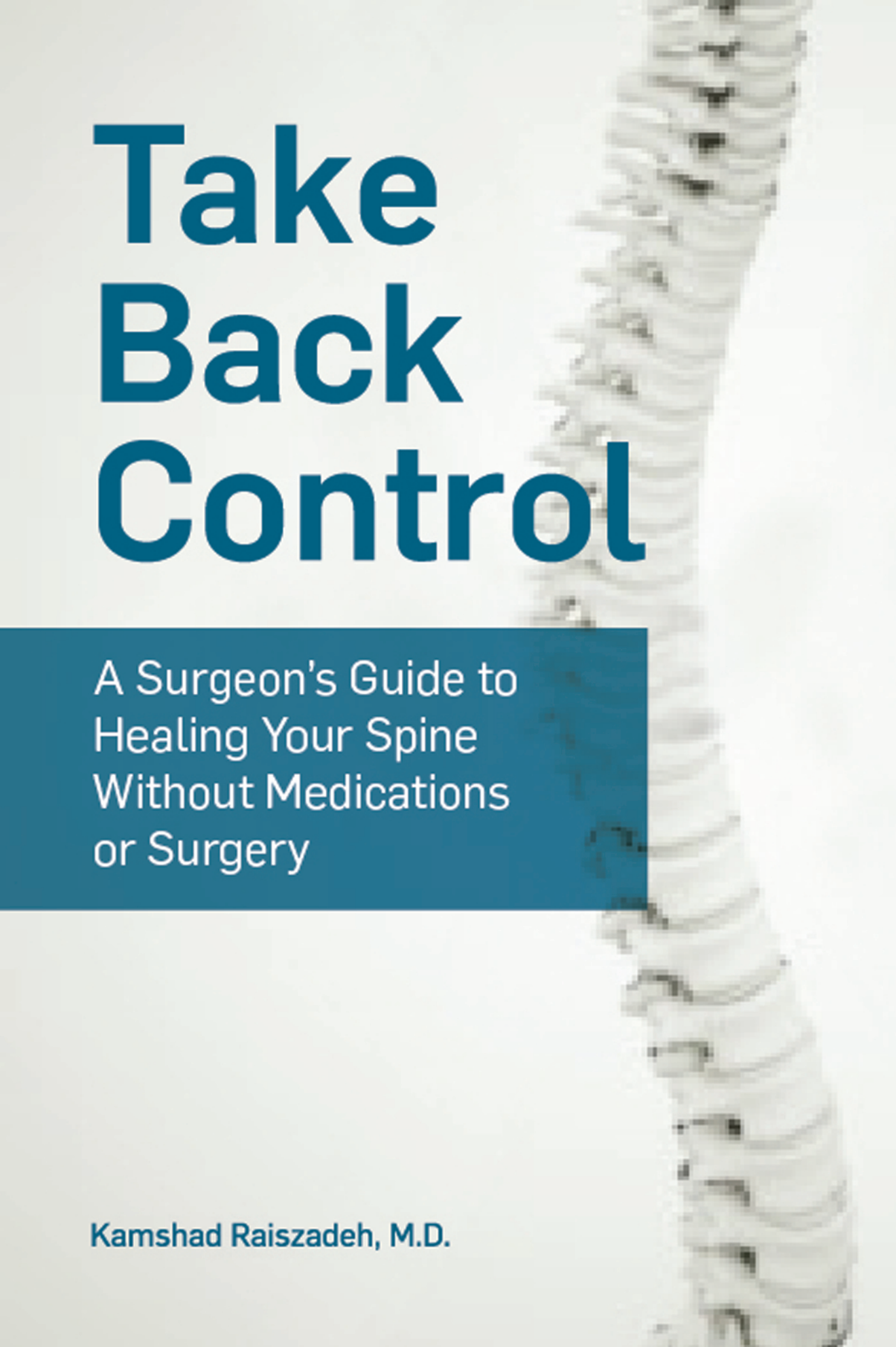
Take Back Control

A Surgeon's Guide to Healing Your Spine Without Medications or Surgery



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Introduction

If you are reading this book, chances are you are suffering from significant back problems. What you might not realize is just how much company you have. Did you know that 80 percent of people will experience significant low back pain at some point during their lifetime?[1] It's true. What's more, 10-20 percent of these people are at risk for developing chronic low back pain and disability—often leading them to quit working and draw workers' compensation funds or disability benefits from the government.[2]

