Dr. David Hanscom

BACK IN CONTROL

Deconstructing the Spine Surgery Decision

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

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Tom Masters: Hello everybody, and welcome to another episode of **Back In Control Radio** with Dr. David Hanscom. I'm your host, Tom Masters, and returning as our guest today is **Dr. David Schechter, one of the pioneers of mind~body medicine**. And today I understand that we're going to have a little role reversal, is that right, David?

David Hanscom: That's right. I'm going to turn the moderation over to Dr. Schechter in a moment, but briefly, he's a **family practice and sports medicine doctor** in the Los Angeles area. Most of his practice is chronic pain, but he's one of the pioneers in looking at the ***mind body syndrome in medicine***. He does a great job, and he's one of my mentors. We're going to reverse roles today. And I'm actually going to try to listen, which my wife would tell you is not my strongest point. Now I'm going to turn over the program to Dr. Schechter, who's will interview me about my new book.

David Schechter: Thank you, David. Well, David, I was excited when I heard that your new book came out, and I think there's such a need for this book in terms of helping both patients and physicians to figure out what role spine surgery may or may not have in their care? Can you tell us a little bit about the writing of this book?

David Hanscom: What happened, in 2006, I was asked to give a talk at North American Spine Society in Austin, Texas. And I was asked to talk about the decision making in spine surgery. What happened, a grid evolved that put my thinking on a grid in a way that allowed me to present it very clearly. It takes a given patient situation, and it takes two variables. One is the state of the nervous system, and the other one is the anatomy. Take control with the surgeon's advice. I'm not against spine surgery, but I'm against spine surgery when he can't see the problem.

My number one goal in writing this book is to stimulate serious discussion around the tremendous amount of surgery being done on normal spines which is, of course, ineffective and ultimately very dangerous. And if I accomplish nothing else in this life, slowing down this juggernaut of aggressive spinal surgery on normal spines is a huge mission for me. That was the original starting point.

David Schechter: Starting with the concept of a ***normal spine***, my question is what tells either the patient or their primary care physician whether they have a ***normal spine***? What would be some indicators?

David Hanscom: I divided the anatomy up into two sections. **Type one, which is a *structural* problem; Type two is *nonstructural*.** In a type one, you have a piece of abnormal anatomy like a bone spur, some type of instability. Then you have symptoms that actually match the lesion. So to be defined as structural, you have to have a bone spur with a matching arm pain or leg pain. If the pain's on the other side, for instance, that would be nonstructural. The symptoms have to be specific. ***For instance, back pain is very nonspecific. So by definition, that is nonstructural, but if you have an unstable spine where it slides back and forth***

when bending backwards and forwards, then that would be considered structural.

What is not structural is degenerative disc disease. You and I both know this, but there's a tremendous amount of data that shows that disc degeneration is normal as you age. It has distinctly been shown to not be a source of pain. And right now we're up over $10 billion a year of spine surgery for degenerative disc disease. It's rather perverse.

David Schechter: So if a patient has leg pain that's felt to be coming from the back, at what point do you think spine surgery should be considered?

David Hanscom: So in that situation, we have a bone spur with matching symptoms, spine surgery is an option, whereas if you can't see the problem, spine surgery is not an option. So the second set of variables is the state of the nervous system, so type A is somebody who's calm, coping with life reasonably well, there's always stress of course. And type B is when the nervous system is what I call hyper sensitized or stressed, and your body chemistry is off, your nerve conduction is doubled, you sense pain more, you don't cope with it as well. The data shows if you operate in the presence of chronic pain, untreated chronic pain, you can actually induce or worsen the pain 40 to 60% of the time. And that's with a perfectly appropriate procedure.

If you have a bone spur with matching symptoms and you're type A, relatively calm, I don't necessarily wait that long to do the surgery because it works pretty well. Now, if you had a major financial loss or family loss or some new stress, and remember that bone spur, it might've been there for a long time, but the symptoms are new, often what happened was change in the family circumstances.

We now do a prehab process where we actually calm down the nervous system in every patient every time it has a stressed out nervous system. We found a significant number of patients, even with surgical lesions, the pain went away and they canceled their surgery. So if you have a stressed out nervous system and you have a bone spur that needs surgery, we really try to wait six to eight weeks before we do the surgery. But it's an option.

