Dr. David Hanscom
BACK IN CONTROL

Evolving a Beautiful Collaboration to Heal Chronic Pain

An interview with Joel Konikow, MD
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 our guest on the program this evening is Joel Konikow, a family practitioner who specializes in the treatment of pain. Welcome.

Joel Konikow: Thanks Tom.

David Hanscom: Thank you, Tom. I'd like to welcome Joel Konikow to the show. Joel knows I'm a long-term admirer of his work, and he and I worked together for about seven or eight years at Swedish Hospital in Seattle. He is a person who really helped transform the entire process and one where people were consistently getting better. Joel is a family practitioner. He treated chronic pain and headaches for many years. I'm not totally sure how we had connected, but bottom line is that he was a major factor in advancing my work at the Seattle Swedish Pain Center.

I would see patients in my spine surgery practice and whether the patients needed surgery or not, I would send them to Joel. He worked with them on calming down the nervous system, adjusting medications, and otherwise helping them maximize healing. ***And it was with him that we literally watched hundreds of patients go to pain free, which is a huge paradigm shift, for both of us in terms of helping patients heal.***

Joel Konikow: I did my medical school education where I was born and raised. Well, undergraduate at University of Michigan in Ann Arbor and medical school, Wayne State University in Detroit, and then I went to the Boston area for postgraduate training at the Berkshire Medical Center, and then I came out here to the Northwest. I had a connection here because I had come out here and hiked and camped during the summers. I always loved the Northwest and it's still home—I came out here in '74 and I worked for an HMO. In those days, you didn't have to be board certified to practice, but I became board certified in family practice, and I left the HMO and started my own practice.

I got disillusioned early on because there were more and more regulations, what you could and couldn't do. And I didn't feel the general practice was intellectually satisfying for me. I felt that I wasn't using the skills and interests and talents that I had. In early '89, I went to a headache conference in Palm Springs. I hadn't had a vacation at a time. We wanted a family vacation, so we went down there, and Seymour Diamond of the Diamond Headache Clinic in Chicago was giving a talk at a conference. We went, and that changed my whole career.

It really changed my life. I was attracted to the field *as an underserved area*. People would *psychologize headaches*. Think, "Well, your pain is not real. It's in your head." And the second part of it was, it was underserved. The third part was it involved women, traditionally neglected anyway even though two out of three headaches, two thirds are women.

David Hanscom: I did not know that.

Joel Konikow: Yes. It's equal with boys and girls before puberty, but after puberty it changes. For every *one man* with a headache, there will be *three women* suffering a headache.

David Hanscom: Is that with all kinds of headaches that women predominate?

Joel Konikow: Migraines, migraines.

David Hanscom: Migraines, okay. Got it.

Joel Konikow: In "cluster" headaches. more men are affected, but cluster headache syndrome is very rare. With migraine headaches, however, after puberty three women have migraine for every man who has migraine.

Yeah. I talked with Dr. Harvey Featherstone here in Seattle, who was at UW, and I had known him a little bit, knew he was interested in headache and he helped me kind of get going. I kept my practice, but I started being interested in this and studied it. Dr. Joel Saper became a mentor of mine. He's a well-known headache specialist and pain specialist in Ann Arbor, Michigan, kind of serendipitously.

And so I studied, I went to headache conferences a couple of times a year, and I learned the field. I connected in Seattle with a doctor named Stewart Tepper, a neurologist. And it became a real focus for my practice. Over the years, I segued into general pain management.

The short of it is that the principles that we learned in the headache work are the same principles with pain sensitization, descending pathways, all these things apply to chronic pain in general. Another interesting thing about the headache world that parallels the experience of chronic pain elsewhere in the body is having the "problem" *psychologized,* and that's what attracted me to it, because *it was a chance to take care of people who were marginalized.*

It was at that time, an Italian physician discovered that there was a substance excreted in the urine of people who had headaches. ***And that was the first real biological marker to show that maybe there was something real about the people who suffered from this pain.***

David Hanscom: Right. Well, as you know, I was a migraine headache suffer for almost 50 years and those are real. I mean, headaches are horrible.