Even scarier, if these symptoms are not addressed in an injured worker, there is only a 50 percent chance that they will return to work after a six-month absence; this declines to a 25 percent chance following a one-year absence and is further reduced to a 1 percent chance after a two-year absence.[3, 4]

It's these chronic back and neck pain patients who account for a significant increase in health costs, about 60 percent higher than for those without back pain.[5] In a recent study published by the Bone and Joint Initiative, total direct costs for persons with a spine condition were $253 billion in 2009 to 2011, a rise of 91 percent from the $132.4 billion in 1996 to 1998, in 2011 dollars.[6] Direct costs are for those services that insurance would pay, such as for doctor visits, hospital costs, physical therapy, injections, and surgeries. This adds up to a staggering direct cost of $8,100 per back pain patient per year.[7]

In addition, an estimated 290 million work days are lost every year in the United States because of low back pain.[8] When the indirect cost of lost productivity is added to the direct cost of care, the total cost due to back pain is estimated at $560 to $635 billion per year in 2010 dollars.[9] This is greater than the annual cost of heart disease ($309 billion), cancer ($243 billion), and diabetes ($188 billion).[10]

And these numbers don't even take into account what happens when people become addicted to the opioid medications that are so frequently prescribed for back pain.

It's estimated that somewhere between 26.4 million and 36 million people worldwide abuse opioids.[11] Plus, a recent NBCNews.com article pointed out that, according to the Centers for Disease Control and Prevention, more than 47,000 people died from opioid overdoses in 2014.[12]

The good news is that, even as I put the finishing touches on this book, the CDC has recently released national standards aimed at putting a dent in the painkiller addiction problem.[13] Essentially, these guidelines suggest physicians point patients toward other methods, like therapeutic exercise, over-the-counter drugs, ice, or talk therapy, before reaching for the prescription pad. And if it turns out an opioid *is* the right choice, the CDC recommends the lowest possible dose for the shortest possible duration.

I truly believe these CDC painkiller guidelines represent a huge step in the right direction. Yet they address only part of the problem. Clearly, back pain is enormously costly, in terms of both finances and personal suffering. With so much at stake for so many, it is critical for us to develop a consistently effective solution for treating the source of pain while containing costs.

Unfortunately, there is no "easy" solution, because no two people are alike. The host of factors that make each person's condition a unique crisis requires and demands an individualized approach to healing.

To illustrate just how complicated a single patient's case can be, meet one of my patients, Dave R.

Early in my practice as a spine surgeon, back in the late 1990s, I treated Dave, a young man in his mid-20s who had suffered an on-the-job back injury as an electrician at a shipyard in San Diego. He was athletic and physically fit—very muscular, built like a bull—but in a tremendous amount of pain.

When I first met him, he had been fighting through the workers' compensation system for two years. In his quest to get people to listen to him and believe he was truly injured, he went from doctor to doctor to seek a cure for his back pain. As Dave's advocate in navigating the workers'

comp system, his attorney worked tirelessly to point out to both him and others how poorly he was doing.

During that time, Dave had seen a number of pain management specialists who were all too happy to continue increasing the amount of narcotics he was taking. By the time we connected, he was on the highest possible dose of Percocet and it wasn't enough. He was desperate to get rid of the pain—he felt he couldn't work or do many other activities—and he wanted to have surgery.

When I reviewed his MRI, his spine looked normal, except for the presence of a "dark disc" in his lower back. While a dark disc is technically not completely normal, it also does not necessarily indicate a structural problem requiring surgery. It's not a fracture, a collapse, or a cause for instability of the spine. It's dark because it has lost some water content. However, the vast majority of people who have dark discs experience absolutely no pain.

In those days, spine surgeons were starting to operate on patients with chronic pain who had isolated dark discs, but my own training had led me to approach them more conservatively. In over 450 surgeries during my fellowship, we had never operated on a dark disc. So at first I discouraged Dave from surgery.

Over the course of treatment, I got to know him pretty well. Dave was a likeable, bright, engaging young man. Yet at times he seemed "out of it" from the medication. He expressed anger about his back pain, his physical limitations, and the fact that his employer and coworkers didn't believe his injury was valid.

