Dr. David Hanscom

BACK IN CONTROL

The Conversation Every Spine Patient Deserves

An interview with Scott Phillips, 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 and Control Radio with Dr David Hanscom. I'm your host, Tom Masters, and our guest today is Dr Scott Phillips. He received his bachelor's degree at the University of Kentucky in his hometown of Lexington, Kentucky, and went on to complete his medical degree at the University of Cincinnati College of Medicine.

He completed a seven-year neurological surgery residency at Henry Ford Hospital in Detroit, Michigan As part of the Air Force Health Professions Scholarship Program, he then served four years on active duty as a staff neurosurgeon at San Antonio Military Medical Center. After honorable separation in 2017, he served the citizens of San Antonio, Texas, before relocating his practice to Wichita Falls and the greater North Texas area.

Welcome.

David Hanscom: Thank you, Tom. I'd like to welcome Scott Phillips back to the podcast. He's a neurosurgeon practicing in northern Texas. He trained at Henry Ford Hospital, and in the first podcast, we told you how we met. And in 2022, he started working with me. He joined our scientific group, and he's gone through a big evolution in his practice.

But what we still wanna focus on this segment is there's a reality of spine surgery that just is not conveyed to the world about things patients hear when surgeons talk to them, decisions made, I think, on false information. I think Scott agrees. And our goal is to give people clear indications of why you should or should not do surgery, what to expect of it.

But more importantly, right, on this podcast, we wanna talk about what people hear that gets construed that I have to have an operation. And very little s- elective spine surgery is, quote, "needed urgently for sure," often not needed at all. And we talked in the first podcast how there's a major downside to failed surgery where people's lives are really just flat out really destroyed, and that's what w- I get to see all the time, and actually why I quit my practice, 'cause I've seen so much of that.

I've seen really badly done surgeries five, three to five times a week. Then, again, we're not gonna talk about this today, but, you know, I was watching hundreds of

patients go to pain-free with minimal resources, no risk, compared to people really having bad results with surgery that just wasn't needed. So Scott, let's jump b- back into this again.

We had a conversation between episodes that I think was really relevant. Um, which one of these things that patients hear that sway their decisions that you'd like to address?

Scott Phillips: Well, you know, very often, I mean, we don't give a, a very clear presentation to the patients as far as what surgery is. And so one of the things that I see, either it's said directly or the patients receive it, is that they went through all of this imaging and they saw the PAs, and then finally they met with the surgeon, and the surgeon said, pointed out the structural the things they saw on the, on the X-ray, and then they said, "You know, I think you should do some more steroid injections or whatever."

So the patients walk out feeling like there is something wrong with their spine and that they, they could see it on the image when they were showed it, but f- they weren't offered surgery, so they, they walk out feeling like, you know, maybe it's bad, but it's not bad enough yet. And, you know, in that situation, if a surgeon doesn't have a, a surgery, they should say why there's no surgery, and this is why your book, your second book, um, Do You Really Need Spine Surgery?, is important because it shows what matches with a good surgery and what doesn't. And very often if there's no surgery, we just, we don't explain that there is no surgery. Another problem that I have in, in talking about things that are not surgery is that, one, people forget that I do surgery. People forget that there are some excellent surgeries.

People think that I'm a pain management, um, kinda doctor. And, a- and it's hard to let them know that all of the other things besides surgery are not, like, instead of. I don't take a patient with an excellent surgery and then offer them, um, a neurostimulator instead or offer them some kind of a pain science program instead of surgery.

It's just the fact that surgery's not even really on the table. And, and people have a hard time seeing that because surgery is always thought of as this last resort, like this just end of the line type of a thing. But in most cases, it's just not even,

for me anyway, I mean, there are people who will offer surgery for less, but if it's not on the table you can't think of that.

And so, um, that's some of the problems I, I see is us not really explaining what the surgery is and why we're doing it and the components of the surgery. Uh, and then from that, sometimes people get upscaled on surgery, but then when there's not a surgery, they don't explain why there's not a surgery.

David Hanscom: Well, it's a big problem that I 100% agree with you with, and I'm glad you brought it up because if surgery is always in the background, you never can really lean into true non-operative care. I'll do this and this and this. Exactly. And when it gets bad enough in a year or two, then I'll do the surgery, then my life will change.

