Dr. David Hanscom

BACK IN CONTROL

An Emerging Model for Effectively Treating Pain

An interview with Kevin Cucarro, M.D.
on Back in Control Radio with Dr. David Hanscom

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Tom: Hello everybody, and welcome back to another episode of Back in Control Radio with Dr. David Hanscom. I'm your host, Tom Masters. Today we have Dr. Kevin Cucarro in the studio with David.

David: Thanks Tom. I'm always excited to do this show, and I'm particularly excited to do this show with a friend of mine, Kevin Cucarro. *He and I have become comrades in arms trying to bring the message out to the world that chronic pain is a curable problem*.

I'd like to introduce you to Kevin Cucarro. He's a board certified pain specialist, and what I'd like to do is actually have him discuss his journey from being a traditional pain specialist to where he is now. But, more importantly, where does he see some of the solutions, going forth, that actually *are* effective in treating chronic pain. Kevin, welcome to the show.

Kevin: Thanks David, I appreciate it for being here.

David: We talked just briefly in the last podcast about your background and training, and where you are today. Can you give us a brief synopsis of how you ended up in Corvallis, and how you ended up in the spot where you are right now?

Kevin: Sure. We talked a little bit about this last week, but very, very quickly for the people that haven't heard that episode, I residency-trained in Anesthesia at the University of Chicago, fellowship and pain University of Michigan, associate program director Naval Medical Center San Diego's pain fellowship program. That's all a way to basically say that I'm supposed to be the most well-known pain person in the medical community, as a pain specialist. And after all that was said and done, I recognized that I didn't understand pain.

When that occurred, I was in private practice in Corvallis. I had moved my family there, thinking that it was the *military model* that was the reason our patients got better. And within the first year, I started doing this deep plunge into, *"What is interventional pain medicine? What's the data on the procedures?"* And recognized, again, if you're not paid to do them, and you do these same studies and look at the data, you very quickly recognize that injections for pain don't provide any long term benefits. In fact, they're associated with substantial harm.

David: Let me stop you there, just for a second, because think I missed something in the first podcast. I don't know of any study that shows epidural injections or cortisone injections work for actual neck pain or back pain. Is that correct?

Kevin: I'll say it depends on what your definition of *"better"* is. So, if your definition of better is maybe four to six weeks of improvement, then we can say, "Oh yeah, they work great." *But, it doesn't matter whether you put steroid, or local anesthetic, or normal saline in an injection.*

David: Really?

Kevin: Really.

David: You can put in normal sugar water and get the same results as with the steroid?

Kevin: Yup, no clinically significant differences.

David: Okay, so the bottom line is, cortisone injections have not been shown to be effective for solving pain.

Kevin: No.

David: Okay.

Kevin: Radiofrequency neurotomy has not been effective. Again, *you have to have a definition of what better* is, because there are pain specialists out there who'll say *"We get short term benefit with it."* In fact, there's one guy, the head of a very active political specialty association—very big in lobbying and making sure that they obtain their funding, who I'll never forget because I'm on the email list still. They're like, *"Yeah, these injections... They say they get better, and so it doesn't matter whether it's saline or not, because if they're saying they get better we should be doing more of them, because they say they're better."* And I'm like, *"Well no, what it means that they're getting better is not because of the injection."*

And there are harms associated with this stuff, so, maybe we should actually figure out why they're getting better, and do more of *that* rather than just doing all the theatrics and ritual that's involved with it. And say, *"The procedure doesn't do anything, but let's do the ritual anyway, so we can get paid and actually harm people with needles. Because they say they're getting better."*

David: Then you and I both strongly agree, one of the essences of actually healing chronic pain is the patient-physician relationship, where a patient actually can feel safe.

Kevin: I think that the key part of people getting better from pain, any sort of pain, is the more safe you feel, whether it's acute pain, chronic pain, or whatever, the less pain you're going to experience.

David: Which means talking to your doctor…

Kevin: *Having a relationship with your healthcare provider is vital to that*. I do want to say, it doesn't mean you have to have a physician or something so that you can be free from pain.

David: I understand.

Kevin: Yes, absolutely. A therapeutic relationship... The old days, when people had their doctors for 40 years, and they walked in and got reassurance that, *"You know what? Your back pain's not cancer, you're going to get better with time."* And they have that

trusting relationship, because they have known, and they trust, and they have that relationship. If we can go back to that, where people could actually interact and have a healing relationship, we'd be in a better place now. That's extraordinarily important. That therapeutic relationship is a big deal.

