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Interview with Dr. Vincent Dole, M.D.
Methadone: The Next 30 Years?

It has now been about 30 years since Drs. Vincent Dole, Marie Nyswander and Mary Jeanne Kreek started publishing their revolutionary research demonstrating the efficacy of methadone treatment for opiate addicts. Over the years, Dr. Dole has been a prolific writer and frequent speaker advocating the importance and benefits of methadone; his views are widely respected and his sage advice has often been quoted by others. Since retiring several years ago, he has been reluctant to grant interviews, so we were delighted when he agreed to share his views with our readers about the present practice and future potential of methadone maintenance treatment.

A.T. FORUM: It seems that, over the years, methadone has been more thoroughly researched and written about than almost any other medication; yet, it's still not completely accepted. How do you feel about that?

Dr. VINCENT Dole: It's an extraordinary phenomenon and it has come to me as a surprise. From the beginning of our research with methadone we were able to rehabilitate otherwise hopeless addicts that had been through all of the other treatments available. I expected methadone would be taken up very carefully by the addiction treatment community, but with some enthusiasm. Instead of that, we've had endless moral and other types of objections which are really irrelevant to the scientific data.
I was surprised, because my background in research had led me to expect that the medical community was a very critical but nonetheless objective group that would respond to solid, reproducible data. Instead I find that we still get the anti-methadone argument of substituting one addictive drug for another.
This is ignoring the scientific data showing that, as a result of methadone treatment, people who have been hopelessly addicted and anti-social and excluded from any normal life or family, are in a wonderful way becoming responsive to social rehabilitation and today constitute a very large number of people who are living normal lives. The fact that people, especially medical practitioners, would dismiss that as unimportant simply staggers me!

A.T. Forum: Do you see such attitudes changing at all?

Dr. Vincent Dole: Yes, especially, outside the United States. I was at a European methadone conference in France recently, and I learned about an extraordinary increase in the application of methadone treatment throughout Europe. The stagnation of our treatment situation in the U.S. is really looking very foolish compared to the application of methadone treatment in Europe. But, they don't have the same bureaucracy that tends to hinder us here.

A.T. Forum: Still, they adopted methadone treatment for opiate addicts much later than U.S.

Dr. Vincent Dole: Yes they did... it's only in the last couple of years. That was the second annual conference on methadone treatment in Europe, and they've shown dramatic increases in the use of methadone - with government approval. The treatment is also being very much extended via general medical practitioners in Europe. Whereas here, the federal government has done everything possible to exclude primary care physicians from participating in the treatment. Have you read the Institute of Medicine report?

A.T. Forum: Yes, we reviewed it in our publication. [See *A.T. Forum*, Vol IV, #2, Spring 1995 for a review of Federal Regulation of Methadone Treatment (ISBN# 0309052408) - available by calling 800-624-

6242].

Dr. Vincent Dole: In a scholarly way, that report summarizes the history, the various attitudes, and the general dynamics of methadone here in the U.S. It's certainly going to open up discussion. But it will also activate the federal Drug Enforcement Agency because the report suggests that the DEA has over-reached their authority and imposed restrictions on methadone treatment which are counter-productive. The report strongly recommends that the government re-examine its role in this matter and I'm encouraged by that.

A.T. Forum: Then, do you believe that methadone might finally "come-of-age"?

Dr. Vincent Dole: I am hopeful and I see good progress. But, you must understand that I'm not really so much concerned about recognition for or boosting the importance of methadone because that, after all, is just one medicine. The most important principle to recognize is that addiction is a medical disease. And, as a medical disease, it's the responsibility of the medical profession to do the best they can to deal with it.

What I want is a rational public health policy and, by no means do my views or opinions limit themselves to methadone. There are potentially other medicines for special uses that should at least be considered and carefully researched for the treatment of drug addiction.

As I view my role these days, my job is not to try to market methadone as though I were some sort of celebrity spokesperson. My job is simply, and always has been, to promote the question; "What can be done about addiction?" I optimistically believe answers will be found, but it may take a whole new generation of physicians to fully appreciate and act upon the "addiction as disease" paradigm.
If you look at the history of medicine, it's astounding to see how many doctors once resisted even the recognition that fevers and various fatal sicknesses were due to germs. A hundred
years ago, what we take for granted today was not at all widely accepted.
As far as the "substituting one drug for another, but you still have an addicted person" argument goes regarding methadone replacing illicit opiates... that also has some historic precedent. When Jenner, 200 years ago, introduced the cowpox vaccination to prevent smallpox, his critics - had they been sophisticated and prejudiced enough - could have argued, "Oh, he's only giving one virus to replace another."

