

**A Life of Clinical Activism:
An Interview with Robert G. Newman, MD, MPH
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There are times when researchers have a responsibility to involve themselves in the political process to try to directly influence policy implementation. In such instances, the familiar, perhaps more comfortable role of the scientist must be supplemented by political activism to avoid research becoming a rationale for withholding help and to ensure its appropriate role in influencing policy.
--Robert G. Newman & Nina Peyser, 1987¹

Introduction

The introduction of methadone maintenance (MM) as a medical treatment for opioid addiction is one of the most significant and controversy-laden milestones in the history of addiction treatment. One of the most singular figures in the early dissemination and continued evolution of MM is Dr. Robert Newman. Dr. Newman has been and remains an adamant defender of MM, but he is also a gadfly who has challenged many MM-related policies and practices—all toward the goals of elevating the access to and the quality of care of MM patients. Dr. Newman's career in addiction medicine spans more than four decades. He has published more than 100 articles and commentaries, more than 20 book chapters, and is the author of *Methadone Treatment in Narcotic Addiction*. Dr. Newman has served on the editorial boards of numerous journals, including the *Journal of Addictive Diseases*, the *Harm Reduction Journal*, *Heroin and Related Clinical Problems*, and the *Journal of Maintenance in the Addictions*. In honor of his contributions to the field, Dr. Newman has received the Nyswander-Dole Award, the Norman E. Zinberg Award, the David E. Rogers Award, and the International Rolleston Award. In August and September of 2011, I had the pleasure of interviewing Dr. Newman about his life and work. Please join me in this engaging discussion.

Medical Specialization in Addiction Treatment

Bill White: After completing your medical education at the University of Rochester School of Medicine and Dentistry (1963) and receiving a Master's Degree from the University of California at Berkeley (1969), you served as the Assistant Commissioner of Addiction Programs for the New York City Health Department. What drew you to the problem of addiction as an area of specialization?

Dr. Newman: It's a case of total unplanned serendipity. I was a resident in public health for the New York City health department. I'd been in the field as a trainee in public health for about three or four months, and I was living in a studio apartment on the upper

¹ Newman, R. G., & Peyser, N. (1987). Methadone treatment: Experiment and experience. *Journal of Psychoactive Drugs*, 23(2), 115-121.

west side of Manhattan. One evening I returned home, and as I entered the elevator, a guy who looked a little bit strange got on after me and said, "Aren't you the doctor who moved onto my floor not too long ago?" I said, "I'm a doctor," and like most New Yorkers, I looked away and tried to ignore the fellow. He said, "Well, what kind of doctor are you?" My response was, "Whatever kind of doctor you need, fella, I ain't that kind." "No, really, what kind?" I said, "I'm a public health doctor," whereupon he literally grabbed my sleeve and said, "I have to talk to you right away." I said, "But you gotta understand, I do not do venereal disease," because I truly thought who could possibly want to talk with such urgency to a public health doctor? He said, "No, I want to talk to you about methadone." I swear to God, I had never heard the word methadone, and I never thought about addiction. This fellow who literally pushed his way into my apartment and refused to leave was Herman Joseph. Herman finally left when I promised him that I would allow him to set up a meeting between me and some woman named Marie Nyswander.

When Herman retold this story many years later, he noted that on the morning of the day we met, he had been to see Dr. Nyswander, whom he truly idolized, and Dr. Nyswander had said to him, "Herman, we need more young doctors in the field of methadone treatment." This was in early 1968. Herman claims to have responded, "I think there's one that moved on to my floor. I'll get him." I kid you not; that is the way I became involved with methadone treatment.

Bill White: That is a remarkable story.

Dr. Newman: If I had missed that elevator, I probably would be a very wealthy orthopedic surgeon now. I had determined to leave the field of public health because I really had no particular interest in it. I was going to go back to surgery, which I had already trained in for two years, and the choice was between orthopedic surgery or plastic surgery. That's what I would have done.

Bill White: How would you describe the state of addiction medicine at the time you entered the field?

Dr. Newman: I think there was a tremendous amount of concern, vastly more than there is today. Heroin addiction was considered to be a true plague or a problem on the verge of becoming a plague. There was a great sense of resignation. Meeting with Dr. Nyswander just filled me with a great deal of enthusiasm for a form of treatment that I felt could make a tremendous difference for a lot of individuals. I knew it could also have a major positive impact on the community as well, but my focus from the very beginning to this day has been the impact on individual patients, albeit one heck of a lot of individual patients.

Expansion of MM in New York City

Bill White: Your early work afforded you opportunities to work with Dr. Marie Nyswander and Dr. Vincent Dole. What are your best memories from these early collaborations?

Dr. Newman: I met with Marie, and as I recall, at the very first meeting with Marie, she brought along a very pleasant fellow in a suit and tie and a jacket, and we chatted about his interest in computers. Then she told me that he was being maintained on a dose of methadone. This was the first patient I ever met. Very shortly thereafter and before I had met Vince Dole, I went out to California, got a public health degree at Berkeley, maintained contact with Marie Nyswander, and came back to New York City. Upon my return, the City Health Department asked me to run a nutrition survey, which really would have been the end of my public health career if that was all that I was going to do.

One day in the middle of this nutrition survey function, I got a call to go see the person who at the time was the health czar of New York—a fella by the name of Gordon Chase—who was the head of all health services for New York City: head of the hospital corporation, the health department, mental health, everything. The commissioner of health reported to him. He called, and I had never seen him, never talked to him, and I walked into his room, and he said, “Hi, Dr. Newman. I want you to know I’m going to make you Mr. Methadone.” I had never seen this guy before, and apparently he had become convinced that the only way to get a handle on the problem of addiction and do something meaningful was to have a very large-scale methadone maintenance program. He asked, “Who could run this thing?” The answer from his staff was “Everybody in the field hates methadone and is locked into drug-free treatment.” Somebody said, “There is a guy who’s a resident in public health who is a friend of Vince and Marie”—Vince Dole and Marie Nyswander—and that was the credential upon which Gordon Chase called me and said, “I’m going to make you Mr. Methadone.” He said, “I want you to develop the biggest, fastest program anywhere ever, and I guarantee all the resources you can possibly need from the city, but your job is to be able to offer every single person who wants treatment immediate treatment.” That was the start of the methadone maintenance program in the New York City Health Department, which grew to about 10,000 patients within two years.

Bill White: Was there tension in your early collaborations with Drs. Dole and Nyswander over such rapid expansion of MM?

Dr. Newman: My personal relationship with Vince and Marie was extraordinarily close. At about this point (1973), my son was about three years old, and one day I said to him, “Tonight we’re going to have dinner with the best friends you have in the whole world.” His response as a three-year-old was “Is Vince and Marie coming over?” Having said that, I wouldn’t call it tension, but Vince and Marie made it very clear in a non-confrontational way that they thought what I was doing could be an absolute catastrophe. As far as I recall, no one in the addiction field and especially the proponents of methadone maintenance supported what we were doing or the scale and the speed with which we were doing it. Everybody was literally petrified that I would create a disaster that would be tremendously visible and that would destroy for decades to come the prospect of methadone maintenance being accepted. So, there was a great deal of concern until it was clear that what we were doing was working just as effectively as any of the earlier, much more modest treatment efforts. Then everybody ran and jumped on the wagon to expand their own programs as quickly as they could.