One day I said to him, "You're not that happy guy I've seen before…and you seem very distant at times. What's going on?" He explained that he was unhappy being home on disability, but didn't feel that he could work. He also felt overwhelmed being a single dad. In short, he was in a bad place. I was very concerned that his long-term use of the medication wasn't serving him and might actually be causing an increased sensitivity to pain.

I sent him back to pain management counseling with instructions to develop a gradual weaning schedule, but he returned to me on even more medication and insisted he couldn't cope without it. I also referred him to a psychologist to help him address the anger and stress he'd expressed, but he wasn't receptive and it didn't work either. Noticing that his back muscles were continuing to atrophy, I urged him to begin some strengthening exercises to stabilize muscles in his back, but he said he was just in too much pain. He was quick to remind me that he had already undergone four different courses of physical therapy and didn't feel that they did much to build up the strength of his back.

Dave finally said to me, "I'm a young guy and normally I can lift a mountain. I can't go through the rest of my life in this amount of pain. I feel like everyone is playing games with me and that you don't think my pain is real. I feel like the whole medical system is designed to withhold care from me. You've got to fix it somehow."

We agreed that he had exhausted all the alternatives to surgery and we would proceed with a disc surgery to fuse the dark disc. Post-operatively, Dave was initially ecstatic. And, six months later, his spine looked very stable; the dark disc was fully fused. Structurally, the operation was a success. The supposed pain generator was gone.

While he was still on pain medications, he said he felt great. So when it was time for his final visit, I congratulated myself on a job well done and told myself I should have operated sooner and not doubted the dark disc as his cause of pain in the first place.

Unfortunately, Dave's long-term follow-up was not so rosy. One year after surgery, Dave was still not back to gainful employment and was angry that his workers' compensation settlement did not adequately compensate him for his pain and loss of function. When I next saw him for a follow-up, his eyes were glazed over and he seemed drugged. But as we again tried to wean him off the medication, he had increasing difficulty with pain. He insisted he needed the medication, and we agreed that there was nothing else I could do for him.

I wondered: *Could it be that initially after surgery, he experienced a placebo effect?* This can be common in surgical patients. Patients truly want to believe they are better after they've made the decision to undergo a procedure. Or: *Did I actually fix the problem but he didn't want to acknowledge this in case he decided to appeal his workers' comp case?* Or: *Could it be that his chronic narcotic dependency—and the lower pain tolerance that resulted—was the real problem?* Or, even more disturbingly: *Should I have never operated on him in the first place since it seemed like we were back to where we started?*

After that, I didn't hear from him for many years. And then, out of the blue, he sent me a letter that surprised me:

> "Doc," he wrote, "I know you did everything you could for me. I'm so thankful you were willing to do the surgery. You counseled me to increase my strength, try to return to work, and get off the medication, but I wouldn't do it. I'm writing to let you know you were completely right. I was scared to return to working out. And, as a result, I became increasingly weaker. The medications were zoning me out, but I was still feeling so much pain that I became a very negative and unhappy person who was not present in my own life.
>
> "As a result of these factors, I ruined lots of relationships…with the mother of my son and other women in my life. I couldn't hold down a job. Finally, my life got so bad that I had to dig really deep. I decided to do what you told me. I returned to the gym. You said I had to be strict with myself no matter how I felt while weaning off the medications…that I had to tell myself that my increasing pain was due to the hypersensitivity caused by the meds and not my actual pain. So I did it. And you know what? After I was done, I didn't need it anymore.
>
> "Pain is not holding me back in my life anymore. Remember how I was such a workout king? Well, I realized I was just a shadow of myself and needed to get back to weightlifting and building muscle. I started biking and added in some other aerobic activity. I got so much energy back. I got strong again. In fact, my pain

> level is very low now and doesn't rule my life. I'm active and I enjoy my life. I even did some vocational retraining and am a carpenter these days…and I have a great relationship with a special woman in my life.
>
> "So I just want to thank you for spending so much time with me. I wonder sometimes what would have happened had I listened to you sooner, even before the surgery. Better late than never, right? You know that happy guy you said you missed? He's BACK!"