And, that would have been true. But the virus Jenner gave was protective and did not have adverse affects on health, while the virus being blocked by the vaccination was one that was a lethal scourge for the whole world. Today smallpox seems to have been totally extinguished by vaccination.
Could this also become true of methadone applied to the treatment opiate addiction in the next 30 years? I feel that if one accepts the fact that addiction is a medical disease, not just something due to misconduct or hedonistic behavior or irresponsibility or whatever else, then doctors have an obligation to evaluate available and proven treatments - and to consider those treatments in the same framework as they would with any other diseases.

A.T. Forum: In some of your writings you mentioned the necessity for a change in medical training regarding addictions. Is that coming about?

Dr. Vincent Dole: Yes... slowly. The question is, "Who trains the trainees?" It takes a generation to turn-over the professors, so new physicians can be trained by enlightened teachers.

I would say 30 years from now that the current attitudes regarding methadone as substituting one addictive drug for another and other negative outlooks on drug addicts in general will seem pretty archaic. What's happening today seems more like a carryover of medieval attitudes that affected much of the thinking toward mental illness in the last century.

A.T. Forum: And yet there are addiction treatment professionals who focus almost exclusively on the behavioral components of addiction.

Dr. Vincent Dole: That's true. Certainly behavioral conditioning has a role to play in addiction. If a person has been a hard core, uncontrollable addict and he goes back to the same neighborhood where he was shooting drugs, he will be triggered by past associations with getting drugs, shooting-up, and so forth. I don't doubt that conditioning can trigger relapse.
But, we must not overlook that the drugs, themselves, have made a change in the nervous system of that person. Renewed exposure to drugs in the addict who's been detoxified is an entirely different experience from exposure in a totally drug-naive person. While behavioral conditioning involving a drug culture which influences a person's addiction may be important, it's silly to think that alone it totally explains relapse.

A.T. Forum: We've heard some arguments claiming that methadone is just a crutch and patients in treatment must eventually give it up or they will never recover from addiction.

Dr. Vincent Dole: That seems like a vague charge that has no answer. A crutch is not a bad thing if you have only one leg, yet it's not nearly as good a solution as it would be if you could regrow your missing leg. Since we can't regrow a leg, why not use the crutch to get about and lead more normal lives?

A.T. Forum: Since managed health care is becoming evermore important, do you think that methadone will become more recognized as a cost effective treatment for containing the costs of health care and delivery?

Dr. Vincent Dole: There's no question that, economically, methadone is very cost effective. If you can take somebody who's been maybe stealing $50,000 a year in one way or another to fund a narcotics habit, and you could treat this person for $2,000 to $3,000 a year - essentially making him or her at least non-criminal and a more productive tax payer - there's a very high multiple of cost benefits there.
Another important factor that strikes me is the effect on families and neighborhoods. If you have a neighborhood that's loaded with uncontrolled addicts who are stealing and otherwise terrorizing the residents, and spreading addiction among young people, you have an enormous but hard to measure cost. For example, what's the cost to society of a broken family?
Our society would be saving itself a lot of money if it made a serious effort to bring into treatment everybody who needs control of their narcotics habits.

A.T. Forum: What do you think about LAAM? [A longer acting formulation of methadone.] It has been around for quite a while though only received recognition in the last two years or so. [See *A.T. Forum*, Vol. II, #3].

Dr. Vincent Dole: It's been around since the beginning of our research, and I looked into it at that time but decided it had no particular advantage over methadone. In some ways, there were disadvantages, because LAAM's mode of action was less well defined.

Nonetheless, it's being promoted now for absolutely the wrong reason. Mainly, by the DEA and other control agencies like LAAM because they believe its use can eliminate the need for any take-home methadone. Such a philosophy could prove very detrimental to persons on lifelong methadone therapy who, after a period of time, couldn't cope with clinic visits even several times a week as opposed to daily. It would drive people out of treatment. So I'm sorry to say that whatever merits LAAM might have, it is being wrongly advanced by agencies who have the hidden agenda of denying any take-home methadone at all to patients that are in need of it. The Institute Of Medicine report was fairly clear in explaining that the DEA has enormously over-played the "hazard of diversion" argument for their own purposes in seeking new ways to control methadone distribution.