David Schechter: I was going to ask, how long does the prehab process go on for and what are the key elements of it?

David Hanscom: I try to get everybody to do 12 weeks before we do any elective surgery. Obviously there are emergencies that are different. With a major spinal deformity, which is also discussed in the book, I prehab people from one or two years before the surgery. There's a complication rate of over 60%, half of those are severe and major complications including blindness paralysis, multiple surgeries, et cetera. And it's not uncommon for people to walk into the

surgeon's office and have a major spine deformity operation recommended on the first visit. And there are so many factors that determine a good outcome.

So by going through the prehab process, which includes sleep, stress management, calming down the nerve system, medication adjustment, life outlook, there's anger forgiveness, physical conditioning, and nutrition. Obviously you and I have talked about **Back In Control** being a primary care wellness book. To solve chronic pain, you have to treat every aspect simultaneously. But by using a process like, first thing, I'd love to be in practice in the same town as you, because let's say Tom needed surgery and he was going through some big loss. I would have him see you for three to six months, or just go through the steps that you go through with all of your patients. And we just had the best results with very few surgical failures once we started doing this prehab process about seven years ago.

David Schechter: So do you think that the percentage of complications and the percentage of failed surgeries is just not widely known by surgeons, or it's not widely known by physicians in general, or is it sort of just ignored?

David Hanscom: All three. There's a paper out of Baltimore published in 2014 that shows only 10% of orthopedic neurosurgeons, spine surgeons, are acknowledging the known risk factors for poor outcomes. 10%. And we've known since medical school that if you're anxious, depressed, catastrophizing, long-term disability, et cetera, there are lots of things that we know have bad outcomes. ***And it's the real deal—people don't do well if their chronic pain is not treated. So these are known risk factors.***

They documented less than 10% of surgeons are actually acknowledging those risk factors before they do the surgery. I know I'm not the interviewer but I'll ask you your perspective on that as far as, I mean, you're a primary care physician dealing with surgeons all the time. And I do have to know Los Angeles is like other major centers, there's lots of spine surgery being done. I mean, what's your perspective on it?

David Schechter: I feel like if I know the patient well, and they're coming to see me either with belief that there's a mind body aspect to their problem, or just as in my role as a sports medicine primary care physician, I feel like I have some control and we can do things like the mind body approach. We can even if we have to do something like an epidural device some time, all of these things, time is a key healer.

David Hanscom: Right.

David Schechter: Whether it's because the patient gains insight or just time takes care of things. And so sometimes just stalling things and slowing things down is helpful.

If I have control and I feel more comfortable, once they get to a surgeon, especially if they self-refer to a surgeon that I didn't kind of okay, it's more challenging because then they have the credibility of the surgeon or the impressive office that he has or the facility that he works at or whatever and then you're trying to overcome that. But I always tell people, slow down the process. There are very few people, and I think you'd agree with this, who must rush to spine surgery and rushing often leads to bad judgment in many things in life, whether it is relationships or spine surgery or other things.

David Hanscom: Right.

David Schechter: So would you say that there, let's say you're talking about someone, and I don't want to be too technical for the patients, but we might have some health professionals listening as well, but let's say you're talking about someone with sciatica, and instead of a bone spur, they have a very large herniated disc, let's say 10 millimeters, 12 millimeters.

David Hanscom: Right.

David Schechter: And the neurological findings seem to correspond to this. So it seems more like a pattern that would be consistent with a structural process although maybe they have a type T personality, a stress prone personality, as I call it. If there are neurological changes, if they begin to develop some weakness in the foot or the toes or these sorts of things that we see with an L5 or an S1 lesion, what are you doing with those people differently than other spine surgeons?

David Hanscom: Well, I was very specific in the book about this. So if there's a neurological complaint, I say, look, this is between you and the surgeon at that point. In other words, everybody's different with neurological complaints as far as the speed of onset, duration, and the severity of the deficit versus some people who have a complete foot drop that's just dead and surgery is not going to help. So the bottom line, the book is for elective spine surgery, which is usually because of chronic pain. So let's say you broke your L4-5 disc which causes pain down the side of the leg. With a soft disruption, the first two or three weeks are severe, but the soft disc often resolves, ***most of these ruptured discs get better without surgery.***

Now, if you can't tolerate the pain and have the disc taken out, that's reasonable also. There are studies that show that actually taking the disc out earlier doesn't improve the overall chances of resolving the soft disc rupture, but it is faster, no question about it. I had my own back surgery 30 years ago and I lasted about six weeks and just went berserk, could not do it anymore. So yeah, that operation works well. If you have a stressed nervous system, even just doing the simple exercises like you talked about earlier, like the stress surviving, a little bit better sleep, medication management, try and calm things down first before surgery helps.