I'm convinced that if the City had not demonstrated—in the face of the prophecy of catastrophe from ALL, including my mentors and closest of all personal friends, Drs. Dole and Nyswander—that massive expansion almost overnight was possible and could be effective, this treatment would have continued to serve no more than a few thousand for years—perhaps to this day. It is not hyperbole when I say NOBODY endorsed what we were doing; EVERYONE expressed grave concern, and the more enthusiastically committed they were to MM, the more emphatic they were in trying to dissuade us from “going too fast.”

Bill White: Are there any stories or lessons that really stand out for you from that period of rapid expansion?

Dr. Newman: The lesson is that one has to set the goal before determining how to proceed. There's some administrative adage that you cannot get there from here, but you can get here from there. In other words, first decide where you absolutely are committed to be and then say to yourself, “Ok. These are the resources I have. How am I going to get there?” But what must remain fixed is the goal. I worked for a guy named Gordon Chase whose highest academic achievement was a BA (major in political science), and whose experience and expertise were in Latin American affairs. He was simply so (totally!) uneducated in the field of health and addiction that he had to rely on common sense, and common sense told him that nothing whatsoever could justify abandonment of the many tens of thousands of heroin dependent New Yorkers who needed and well might want treatment—and the instinct that nothing existed that could provide care promptly to as many people as methadone maintenance.

Every single objection I raised—and I raised objections that I had heard from Vince, Marie, Herman, and everybody else at the time. They said, “Well, you need six weeks of training, and you need this. You need that. When you open the new clinic, you can't admit more than one or two patients a week for the first whatever.” Every single objection I raised, Gordon's response would be, “Is it really better to leave people on the street to shoot dope who want this treatment that you think is effective?” My bottom line answer to him was, “You're right. We have to do whatever it takes to achieve the goal.”

Gordon Chase's compelling argument was this: Imagine a woman barging into your office one day telling you her son, a long-term heroin addict, had applied for treatment but was turned away by your program and put on a waiting list because you had no room—and then died of an overdose. He said, “Bob, you tell me what excuse for moving slow you will give this woman that will elicit the response, “Oh, I understand. Of course you had to wait until all the furniture was placed, or of course, you didn't want to burden the new staff with too many patients. My poor son had to die, but at least I understand now that it was for a very good reason.” He gave me that speech once or twice until I got it. Within two years, we had over 10,000 people enrolled, and within about three and a half years, the City was able to have notices in subways and other places say, “If you have a problem with heroin addiction, we have treatment available for you. This is the number to call.”

If Gordon Chase had known what he was doing, he would have been just as conservative and cautious as everybody else was at that time. And I should add the following illustration of Chase's thinking, as a result of not being encumbered by too

much knowledge. About three or four months into the planning and implementation of the methadone maintenance program, he called me in, and he said, “Bob, in addition to the methadone maintenance program, I want you to do something for me. I want you to create a very short-term ambulatory detox program.” I said, “Listen. This is ridiculous. Detox doesn’t accomplish anything. There’s going to be almost 100% recidivism. Let me focus on expanding this large methadone program that ain’t never been done before, that most people say can’t be done. Don’t bother me with this ridiculousness.” He basically said, “Listen. No matter how fast you expand and even when you achieve the goal of treatment on demand with methadone, there will be heroin addicts who simply will not be willing at any particular moment to contemplate or to pursue a life without using heroin. For those people who want a one week or one month or indeterminate period of freedom from the need to shoot dope, the City has to be able to offer a short-term, absolutely no-conditions alternative, and that’s what detox will provide.”

Basically, he ignored my protests, and said, “I promised to make you Mr. Methadone and make it possible for you to create the biggest methadone maintenance program, and now you’re going to have to do this for me.” I can say with absolutely no support, no understanding, no anything from anyone except “Are you out of your mind,” we created the Ambulatory Detox Program of the City of New York. In its first 12 months of operation, we had almost 20,000 admissions. For three and a half years, it operated with between 20,000 and 22,000 admissions every year.

The Detox Program was an important lesson that unfortunately has been ignored for 35 years, including by me because I haven’t spoken about it until recently. One of the things that we discovered—and all these data are in a book that I prepared after the experience—was that of the patients admitted to the ambulatory detox program, some 60% had never before been in any previous long-term treatment, and this was a sample of admissions from 1974 when one could get drug-free and/or methadone maintenance treatment in a matter of weeks, so it was not due to a shortage of treatment availability. Even among those who claimed to have been addicted to opiates for 20 years or more, half of them had never ever been in long-term treatment. Chase’s hypothesis that there were people who were willing to accept short-term detox but not willing at a particular moment to contemplate long-term abstinence was absolutely correct. The ambulatory detox program, to everybody’s surprise, resulted in some 15% of those admissions asking for referral, accepting the referral, and within 30 days, showing up to begin treatment. And yet ambulatory detox as a freestanding, independent treatment essentially doesn’t exist anymore anywhere in the country as far as I know. Gordon was right, but we’ve ignored this lesson.

Bill White: From what you’ve said, Gordon Chase is one of the unsung heroes of modern addiction treatment.

Dr. Newman: He is totally an unsung hero, and it was also heroic for John Lindsay to appoint him Health Services Administrator. That appointment was soundly vilified by the public health community and by the New York Academy of Medicine, but what Gordon Chase achieved has stood the test of time.

Bill White: I have heard that you actually operated a methadone clinic on a ferryboat during this expansion era. Could you share that story?

Dr. Newman: Creating the methadone clinic on a ferryboat was one of the highlights of my professional life. A meeting of a handful of methadone program directors was convened (in the board room of Beth Israel Medical Center) by the Drug Enforcement Agency (different name then) and told in confidence that in a week they would close down a private methadone "mill" that allegedly was selling methadone dosages to several thousand people. We were asked to gear up to accept all who came in the hours/days after the clinic was shut down—an extraordinary display of concern by the federal drug officials for the well-being of addicts!

A great public relations fellow working with the City, Mike Blumenthal, was at the meeting and as we left, he told me: "I'll get the city to give you a ferryboat," and 48 hours later, a decommissioned Staten Island ferry was docked where the World Trade Center was later built. The unfortunate name of the boat—Gold Star Mother—caused a major outcry by veterans' groups and others who said that treating addicts on a boat with that name disgraced the memory of fallen heroes and their loved ones. (Gold Star Mother was the designation of women who had lost sons in the First World War; they were given gold stars to display in their windows.) It also didn't help that "mother" was the street name at that time for the dealers who sold addicts heroin—hardly a good name for the provider of methadone!