Joel Konikow: Right, right.

David Hanscom: Migraines are crippling and you can't find a structural lesion for them. You and I both know very clearly that when your body chemistry is off, that is *real. Just*

because you can't see bone spurs or another structural problem, it doesn't mean your body isn't reacting to it. And logically, it makes sense that *most physical changes in the body result from the body's chemistry*, *not some structural problem.* But migraine headaches, I mean I would have them every two, three weeks. They're gone, but my goodness, this is really a horrible problem. **You say, even people with migraine headaches are marginalized in medicine?**

Joel Konikow: I saw people with all kinds of headaches, so I acquired expertise in it, and I would diagnose the unusual symptoms, like cluster headache and the chronic but intermittent *hemicrania continua*. There are a lot of subcategories, but migraine is by far the largest, and ***most headaches are actually migraine***.

It was really just a positive experience. And what you're saying, I want to pick up on. ***It turns out that the brain is the progenitor of the headaches and actually really causes them.*** And yet there were all these other factors that made for both **acute intermittent migraine**, which is what people know, but *there's also* ***chronic migraine*** *which is a really, really difficult problem.*

I first learned in the literature about the work of a psychologist working with Dr. Saper. *Dr. Elvin Lake* published research on the factors that cause chronic pain. No surprise, but he reported that high Adverse Childhood Experiences (ACE score) like abuse and all kinds of other things factored into chronic pain and made the brain more sensitive from then on to pain.

David Hanscom: ***We now know that the brain flat out gets inflamed in chronic pain***. You have inflammatory changes in the brain and it can't be good. I mean, you have inflammation in the brain that can't feel very good no matter which way you look it. And just because you can't see it on a test doesn't mean it isn't there.

As far as your headaches, I'm just curious—you treated headaches primarily for 20, 25 years or so?

Joel Konikow: Well, it wasn't purely a headache practice. I treated headaches through my whole career. Even at the Swedish Pain Services, I treated patients with headache. It was a *sub, subspecialty*, I guess you could say, but I didn't only do that. The clinic was set up for treatment of chronic pain, and there was a lot of success with that which is one of the reasons I loved it.

Because by talking with people, you spend time getting a good history, which is the key. Medications management was increasingly a part of the practice for both acute and chronic head pain. ***We used opioids extremely rarely, if at all, and eventually not at all for headache.*** And that more and more there was research on some of the medications, non-opioid medications; **and then the triptans came out, sumatriptan and now about seven more triptan medications for acute pain, and that just changed everything**. But the treatment, I think people who worked with me and other headache specialists around the country and around the world got pretty good results. People who

stayed with the treatment, which included things like biofeedback and relaxation, did better. We didn't cure it, but we managed it so that they had a much better quality of life.

David Hanscom: Right. In the second part of our podcast, we're going to talk about your specific approach just in the last few years since you and I started to work together. You already have lots of success with headaches using medication management and relaxation techniques. I'm just curious about your evolution into the **DOC Project**—sometimes called the **Back in Control Project**—how have things shifted for you—how are things different now compared to back before we started working together.

Joel Konikow: ***Yes. Well, it's really a different world. Your (Direct your Own Care) DOC Project, as well as Howard* Schubiner's *Mind Body Program work that you introduced to Dr. Irving, and me as well as others here in Seattle, changed everything.***

I'll tell a personal story. I know we've talked about this I think. We met after you did surgery for my wife. I don't think she'd mind me saying this publicly. Yeah, I had met you in the office. But after the surgery, which went really well—she's doing well after almost a decade and a half now after the fusion, you got interested. We talked about what I did because the focus was on my wife, on Barbara earlier. And you got interested in the fact that I was interested in doing pain work and that set something off in you. And over the next couple of years, we met for dinner and we'd talk. And then I started going to the Swedish meetings that you and others were having at Swedish.

At that time, you were developing the DOC project. I saw it develop from the beginning. And by the time I joined Swedish, partly on your recommendations, you and I were set to work together. That changed what we could do. Because my mentor at the clinic between yourself and Dr. Irving, until then, we really didn't have much to help people with chronic pain. We could counsel them. We could reassure them. We could deal with the other issues around it. We used opioids when we had to. We didn't have any really great treatment.