David: And Kevin and I have both been pretty heavily penalized by our profession for actually taking time to talk to our patients. Now I'd like to spend more time having Kevin talk about the emergence of his group he calls the Painiacs. So, I'll just say really quickly, maybe just tell us in two sentences about your experience in private practice, and why you quit doing private practice.

Kevin: So, private practice, what happened was it came to a head when, number one, I knew that the injections weren't working. I go, "There's something wrong here." So then I went back to pain, and I started actually studying pain. And I didn't even know as much then, as I know now, but what I knew, didn't work, and I knew what made pain worse. So, promoting passive coping, increasing what we would call biomechanical pain belief, the idea that pain oozes like puss out of structures or something like that.

David: I'm sorry, I didn't understand. Say that again, please.

Kevin: So, biomechanical pain beliefs. The idea that if people believe that pain equals damage, that pain oozes like puss out of a structure.

David: Right.

Kevin: And those are the words that we use in *interventional medicine*, we call things *pain generators,* right? And we're going to burn the pain nerves. *But the more people believe that, the worse they do.* And the more people don't feel they have control, the less confident they feel in an ability to manage or control their own pain, and the worse they get. And the more distress they experience, the worse pain gets. And so when you look at what my model was, what was I doing with an injection? I was promoting biomechanical pain beliefs, because I was "injecting" or "burning" pain generators. I was reinforcing *passive coping,* because if you're doing something to someone, the person whose in control of that therapy is the *practitioner*, not the *patient. So, I'm pulling away control of their pain from them. I'm decreasing their sense of self-efficacy, and a lot of the times I'm increasing distress.*

And so the choice was, do I continue to practice, getting very well paid, to do procedures that, actually, were making people worse, because they made those fundamental risk factors worse over time. Or, you do something else. And I don't want to say that was an easy choice. It should have been an easy choice, but it's not when you have family, and mortgages. Very clearly I remember, I was having panic attacks in the middle of the night, and there was this one moment, I'm like, *"You could have a choice between are you going to be financially bankrupt, or are you going to be morally bankrupt?" Because you can't forget this stuff.*

And I've seen people do that. They do this mental jujitsu and say, "Well, actually, I know the injections don't work, but they need it to break the pain." It's all BS. All they're doing is trying to make themselves feel better, because we get paid to do the injections.

David: Right, exactly.

Kevin: So, anyway. That's where I drew the line. And when you stop doing injections, your RVU's, your relative value units, start taking the plunge. And very quickly my medical group was like, "Well, you're not making any money." And I said, "Well, let me just show you the data. And if you want me to harm people for money, I'm not going to do that." And then we ended up parting. We ended up parting.

David: Can you explain briefly what you're doing now? That was about, what, three years ago you started this?

Kevin: Oh, no. That was a long time ago. That's six years ago. Almost six years ago now.

David: Wow. So, quick question. I know you and I met, and I have the same issue, where I just [inaudible 00:09:11] certainly weren't working, and we were really having people with these big operations, and it's been a huge journey for me also. But had you been exposed to [inaudible 00:09:22] and neural science pain when you first met me?

Kevin: He came after. And so what had happened is, I think what most of us do, or I guess the few of us that question the madness of the system, is we start looking around, and one of the top books that I saw was Healing Back Pain from Dr. John Sarno, so I bought that. I'm like, "Some of this makes sense, but some of it doesn't." And then I got to Howard Schumann, I bought his book, and I talked to Howard. I bought your book and talked to you, but there were always these things that I wanted to know more about, and so I just kept reading, and reading, and reading, and then eventually that moved me into Warner and David Butler's work. And I still think Moseley is probably the top pain researcher in the world, I have nothing but admiration for him.

Kevin: But, now I'm reading mostly scientific studies. There are not a lot of books published that really have good stuff that I want in them.

David: All right, so I feel good about this. I feel good about introducing Kevin to a whole new world of neuroscience, which makes his journey really excellent. But see, I've now delegated the learning to you. You get to do all the research and actually teach me. [inaudible 00:10:35] has honestly been one of my mentors, he introduced me to Lorimer Moseley a few years ago. We spent some times with them, Lorimer Moseley, by the way, his name is Lorimer Moseley. You'll see him on YouTube about how pain works. Wonderful TED Talk, very entertaining. Super nice guy, and we all have our various version of essentially the same journey, that something's painful because your brain says it's painful. Period.