Two or three days later, the boat was towed from some ferry graveyard on Staten Island to Battery Park. The private clinic was closed as planned, and we accepted almost 500 patients the very first day. The City's program at that point had accepted its very first patient only 7 months earlier and already was treating several thousand patients. We subsequently did retention analysis and other studies, and those ferryboat patients did as well as all other patients.

The experience prompted us to open large "holding units"—about 4 in all—where we accepted thousands of patients from the waiting list with only modest "support" services. When the Trade Center construction began, the boat was towed to the West Village, and the community went nuts, but the boat remained with about 1,000 patients in all for about a year. Late fall 1971, after being moved to Greenwich Village, we had to provide heat, and the only way to do it was to start the engines and keep them going 24 hours a day.

In the beginning, until the administration of Roosevelt Hospital kindly made its pharmacy available, I would keep about a week's worth of ferryboat methadone in my apartment. I'd deliver the methadone for the day each morning and bring all the unused methadone home at night—usually on the stroller that also held my 1-year-old son.

Once, while the boat was still at Battery Park, I got a call at 2 or 3AM from the firehouse that was located right there asking if I owned a ferry and telling me the boat was sinking! The fresh water supply was provided to the bowels of the boat from a fire hydrant on the dock, and the connection within the boat had ruptured. The boat was half gone before the firemen noticed what was happening and turned off the water at the hydrant. Exciting times. Great times!! And clear demonstration that nothing prevents massive overnight expansion of effective treatment when there's a will to do so. And yet

today, waiting lists exist in many cities in the US, Canada, and around the world—people forced to wait years! Inexcusable!

The Narcotics Register

Bill White: For two years, 1972-1974, you served as Director of the New York City Narcotics Register. What exactly was the Narcotics Register, and what did it teach us as a field about narcotic addiction?

Dr. Newman: I think we learned a lot of things. After I had taken over the methadone program, I heard that there was something called a narcotic register. I had absolutely no idea what it was. Basically, it was a room literally filled with shoeboxes containing these paper reports. There was virtually nothing you could do with the information. One of my key staff members, Margot Cates, somehow managed to put some 150,000 reports onto a computer-analyzable database from which we generated some wonderful reports. We were able to generate some reasonable estimates of the magnitude of the heroin addiction problem in New York City. We did some follow-up studies, reports to the registry before applying for treatment, while on the waiting list for treatment, after admission to treatment, and after discharge from treatment. Absolutely fascinating.

The ultimate lesson for me was that nobody gives the least bit of a damn about data. Data have rarely if ever persuaded anyone to change their view of anything. The last thing I did before leaving city government was to successfully convince the newly appointed Commissioner of Health, Dr. J. Lowell Bellin, to let me destroy the narcotics registry and wipe out the database. I was concerned that the data could be misused and even more convinced that it offered little benefit. And we got rid of it. I tell you there were some researchers who acted like I just crucified the Lord and hung him up on the cross. They were just beside themselves. I had zero regrets, and I still have zero regrets.

Bill White: When did the registry end?

Dr. Newman: It must have ended the last week or two that I was in office, which would have been December of 1974. There are a number of studies that were published, and I've got a number of studies utilizing the registry in my book on methadone treatment. The irony is within three months of telling Lowell Bellin that he ought to eliminate the New York narcotics registry, I was doing a consultancy in Hong Kong, and they had a registry, which was just about as useless as the New York City registry when I took it over. I told the people in Hong Kong, "Listen. My advice is you probably should get rid of it all together, but if you want to have a registry, then the person you should have come here and create it is this brilliant Swedish Jewish fellow, Bent Werbel, who created the New York City computer-based registry." They said, "It's a deal," and they hired this fellow, and he spent the next year in Hong Kong creating a registry that's been functioning ever since. (I was recently reminded that, at my recommendation, funding for Mr. Werbel's consultancy to Hong Kong was provided by Mathea Falco, at that time the Assistant Secretary of State for addiction matters.) Every three to six months, they issue a report. They send me a copy faithfully, and it's extremely useful. As far as I know, there's never been a breach of confidentiality. The government uses it for planning

purposes. Do I have misgivings about it? Yeah, but I have no regrets about having helped them create it.

Distinguishing Features and Misconceptions about MM

Bill White: At the time you began your work in methadone treatment, there was extreme pessimism about the treatment of opiate addiction going back almost a century. What do you think distinguished and continues to distinguish methadone maintenance from other treatments before and subsequent to its introduction?

Dr. Newman: What distinguished MM was giving up the notion that addiction is a condition that can be cured, and recognizing it as a chronic condition characterized by a very high post-treatment relapse rate. It's that recognition that I think turned things around, and it was Vince and Marie and nobody else who had the wisdom to say, "Listen. We have now had 22 long-term hardcore recidivist heroin addicts who have been on our research unit at Rockefeller Institute. We have put them on methadone doses and increased the dosage, and we have seen a remarkable transformation. Some have asked to be excused from the ward so they can pursue a job that they've heard of or pursue education or whatever." They said, "We've got something that seems to be effective in turning lives around. Let's see if it works on a larger scale."

Everyone else was saying—and to this day, most people still say—"Yeah, so these people are doing well, but what would happen if you stopped the methadone?" Vince and Marie never went there. They did not speak about lifelong methadone; they did not speak of optimal duration of treatment. They did not speak of optimal dosage. They simply had a very pragmatic, evidence-based view of a problem that kills people, destroys lives, destroys community, whose adverse effects can be reversed in most patients who volunteer for this treatment, and that's as far as they left it. They said, "Let's see how it works in real life in a clinical setting."

They understood that opioid addiction was not a problem of willpower that their admonition to "just say no" could cure. Unfortunately, to this day, you talk about methadone treatment and even people who accept it ask, "Just one question: how many people can get off this stuff?" You say, "It's like the use of insulin in diabetes or any other treatment for any chronic illness that you're unable to cure: when treatment stops, you've got to expect relapse." A distressingly large number of very well-intentioned, thoughtful, smart people respond with, "But if the condition is still there and if you stop treatment after 2 years or 20 years, and the same likelihood of relapse persists, Dr. Newman, what have you accomplished?"

I have to tell you, I hear this to this day, and I hear it around the world. If you try to explain such thinking to an 11-year-old, I think the 11-year-old would say, "Gee, I already knew all you adults were crazy. It just doesn't make any sense." The key is to accept addiction—and opiate addiction is the only thing I profess to know anything about—as a condition that we do not know how to cure. The defining characteristic of this condition is not dependence, nor use; it's the likelihood of relapse after abstinence is achieved. That is what defines the condition. Anybody can achieve abstinence. Lock up a long-term hardcore addict in a closet for a week, and you'll have achieved abstinence. The disease or the condition is defined by the fact that relapse is the rule rather than the

exception. Unfortunately, people just can't accept that even though in the alcoholism arena, this same idea is the bedrock of AA. You tell a zealous AA advocate, "My uncle used to be an alcoholic," they'll stop you right there. They'll say, "You don't understand. There's no such thing as 'used to be an alcoholic.'" "Ok, he used to be a heavy drinker until the last 15 years. He's been totally abstinent. Surely he can stop going to AA meetings without risking relapse?" The answer is, "Absolutely not; that person is as much an alcoholic today after 15 years of total abstinence as he was 15 years ago when he was drunk out of his mind every day." That fundamental bedrock of AA philosophy people have not been able to transfer to the field of narcotic addiction. It's tough to understand.