Joel Konikow: With the DOC project, and then with Dr. Schubiner's work showing what we were dealing with really, the source of the chronic pain, we were able to help people heal with or without surgery. And most people who came in did not have a structural problem, did not have a disease in the classic way, but they had, as you say in your work, a brain on fire with inflammation; we had to calm things down and teach them another way to deal with it. We had success where you couldn't find success before.

David Hanscom: Right, so we started keeping a list. I don't know how long the list was at the end. We didn't get a complete list, but we had several hundred patients literally go to pain-free. The data shows that only 20% of physicians are comfortable treating chronic pain, less than 1% *enjoys* treating chronic pain. You and I had a good time.

Joel Konikow: We did. It was the best part of my career. It was the pinnacle of my career. I know we've shared that and I've shared that with others. It was because pain patients are in a tough spot, and I didn't have that so much with the headache patients I saw. But with patients with chronic pain of other types, there was kind of a *conflictual relationship*.

And with this work, we could be their advocates, not with everyone. There were other issues around opioids, that kind of thing. But I think it was a positive relationship on both sides. And part of it, the best part of it was for me personally, besides the joy of seeing people improve in their lives, is that I was improving in my life. And that's because both at work and home I was doing the same things when I asked patients to do. ***I was meditating too because that was just the right thing to do to understand its power***. And my chronic back pain started to evaporate when I used these methods. The other part was just the relationship you and I had, the success I was having the clinic, the wonderful staff there. It was just a mutually supportive network that just was a joy to do.

David Hanscom: Well, from my perspective, what you offered patients was *not having an agenda,* which was not very common these days in medicine. I mean, you were able to just wait it out—*just be with the patients*. And I still think the DOC Project is a framework that outlines documented, effective treatments in a structured manner and people can figure out their own solutions. It's basically a framework, but I still think that the essence of healing is the doctor-patient relationship, and that it is still probably the biggest factor in success with a patient.

What you're able to do is actually just be with the patients. Maybe they were ready, maybe they weren't, and the door is always open. People would flare up and you'd sort of wait that out. They would get better. You'd enjoy that with them. But it was unusual that, I think, maybe your pain practice background helped you do this.

When I was at Sun Valley doing solo spine practice, I did the same thing. I didn't have an agenda. I just simply worked with people where they were at a given time, and basically just gave them support and structure *for them to figure things out*. I don't know what you think, but usually within about three to six months most people got dramatically better.

What is so unusual to me is the fact that you are able to simply be with a patient. I still think that the essence of healing chronic pain, whether it's mental pain or physical pain, is feeling safe.

And when you feel safe, it changes your body's chemistry from a stress profile of adrenaline and cortisol to a relaxation profile, which is oxytocin and dopamine, which is a dramatic differentiator in your sense of well-being number one. But second of all, it actually slows down the nerve conduction and the pain actually physically disappears.

David Hanscom: I don't know about you, as patients as I saw get better, when I saw them walk into the office really essentially pain free, I'd go, "What?" I don't know how you felt, but I'm always continually amazed how dramatic the changes were and I think that's what it was pretty fun for both of us.

Joel Konikow: It was. It was. Yeah, I'm reliving those moments now that you say it, and I should say for whoever is listening, I retired about just about a year and a half ago, mid-March '18, not that long. I still go back and visit everyone. I love the people who I worked with.

I think that the time was really important. When Dr. Irving hired me, I said I want an hour with patients and he said I could do what I wanted, so I continued seeing patients for an hour, and often these were complex people with complex problems. I'd see them and for history and exam.

David Hanscom: Joel, I mean, the funny part for me, I would come out of my clinic literally every day. We see anywhere from one to three or four patients every day in clinic that were just doing incredibly well. And the thing that was exciting about the whole project is that these documented, effective treatments are something that patients do on their own. It's not a book that you read and you're problem is fixed. The issue is you have to learn and practice the tools that actually calm down your nervous system.

