) who deserve accolades. I feel as though I was blessed to talk with him. I hope this article conveys even a bit of his gracious and humble manner. [See p. 1, "An Interview With Dr. Dole"]

**Interview With Dr. Dole (from p. 1).**

attend classes, while still residing at the hospital and participating in the tests. Eventually, they were both attending classes off the hospital grounds while still living there. They were both still taking their methadone daily. As far as the doctors could tell, they were both "cured" of their addictions! It is from this auspicious beginning that the current state of methadone maintenance has evolved.

Unfortunately, politics was forced upon the equation, and methadone maintenance still hasn't reached its full potential because of that fact. Drs. Dole and Nyswander went on to study further the effects of MM on tens of thousands of patients. It is as the "Father of Methadone Maintenance" that I think of Dr. Dole.

So, with the background described, what follows is an interview I conducted with Dr. Dole over a two day period in January of 1998. I simply hope I am able to convey one-tenth of the sincerity and intelligence this man possesses. His humility and genuine caring are what I feel make him a great man. If I never meet another historical figure in my life, I am very glad that Dr. Dole was my "brush with greatness!"

**Odus:** Dr. Dole, how would you go about improving today's methadone programs?

**Dr. Dole:** First and foremost, I must address the whole issue of urinalysis. The nature of the whole interaction points up to me one of the most glaring and disturbing faults with the treatment of addicts. That is, namely, that the urinalysis is used to find fraud or deception by a patient instead of a means of documenting what has been accomplished by them. If you have such an adversarial relationship between a clinic and its patients, it is a bad clinic. Many clinics tend to act as some sort of police agency, thinking they can stand over the patient and somehow or another cure a patient by holding a big stick over his head. That isn't a very therapeutic approach. The whole image just isn't something I would have ever dreamed about, and that is sad, but it is not uncommon.

A lot of this is because untrained and fundamentally cynical people are often recruited into being counselors. How can someone with this disposition counsel anybody? They come into it with the attitude, "O.K., you aren't going to fool me. I'm on top of every little trick you can pull." That attitude is the most anti-therapeutic attitude one could have! This is then reinforced by government policies, which task the clinics with being policemen! When you've lost the "WE" in a patient/clinic relationship, you've lost the heart of the program.

**Odus:** What do you think of the government's role in methadone treatment?

**Dr. Dole:** The nature of government intervention is very heavy handed in a political way. It has suppressed the normal medical responsibility. The restrictions, which are so politically loaded, are meant to restrict and contain methadone treatment, which is politically unpopular. That type of repressive, negative attitude tends to drive out the most responsible and caring doctors. It leaves, therefore, only "jobs to be filled," as in warm bodies to fill positions as opposed to caring professionals. I think government tries to separate the addiction field from what it considers the "legitimate medical field."

Therefore, it became a much more administrative type job than a medical job. I notice that today the majority of clinics are owned by nonmedical people. I would like to see it brought back into the medical field, as opposed to the administrative field it is now in. The result of government has been to alienate the medical profession from methadone treatment. This results in what would be otherwise caring individuals (doctors) having an indifference or even hostility toward methadone. Even backing up and changing legislation wouldn't stop that attitude overnight.\*

**Odus:** Should counselors start a patient's treatment with the goal of eventually being totally drug free, including free of methadone?

**Dr. Dole:** I think that has been a very serious misunderstanding from the beginning. The goal is NOT abstinence, the goal is to become functional. The data collected over the years has shown that abstinence is an unlikely goal. It is a terrible mistake to put someone in the position of either eventually becoming abstinent or becoming a failure. I am very sorry to hear that many clinics continue to do just that. Unfortunately, that is a philosophy at many clinics. They are willing to "put up with" maintenance in the short term, but they feel that a patient isn't really "cured" unless they are abstinent.

**Odus:** Do you see any similarities between your model and the clinics that exist today?

**Dr. Dole:** Well, of course I see similarities, but the main difference is the philosophy, which has been drummed into them by those who are anti-maintenance, that the patient isn't "cured" unless they are "drug-free", no matter what else. The patient can be employed gainfully, taking care of his family, and in all respects a fine citizen; still, they feel that unless he is free of methadone, he isn't "cured". That is totally opposite from what I believed then and still believe today.

**Odus:** What do you think of the policy, by which most clinics seem to abide, of forcing a patient to detox due to illicit drug use?

**Dr. Dole:** I think it totally misses the point from a medical standpoint. I feel that each and

every patient should be examined by the doctor individually and treated like an individual. I like very much the concept of dealing with one thing at a time. If the patient has shown some sign of a problem, the physician should talk with him. He should ask him, "How are you doing? What is the problem, and how can we help to eliminate the problem."

**Odus:** What percentage of your patients were eventually able to live completely free of all drugs, including methadone?

**Dr. Dole:** You see, even you are prejudiced to a degree; you want to know how many people get off methadone altogether when the question should have been, "How many patients were able to achieve a normal life consistent with their own abilities, strengths and so forth." The answer to that question is, "quite a large percentage were able to go on with their lives with some people reaching very high social and employment positions."

**Odus:** I understand you were working on obesity before you became involved in drug addiction. Did you find that the two addictions (food and drugs) were similar or were they totally dissimilar?

