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What it’s like being a methadone doctor

Written by Dr. Joh Crosby on November 28, 2017 for CanadianHealthcareNetwork.ca

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I recently had lunch with Dr. Andrew Worster, an old friend from my emergency days 25 years ago. He works at an opioid addiction clinic in Cambridge, Ont., and still does ER shifts at Hamilton General Hospital. He works in the ER one or two eight- to 10-hour shifts per week but doesn’t do night shifts any more so he enjoys the two jobs. He has been practising for 26 years and also runs a non-profit corporation called BEEM—Best Evidence in Emergency Medicine—which conducts evidence-based emergency medicine courses for emergency doctors worldwide.

Andrew works in the addiction clinic on Monday morning and all day Wednesday. It is a private business and they help patients get healthcare cards. He says that 70% of the patients are functioning, with jobs and families.

Many patients start with chronic pain and about 50% work at physically demanding jobs, hence, they use opioids to get through the day’s work as their bodies are wearing out on the job. They start small and gradually require higher and higher doses for relief.

Andrew said he feels opiods are sometimes appropriate for short-term severe pain but not for non-cancer chronic pain.

Andrew noted that doctors and the patients have to accept that in life there will be pain. In the ER, he often gets patients who tell him that their GP has done nothing for their back pain. For ER patients with severe, debilitating pain, he sometimes uses ketamine (15 mg I.V. over 15 minutes) to break the cycle of pain and spasm but does not prescribe opioids upon discharge.

In the methadone clinic Dr. Worster spends 20 to 30 minutes with the patient on the first visit, then five to 10 minutes per followup appointment. The clinic staff dispense one dose of methadone per day on the doctor’s prescription, and watch them swallow the liquid methadone or take the crushed suboxone sublingual tablet. As patients continue to demonstrate abstention from drugs, they gradually earn take-home doses at a rate of one per week each month. These are removed if the patient relapses.

Once or twice each week, patients must leave a urine sample for drug testing: males do it on video and females are watched by a female nurse to make sure they don’t substitute urine from someone else. The urine is tested for methadone or suboxone to make sure patients are taking it (not selling it), and is screened for benzodizapines, opioids, cocaine and other drugs of abuse. Positive test results are discussed with the patient to determine the cause(s) of the relapse and the associated risk of recurrence.

What about marijuana? Andrew said that because so many patients routinely use cannabinoids, they do not test for it but he does counsel patients on its adverse effects.

Andrew said he treats addiction, not pain, and more than 90% of his patients are self-referred. Although some don’t want their family doctor to know, this attitude is discouraged and the patients are advised that they need the family doctor to be in the loop.

Dr. Worster said some patients report that their family doctors have abruptly discontinued their opioid prescriptions and won’t treat their chronic pain when they find out they have been to the methadone clinic. Although he doesn’t treat chronic pain, Andrew recommends Tylenol, NSAIDs, physio and a pain specialist referral as non-opiod strategies for chronic pain. I told him as a GP that the patients often can’t afford physio or counselling and wait lists for pain specialists are brutal.

Highly motivated patients do well and many own their own businesses, Andrew added.

In terms of methadone use while driving and operating heavy machinery, he said his patients have all been doing this while taking varying doses of opioids for many years and that if there is no perceived increased risk, patients are not reported to the ministry of transportation. However, they do counsel patients about these safety issues. Andrew said if the clinic reported patients to the ministry, very few would agree to start treatment.

What drives the patients to seek methadone treatment? Some are seeing their businesses or jobs suffer, some are told by their spouses that they will leave them if they don’t get help. Some are just tired of the lifestyle of having to seek drugs to ward off withdrawal.

What about the socially disadvantaged? Andrew said he concentrates on harm reduction for all addicted patients, such as getting them off needles, which can cause cellulitis, abscesses, hepatitis or HIV.

About 10% of patients are hard-core addicts with no stable housing, and are often living in shelters or couch surfing with friends and/or family.

The most common mental health diagnosis Andrew sees is anxiety.

Andrew advises doctors interested in this type of work to never work harder than the patient—good advice for a lot of treatments.

Cost

Methadone costs approximately $6 per day and is covered by government welfare and private drug plans but many working patients pay out of pocket because it’s still cheaper than street opioids.

The Ontario visit fees are the same as for family medicine office visits ($33); although, the overhead is quite high as the clinic is open seven days each week, urine testing and monitoring equipment is needed, as well as medication dispensing and support staff.

What is the cure rate?

When I asked, Dr. Worster answered, “What is the cure rate of diabetes, hypertension or hypercholesterolemia?” We treat these as chronic, incurable diseases that we try to control to avoid harm to the body. He says that once people accept that addiction is a disease with its own signs and symptoms, it becomes much easier to help patients and to deal with some of the difficult behaviours. He added that seeing people overcome the challenges of addiction and take control of their health and their lives is extremely rewarding.

What do you think of addiction clinics? Comment below or email me at drjohncrosby@rogers.com.

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