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In Search of Sane Pain Policies: An Interview With Richard Lawhern, Ph.D.

By Josh Bloom — November 10, 2016

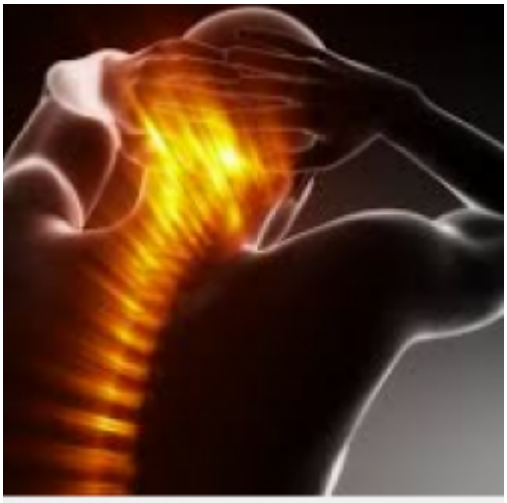

Photo: Neurology-central.com

Richard A. "Red" Lawhern, Ph.D. is a long-time advocate for chronic pain patients, their families and their doctors. His training is in systems engineering rather than medicine, but he is author of multiple online commentaries and papers on neurological face pain, psychosomatic medicine, and US government opioid prescription policy. The following is an interview and is his opinion on the crisis we face.

JB: How did you become involved with this issue?

RL: My wife developed agonizing face pain in 1996, which was diagnosed after a year and visits to six doctors as trigeminal neuralgia. Her neurologist could offer little beyond the name of the disorder and a prescription for an anti-seizure medication. But he also suggested a support group: The US Trigeminal Neuralgia Association (TNA), where we heard a presentation by its president Claire Patterson. It struck a painful chord. After the lecture, I knew I wanted to be involved, and spoke with Claire.
I was invited to join the Board at TNA as webmaster and online research analyst, and am now involved with multiple Internet chronic pain sites. They can use all the help they can get, because, as I have recently noted in a public address [link: http://www.lawhern.org/CDC.htm [1]], " ***The CDC Opioid Treatment Guidelines for Chronic Pain Are Neat... Plausible... and Mostly Wrong."*** *Endless suffering and misery have resulted from their bungling—something I would not wish anyone to discover first-hand.*

JB: Can you describe some of your personal experiences with people with under-treated pain?
RL: Over the past 20 years, I have interacted with thousands of pain sufferers, a few hundred whose pain was so intractable to non-opioid therapies, that they were given opioid drugs as a last

resort. In many of these people, prescription opioids have made the difference between total disablement or death by suicide, versus at least a marginal quality of life and function.

> ***"In the years I have corresponded with chronic pain patients, I cannot recall more than three or four who needed to enter drug rehab."***
> ***Richard A. Lawhern, Ph.D.***

JB: Now that there is a new, even stronger push to further restrict opioid drugs, we've all heard stories about people with legitimate needs being denied drugs that are making their lives bearable. What have you seen?
RL: During the last two years, I have increasingly heard from patients who are being subjected to a systematic campaign of medication denial and personal stigmatization by the mainstream medical establishment. Patients who have been successfully and responsibly managed for years on prescription opioids are now being labeled as addicts and denied renewal of medication. In some cases, people have been dropped by their doctors with no attempt to manage their physical withdrawal symptoms. Doctors are being driven out of pain management practice by an over-zealous witch hunt headed by the US Drug Enforcement Administration (DEA).

JB: Pain management is a very complex issue, for example, balancing the legitimate needs of people who suffer from pain with the prevention of others from becoming addicted. In your opinion, what is the most important facet of this enormous problem?
RL: The most important thing to know about the so-called " epidemic of prescription opioid overdose deaths" is that it is has been seriously mis-characterized. By trying to solve the wrong problems, I believe it is inevitable that government policy on the issue is presently misdirected.

Lost in the current hype and hysteria concerning opioids is the reality that the great majority of chronic pain patients do not get a euphoric high from the use of opioids, and do not experience the drug cravings and psycho-social behavior distortions that addicts without chronic pain do. Physical dependence and withdrawal symptoms can and do occur, but can be medically managed.