But with an acute soft disc rupture, it's hard to deal with. What happened in my practice which blew me away was the discovery that normally if a patient walks into a doctor's office or surgeon's office, generally there is a 10-20% chance of actually having an operation recommended; with many surgeons now it's up to 40-50%. And this has become very aggressive as far as the number of procedures being recommended. It turned out that the rehab became so powerful that even the surgical lesions started getting better without surgery. And these are the ones with bone spurs only, not a soft disc rupture. These were not going to improve with time like a soft disc rupture can.

David Hanscom: I had over 120 patients with severe spinal stenosis, leg pain, difficulty or inability to walk, who canceled the surgeries over about 12 weeks because the pain disappeared. I didn't expect that. So my surgical commercial rate on elective surgery, again, based on pain versus neurological deficit dropped under 5%. So I literally put myself off out of business.

David Schechter: So let's go onto the category of people with actually ***just low back pain***, rather than low back with leg pain or leg pain primarily. Should any of those people ever get spine surgery?

David Hanscom: ***Essentially no.*** The only exception to that would be people with a very unstable segment where you bend forwards and backwards and the vertebrae slip on each other, but even then, I still do the prehab for at least 10 to 12 weeks. But nonspecific back pain is harder to define, you can't really match up with, let's say a given disc is the problem, we don't have any diagnostic tests that tells us which disc that might be. And the success rate for a spine fusion for back pain is about 25%, that's it. Chapter eight in my book documents the data behind fusions for back pain. There's not one research paper in 50 years that documents that back surgery should be done for back pain, not one.

David Schechter: Certainly the ***category of people with back pain only or back pain primarily*** is where we're beginning to make inroads in the community with some of the surgeons who know that *I like to work with chronic back pain patients who don't need surgery*. And the good ones are not operating on ***back pain only*** **or** ***back pain primarily*** cases, and we're getting great results with the mind~body approach. So it sounds like you concur with that, with the exception of a small percentage of people with severe spondylolisthesis or unstable spines, which is a different category.

David Hanscom: Part of the *prehab criteria* is if you come in with leg pain and back pain, I first want to say, *back surgery doesn't help back pain or leg pain*. ***Part of the prehab process is to decrease back pain about 50% or more before we do the surgery for the leg pain***. In a few cases when the leg pain is compelling I've done the surgery anyway, but the back pain got way worse—very discouraging.

David Schechter: So David, you're pointing out again that a common sense approach combining holistic or naturopathic medicine with time is a successful in reducing and unnecessary back surgery.

David Hanscom: Right.

David Schechter: That's really what you've been advocating for years, I think quite effectively, in treating the national health problem of chronic pain in this way.

David Hanscom: Everything in both books is based on documented medical practice. I said earlier, *doctors are ignoring known documented medical practice that actually helps calm down the nervous system and pain*. So you and I and a few others in our group do understand that ***chronic pain is actually solvable, not just to be managed*. Most of the medical profession for some reason has missed the *neuroscience research that tells us how to do this*. And then we start and continue doing surgeries that have no data to support efficacy.**

David Hanscom: You know I quit my practice in December because I was seeing three to five patients every week with really tough things done to their spines that were disabling them? And I ran across a kid who's in his thirties and was paralyzed by a five point infusion that should not have needed surgery—paralyzed! He was 32 years old. I actually quit mentally on the spot, but it took me another six months to wind down my practice. I felt compelled to get out and pursue this project full time. So I didn't really retire, but I switched gears to public speaking, podcasts, writing more books, teaching, and online programs.