Bill White: What do you think are the greatest misconceptions about methadone treatment among addiction professionals, the public, and policymakers?

Dr. Newman: I think it's the notion that all we're doing is substituting one drug for another—substituting an illicit high with a legal high. As early as around 1970, a fellow named Dobbs, a physician working in a methadone program in Washington, wrote a paper—I think it was in *JAMA*—in which he attributed whatever success methadone had to the charisma of Marie Nyswander. Even to somebody who would never sell Marie's charisma short, that clearly was not the case. He said we were replacing an illegal euphorogenic substance with a legal euphorogenic substance. My comment then and now, especially in America where billions of dollars are spent on medications for no other reason than the claim (and the hope) that they make you feel better (Zoloft, Prozac, Viagra), is, "What else is new? What do any of these substances cure? Nothing!"

If it were in fact true that methadone maintenance produces euphoria, the answer would be, "So what?" But the irony is it doesn't! This has been absolutely, unequivocally demonstrated; tolerance develops! Every second-year medical student who has observed the effort to continue to provide opiate analgesia to a terminally ill cancer patient knows tolerance develops. It develops to the analgesic effect. It develops to the pupillary constriction effect. It develops to the nausea and vomiting, and it develops to the euphoria. People think methadone is a way to coddle addicts, give up on the problem of addiction, and pass up the opportunity to get people clean and keep them clean. That view is contradicted by every credible study that has ever been done in the field of addiction.

Bill White: Do you attribute to these kinds of misconceptions the stigma that continues to be attached to methadone?

Dr. Newman: I think so. People have totally forgotten what methadone is all about. What they know is they sure as hell don't want it in their backyard. The view is that if the government wants to provide dope to junkies, good luck, and if it helps reduce crime, so much the better. But whatever you do to those junkies, you're not going to do it on my block.

Opposition to methadone is not like the abortion debate, where some people will lay down their lives to prevent abortion occurring anywhere in the world. With methadone maintenance, if you provide it over in Brooklyn, nobody in Queens or Staten Island or Manhattan is going to give the least bit of a damn about it or argue against it—

unless maybe it's because they resent their taxpayer money supporting it. There is a pervasive perception, defying all the scientific evidence, that methadone is just bad, and a poor, second best substitute for what we should really be doing with and for people who are opioid dependent.

Just in the last few months, I've started to collect examples of this view from fields that have absolutely nothing to do with addiction. *The Economic Times of London* recently said some particular fiscal policy "is a methadone approach to the financial ills of the stock market." This reflects the image of methadone as a second-best treatment choice. It's so ironic that those who know the science—including WHO, UN, NIDA, CSAT, and SAMHSA—refer to methadone maintenance as the gold standard of treatment for opioid dependence. They don't say, "If all else fails,..." What we know today from decades of scientific studies and clinical experience is that nothing is more effective in the treatment of opiate dependence than opiate substitution with methadone or buprenorphine.

Stigma is the cause of the negative reaction elicited when people hear the word methadone. So, yeah, whether it's a housing company official, an employment agency person, or a doctor or nurse, you've got problems if it's known you are a methadone patient. If somebody walks into an emergency room and says, "I've got this God-awful pain in my stomach, and by the way, Doctor, you should know I've been on 110 milligrams of methadone per day for the past five years," the likelihood of good, quality, compassionate care for that condition is going to be much less than for the person who walks in and is not known to be a methadone patient.

Bill White: You once shared with Lisa Torres and myself that you thought some of the greatest stigmatization of methadone treatment was actually shared and reinforced by providers of methadone treatment. Could you elaborate on that idea?

Dr. Newman: It's a very painful conclusion that I came to almost from the very beginning. The status of methadone treatment has suffered in significant part due to the horrendously unprofessional attitudes and practices of the staff that provide this treatment (clearly, there are exceptions!); in many instances, they reflect hostility towards patients and treatment that is even greater than exists in the community at large. No one needs more education in how to treat the condition and the patients than some providers of MM. They are the ones who are often punitive; who place dosage ceilings that are known to be a potential death sentence; who demand that all patients, forever, piss into a cup under direct observation of staff; who punish patients for showing signs of the condition being treated—drug use—by lowering (!) their methadone dosage and ultimately "terminating" them. Providers have proudly published papers describing how they dealt with unemployment among their patients (perhaps aiming for greater rate of "recovery"?) by giving the unemployed a couple of months to find a job, and if they failed, throwing them out of treatment. The providers in many programs pressure patients into "tapering" when they believe it's time to "discard the crutch" of methadone. And it's the provider community, overwhelmingly, that is prepared to fight to the death so-called "interim" methadone as an alternative to abandonment for the huge proportion of dependent individuals who want and need help but can't get it and/or can't afford it and/or don't want it in a "comprehensive" program.

Bill White: I'd be very interested in hearing your thoughts on the evolution of methadone treatment over the course of your career.

Dr. Newman: I'm afraid that the hostility toward it has grown. I think the vested interest in keeping methadone treatment a monopoly service that is the exclusive property of a small handful of providers has persisted and become even more solidly entrenched than ever before. Ironically, the fiercest opponents of allowing a new proposed clinic to open have often been other providers of treatment. Of course to the methadone providers in the early '70s, that's not news because the drug-free programs of that era were the fiercest opponents of methadone treatment. You would think that they would say, "Hey listen, we're here to take care of a problem; we have limited capacity, and there are other types of treatment that some may prefer." But that's never been the case, although the leaders of drug-free treatment have figured out that the existence of methadone maintenance is not a threat to them.

The current providers of methadone include some spectacularly wonderful methadone treatment programs, but there are also other methadone treatment providers who do want to maintain the status quo and restrict availability and maintain total control over the lives of their patients. They have total control, and they like that. I think that's very sad. The power of the methadone maintenance provider over its patients is absolute under the current system.

Access to Methadone Treatment

Bill White: What are your thoughts about increasing access to methadone treatment?

Dr. Newman: In your writings, Bill, you have called for increasing "attraction, access, and early engagement." It sounds like motherhood and apple pie (or at least, apple pie!) to say earlier intervention leads to better results. When it comes to opiate dependence, however, I'm not sure there's any evidence that this would be achieved in the current environment. "Outreach teams" probably would be super, but one could do "outreach" for virtually no cost, with essentially no personnel or space requirements, and with implementation literally overnight. Just place prominent signs in every ER and ambulatory care center simply saying: "dependence on narcotics is a medical problem for which effective treatment is available . . . ask the staff for a referral." Or you could post a list of treatment facilities anywhere and everywhere! Think of the phenomenal (and wonderful) radio, TV, and subway ads of the New York City Health Department to encourage people to take steps to get help with smoking cessation—including the offer of free products that "substitute" non-inhalation routes of nicotine delivery. For opiate dependence: zilch! If there were such outreach efforts, the available "slots" under the current system would be used up in days, if not hours.