Depending on which point in time you evaluate Dave's case, you would have come up with a different conclusion as to the effectiveness of certain treatments. At some points, it seemed that surgery was a fix. At others, it seemed as though medications were a fix. During certain periods of time, Dave was a victim, and during others he was empowered. Early on, it would have seemed that X-rays or MRIs alone were enough to effectively diagnose and direct treatment for his back problem. Later it became clear how complex chronic back pain can be.

I've seen this pattern of uncertainty and continual change play out over and over again throughout my 19 years in practice. And I've come to realize that this is the crucial takeaway: It is the long-term outcome of the patient that matters most. The story behind the pain—the actual person experiencing, interpreting, and even creating it—is so important.

In Dave's case, he was a fit and strong young man at the time of his injury. He became overwhelmed by his pain and negative thoughts, and was convinced that he had neither the tools nor the power to change his condition. He felt that he had to actively fight for a surgical fix. He lacked the understanding of his condition as well as the maturity, emotional support, life circumstances, or resources to choose strengthening over pain medication for a comprehensive approach to recovery. But every patient's life circumstances are completely different, and, therefore, so is their path to recovery.

What is needed is a customized and holistic approach to the problem that fits each individual. But it can be challenging for a single patient to get consistent guidance about the best treatment

from a spine surgeon, a chiropractor, and a physical therapist…not to mention an insurance company, an attorney, and an employer.

How Did We Get to This Point?

Before we can talk solutions to the epidemic of chronic back pain (and all of the factors involved in treating it), we need to understand how we got here. Why *are* there so many "Daves" out there? Why are so many people in constant pain, addicted to pills, and convinced that invasive surgery is a cure-all for a problem that, in reality, *doesn't* usually require a step as drastic as going under the knife? And how has "the system" accelerated the problem?

Let's start at the beginning. In the old days, patients frequented their family doctor. If you were a patient, say 50 years ago, not only did your family doctor know you, but he knew and had likely treated your other family members as well. Therefore, he had some context to any diseases you might have suffered from. There was no insurance back then either, so you always paid "out of pocket." The doctor didn't order unnecessary tests since he knew you personally and wanted to balance your health needs and your financial ones.

It's worth mentioning here that costs were much lower in years past. (This is partially because many expensive high-tech innovations hadn't yet occurred but also because of many other factors like the lack of widespread health insurance usage and the lack of government involvement.) Still, the patients of yesterday thought twice before utilizing healthcare services since it always cost them directly. There was also likely less of a belief that we should rely on technology to understand and cure any of our discomfort. In general, the spirit of healthcare was less of an entitlement and more of a privilege, with an element of personal accountability and choice.

Eventually, though, insurance companies *did* get involved in the system. Even though accident insurance was first offered in 1850, programs like this did not evolve into the modern health insurance structure until the middle to late 20th century. Before 1965, only half of all seniors had healthcare coverage, and since they utilized the services more frequently, they paid three times as

much as younger adults despite having lower incomes. (Clearly, the system has never been totally perfect or "fair.")

Government began to exert more control when the Medicare and Medicaid programs were signed into law in 1965, allowing coverage for the elderly and the poor. Medicare was later expanded to encompass patients with disabilities. Although a vital coverage, Medicare's financial difficulties are well known as more of us live longer and unmanaged access to Medicare has led to overutilization in many areas. Because of this, and for many other reasons, costs have since skyrocketed. Costs have risen despite a persistent lack of insurance coverage among many working Americans and despite the fact that many doctors are more limited in how and what they can prescribe to their patients.

Today, insurance companies—which are focused mainly on reducing costs and not as heavily incentivized to improve care—often employ "review physicians" to deny access to surgery, which only further fuels the patients' motivation to pursue it. Even though they do cover obesity screening, they often do not reimburse for instruction in physical exercise, either in a class setting or from an exercise therapist. Often these programs are too little, too late.

For its part, Medicare pays lip service to the benefits of exercise, strengthening, and non-operative care in the treatment of back pain, but its policies do not support its stated philosophy. Medicare limits the amount of therapy it allows per year and reimburses only physical therapists to perform non-operative care. Lacking the choice to visit exercise physiologists and kinesiologists, or even to attend physician-supervised programs, these patients exhaust their coverage without achieving a sustainable change in their habits.