Kevin: Period.

David: We've made lots, and lots, and lots, and lots of modifications to that. But the bottom line is, pain is a construct as a result of sensory input, and your brain is-

Kevin: Sensory, emotion, and cognition.

David: Okay.

Kevin: You have to put all three of them together.

David: I agree. So, there you go. So anyway, Kevin's become one of my teachers, that's one of the reasons I have him on the show. But, Kevin's done a wonderful amount of research. But anyway, what I want to do is jump into some things that are happening that are positive. So, you're still in Corvallis. You've been there, what, five or six years. I'm sure you've been there longer, but you've been out of practice for that many years. And you're on a remarkably focused mission to bring these concepts out into the world. I got introduced to your group through... How did I meet Sharna? Is that through you, with the Painiacs?

Kevin: Mm-hmm (affirmative). Yup.

David: Can we talk about Painiacs for a second, how that happened, and why it's still thriving?

Kevin: So, I'm going to try to keep that story shorter. But what basically happened is when I was leaving practice, I was extraordinarily distressed, didn't know what I was going to do. But I just figured I was going to talk, so I did some ground rounds, and I was doing lecture talks to the residencies here. And really the family practice residency, they really care about their patients. I'm going to be blunt about it. They're very interested in this. So I continued to do that, continued to learn, and as I learned I wanted to teach.

And what basically happened is, there was a chance for some grants in the area, and a couple family physicians that I had been sitting with, and talking with, and wondering what to do. And they go, "Well, you should apply for a grant." And I had all these grandiose ideas about this, that, and the other thing. And they said, "No, you need to get a grant to get paid to do what you're already doing," which is basically coming in and teaching doctors. So I got a grant, and I basically went into 13 patient centered primary care homes in our region in three different counties, and started teaching the docs pain. And as I started teaching the docs pain, what I recognized is—and this is such a big problem—I could get these docs starting to understand the concepts, but then they would refer patients out. And then, as soon as the patient left our little protective community, they went somewhere else, and they had another healthcare provider just immediately destroy it by reverting to, "Your pains coming out of your bulging disk, and this and that, and there's nothing you can do. And I don't know why you're coming to see me."

And one of the worst encounters that happened when a doc referred to a physical therapist, had a 45 minute discussion, got the patient involved, the patient was bought in, and the physical therapist's first words were, "I don't know why you're here. Your

back has so much degeneration in it that nothing's going to work. But I guess we can try."

David: Great.

Kevin: So I got a second grant. And with that grant I went in, and I started working with the physical therapist. And what was interesting with the physical therapist, is they have more time to spend with their patients. And I started having more of them buy-in, and with that was Sharna Prasad. Before I had got my grant, I had been meeting with her for over a year. And I didn't know it at the time, but it was because she had actually had back pain, and she was trying to figure this out. And she likes to say she was a slow learner, I think I was just a bad teacher.

But, it was about a year that we were meeting monthly and having discussion on pain, then she went to her national conference, and had another physical therapist get in front, and ask these questions about pain; it was when she was with her peers, someone said*, "Pain is protection."* And she said all this stuff came together, and "Clicked." And she knew it. And so with Sharna, who was a physical therapist, there was a social worker who had some pain groups, who I heard really positive things about in how she was interacting with her patients. So I just started reaching out to people I knew who were working, were passionate about pain.

David: Right.

Kevin: I started talking to her about pain, and teaching her a little bit. And she completely revamped her curriculum into more of, instead of this idea that there's nothing you can do about pain, you can only manage it, and accept it; her program is now about how you can transform pain. It's not just about accepting it—*it is accepting where you are so that you can start taking actions to pursue the activities that you need to do to get better.*

So, Sharna, Leanne, and a couple others, Lorimer, were coming to Seattle in 2016. And I got about five other members of our community, none of them ended up being physicians; they were all ancillary healthcare providers. We went there, to the conference that Lorimer and David Butler were putting on. Actually, Mark Jensen from the University of Washington was there, too. That's where I introduced you to Lorimer, and had dinner that night. And that little coterie of people—when we were getting home, they were so fired up. Because we go to this conference, and we're sitting down, and we're having these discussions, and you get excited. Because now there's this idea that there's nothing you can do, and like you said, *nobody likes to treat chronic pain. And I believe it's because they think there's nothing that can be done for it.*

David: Right.