Bill White: Do you think we'll see a day when methadone maintenance will be mainstreamed into office-based treatment?

Dr. Newman: I hope so. I have to say that the current so-called mainstreaming that is represented by medical maintenance is very nice for the few people who have it but is almost meaningless in the grand scheme of things. The patients who are given this privilege of getting their once a month pickup from a physician in a non-program setting must remain on the caseload of and the clear responsibility of the treatment program. The physician is allowed to provide methadone only as an agent of the program. Very few programs permit medical maintenance anyway. I am hopeful this will change. The hope that I have is that other medical disciplines for which addiction really doesn't hold any particular interest will realize that if you want to optimally treat an opiate dependent patient for any medical disorder, there is no way that you can achieve your professional therapeutic aims if you ignore the opiate dependence. I think physicians will realize that the practice of their specialty field cannot be segregated from addiction-related problems. My bottom line hope is that the medical profession and the community ultimately accept addiction like any other chronic medical problem and accept the methadone maintenance patient as they accept other patients needing medical care.

Bill White: Do you think the monopoly of the clinic system in the US has slowed the elevation of the quality of treatment for methadone patients?

Dr. Newman: I think it certainly slowed the availability of treatment, and it has most definitely slowed, essentially stopped, the mainstreaming of this form of medicine. Who are the experts in methadone maintenance treatment? Who are the experts in treating addiction? It's the providers who today have a monopoly on methadone maintenance. Who are the fiercest opponents of mainstreaming methadone and letting office-based practitioners prescribe the stuff? It's the people who own the monopoly today. So, who is supposed to speak for the office-based practitioner who wants to address this problem in her or his patients, assuming there are such practitioners? And surely there are some. Who is going to say, "Well, listen, let's figure out how to do this." Of course it's possible. It's not only possible, it's highly desirable because you're going to get much better control of the epilepsy, or the hypertension, or the coronary artery disease. How can you treat a patient with hypertension—severe, potentially lethal hypertension? How can you treat that patient who is an opiate-dependant individual even under circumstances where the person is lucky enough to be receiving methadone treatment at some other facility? If the patient is not in treatment somewhere else, you're not going to be able to do it at all. But of course, when you have specialty societies like the American Society of Addiction Medicine, it makes it that much more difficult to foster the notion that this is a condition that all physicians should be treating within the limits of their training. It's terrific that we have specialists, but I've never heard of an endocrinology association or society, or an endocrinologist as an individual, say, "Gee, it's really appalling that those family practitioners are prescribing insulin to diabetics."

Criteria for Evaluating Methadone Maintenance

Bill White: What criteria should be used to evaluate methadone maintenance?

Dr. Newman: Whenever the evaluation of addiction treatment is viewed in a way that would be unthinkable for other medical conditions, I think it should make people stop and say, “Hey, what justifies this unique, unprecedented orientation?” One aspect of measuring success in methadone treatment—an aspect that is a prerequisite for continued treatment in many programs—is abstinence from all illicit drugs. There are programs in America that terminate patients if they have evidence that cannabis has been used. Whoever heard of a patient who is in long-term treatment for hypertension, diabetes, asthma, or glaucoma where the doctor says, “Oh, listen, just by happenstance, we happened to do a urine toxicology. It was really by mistake, but we see you’ve got cannabis in your urine. We don’t allow that, and if we ever have evidence of you using cannabis again, we’re going to terminate your renal dialysis or your hypertension treatment.” Drug use is the reason to provide addiction treatment, not end it. In many programs, methadone maintenance patients whose urine demonstrates use of heroin are given a few chances, and then they’re thrown out of treatment. It’s completely ridiculous.

Any time the efficacy of methadone is being discussed, the question invariably rises in countries throughout the world, “Dr. Newman, it all sounds great, and we’re for it, but tell me, how many people achieve and maintain abstinence without methadone? What’s the success, the long-term success?” “You mean long-term in terms of being able to keep a job, employment, family, and so on for 10 years?” “No. After treatment ends, what’s the success?” Whoever heard of evaluating treatment like that? It’s like evaluating the success or the effectiveness of birth control pills by measuring the number of pregnancies that occur in the 12 months after the pills are discontinued. It’s laughable, but that’s exactly what people do with regard to methadone maintenance treatment.

Isolation of the MM Patient

Bill White: Do you think the resulting isolation of methadone patients has contributed to the stigma attached to their treatment?

Dr. Newman: Absolutely. It’s a self-fulfilling prophecy. The fact that the stigma is there leaves methadone patients, especially those who can “pass”—who look and act normal, healthy, and give no indication of being junkies according to the popular stereotype—those individuals are going to be unlikely to say, “Hey, doc, or hey, nurse, I think you should know I’m on 120 milligrams of methadone.” They hope and pray nobody finds out about that because they know the stigma exists. They’re not going to tell their boss if they can possibly avoid it. They’re not going to tell the housing project manager if they can possibly avoid it. They’re not going to tell the emergency room doctor when they come in with a broken ankle. The patients recognize the stigma.

The tragedy is that methadone patients share that negative bias to a large extent. Patients are part of the general community and often share the biases of the community. And they consider methadone treatment as something negative. That’s why there is tremendous pressure on the part of most patients to pursue detoxification. The ethical physician and counselors who say, “Listen, we’ll help you achieve whatever your goals are, but first, we want you to understand—we want to ensure there is informed consent related to this decision. We want to make clear to you that while we will provide every support, you’re always welcome to come back. We’ll never turn our back on you. If you

detoxify from methadone, first of all, you have a better than 50 percent chance of relapsing to heroin use or illicit drug use. You should also know, especially in the first few weeks following detoxification, that you have five, six, ten times greater likelihood of dying than you would if you stay on methadone.” I don’t think that that discussion occurs. So, patients act on the stigma. They also are quick to pick up on the stigma that exists among staff—stigma that may be expressed by those who would say, “Oh, thank heaven, you’re finally mature enough and well enough to consider giving up that crutch. Let’s figure out a great taper schedule.” Patients perceive such attitudes and internalize self-hate related to their addiction status and their status as methadone patients.

Stigma and Abstinence Orientation

Bill White: Could you elaborate on what you perceive as the harmful consequences of stigma and the abstinence orientation in methadone treatment?

Dr. Newman: I could write a book on that question. I think the greatest and most tragic consequence of that orientation is that it basically leaves staff and even more tragically, patients, fixated on detoxification from methadone and achievement of abstinence as the ultimate criterion of treatment success. This is absolutely fine for those who want it if they know precisely what the risks are. The risk has been clear and consistent for over 40 years of clinical practice and research: relapse following methadone treatment cessation is the rule rather than the exception. Yet the negative orientation regarding maintenance treatment with methadone—too early to tell for buprenorphine—leaves staff to push and patients to request detoxification without sufficient understanding of the fact that relapse, with all of its horrendous consequences, including death, is more likely than not. That’s the biggest problem.