A.T. Forum: How do you feel about needle sharing programs as part of a harm reduction approach regarding drug addicts?

Dr. Vincent Dole: I don't have any objection to them. To the extent that the narcotics addict is properly stabilized on methadone, such programs would become unnecessary. But, unfortunately, methadone is specific to opiates and it does not eliminate cocaine use via injection.

I think, specifically, the job of the whole healing profession should be to do the best you can for the health and well-being of individual addicts and the society in which they live. That includes needle exchange programs; there's nothing incompatible with those and harm reduction.

A.T. Forum: There are still many clinics which have so called "low dose methadone policies." On the one hand they are in favor of methadone as a modality, but on the other hand they seem to have a bad attitude toward it. What are your reactions?

Dr. Vincent Dole: That's entirely contradictory according to the past 30 years of research... yet, such clinics widely exist due to a combination of ignorance and prejudice! They just do not understand the pharmacology of methadone, nor do they subscribe to their mission of normalizing the life functions of their patients so far as possible.

A.T. Forum: What about other clinics we've heard about who use methadone as a reward or punishment for compliance with program rules?

Dr. Vincent Dole: Again, that's a result of ignorance and stupidity! My feeling is that the problem comes, ultimately, from the fact that people just cannot accept the change in their thinking to accept opioid addiction as a bonafide disease.

A.T. Forum: What about "Interim Methadone" [see *A.T. Forum*, Vol. II, #1] that was introduced as a way to get people into treatment faster. It doesn't seem to have gone anywhere?

Dr. Vincent Dole: It's been violently opposed and I think wrongly so. In a perfectly rational world, anybody who has the qualified need for methadone to allay their opiate habit should be able to receive it. Some people need only methadone, while others, in addition to the medication, have social or psychological needs, or other complications that have to be looked at.
Federal and other authorities tried to put one-size-fits-all restrictions on interim methadone by saying that after a certain time period every patient must be placed in a comprehensive service program. That becomes impractical and effectively puts a straight jacket on interim methadone.

A.T. Forum: It seems that many of the methadone programs are against interim treatment as well.

Dr. Vincent Dole: I don't know just what their motives are, but I certainly have been unhappy to hear of methadone clinics coming forward and staging very strong opposition to minimum social services for people who would benefit from methadone alone. For instance, I would expect that someone who has a family and a job and is productive does not need to come in three times a week to be counseled on his "problems."

A.T. Forum: Similarly, it seems the medical maintenance model has been fighting an uphill battle.

Dr. Vincent Dole: Medical maintenance was something we started at least 15 years ago when Dr. Nyswander and I were dealing with patients who had been in methadone treatment for 10 to 15 years, were fully employed and very responsible citizens, and needed only a continued supply of methadone. I think part of the battle over this has been due to existing programs which feared their budgets and their rationales for operation would be questioned if one could show good results by having patients receive methadone from private physicians. In Europe, they are making much broader use of primary care physicians for methadone delivery.

A.T. Forum: What are your views of methadone patient advocacy groups?

Dr. Vincent Dole: Presently, I think such groups are very helpful and are making a positive difference in improving the field of methadone maintenance treatment. To a large extent the contempt with which many regulators and program administrators have treated their patients seems to me scandalous.

I'm very much concerned right now with improving the attitudes of people who are running jails and prisons so that they give proper medical treatment to opiate addicts who are taken into custody. The underlying problem is one of basic human rights. There are people in methadone programs who, for one reason or another are put in jail, get no treatment, and are forced to go through withdrawal.
Why are these patients treated that way? Because there are people in authority who don't care and believe that it's the patients' problem; they brought such misery on themselves by becoming addicts in the first place. I think we need to have advocacy groups to protest those sorts of situations. I'm not saying that every position of every advocacy group is necessarily right. But I think that, in our society, any group that believes it is suffering injustices deserves the right to be heard. In the future, I think methadone patient advocacy groups are going to grow in proportion to the numbers of people or programs who abuse their powers over methadone patients.

A.T. Forum: Have you seen any improvements in the treatment of addicted prisoners?

Dr. Vincent Dole: As a matter of fact I was recently at a remarkable symposium held at Riker's Island city jails here in New York. It reminded me of a time 25 years ago when I went out there and they had riots. At that time, with support from the commissioner and warden, I set up addiction treatment programs right in the cell blocks.