Kevin: And someone's coming in your office... And most people go into healthcare because you want to help people.

David: Right.

Kevin: If you don't feel you have the tools for it, if you feel there's nothing you can do, that frustration oftentimes... That's very distressful as a practitioner, that frustration oftentimes gets reflected on the patient themselves, but it's really about us, not them. And so this group got very excited, so we formed a little organization. At the time we called it the Mid-Valley Pain Alliance and we've been totally grass roots. There's about five of us, we've started doing community talks, doing lectures in different towns, about monthly. And then more of the community started going through our pain programs, like Sharna's wonderful pain program out in Lebanon, Oregon and Leanne's fantastic pain program, working some really, really complex pain in Albany.

And as patients started coming through, not managing anymore, they got excited, and they wanted to become involved. And so, this little organization of Painiacs is now mostly *non-clinical* people.

David: You use the word Painiacs. That's a pretty interesting word. It implies being pretty excited about what you're doing, and I think it's fantastic. I love that word, Painiacs.

Kevin: We have community members—people who've had pain for decades, who are doing so well, their friends and family go, "What has happened? You look great." And they go, "It's pain, and you got to come to these meetings." And they get so excited. And their friends are like, "Whoa, stay away. You're scaring me because you're so passionate about that," because they feel so good. And this goes beyond just the healthcare system. It is this idea that people are like, "How could you be excited about pain?" And I'll return to it—*the more you understand pain, the more you see how these pieces fit, the more appreciative and the more amazing it is, and the more excited you get.*

David: One of the things that happens, which is sort of a paradox, in that I probably have over a thousand patients now that have *gone literally to pain-free*. And when I say pain free, it doesn't mean you get rid of the day to day pain that comes and goes, but the grip of pain loses its strength, you don't keep going to medical doctors over, and over again for a cure. And what I'm excited about is that when you break loose of chronic pain, not only do you get your life back, but you thrive at a level that you've never experienced before in your entire life—even way before you started having chronic pain. Remarkable things happen, like new jobs, your relationships improve, there is energy for pursuing commitments like going back to school, and so on.

But, also from the patient's standpoint; think about your doctor walking into the room and you're labeled a drug addict, or somebody ho's faking it, and people know the labels. They hate them. I know what it's like to be labeled. But think if your doctor walks into the room and was just excited to see you. That's a pretty big different interaction, it's huge. And I came out of my clinic everyday always inspired, excited every time. I agree with you, you have to temper your enthusiasm, but you watch someone and connect to their own healing capacity. When you think somebody's been in chronic pain for 5, 10, 15 years and all of the sudden they're free, it's beyond words. You don't know what to say. They can't say anything, I can't say anything.

The record is a woman who was in chronic pain for 55 years. She's now been free for about 6 years. She's 83 years old now and just keeps thriving, and thriving, and thriving.

Every year she looks better, it's unbelievable. Where do you see the next five years, as far as some of the things that you're trying to do to get some of these concepts more out into the real world?

So, first question again, I asked you before the interview was, I'm assuming in the Mid-Valley Alliance that you've probably seen a fair number of changes within the valley over the last five years. Correct?

Kevin: It's never as fast as you want.

David: Right.

Kevin: It's never as fast as you want, but you have more and more people talking. And what I've sort of come to terms with, is this is not something that the healthcare system is going to address anytime soon.

David: Because why?

Kevin: There's no incentive to do so.

David: Financially.

Kevin: There's no financial incentive. And there's some interesting stuff here, like Warren Buffet's compatriot Charlie Munger's phenomenal thinking papers. In one of the ones which I'm glad I didn't read six years ago, because I probably would have stopped, was this, "Never try to fight incentivized behavior, because you're going to lose every time." In a healthcare system there is absolutely no incentive to change the paradigm that we have because the payments don't line up.

David: Right.

Kevin: So, it's not going to be the healthcare system. But, from a community standpoint, what gets exciting is the more you understand pain, the more you can take care of yourself, and for us, *it's no longer just about pain, it's about your health*. It starts doing the "steamroll," and then it starts into other healthy behaviors, into the thriving behaviors. For a community that's good. I just don't think the change is going to come from the healthcare system. *They're going to be the last ones to change*; *it's going to come from communities.* It just needs strong communities that actually start seeing the hope, and I hope nobody listening to this gets offended, but I'm sick of these organizations saying people with pain *can't get better*, so you have to give us more drugs, you have to do all this, because we can't get better. That's not true. *Just stop for a moment, and question those fundamental beliefs, because they haven't been working.*

Kevin: Take a moment and just say, "What if I'm wrong?" Go back to the science and start challenging that stuff, and what happens is... We need more organizations to be more pro-pain, rather than pro-drug or pro-surgery.

