

An Interview With Dr. Vincent Dole - (Part I)
by Odus Green

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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 Brecher, 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 60's 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 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 this year. 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 Green: 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 re-enforced 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 Green: 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 Green: 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 Green: 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 Green: 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 Green: 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.

**Dr. Vincent Dole Interview (Part II)
by Odus Green**

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This is the second of a two-part interview with Dr. Vincent Dole, Father of Methadone Maintenance. This material was gleaned from two separate conversations we had over a two day period in January. Dr. Dole is without doubt one of the most humble, self-effacing men I have ever had the pleasure of meeting. I can only hope this interview can convey the intelligence and dedication of this man. To this day, he is still very much involved with Methadone and its application toward freeing drug addicts from their dilemma. That dilemma being the black market which the government keeps strong and viable simply by keeping drugs illegal and treatment all but unobtainable. The fact is, even if one is able to get into a treatment program, the rules which govern dispensing methadone are archaic and very constraining in their application. Hopefully, one day methadone will be available through private physicians. Only then will many people be able to lead full, normal lives. As it stands now, we will continue to be "punished" as long as we remain in treatment.

Odus Green: How do you see "for-profit" clinics affecting Methadone treatment today.

Dr. Dole: I believe there is too much prejudice against "for-profit" clinics. While there is some foundation for prejudice against them, you must remember that any hospital or medical clinic is in business to make a profit. Now, to open a Methadone clinic strictly because you see a profit is doing nothing more than handing out medicine; that

is obviously wrong and motivated by greed. Still, if you look at the history of practicing medicine, doctors have always had to make enough money to eat. I do not see making a profit as a bad thing, and I think it can be good, particularly if it breeds competition. You see, if money is being made, then others will want to enter the field, and this keeps any one person from having a monopoly, thus charging whatever he wants. Competition will ultimately keep the prices down to an affordable level. However, I do not at all like the idea of exploiting people to make money.

Odus Green: How do you feel about the licensing procedure for Methadone clinics?

Dr. Dole: Well, I do believe it helps keep out many doctors who would otherwise not be the best choice for the position. However, it also tends to facilitate the hiring of people with little scientific knowledge and they don't really care either. Some of the people who are lower on the scale tend to see themselves as simply "filling a slot" and only there to fulfill the rules. This is not the best environment in which to carry on treatment. In some states, the system is set up so that it is purely political in nature, and that is definitely detrimental to Methadone treatment. These politically based clinics are typically some of the worst around.

Odus Green: How do you see private physicians fitting into the scheme of things in the future?

Dr. Dole: I feel that this will go a long way toward addressing the size problem we are faced with now. Many clinics have way too many patients on their programs. There is no way one physician can handle 500 or 600 patients. Also, this translates into counselors having 50 or 60 patients. You can't assure proper treatment when it takes all your time simply to fill out paper work. With all the paperwork required, there is simply no time for counseling, and this is a sad situation.

Odus Green: Have you read the "Swiss Heroin Report" and if so, what did you think about that?

Dr. Dole: Well, yes, I did read it. The question, "What did I think" reminds me of the old question "How's your wife?" and the obvious answer is, "Compared to what?" My feeling is, the attitude with which the Swiss approached this is a pragmatic one. They left behind the presumptions and simply said, "Let's just see what we can do to help," and that in itself is a good thing. I feel that this alone makes it much more successful than a repressive study. Unfortunately, it is posed here in such a way as to say "Which drug is more successful, this drug or that drug?" My own experience is that heroin is not an ideal drug for maintenance simply because its period of action is just too short. Also, injection is not the ideal way to give a medicine which will be taken frequently.

Odus Green: What do you think about drug prohibition altogether?

Dr. Dole: Now, that is an open-ended question. By that I mean, you can't just give a "yes" or "no" answer to it. Certainly, prohibition as we've seen it has been unproductive. It has had the opposite effect from its intentions. The question is, "What can we do to ensure the rational use of dangerous drugs?" The forces of prejudice, ignorance, and demand are such that it cannot be "solved" by policy or law. Taken in context of time, it is obvious that these drugs have been used since their discovery and will continue to be used in the future by some people. What to do about that, I don't have the answer. There is no policy which can change anything overnight, which is what politicians will try to do. Actually, political expediency is sometimes hostile to common sense. All we can do is try to change the trend in which the country is heading.

Odus Green: From my reading, I understand you had many detractors during your years of research. Who were they, and why were they against your work?

Dr. Dole: Oh yes, there were many who didn't like what I was saying, especially the "*Federal Bureau of Narcotics and Dangerous Drugs*" (BNDD--this is the forerunner to today's DEA). They tried every way possible to discredit me. Luckily, I was sufficiently entrenched in the University system that they couldn't do anything. Their power was too weak to reach me there. Now, Dr. Nyswander actually did risk imprisonment in her work. She was simply a private practice doctor who risked her freedom many times to help addicted persons. In that position, she didn't have the protection I did being a University researcher. I will say there was a lot of drama between myself and Mr. Anslinger (Mr. Anslinger was the head of BNDD).

Odus Green: Anything you'd like to add for folks to know?

Dr. Dole: Just that you people who are involved in advocacy, keep up the work. I have seen changes come about because of people becoming involved. It is these who are the real heroes in all this. Without advocacy, changes will not come about within the present system.