Today there is a remarkable medical establishment out there in that prison providing good medical care, including methadone treatment, to prisoners. The symposium was sponsored by very hard working and well-informed doctors and administrators who are looking today at an entirely different prison system than I was years ago.

Unfortunately, this was in many ways a special case, because once you travel out of New York City into upstate New York, you're still confronted with those same archaic practices that I saw back in my early days.

A.T. Forum: Why have you been so reluctant over the past several years to be interviewed by the press regarding methadone treatment issues?

Dr. Vincent Dole: I've seen the sensationalism in print and other media that seems to appeal to the public; such stories are only intended to provide entertainment or stir-up public excitement. For example, if you had a methadone clinic serving 100 people, and 99 of them were doing quite well or at least better than they were before, and one rogue patient goes out and robs an old lady, what is the sensational headline on the story going to be in tomorrow's newspaper?
In the past, when I've been contacted by the media, they are generally looking for a controversy: a problem, a claim, an impassioned denial, an equally impassioned accusation, and so on. This doesn't really advance the public's understanding of the benefits of methadone treatment as far as I can determine. But it does sell newspapers.

I have a belief that, in time, things will be seen in their "true colors." I have faith enough in the overall process that, if reasonable people will speak freely and honestly, the truth will come forward. But, it may take a whole new generation for that
to happen.

A.T. Forum: At some future time, do you believe methadone will be replaced by more effective medicines or better treatment protocols?

Dr. Vincent Dole: I would think so and hope so. Methadone is very valuable and efficient in controlling a specific kind of addiction, namely opioid addiction, and normalizing addicts in their life activities. But the emphasis should be on the fact that you're controlling the disease; you're not curing the disease. In time,

and with full knowledge of all disturbances in the neurohumoral systems in the brain, we may find ways to remedy and cure or restore a person to "normal."

Immediate and important questions to quickly resolve might be: What is addiction in terms of physiological and biochemical processes? Why is one person susceptible, whereas another might seem immune?

I've talked to people specializing in infectious diseases and I asked, "Why is it that some people get fatal tuberculosis in the inner cities and most people don't?" The answer is some people are more susceptible than others.

That doesn't advance my knowledge much, but, it shows me at least a parallel concerning addiction. We must ask, "What does one mean by susceptibility? There's so much biological variation in the development of organisms through their lifetimes that there's something to be learned from genetics and other environmentally induced differences which may produce such susceptibility. During the next generation, this may become the key that will finally open the lock to understanding addictions.
This leads into considerations of genetic engineering and various other modulations of the brain control systems that may lead to actual cures for addiction when knowledge permits. I don't think such solutions are going to come in my lifetime, but I believe they will come.

As with anything else in science or medicine, what one tries first to do is respond on an immediate basis to today's problem. The second thing is to look beyond today and see how this problem can be prevented or totally remedied in the future.

A.T. Forum: Could you summarize your thoughts about the next 30 years of methadone?

Dr. Vincent Dole: If you want to characterize my feelings toward all of this from the perspective of my past 30-odd years in the field and my projection 30 years into the future... it's that I've seen substantial progress regarding methadone maintenance treatment as a modality. I see this even more clearly in Europe where they're starting with fewer of the bureaucratic burdens that we have here in the U.S.
I am optimistic about the future. A generation has passed since our original research regarding methadone, and a new generation in the scientific and medical establishment is coming forward with more open minds to teach new medical students. At the same time, there are strong developments in our scientific knowledge of brain chemistry and functions coming out of laboratories around the world.
We know now that the brain is a much more complex biochemical organ than just nerves hooked up in different networks. There is a finely tuned and balanced, yet very complex, system of neurohumors working in the brain that control each person's reactions to stress and pain.
My optimism comes from a belief that goes beyond methadone, which is after all just kind of a first probe into dealing with today's addiction problems. I believe we will be able to uncover more substantial knowledge of what goes wrong in a person whose behavior becomes addictive and pathological. In a sense, my optimism is much more assured when I look upon this business of understanding the neurochemistry of addiction..

I have confidence that experience and the truth will bring us more rationally to ways of dealing with addiction treatment, and that we're just now overcoming rather medieval attitudes toward addiction and beginning to appreciate it as a medical disease.