David: Right.

Kevin: And that's a little bit harder, because I think we're at the tip of the spear that's just starting to get a little bit of momentum in small little pockets.

David: I gave a lecture at a conference where Kevin and I were both lecturing a few months ago to the Mid-Valley Pain Alliance. There were about 120 people in the room including a lot of primary care physicians. And the energy in the room was just unbelievable. I was so excited about that. Kevin gave a wonderful pain talk, and was able to talk about really the insanity of what we're doing in surgery.

David: Who was the one that presented those patients who were doing so well? There were four patients who stood up and told their story. Who was that from?

Kevin: Joletta Belton out in Colorado. She's not in our group, so she comes in because she has a different story. But she was very good, and gracious about being the emcee for that event. Then we had Tom Core, who was one of the first people to go through Sharna Prasad's program, the mindfulness, movement, and pain science program.

We had Cindy Orr, a young woman who had crushing headaches, thought she was going to die; was diagnosed with, I think, Lupus, and other autoimmune conditions, on 19 medications—she's on nothing now; she runs a horse rescue for traumatized horses, and is really involved with the community.

Kevin: And I think Moe Forrest was there as well. She's our 74 year old who had pain since she was 14, and she's our "super thriver." She runs two or three different groups for community members who've gone through programs, value's groups, goal groups, and pain groups. And I think those were the people that were involved in that talk.

David: I just had this thought today, one of the negative chronognostic factors (subjective awareness of the passage of time) for chronic pain is belonging to a pain support group where a patient ends up talking about the pain all the time. I was just trying to think about, why not form wellness support groups?

Kevin: Yes.

David: Right? You're in pain, but you can't solve pain, you actually move into wellness. But again, you and I could talk for days on this. But, Kevin, this is fantastic. I think we'll probably do a few more interviews like this in the next few months. This is fantastic. I think Kevin and I are here both to say that chronic pain is a solvable problem, you don't have to live with it, the neuroscience is right there. What is call mainstream medicine, actually, is not mainstream medicine. Those practicing in that arena—where you and I were for many years—actually are not following the known data at all. And it's really unbelievable what they continue to do in spite of the data. *Essentially every procedure we offer in spine care, just for spine care, has been documented to be ineffective.*

David: The treatments that do work, and there's plenty of them that do work, are actually **not** covered by insurance. And right now we're just simply not giving people adequate care. *Mainstream medicine, if you want to call it that, has no leg to stand on*. They're actually way, way off base. *But we're here to tell you chronic pain is a solvable problem.*

David: Any other final thoughts, Kevin?

Kevin: No, I would absolutely and 100% agree with you. I would say though, if there's somebody listening that wants to be critical, all those non-surgical, non-intervention, non-drug things have low levels of evidence. And that's true. I would say that the low level of evidence have to do with the model that most of them teach. If as a provider you go in thinking that pain *can't* change, you'll go through an ACT program, or do CPT, and end up just telling people that as a provider, you can't do anything about it, and so you have to think differently, it's not going to work really well.

David: Absolutely.

Kevin: But even if that was the case, low value, non-interventional, non-dangerous care, with no side effects versus low or no-value, highly invasive spine surgery, injections, or drugs, which one do you actually think you should pay for?

David: Right. Exactly right. And the other thing that I find is, again, people are excited they really do come out of the grips of chronic pain; but when they look backwards, it's disturbingly simple, actually, how to do it. It's not very hard. No risk, not expensive, and again, that's a different discussion about how you actually do this, but it's disturbingly simple compared to everything that a patient's been put through. And it makes no sense at all.

David: Kevin thanks again. It's always good talking to you. We will obviously stay in touch in the near future.

Kevin: Thank you for having me, appreciate it.

Tom: David and Kevin, thank you again for another insightful episode about an exciting new approach to pain. And I want to remind our listeners to be back next week for another episode of Back in Control Radio with Dr. David Hanscom. And remember to visit the website at www.backincontrol.com

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Note: The original transcript of this episode of Back in Control Radio with Dr. David Hanscom has been edited for readability