Whatever it takes to get this message out there that spine surgery flat out right now is dangerous. *If you are a surgeon, you can only fix it if you can see it.* You shouldn't do any elective spine surgery until you spend at least 12 weeks doing the things that help calm you down and optimize your outcomes. I used to ask my fellows, "When was last time you saw a surgical failure in my clinic?" What happens at prehab is that many people get better without the surgery, and the ones that do surgery have less pain, better rehab, better mindset, and good expectations. We had the best time in clinic with our patients. We didn't have the failures that I used to have.

David Schechter: So the answer for patients and the answer for doctors is to read, **Do You Really Need Spine Surgery?** and really take the messages to heart. Understand the sympathetic nervous system and the risks of operating. Learn the prehab or the Direct your Own Care (DOC) program to apply where appropriate in their offices and at home.

David Hanscom: We made it very concise. The middle part of the book is the background on why the book is important, and then the final two long appendices really go into what makes a specific diagnosis ***structural versus non-structural***. It is a reference book that people can actually get through very, very quickly and make a good decision. So I'm very excited about it because many of my friends have used the decision making grid process for a long time. I'm excited to get the grid into print and allow people to use it as they see fit. So I'm pretty excited about it.

David Schechter: Have you heard from any primary care residency programs that would like you to speak there, because it sounds like you really need to get out to physicians as well as patients with this book?

David Hanscom: I'm working with some healthcare systems, focusing on physical therapy, chiropractic, naturopathy, and primary care—the people who are in the trenches with the patients and can help calm them down and establish a relationship, *which is a big deal*. The book proposes accountability of the surgeon to referring practitioners and to patients and gives you the right questions to ask the surgeon to secure that accountability. If a surgeon decides you should have surgery, this book gives you your power back in terms of making an informed decision. Now you can ask why? What is the detailed reason, can the surgeon explain it? The book gives you the tools to actually have a decent conversation with your surgeon about why you do, or do not need the operation.

David Schechter: This seems like a very helpful guide for everyone, and a chance to explore the subject as deeply as you need to, depending on your background and the field that you're in.

David Hanscom: So David, thank you for being the interviewer. We have three minutes left. You can ask me any final questions.

David Schechter: Okay. So how are we going to change medicine? This is a bigger, broader question, although it certainly relates to your book: ***How are we going to change physician practice, both the surgical and the nonsurgical level? What's going to happen? How are we going to impact this?***

David Hanscom: I think the number one thing, and I've said this for a long time, is that the fee schedule for doctors talking to their patients, particularly in primary care, should be tripled or quadrupled. Second of all, we need to quit paying for procedures that don't work. I told you about the paper documenting that every procedure we do for chronic back pain and knee pain is ineffective—period. And you and I both know that if you have *phantom limb syndrome*, you can't do more surgery on a limb that isn't there. Phantom limb pain phenomenon can occur in any part of the body, and we're just throwing risky and expensive procedures at patients from every direction that we can.

And we talked about different capitated payment plans. We've watched it, you and I have watched this for 30 years. That's not going to work. My wife keeps telling me not to do this, but even from a political standpoint, you and I both know if we quit paying for procedures that did NOT work and paid doctors to talk to their patients, that you'd probably save at least 40% of the healthcare costs that we're incurring right now. ***There's plenty of money in the system but we're spending it on procedures that don't work.***

David Schechter: Procedures are tremendously expensive and tremendously lucrative, not just for physicians, but for hospitals and for surgery centers and all of this stuff, because fees are often triple what the physician is paid to do the procedure for the facility itself.

David Hanscom: Right.

David Schechter: And there's a tremendous perverse incentive in this regard to operate and to do procedures rather than, as you pointed out, to rehabilitate somebody, to talk to them, to listen to them. And you've spoken to the converted here in terms of someone who has a family medicine specialty, that primary care doctors need to be paid more, and that this would lead to a healthier population and a lower cost healthcare system.

David Hanscom: Well, as you know, listening is a proven treatment modality, number one. Number two, I mean, how do you actually solve a problem if you don't know what the problem is? And I mean, I can't even begin to tell you how random these surgical recommendations are. I had one of my fellows call me from back East saying he was actually going to sign up a patient for surgery for a L5 S1 fusion for a spondylolisthesis. The guy had tendonitis. He had bilateral iliotibial band tendonitis. The surgeon never saw the patient. I have one doctor's wife who was fused from her neck to her pelvis when records show that on the first visit, she had a completely normal spine. She had two months of muscular back pain after weightlifting, and she ended up housebound, high on psychotics, and she went psychotic.