This means those who truly need guidance, support, and monitoring must seek out their own treatments and pay out of pocket. Many elderly people with fixed incomes are not willing (or able) to make this investment, which leads to worsening cardiovascular and musculoskeletal health.

As for injectionists and surgeons, Medicare reimburses them in a fee-for-service fashion. While this does allow providers to proceed with injections or surgery without authorization, it does not hold them accountable for the patient's overall outcome. This encourages more utilization of services and less coordination of care, since care is provided in disconnected silos.

Meanwhile, as the insurance system was evolving, the medical field was developing the most technologically advanced treatments in the world. The pharmaceutical and medical device companies brought about great innovation, revolutionizing the diagnosis and surgical treatment of all conditions, including those of the spine.

With the development of advanced diagnostic tools, we doctors were supposed to be able to pinpoint exactly what was wrong with our patients. Unfortunately, this did not happen in every case. With regard to the spine, the most relied-upon test, the MRI, is notoriously unreliable. It can show "abnormalities" in completely asymptomatic patients. Likewise, neck- and back-pain patients tend to blame their discomfort —which may actually be due to their anxieties and stresses or lack of conditioning—on their "objective" yet completely irrelevant MRI findings.

Motivated by the belief that every pain has a scientifically identifiable cause, many patients expect modern medicine to "fix it." And often, we can. With the help of innovative surgeons, the medical device industry has enabled us to repair spinal fractures, remove tumors, straighten and realign deformities of the spine, remove compression on nerves, and treat spinal infections. We have used similar technology to try to remove the most common presumed source of pain, the disc. But as we will discover in the following pages, the source of back and neck pain is not always so simple to identify and fix.

As the medical industry has surged ahead, patients have become more sedentary than ever before. Not only do we take cars to our destination instead of walking, we often sit all day at work. What's more, we are too busy keeping up with frantic schedules to exercise regularly. Ironically, despite fueling the great advances that have revolutionized our work, home, and social lives, technology has not only left the back problem unsolved, it has contributed to it. With our

minds occupied and entranced, we often stay buried in or contorted around our laptops, mobile phones, game consoles, or desktops, compromising the structures in our spines.

Our diets have also changed for the worse. Processed foods have become widely available and inexpensive. We subsist on packaged "non-foods" in lieu of the real nourishing foods that have sustained humanity for thousands of years. Additives such as high fructose corn syrup taste great, but only whet our appetite to eat more, feel less satiated, and signal our bodies to store more fat on our frames. Between our now overweight and unconditioned bodies, our constant imprisonment in poor posture, and our ever-increasing stress levels (which as we will soon learn also impact the problem), it is no coincidence that everyone has started developing chronic back pain.

The Healthcare Practitioner's Current Reality

Today, I recognize that I did not have the resources or capability to evaluate whether Dave's non-operative treatment was adequate. This is a problem that all spine surgeons face, to a degree. Even though we all refer patients for non-operative treatment—mainly having them undergo physical therapy—there's no accepted standard to tell us, "Okay, our non-operative efforts have failed and it's time to resort to surgery."

The challenge is that the physical therapists, chiropractors, and medical doctors who serve as the first lines of defense often evaluate and treat spinal condition patients very differently from one another. You don't need an advanced degree to know that patients won't get consistent results if disparate practitioners all speak different languages and treat patients with dissimilar diagnoses and plans. Plus, they tend to employ passive modalities that focus mainly on reducing pain complaints and don't empower patients to treat themselves.

Meanwhile, pain management physicians have a large arsenal of strong medications and prescribe them more liberally than do other practitioners. They often focus on the patient's pain level and not on her functional level. The injections they prescribe often temporarily work but are not proven to have any long-term effectiveness.

Finally, consider the surgeons. Because typically there is no integrated approach to help different kinds of care providers to work together to assess and develop a treatment plan, we spinal surgeons often find ourselves in the position of being the patient's "last resort." And because our training focuses on fixing what is broken—and is often very isolated from other types of care providers and treatment modalities—we end up with lots of patients like Dave.

In other words, desperate patients who have seemingly "failed" to improve by all other modalities come to spinal surgeons for a fix—and we often oblige with (not surprisingly) a surgical solution. Unfortunately, because we are not always dealing with an obvious problem with a clear-cut solution (like, for instance, a broken bone), surgical outcomes can vary greatly.