And once people learn those tools, they would "fail frequently". In other words, *they would have flare ups, but they had the tools to come out of the flare ups more quickly.* And then my sense was that they always get better over time. In other words, it wasn't something that they learned and went back into their old pain pathways. They would learn the tools, and then every month that went by, they'd just *get better and better at using the tools*.

Joel Konikow: Yes. And what I saw was, I called it a spark, and we would talk about this. You could see when people would take off—there was what I called a *spark* that indicated people saw things in a different way. They understood their pain differently, they weren't scared about it, and they were opened to going forward—***and they chose their own path.***

And what I did was, and sometimes I would be out of the norm in the sense that there were people that I let continue their opioids if they weren't on dangerous doses, initially, initially, until they felt comfortable. And when you said about safety, I think you really touched something that I think is really important. ***People do need that, and they need a place—they need space and they need time to heal.*** And I think we gave them that, and that was something really important.

Joel Konikow: I think the most important thing was learning how to listen. I continued to work on that myself. That was the thing that really made it a joy, *because it didn't drain me like it seems to drain other doctors dealing with chronic pain.*

David Hanscom: Well, again, part of the approach is an awareness of how strongly people want to feel safe. I was one of those people. I was trained that the way to deal with chronic pain and disability was to become tougher, more stringent, set boundaries, et cetera. It's the wrong thing to do.

Historically, most physicians including myself label patients, "Well, that's a pain patient," or this patient must be faking it or malingering. And when I talk to pain patients universally, every one of them feels like they're not really being heard. It's bad enough not feeling heard because you're going to the doctor to actually have your problems seen and heard. First of all, if you don't feel heard that doesn't feel very good.

Then I think the final insult is when you get labeled by your healthcare providers. Nobody likes being labeled. None of us like having it implied that we're not really speaking the full truth about our pain, or whatever we're doing to manage it. And the bottom line is in medicine, the chronic pain epidemic continues to grow, and we're not solving it as a medical culture.

Chronic pain remains a top issue in major medical centers and major conferences around the country. There are all sorts of things to do for chronic pain, but we're throwing random, simplistic solutions *without listening to the patient complaining of a complex problem—PAIN.*

By definition, the three parts of healing is first of all, understanding the problem, which means listening. Second is treating every aspect simultaneously like fighting a forest fire. And the third part is the patient taking over control of his or her own care. ***If you have a complex problem like chronic pain and each person is unique, really by that definition, the only person that really can solve the problem is the patient.***

I'd like to finish this section up by just talking about the last year in practice, because it felt like to me that you actually jumped in deeper with the project. Also, I felt like your patients were consistently getting better and more quickly. What were some of the final paradigm shifts that you experienced during your final year of practice?

Joel Konikow: Wow. Let me start by saying, I'm going to maybe go back a little bit to say something that I think is one of the most important things we didn't touch on. And then remind me, if I may, and you can stop me if you want because I have to think about that a little bit.

But what really was key, and I know the focus is on you and me and the work, but I want to say something that's really, really key and that is this--no one

provider can do this on their own with a patient. **No matter how well-meaning we are, how much knowledge you have, and even if you use the DOC Project,** ***this requires a team***. ***A great example of that related to the work you and I did together—you the surgeon and me the non-surgeon, because I relied on your judgment, and I know you relied on mine too.***

Sometimes there would be tough problems. Does this person have a structural problem? And you'd see them twice or even three times, but still say, "No, Joel, they don't." Other times, when I'd send a patient to you saying I think there's a structural problem, and you might say that time, golly, there is one. Sometimes people had to have another surgery. It was that kind of trust between you and me that was crucial. And just the support of the whole team was really huge in our success.

David Hanscom: I agree. It was very distressing to me, though, that treatments like biofeedback, meditation, relaxation, the different medication adjustments, most of those actually aren't covered by insurance. ***You and I'd be looking at a given patient and we know what the patient needed and we couldn't get it covered, incredibly frustrating,***

Joel Konikow: Right. Yes. Sometimes it was that way. Paradigm shift, that's a harder one. My paradigm shift really came early on with your work, the DOC project showing me a way. I went slowly. I wasn't sure about it. But as I started to work on it, I really saw how well people were doing under your care, and I mirrored and modeled that.