Bill White: You have also noted—I think in your 1987 *New England Journal of Medicine* article—the direct relationship between the dose and duration of methadone and the disdain with which patients were perceived. Do you still feel that that is the case?

Dr. Newman: I do. When critics, including patients and staff, get beyond their general revulsion concerning the provision of methadone maintenance to the point where they can focus on dosage, there is a clear sentiment that the higher the dosage, the greater the revulsion toward methadone treatment, and the more one can get the dosage down, the better off the patient is medically, psychologically, morally, and socially.. That’s just nonsense. Dosages should be determined like in any other field of medicine, based on what the patient is responding well to. There’s no moral judgment as to how much penicillin one uses to treat gonorrhea, and there shouldn’t be any moral judgment as to how much methadone a patient is receiving if the result is satisfactory.

Bill White: There seems to be this paradox that the longer someone is on methadone and the better they’re doing, the greater the stigma attached to their treatment and the greater the pressure to end it.

Dr. Newman: I tend to focus so much on the general stigma that's associated with anybody who's receiving methadone, but you're right. I'll give you a case in point. Some 40 years ago, I had somebody working with me in the city methadone program. He was a wonderful fellow who had completed his Bachelor's degree and gone to night school and gotten his law degree and passed the Bar. All the while, he was a methadone maintenance patient. He and I went to see a judge in Staten Island who was demanding that people get off methadone as a prerequisite for probation or parole. We went to see him so that this lawyer staff member of mine could tell this judge of his accomplishments and that he was able to do it all while he was on methadone. I'll never forget the judge's response. He said, "You are even more despicable in my eyes than the average methadone patient. If you were my son, I would disown you because you have demonstrated that you have the capacity to be successful and you have willpower, and yet you continue to take that methadone as a drug substitute." That's an example of where somebody, precisely because he was successful, was particularly vilified by this judge.

Bill White: I'm wondering how patients treated with methadone respond to similar family attitudes toward their treatment.

Dr. Newman: It must be terribly, terribly frustrating—especially for the more successful patients. In many cases, they cannot tell their employer. In many cases, they cannot tell their families. When they have told their families, very often the stigma leads the husband, wife, parents, children, or other family members to apply this unbelievable pressure on the person to detoxify. That's just a tragedy. You'd think they would applaud. You'd think they would consider the patient a hero who was able to leave behind a life of illicit drug dependence and get his or her life together again. But no, they say, "When are you going to come off that methadone, Pop?" It must be terribly disheartening. And all too often, Pop has the same negative image of the treatment as the family does. Unfortunately, we know what happens when people detoxify. No matter how well they're doing, it does not alter the risk of relapse.

Stigma Effects on Addiction Professionals

Bill White: How does this generalized stigma affect addiction professionals?

Dr. Newman: It's a vicious cycle. We're all part of this same society that has this negative view in general of methadone, and more recently buprenorphine, treatment. It is no wonder that staff not only encourage, but in some cases, require people to detoxify after a certain period of time. The first paper by D'Aunno, which was about 20 years ago, surveyed methadone programs throughout the country in terms of dosage policies. What he found was that the average dose of methadone was below what was even then considered to be optimal for effectiveness—lower than 60 milligrams. He also asked about policies toward detox and, as I recall, half of the programs encouraged patients to detox within six months. I have always maintained that there should be a requirement for written informed consent prior to detoxing from methadone maintenance. I don't know of a program in the entire country that has written informed consent for terminating methadone treatment.

Bill White: What kind of responses do you get from other physicians or the public when you discuss your work in methadone maintenance?

Dr. Newman: When I describe methadone maintenance and its pharmacology, rationale, and effectiveness, there's a nodding of the head, but generally, it's a lack of interest—a lack of desire to be involved in this field. I have not been able to encourage advocacy by any professional groups. The American Association of OBGYNs, they ought to be among the leading, most vocal, most demanding advocates of having the right to provide methadone maintenance or buprenorphine treatment, but they don't. How many prenatal clinics around the country have physicians who are certified to write prescriptions—waivers is the technical term—for buprenorphine for their prenatal patients who are opiate dependent? They don't. Generally, if they know and if they're smart, the prenatal clinics will say, "Hey, listen, there's a methadone clinic across town, and I really think you ought to apply and you ought to enter treatment." Most of them don't even do that. Most of them say, "Oh, God, you're on methadone? You're on heroin detox? Just say no!" There's just a lack of understanding, lack of interest, lack of commitment, and it's very tough to break through that.

Concerns about Calls for Recovery-oriented Methadone Maintenance

Bill White: You've raised concerns about the call for greater recovery orientation in methadone maintenance treatment. Could you share your concerns about that?

Dr. Newman: I admit to concern over the concept of "recovery-oriented methadone maintenance (ROMM)." What would one say is the opposite of "recovery-oriented" MM? Are folks suggesting that there is truth to the widespread view that many/most MM providers hand out methadone and nothing more (a criticism voiced with particular vehemence and vitriol against "for profit" facilities)? Whatever one sees as the differences between ROMM and "other" MM—what conclusions can be drawn? The reality is that if we demand "recovery" as an orientation and practice and insist upon extensive supportive services, staff, programs, etc., we'll make the gap between availability and need for treatment even greater than it is today. Plus, we have to accept the reality that a lot of people who can benefit from MM do not want, may not need, and might be incapable of affording all those good things we experts believe are essential for "recovery."

Before the first patient was admitted to the New York City Health Department program, I infuriated my colleagues by giving a talk at one of the initial national methadone conferences expressing concern that government-operated or controlled MM programs would refuse to tolerate patients who might be politically radical, numbers runners, or happily unemployed welfare recipients. Today, I worry that in advocating "recovery orientation" of MM, the perception will be that patients not buying into this orientation will simply be abandoned.

My fear is that this recovery orientation is just going to be perceived the wrong way. It's going to be perceived as recovery meaning abstinence from legitimately prescribed and effective medication as well as from illicit opiates, and that's my concern.

It strengthens and reinforces this already overwhelmingly prevalent view that methadone maintenance treatment should lead to total abstinence. I'll give you a case in point that really demonstrates this unequivocally. In Germany today, it is considered a criminal act if a doctor prescribes methadone without abstinence being the goal. Even though it's not routinely enforced, that's just appalling. We've had examples of attempts at this type of restrictive legislation in the States. Pennsylvania within the last 12 to 24 months had legislation pending that would have said after two years, methadone maintenance must stop. Period. End of discussion. How can you legislate something like that? I think that's either an intended or misguided consequence of a recovery orientation. I worry its proponents will say, "If you don't detoxify, how are you ever going to achieve recovery?"