David Schechter: These are the most extreme examples imaginable, but it's incredible when you run across them. I mean, to me, it is astonishing that people pay for this. Why these doctors are not drummed out of the profession is hard to understand.

David Hanscom: But I do think that for the medicine to change, it's going to have to come from the public. Right now the business of medicine does not have any particular interest in changing things. And so it's got to come from the public. And I don't know what you think, but I mean, my sense is the public is getting some sense that things aren't quite right currently. I don't know. What do you think?

David Schechter: I think there's definitely a move in this direction. I don't know if it's as powerful and strong enough as you and I would like it to be right now. ***Sometimes the public wants to change, but doesn't know what change it wants and wants to be educated.*** That is what you're doing, going out there and speaking, doing podcasts, and writing this important book. All of these things are going to contribute to needed change. We're all trying to do our part, either seeing patients or writing or both—it's just a challenge. There aren't enough of us advocating.

I'm trying—I think you're doing this as well—to speak to some of the larger healthcare carriers, Cigna, Aetna, and United Healthcare for example, because

then whatever effect you can have is multiplied dramatically. So those types of things may have an impact. And maybe some other large medical schools and medical centers, I mean, there's plenty of data here and as you said before to me, ***the data's on our side, not on the other side.***

David Hanscom: Right. ***Mainstream medicine*** needs to be ashamed of itself. They're the ones that should be on the defensive because *what they're doing has no data*. *It just doesn't.* I actually have to tell you one story because you reminded me about working with healthcare systems. I'm working with a large healthcare system currently but won't mention the name at this point. Their head pain psychologist told me about a patient, a gang member who was involved in a gang-related incident that caused the loss of his leg from a shotgun accident.

You have a patient with phantom limb pain, on high dose narcotics, really angry toward the system for a couple of years. Now he is a demanding, aggressive, really unhappy, unpleasant patient. He came into the pain center and they gave him my book, the **Back In Control**, *A Surgeon's Roadmap Out of Chronic Pain*. He started going through the process, the writing, relaxation tools, and going through the rest of the process including forgiveness. And in three months, his phantom limb pain disappeared, which I have seen a few times, but don't really expect. He came off all narcotics. He is going back to school to become a drug and rehab counselor. That's all in three months. So, I mean, thinking about just the cost alone to the healthcare system with that one patient should be eye-opening.

David Schechter: A***s we know in healthcare, 5-10% of the patients drive 80% of the costs***. Of course, a few of those patients have terrible conditions with cancer, or need a heart transplant, and those types of things that are very costly, ***but the costs associated with chronic pain and medically unexplained disorders are a big piece.***

David Hanscom: Right.

David Schechter: I've been looking for some corporate inroads as well to try to have an impact for those companies that self-insure. It's an uphill road, but I think we have the data and the evidence behind us. We'll continue to get more evidence. Obviously there are a few physician colleagues of ours who are publishing more and more research. So that's a benefit as well.

It's not that you and I don't want the people who need spine surgery to get it, we just believe that a very small number of people actually need it.
And that there's more that can be done for individuals with back pain, leg pain, neck pain, arm pain, and so on *prior to operating on them*. That's really why you wrote your new book, **Do You Really Need Spine Surgery?** *Take Control with a Surgeon's Advice*. And I'm so glad it is out there.

If the treatment is a tumor, mind~body treatment would be the inappropriate treatment right off the bat. You need to get that tumor taken care of.

So, just looking for the right treatment for the right patient—that's the logic behind it, and always has been.

David Hanscom: David, thanks for interviewing me. Are you doing a podcast right now or not?

David Schechter: I'm not, but I'm just glad to help you out here and interview you for this new book.

David Hanscom: All right, well I appreciate this very much, that was really enlightening and encouraging. We'll get in touch pretty soon. Thank you very much.

David Schechter: You're welcome.

Tom Masters: I'd like to thank our guest, Dr. David Schechter for playing the role of interviewer on this podcast today, and for sharing the perspective of the primary care physician on Dr. David Hanscom's new book, **Do You Really Need Spine Surgery?** I'm your host, Tom Masters, reminding you to visit us next week for another episode of **Back In Control radio** with Dr. David Hanscom. Please 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.