One of the paradigm shifts for me was the motivational interviewing which really helped tremendously in helping to engage people. Because one of the issues we had was there were a lot of people who came through the clinic, who you and I knew both in your clinic and mine that we took care together, that they could heal, but they didn't want to. ***They believed that they had a physical problem and needed more injections or surgery, whatever.***

I tried to work to help them in the motivational interview and engage them to have that ***spark*** come when they said**, "Aha, I see a path out of this."** I found motivational interviewing to be a huge change during my last year and a half in practice, just engage patients and making less mistakes, ***engaging them and being able to listen more to their ideas was a huge help to me.***

David Hanscom: Could you review really briefly the essence of motivational interviewing?

Joel Konikow: People who come in to see the doctor want change. They want *something* to change and yet, they're only willing—at each point—to do so much. And they have a culture and they have a life and they have a family history and they have a personal history and they have issues. We all have that.

At a particular time, a certain thing is right for someone. *Do they want to get off their opioids? How much time do they have? What are their resources? What else is going on in their life?* In motivational interviewing, the idea is to find out what will help each person **at this time** make that change and *commitment to helping themselves*, and how that would play out.

Again, it's profoundly helpful because it allows us to listen to them in a way that is therapeutic. So in considering all the treatments, you could say, "Okay, for Jane, path A is better. For Mark, maybe path Z is better." That was extremely helpful.

David Hanscom: Well, Joel, I need to wrap this segment up, but I really am excited about your approach, and I learned a couple of things myself that I did not know about how you evolved. I do want to mention one person. I can't mention her name, but you recently saw her at a conference. We both had worked with her. She'd been in chronic pain for 55 years, and she's been really free of pain for almost five years now.

The thing about her history—it goes back to asking a simple question, "What stresses are going on in your life?" ***Pain isn't stress, it's the chemical changes stress causes***. **If you're under stress, it changes your body chemistry *which affects every cell in your body. There are 50 trillion cells in the human body. Each one of them is based in the stress chemical pathway so it creates physical symptoms. And when it's sustained, people get sick.*** People in chronic pain die on the average seven years earlier. It's been documented that the effect of chronic pain on a person's life is similar to having terminal cancer. ***This is not imaginary pain***.

The critical question that was never asked of our shared chronic pain patient by her early providers 30 years ago when her husband committed suicide, and again 10 years later, when her son committed suicide, was simply "*what is going on in your life*." Nobody ever asked those questions about what was going on in her life, so her early providers missed the diagnosis. I mean, talk about stress. Her body chemistry was way off and *sustained* in that internal tissue-damaging way.

When she came to us, it took a while to help her calm down, but it's been remarkable to watch her go from 55 years of chronic pain to relatively pain free. Been really a remarkable ride, and that's just one of the people we worked with as you know. But yeah, ***just listening is a huge deal***.

Joel Konikow: Yes. I remember seeing her at the conference and it was a pleasure. I'm smiling warmly with a full heart just remembering meeting her again. I would tell patients, "I might know more about medicine, but you know more about what you might need and direction you might go." It was more than a friendship. It was a doctor-patient relationship, but they were at the center. We made put them in the center of care, and that's what motivational interviewing does.

David Hanscom: Joel, thank you very much. We're going to talk to you in the next podcast about the actual exercises and approaches you have used throughout your career. I'll let you spend a little bit of time on the opioid situation. I think you and I have a very similar philosophy about that, but I really appreciate your time very, very much. Honestly, Joel probably kept me going for five years longer in Seattle because we had such a great time watching people get better. It was a really remarkable experience.

Joel Konikow: David, you're welcome. Thank you. Take care.

Tom Masters: I'd like to thank our guest Joel Konikow for sharing the evolution of his practice in the treatment of pain. And I want to remind our listeners to join us next week for another episode of Back in Control radio with Dr. David Hanscom. I'm your host, Tom Masters, reminding you to visit the website at www.backincontrol.com.

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