JB: What did policy makers get wrong?
RL: While deaths by drug overdose are certainly a public health crisis in the US, the most prevalent causes of opioid deaths are street heroin, a flood of imported fentanyl from China and Mexico, and the diversion of stolen or fraudulently obtained prescription opioids to addicts who are not patients. Chronic pain patients ***did not*** *cause the "overdose epidemic". Restricting opioid prescriptions to legitimate pain patients will not solve this epidemic. It will simply cause cruel and unnecessary suffering.*

JB: Do you have statistics to back up your claim?
RL: In recent State-wide studies, a quarter or fewer of overdose victims have a current medical prescription for pain relievers. Likewise, many of these deaths also involve alcohol or other drugs. In the limited number of published studies of addiction in chronic pain patients, risk of opioid abuse disorder varies between 10% and 2%, depending on the study you believe. Risk of death by overdose is less than one-tenth of one percent -- a number exceeded by an order of magnitude in the 440,000 deaths per year due to medical errors in hospital settings, often involving non-opioid prescription drugs.

JB: Addiction was around long before any attempts to fight it; heroin, cocaine, crack, methamphetamine. Can you compare attempts to address or control these other drugs with those ongoing with opioids?
RL: The most reliable predictors for drug addiction are status as a teenager or a personal history of unemployment and poverty (see Maia Szlavavitz, Scientific American). These are social failures beyond the ability of law enforcement to remedy. Attempts to "control opioid addiction" by denying needed and effective medication to chronic pain patients are a fundamental violation of human rights and doomed to failure.

JB: Do you believe that these restrictive policies have had any benefits? If so are there data to support this?

RL: If there are data to suggest benefits to either pain patients or addicts, I have yet to see it. There are, in fact contrary indications, and your recent article addresses some of them. Likewise, the FDA has become aware of potentially counter-productive policy in some of the expert presentations at the second workshop of the US Academy of Medicine "Committee on Pain Management and Regulatory Strategies to Address Opioid Abuse" (November 4th, 2016). Whether the Committee or the FDA will choose to ignore these concerns has yet to be demonstrated.

JB: You seem to hold the CDC in particularly low regard for the current situation. Why is this?
RL: There is ample evidence that the CDC "Guidelines" on prescription of opioids in adult non-cancer chronic pain are deeply flawed by weak or no scientific support, professional bias, errors of methodology and process. Although some of the members of the consultants working group that wrote the guidelines had a background in treating chronic pain, the main background of the group members seemed to be focused on prescription opioid abuse. The Guidelines are being enshrined in State laws and regulations which doctors correctly see as a threat to their licenses if they treat patients as individuals. The only ethically sound response to this collection of atrocities is immediate withdrawal of the Guidelines for a re-write by a group which includes both more stakeholders and more expertise.

JB: What are your feelings on the “war on drugs?” Has it ever been successful?
RL: In a word, no. One very telling statistic was quoted over 35 years ago by Martin L. Gross in "The Psychological Society - the impact and the failure of psychiatry, psychotherapy,

psychoanalysis and the psychological revolution" (Random House, 1978). I believe this statistic remains valid today: Among drug addicts, approximately half will at some point in their lives voluntarily take themselves off drugs and remain drug-free thereafter. There is no statistically significant difference in outcomes of various addiction therapy programs claimed to facilitate this result.

JB: What is next? How do you see this playing out over the next few years?
RL: The future under a Trump administration is decidedly cloudy. In the wake of the medical disasters created under the previous Administration, significant attention needs to be focused upon top-level political appointees, to ensure a better balance between Industry operators, research specialists, and practicing doctors with a more immediate hands-on understanding of patient needs. Lobbying of Congress and State legislatures is needed, to demand withdrawal of restrictions on opioids for those who need them, and implementation of more effective policies to interrupt the diversion of opioids into addicts' hands. A lot of this advocacy is likely to fall to folks like me, who are not suffering from crushing financial hardship or disabled by pain itself.