Prescription Opioid Addiction

Bill White: Will the growing addiction to pharmaceutical narcotics alter public perceptions of addiction and treatment?

Dr. Newman: It's going to have a number of effects. One, unfortunately, is that it will make it increasingly difficult for chronic pain patients to get serious, effective relief of their chronic pain. Optimal pain relief has been an enduring problem of medicine. It has eased somewhat in the last 10, 15 years in America and some other countries, but I'm afraid it's going to become progressively more and more difficult to find a doctor who's willing to treat chronic pain optimally.

Perhaps if one had to look for some silver lining on this horrendous problem of prescription drug abuse, it's that more and more people who do not fit the stereotype of the junkie will be recognized as having a problem and deserving help. As more and more congress people, people in the general community, and physicians have children who develop a problem with prescription drug use and can't get treatment for it, I think it will make people more receptive to opening the doors to treatment. I think that's why alcohol treatment, whatever is available, is not generally frowned upon, is not generally so stigmatized. Everybody knows an alcoholic.

People view, incorrectly as it turns out, opiate dependence as a problem of "those minority groups," whom they often consider basically incorrigible anyway, and they're lazy, and they're welfare frauds, and they're crack whores and never get a job, and they're not really red-blooded Americans like the rest of us. As long as that's the popular view, the condition, the patients, and the treatment will not be accepted. As more and more people know some nice, middle class white college student who has died of an overdose after a year of fighting addiction to oxycodone, I think it will make people change their orientation. It's a tragedy that there has to be so much suffering, so many lives lost, in this learning process. I'm afraid that that may in fact be necessary if there's going to be a change in orientation.

The Future of Methadone Maintenance

Bill White: What are your thoughts about the future of methadone maintenance, both here and internationally?

Dr. Newman: I'm hoping that pragmatism will win out, and we've already seen it win out in a number of countries where one would least expect that to occur. For instance, the Islamic Republic of Iran has embraced methadone maintenance treatment wholeheartedly. They have something like 100,000 people receiving methadone, about half of them in prisons if you can imagine it. This is Iran! China made the decision some years ago that their economy—their wonderful, capitalist-and-communist economy—can't tolerate millions of addicts, and they did something about it. They embraced methadone maintenance and within a couple of years, they had more than 150,000 admitted to treatment. Pragmatism can overcome a lot of things.

I think in America, sooner or later, the politicians and the public will realize the war on drugs has not been and cannot be won and is not worth the billions and billions of dollars that it's costing. They're going to say, "Let's look at treatment and replicate what works on a major scale." There's only one answer, and that's methadone with a role for buprenorphine as well. That's the answer. I'm hoping that when the alternative is clear, there will be demands to make this relatively inexpensive and effective methadone treatment available to all who need it. That's my hope.

Bill White: Do you think we will see a day when interim methadone maintenance and office-based methadone maintenance for stabilized patients will be widely available?

Dr. Newman: Well, both of them, as you know, are legal today. Interim methadone is virtually unused in America even though there are cities in America that have—to their shame—waiting lists of 18 months or more. Why don't they employ interim methadone, which is legal, which has been shown to be tremendously effective compared to the alternative of leaving people out on the streets? I really don't know. It's mind boggling. Interim methadone is not used even though it's been shown to be very effective. The concept has been grudgingly accepted in a couple places and overwhelmingly rejected in most.

In terms of medical maintenance, which is also legal, it's to my knowledge minimally available in America for a lot of reasons. One is that an office-based physician has to accept patients that are not really her or his patients. These are patients who continue to be, according to the law, the responsibility of a program, and when there are problems, the physician has the obligation not to deal with those problems, but to send that person back to the program. The physician is responsible to the program for documenting the treatment progress and so on. Then there's all kinds of problems in terms of how the patients get the methadone. The physician can't prescribe it to be given in a pharmacy, so there has to be some very special arrangement made. So, it's all nightmarish for the few who are willing to do this.

I believe the biggest obstacle is the treatment program monopoly that does not want to share their patients with office-based practitioners. God forbid if the word gets out that patients could do wonderfully well being treated by normal, regularly-licensed physicians in their private offices. Their fear is: who's going to continue to support the notion of methadone clinics? I suspect that most methadone programs don't even utilize the flexibility they have to have their patients who are working, stable, and meet all the other criteria pick up a month's worth of methadone. I think that's the exception rather

than the rule. I think most programs, if they're generous, have two-week take-homes. There are some that have 30-day take-home, but I imagine if you did a survey, only a small percentage of patients who meet the regulatory requirements for 30-day take-home privileges receive them.

International Work

Bill White: Dr. Newman, let me take you to the area of the international work you've been involved in. I know you've had opportunities to consult in Hong Kong, Thailand, Australia, and other places. Could you describe some of your experiences with this work?

Dr. Newman: First of all, I think consultants generally learn more from the people they're advising than they offer to those people. Certainly, that's been the case where I'm concerned.

I learned from Hong Kong over 35 years ago that the most important ingredient of an effective approach is to make a commitment that every single person who wants and needs treatment will get it. I did not have that orientation when I began my consultancy with them. Instead, I laid out what a very loose staffing model should be for Hong Kong, not nearly as demanding as here in the States. Instead of 35 patients per counselor, I said, "You could go to 75, maybe even 100 per counselor." Basically, they listened very politely, read all the things that I wrote, and then they went ahead and created this massive methadone program, which at two years had enrolled 10,000 patients without any social workers, counselors, or nurses at all. They had an auxiliary medical service. When I inquired, "What about all my wonderful recommendations?" they replied, "Oh, they were brilliant, terrific. We love them. Some day, we're going to implement them, but meanwhile, obviously, we're not going to leave people on the streets who want and need methadone because we don't have any trained social workers." That's what I mean by this pragmatic orientation.

Countries like Vietnam that continue, according to a recent *New York Times* article, to have basically slave labor camps, which they call educational centers, where they lock up tens of thousands of addicts, are realizing that this is not an effective long-term solution. They now have about a dozen methadone clinics, paid for by American taxpayers incidentally, to provide treatment. Malaysia used to have a rigid philosophy of, "You deal with drugs and you're going to die. We're going to hang you. And if you're a drug addict, you're going to a camp"—and I've got films that show it—"we're going to beat you with a bamboo cane. That's going to be your treatment for 18 months." Malaysia now has tens of thousands of people receiving methadone treatment.

The amazing thing to me is that these very diverse localities—China, Iran, Croatia, Eastern Europe, France, Germany—have made a commitment to provide treatment and are letting nothing stand in their way. Not staffing, not finances, nothing if the commitment is there. That's one thing that was a major, major lesson for me and should be a major lesson for the world.

Another lesson is that the demand among opiate-dependent people for treatment and specifically treatment with methadone is universal. It's not that, "Oh, yeah, those American addicts, they like that methadone stuff." Methadone is as much in demand

among drug-using people in Malaysia, Iran, the Ukraine, or Hong Kong as it is in the Los Angeles barrio. That again is a very, very important lesson.

