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Juggling Two Full-Time Jobs — Methadone Clinic Engagement and Cancer Care

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After his head and neck cancer was diagnosed, Mr. C. was referred by his oncologist to a palliative care team to address cancer-related pain, an expected side effect of curative therapy. That team — which included one of us (K.F.J.), a palliative care nurse practitioner — is often called on to manage pain in patients who have both a serious illness and opioid use disorder (OUD).

Mr. C. was worried about whether he could continue receiving methadone treatment for OUD. His worries were well-founded. Undergoing cancer care while engaged in the methadone-clinic system is like juggling two full-time jobs.

A 66-year-old musician, Mr. C. was a model methadone-clinic patient. After adhering to daily observed methadone treatment for years, he had ultimately been granted the privilege of “take-home dosing,” so he had to go only every other week to pick up his methadone. For decades, methadone treatment had improved his quality of life and function, allowing him to work as a peer recovery coach and a musician at his church. That is, until his cancer diagnosis threatened to compromise his hard-earned recovery.

First, he had an unexpected finding on his urine drug test. Unaware that he was receiving methadone, his oncologist had prescribed oxycodone for cancer pain. Because of the

Identifying details have been changed to protect the patient’s privacy.

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profound stigma against it, OUD is often not documented in the medical record.[1] Further complicating matters, methadone dispensed by clinics does not appear in prescription drug monitoring program databases along with other controlled substances.

When Mr. C.'s routine urine drug test detected oxycodone, the methadone clinic revoked his take-home privileges, necessitating a return to daily visits. At that time, a typical day for Mr. C. involved waking up at 5:30 a.m. to prepare for the hour-long drive to receive his methadone at 7, followed by an hour-long drive in the opposite direction to chemotherapy at 9 and radiation at 11.

As he became sicker, daily attendance at the methadone clinic became untenable — and dangerous, given his coexisting conditions. One day, he fell down while waiting in line at the methadone clinic because of dehydration and hypercalcemia that had gone unnoticed. He also had worsening pain and secretions from mucositis and diminished oral intake. Meanwhile, he had escalating opioid cravings because of his erratic attendance at the methadone clinic.

Mr. C. deserved better. His palliative care and cancer clinicians had a meeting and called his methadone clinic. They asked the medical director to pursue a "medical exemption" allowing Mr. C. more treatment flexibility (take-home doses and coprescription of other opioids). The director declined, instead suggesting that the palliative care team take over providing methadone by prescribing it "for pain."

The team wondered whether that work-around was legal. Regulations require methadone for OUD to be dispensed by a federally licensed clinic or hospital. Although there is legal ambiguity when a patient has pain and is also receiving OUD treatment, this solution might not be sustainable once Mr. C. had finished cancer therapy. It seemed unlikely that his rural pharmacy would dispense high-dose methadone even "for pain."

Perhaps he could be shifted to buprenorphine, another standard treatment for OUD. But sublingual buprenorphine tablets do not dissolve well when patients have the dry mouth that's common in both older adults and people undergoing cancer treatment. By contrast, methadone is a drug that nearly every palliative care clinician is well-versed in prescribing and that is regularly used for cancer because of its many advantages (affordability, long half-life, multiple formulations).[2]

Since there were no other options for treating Mr. C.'s OUD, the palliative care team took over prescribing methadone, splitting his 120-mg daily maintenance dose into three 40-mg doses and indicating "for cancer pain" on the prescription that he filled at the cancer center's pharmacy.

Several months later, Mr. C. completed his cancer treatment, with scans showing no evidence of disease. But the methadone clinic would not take him back on his stable methadone dose because it had not been prescribed by another methadone clinic. To receive care at the clinic once again, Mr. C. would have to start at the conventional initiation dose of 30 mg per day, a 75% reduction from his previously effective regimen.

In addition, the clinic would not allow the daily methadone dose to be split into two or three smaller doses. Split dosing was allowed only at their clinic for pregnant patients or for patients with a fast methadone metabolism as confirmed by peak and trough blood drug levels. In Mr. C.'s case, divided methadone doses were necessary for treatment of pain, since the analgesic properties of methadone last only 8 to 12 hours. Practitioners at his clinic, like those at other methadone clinics, believed that they could not treat chronic pain, a common sequela of cancer treatment. Perhaps some methadone clinics would have afforded Mr. C. flexibility, but given routine federal scrutiny and the reality that most clinics are for-profit entities motivated to encourage visits that generate revenue, that doesn't appear to be the norm.

It's hard to imagine a less age-friendly or person-centered system than the one Mr. C. encountered. In addition to being punitive and inconsistent with core harm-reduction principles, as well as failing to address coexisting conditions, current U.S. methadone regulations do not reflect the shifting demographic trends in the population with OUD.

One study of methadone clinics revealed that 20% of their patients had been diagnosed with cancer, and more than 60% had more than two chronic health conditions.[3] Adults over 50 years of age make up the largest subgroup receiving care in methadone clinics. This aging cohort often has complex conditions and greater-than-average need related to health, function, and mobility. Mr. C.'s care should align with his priorities by encompassing continuing successful treatment of both his OUD and his other medical problems. Current methadone treatment regulations make it impossible to achieve that goal.

Advocates working to reform methadone regulations are beginning to recognize the shortcomings of existing policies, but their efforts do not go far enough. For instance, proposed federal rules would improve access to take-home doses, reflecting evidence that greater use of this approach results in fewer treatment disruptions and does not increase overdose rates.[4] Similarly, the Modernizing Opioid Treatment Access Act (H.R. 1359) would allow physicians who are board certified in addiction medicine to prescribe and dispense methadone outside designated methadone clinics. These changes would be a substantial improvement and an overdue public health response that would expand methadone access, potentially reducing opioid-related deaths and hospitalizations.

However, relying solely on methadone clinics to be the gatekeepers of methadone for OUD and leaving out the rest of the workforce — primary care, palliative care, and other physicians and advanced practice providers — is problematic. These clinicians regularly encounter people with OUD, and ironically, the availability of addiction specialists is so limited that even medical directors of methadone clinics are not required to be board-certified addiction specialists. While 21.2 million Americans have a substance use disorder, only 1883 physicians nationwide were certified in addiction medicine as of 2018, according to the American Board of Medical Specialties.

Especially for (but not limited to) people like Mr. C., integrating methadone treatment into general medical care is critical. Many other countries allow methadone prescribing by generalists and dispensing by pharmacies. Integrated models for OUD treatment

provide equivalent efficacy to care in addiction-specialty settings, with the added benefit of coordinated management of multiple coexisting conditions. Indeed, palliative care and addiction experts now recommend circumventing the official methadone-clinic system for patients with serious illness.[5]

Continued fragmentation and segregation of OUD treatment from standard medical care is dangerous, punitive, and wasteful of scarce health care and human resources. Some, though probably not all, clinicians will be willing to make an exception and write “cancer pain” on the methadone prescription, knowing that they’re capitalizing on a policy loophole rather than offering a clinically complete solution. But when policies have been built on fallacy (i.e., stigma) rather than reflecting patients’ and clinicians’ needs, policy must evolve along with the evidence.

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