Chronic pain is now recognized as a complex "psychophysiological" behavior pattern. In other words, it's not purely a sensory phenomenon that you can easily divide into distinct psychological and physical components. And, in my experience over the years, addressing it properly requires a multi-pronged approach. Unfortunately, such an approach has not been widely available.

To fill this void in the marketplace for spine health, my team and I created a program called SpineZone. It incorporates many of the above-mentioned principles, all integrated within one coordinated and well-orchestrated system. All patients, including those with the most deconditioned core muscles, receive strengthening that they are able to tolerate even if they are suffering from pain. We record, follow, and treat their postural issues as well as provide both home exercises and stretching programs.

During therapy sessions, patients are supervised by a combination of exercise physiologists and physical therapists in order to achieve cost effective and sustainable results. The patient is guided through the entire process by a spine "coach," who is the patient's go-to person. It's the spine coach's job to coordinate treatment and navigate the patient through the process.

If a patient is focused on previous MRIs or X-rays, or is afraid to engage in rehabilitation for any reason (including previous surgeries), a physician assistant or spine surgeon reviews their

concerns and places (often irrelevant) diagnostic findings in the proper context. We educate patients and reassure them that most conditions will improve without intervention—again, *despite* significant findings on an MRI.

There are, however, some cases where we become concerned by the patient's lack of progress or by certain physical examinations' findings. Only in rare cases such as these do we recommend appropriate specialized X-rays or advanced imaging such as an MRI.

In order to follow our results, we initially measure the patient's core strength and use proprietary software to monitor the improvement of this strength as well as other outcome and satisfaction measures during the course of the program. The coaches and clinic managers are alerted when there are warning signs that a patient is not progressing. This is when the team charts an updated treatment course by obtaining input from each other and expanding the care to include the skill sets of everyone on the team.

We obtain data from the insurers and medical groups to continue monitoring the participants' utilization of health services and to assess the cost-effectiveness and value of our program. We regularly report these findings back to the medical groups. Our goal is to have an integrated team employing the best available knowledge from multiple different specialties in order to provide a systematic way to treat patients—all focused on getting the best, reproducible results.

By the way: SpineZone patients often have great success in cutting back on prescription drugs of all kinds, including narcotic pain medications. (More on this in Chapter 3.)

Now, I'd like to touch on the sensitive issue of money. The reality is that your insurance may not pay for the best possible treatment as described in this book—and if you're on Medicare, without some reform, it definitely won't. But your health is absolutely worth investing in.

Here is the truth: The best treatment option for dealing with your chronic back pain likely isn't surgery or injections. It also isn't likely to be years of addictive prescription drugs or a few rounds of physical therapy either, yet these are often the go-to treatments that insurance

companies are willing to pay for. The solutions to lasting relief from chronic back pain *are* likely to be the ones I will describe in this book. These treatments are life-changing for many patients—but only if they believe that a pain-free life is worth investing in. They must be willing to take the time to understand their conditions and also invest personally in any treatments that may not be covered by insurance.

You may be thinking to yourself how unfair it seems to pay monthly insurance premiums and still be expected to additionally pay for the program that actually heals you from pain. I agree, to an extent. Unfortunately, this is where we are *today*—I hope this changes soon and I believe it will eventually, as everyone becomes more comfortable with the idea that a holistic and integrated approach to healthcare is the commonsense answer that we've been looking for.

In the interim, I encourage you to change your perception of what is "worth" paying for. Often people don't think twice about committing to expensive cable TV packages, for example, but are reluctant to spend an equivalent amount on services that may have a far greater impact on their quality of life. Also, many health plans and medical groups' experience have shown that it's better to have patients share some of the responsibility for their care so they are more vested and don't either overutilize or take the service for granted. (This is the reason for co-pays and other shared cost structures.)

You may not be struggling with Dave's addiction to pain medications or his emotional challenges, but I suspect his journey resonates with you as a fellow sufferer of chronic pain. I encourage you to remain positive and read this book with an open mind. Whether you are young or old, trying to recover from an acute injury or a structural defect you've had for a lifetime, you deserve the least invasive solution to your pain that offers the greatest hope for long-term recovery. You deserve to put the pain behind you and get your life back on track.