The third very important lesson is that methadone is effective, no matter how you measure it. In all these different environments, all these different social settings, with all kinds of different social, economic, and racial backgrounds, as well as different routes of drug administration, it's basically effective for most of the patients who receive it. That shouldn't be so surprising because if you ask, "How effective is penicillin in the treatment of gonorrhea in all these diverse places," people would say, "What are you talking about? Of course it's going to be effective. If you give the right dose, it's going to kill the disease." But in the field of addiction, we say, "Oh, it's all social and psychological and depends on the upbringing and the environment and all these other things, as well as the social tolerance and political environment." Methadone works everywhere regardless of differences in these contexts.

Bill White: There would seem to be very profound implications for theories of addiction in what you've just described.

Dr. Newman: Absolutely. People who say this is a psychosocial disease, what the hell psychosocial characteristics do the tribespeople in Northern Thailand or Laos have with the African American addict in Central Harlem or the addict in the barrio of Los Angeles? There are no similarities except the dependence on opiates and the desire to be free of all the problems that are associated with that dependence.

People of Influence

Bill White: Who are some of the people who've most influenced your views on addiction and its treatment?

Dr. Newman: I have to tell you, and I think Marie Nyswander would have given exactly the same answer, first and foremost, it's the patients. There's nothing that any college or colleague can tell you that's going to have the same impact as seeing and listening to patients tell their stories of what treatment, and particularly methadone treatment, has meant to them. Nothing compares to listening to patients—what they find positive about treatment, what they find negative about treatment. They have been my most important teachers.

Certainly, Dr. Dole and Dr. Nyswander were objective, tremendously intelligent, tremendously empathetic, real doctors as well as real scientists. They were not people of whom one could say, "Oh yeah, they couldn't make it in the real world; they became doctors to addicts." These are people who in their own right had tremendous success as physicians and as respected professionals who devoted their attention to drug addiction when very, very few other professionals would. That in itself was inspiring to me.

No one has influenced me more significantly than Herman Joseph, who in that elevator ride from the first floor to the 10th floor, basically introduced me to the subject of methadone treatment and challenged me to become involved in it.

And then there are international leaders who have overcome and/or not been burdened by the restrictions and the stigma and the hostility that we face in America, and

who demonstrated what could be done in an environment where there's an accepting, rational approach to addiction. There are my Swiss, Australian, Croatian, and German colleagues, and many others. For me there are a lot of heroes in this field.

Personal Legacy

Bill White: What is the most important legacy you hope to leave the field of addiction treatment?

Dr. Newman: It's hard to say. I haven't left too much. Then again, I shouldn't belittle what I hope I've contributed to the field. The bottom line is my advocacy for what I consider to be the most critical premise underlying a rational approach to drug addiction—that it is a medical problem. You can call it a disease, or condition, or anything you want, but it's a medical problem—for which a treatment exists, but for which at the moment a cure does not. This condition should be viewed as any other chronic medical condition that people have. If it is viewed the same as any other chronic disease, if the patients are viewed in the same way as any other chronically ill patients, if the treatment is viewed and measured in terms of effectiveness the way all other treatments are measured, then I think the long-term answers to the problem of addiction will be self-evident. To me, every single question that one can raise with regard to methadone maintenance needs to be viewed in the context of the principles and practices underlying treatment of all chronic diseases.

The absolute power over methadone patients does, I am afraid, in many instances lead to an abuse of that power and a lack of tolerance on the part of programs for patients. If a patient curses at a counselor, some programs will simply say, "That's it, fella. You're on a rapid taper, and you're out of here." If the guy says, "There's nowhere else to go. The nearest clinic is 80 miles away," the response is "You should have thought of that before you told the nurse to go screw herself." That's the end of the patient. If the patient dies, they say, "Well, that's what happens when you don't play according to the rules, you don't fulfill your contract with the program, and you're disrespectful." It's sad because whatever the "offense," it surely does not merit capital punishment, which is precisely what denial of continued treatment can mean. Again, I would hope that my legacy would be that staff, patients, the community, and professionals should view the condition, the disease, and the patients like any other. If they did that, I think there would be a very, very good treatment system for opiate addiction.

Bill White: Is there any other personal guidance you would offer a young physician or counselor just beginning work in addiction treatment?

Dr. Newman: Yes, I would say that it's easy to get overwhelmed by all the negatives and all the problems and all the difficulties and all the controversies and overlook the fact that this is a tremendously gratifying, rewarding field for providers of care. First of all, many patients for the first time in their adult lives are greeted in many programs—not all, alas—with respect, with a clear message: "We are here to help you." How many times does the heroin addict on the streets of Detroit encounter anyone who says, "Mr. Johnson, I am here to help you"? So, first of all, there is this astonishment and tremendous

gratitude on the part of new patients that in itself is remarkable and gratifying beyond description. Seeing the dramatic turnaround that many—clearly not all, not as many as we'd like, but that many—patients achieve also obviously is deeply gratifying. The turnaround can and often is dramatic, and what a privilege it is to intervene successfully in lives that otherwise are just a horror and without treatment, too often doomed to end in death.

So, my message to young professionals entering the field: don't do this because you have a Schweitzer complex. This is a field where you can get so much gratification by doing so much good for people who will be vastly more appreciative than patients in almost any other chronic medical field. So, I would tell people, hey, you want a really gratifying field? This is it. You can really make a difference. At the same time, you can also be doing a great deal of good for the general community, but I'm not out to create a whole bunch of public health doctors. Let somebody else do that. I'm saying for the clinician, for the one-on-one doctor, counselor, or nurse who wants a gratifying field to be involved in, maintenance treatment of opiate dependence certainly is one to consider.

Bill White: Dr. Newman, I have one final question, and it has to do with how you were able to sustain your involvement in addiction treatment through all these years at the same time you served as a CEO of a large complex healthcare system?

Dr. Newman: I balanced this for about 25 years reasonably well, but I did step down from the CEO position 10 years ago, and now in my retirement, have more time to spend on my involvements in addiction treatment. My wife always says that I should get a job so I can spend more time at home again. There's a lot to that. I was able to do both first of all because I was asked by people to do both. The hospital board of directors wanted me to stay on as CEO, and people in this country and overseas who knew of my work in methadone treatment continued throughout my time in the hospital as CEO to ask me to contribute to and participate in their addiction treatment efforts. And I was permitted to do both because of the truly extraordinary tolerance of the board of directors at Beth Israel Medical Center, who said, "Listen, we're not going to stand in your way of doing good beyond the walls of this institution. If you have an opportunity to help the addiction field in Hong Kong, then we're going to do everything we can within reason to make it possible for you to accommodate that while you're at the same time responsible for the hospital." There are not too many boards of trustees that would be altruistic enough to take such a position.

Bill White: Dr. Newman, thank you for this engaging conversation, and thank you for all you have contributed to the modern history of addiction treatment.

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**Selected Publications of Dr. Newman Recommended by Bill White
for Addiction Professionals and Recovery Advocates**

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