**Dr. Dole:** Actually, they are similar in some respects and not similar in others. The biochemical control mechanisms that govern the release of fat are not the same as the control mechanisms that deal with pain; there is a world of difference.

On the other hand, I can tell you that in a social sense and even in a medical sense, they are both dealt with by prejudice rather than by intelligent analysis. I can tell you that I have worked with obese people who could only maintain a socially acceptable weight by living on a starvation diet. Many obese people have no control over how their body deals with calories, much as many people cannot control the craving for heroin. Still, the biochemical reasons are different.

This ends part one of the interview. I certainly hope y'all enjoyed reading it half as much as I enjoyed writing it. See the March issue for Part 2 of the interview.

I will appreciate any comments or constructive criticism. - **Odus Green**

*[See p. 2 to read about research Dr. Dole performed that helped wounded soldiers.]*

*\*The federal regulations have changed since this interview took place in 1998. Though the new regulations take some tentative steps to put methadone treatment into the realm of mainstream medicine, most of the problems Dr. Dole discussed still exist.*

## Pay Close Attention to Holiday Schedules

As you know, most [but not all] methadone clinics close certain days during the Christmas and New Year's holidays. Unfortunately, it seems that many patients were unaware of which days their clinics would be closed. Patients who have no take-home "privileges" receive take-home doses for the day or days the clinic will be closed. Thus, it is important that patients know their clinic's holiday schedule so that they make sure to attend the clinic the day before the clinic will be closed and bring along a lock box, as most clinics require take-home bottles be placed in a lock box. Even patients who normally obtain take-home doses need to pay attention to their clinics' holiday schedules, as their take-home schedule may be changed during the holidays.

One methadone clinic closed for the Christmas holiday on a Thursday and Friday--patients who normally did not get take-homes received two take-home bottles on Wednesday and had to return to the clinic on Saturday. Then for the New Year's holiday, the clinic was closed on Wednesday and Thursday. Many patients had not checked the clinic's New Year's schedule in advance and had mistakenly assumed that the clinic would be closed on Thursday and Friday as it had been for the Christmas holiday. As a result, many patients came to the clinic on Tuesday without a lock box. Most likely there was at least one patient who skipped going to the clinic on Tuesday, thinking that they would only be missing a dose for one day but would actually miss three doses: Tuesday, Wednesday and Thursday.

One patient went to the methadone clinic on Tuesday, ingested her Tuesday dose at the nurse's window, and rushed out of the clinic before the nurse could give her the take-home bottles for Wednesday and Thursday. A clinic staff member followed her out of the clinic to stop her, but she got in her car and left before the staff member could get her attention. She must have been upset when she came to the clinic on Wednesday and discovered it was closed; she would not be able to get another dose until the clinic opened on Friday.

To avoid such problems, patients need to find out how their clinic notifies patients about holiday schedules. Usually, such information is posted on a specific bulletin board in the lobby or on a wall in the lobby in a prominent locations (i.e., next to the receptionist's window, next to the dosing window, and/or on a wall adjoining the area patients wait in line to dose), but some clinics may use other notification methods, such as passing out flyers. If it is getting close to a holiday and you have not seen a posting or flyer, by all means ask your counselor or the receptionist! Patients should pay attention to the calendar, as most, if not all, holidays in which their clinic will be

closed are predictable. Common holidays for clinic closings include Christmas, New Years, Martin Luther King Day, Labor Day, Fourth of July, Memorial Day, and Thanksgiving. If you are unsure about when some of these holidays take place, you may want to purchase an inexpensive calendar--most will list these holidays. You may even want to write a reminder on your calendar to bring a lock box the day before the clinic will be closed so you do not forget to bring it that day. Rarely, a methadone clinic will cut their hours short the day before they will be closed; if different operating hours are noted on the posting or flyer, make sure to write down those hours so you don't come after closing.

As an aside, it is recommended that you provide your clinic with updated contact information if you move and/or change your phone number. In the aforementioned case of the patient who left her clinic without getting take-home bottles for the New Year's holiday, a clinic staff member tried to call her to inform her that she needed to return to the clinic to get two take-home bottles, but the staff member could not reach her because the contact information in the patient's file was outdated. Had the patient provided the clinic with updated contact information, the staff member could have reached her by phone, and she would have had enough time to drive back to the clinic and get her take-home bottles before the clinic closed.

In addition, many methadone clinics ask patients for a relative or friend's phone number and address that they can contact in case of an emergency. Patients should keep this information up to date, as it would come in handy in the unlikely event that an emergency arises (i.e., the patient has a heart attack at the clinic). Some patients do not wish their family to know that they attend a methadone clinic, but if at all possible, patients are advised to provide the clinic with one person's name, address and phone number--and keep this contact information up to date.

Apologies for taking up newsletter space with what are mostly common sense recommendations, but we don't want to see any patients' holidays spoiled by missing their methadone doses.

**Editor's Note:** We would like to take this opportunity to thank the staff member who tried to call the patient in the case discussed above. She went out of her way to assist this patient, even though she was neither the dosing nurse nor the patient's counselor. We hope that more staff at methadone clinics will follow suit and go out of their way to provide assistance to the patients they are serving.

Some clinics need to do a better job of notifying patients of their holiday schedules by posting them in a more prominent location. Moreover, clinics need to understand that patients make holiday plans in advance, and therefore should notify patients of their holiday schedule further in advance of the holidays.

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