And first of all, like you said, surgery isn't even on the table because there's not a surgical lesion, and surgery is a definitive answer only for a definitive surgical problem. And we're not gonna go into that today, but that's what my book... why my book was written, because I wanna identify what problems are amenable to surgery, which ones are not.

And then even if you have a surgical problem, if your nervous system is fired up, we call it type B or an excitatory nervous system, the results are often worse even with the right operation. So that's why we do a process of calming the nervous system down before every elective surgery. And as I mentioned in the first podcast, I had over 100 patients, as we calm them down with do- with strategies before the surgery, the pain would often disappear because the pain threshold was changed.

So the ex- the, uh... Y- you're right, that's a very important point that I had forgotten about, is that there's always expectation that surgery is a definitive answer. I'm basically gonna be treading water until I get the surgery. Um, it's a disaster

Scott Phillips: Yeah, a-absolutely. When there's not a surgery, they should know that.

But instead they're just cast off to the same, um, conservative therapies that... I wonder what doctors will say, 'cause if you say, "Hell, you know, you should try acupuncture or chiropractor or whatever," um, if they've never tried it, that's kind of maybe a good recommendation. But what do they say to the patient that says, "Well, I actually already did that, like 10 times, and all the things I- all the things you told me I should do right now I've already done"?

And so I don't know how doctors, uh, surgeons get out of the exam room i- in that situation, but they usually find a way to shuffle out.

David Hanscom: Right. So the thing that's changed for me, in 1993 when I found out the results were so badly, I quit doing surgery, but I did not have an alternative. So my first seven years I felt guilty if I could not give them a definitive answer.

And then for the patients it's devastating because I am the definitive answer, quote, being a surgeon. I could not give it to them, so what do I do now?

Scott Phillips: You know, David, you just, you just hit a chord with me. Uh, I think that's the, I think that's the number one thing that's kept me on this course and, and maybe it's, it's not altruistic.

Maybe it's because I have wanted to know a- and I felt inadequate if I couldn't, um, kind of fix a problem. I mean, we didn't, we didn't go into surgery to manage anything long term. We go- we went into surgery for a definitive fix, and then through my training and experience, you find out that there's not...

In the office setting, again, outside of emergency situations and whatnot and, and just the usual case, there, there just is not something to fix. And then also just even wanting to understand, well, if I can't see it, where, where's it coming from? Like it has, it has made me feel inadequate and, and, and that's why s- that's actually why I stayed on, on the path

David Hanscom: And life is different now, isn't it?

Scott Phillips: Yeah, no, I feel like I have a clear understanding. And, and my job in, in the clinic is to, um... Well, gosh, I spend a lot of time undoing, um, some of

the beliefs that people have, at least trying to. But bottom line is my job is to do the evaluation, see if there's a p- symptom that matches with the surgery.

If it does, I can explain that surgery. I can explain it- that it is, it is an option because usually it's, it's an option. Um, and then I can explain how good of an option it is. If it's a really good option, I'm gonna really get behind it and, and say, "Yeah, this is the best option for you." It might even be an option that I don't wanna take, and I'll say, "Maybe the risks are too much, but this is an option.

It's on the table." But the vast majority of the patients then I'll shift over into, "Well, what else can I do?" And that's where I explain the, the usual things that everyone knows about, physical therapy, acupuncture, chiropractor, um, you know, you name it, spinal injections. But at the end, after that, and I- I've actually kind of u- used language that kind of leads up to this, but then I'll s- I'll mention your book, I'll mention the Boulder back pain study, and I'll say that there is one more thing you can do.

And not only can it be a treatment, basically learning about the pain system, um, and I call it pain science, but learning about it is its own treatment. And then it also provides, if you get into it, it also provides an explanation for why it is there. And I just say it, like you said, I took your advice.

Don't go, don't try to convince everyone, just mention it briefly, which I do. And if patients ask questions, I'll tell them more. If they call me back, I'll help them through, and those are the ones that get better. But there's a lot of patients that, that I never see again. And the bottom line is I've done my job.

I've given them the full surgical assessment. I've told them all of the options they can do, including the ones that most people don't know about yet, which is the pain science. And then I've done my job. I can't fix someone, but I can show them the answer. And so I have been sleeping very well at night knowing that I've done my job.

And to not mention, um, the pain science, I think would be unethical because it is an option and it, it does provide an explanation that has been missing for, I don't know how many years, 100 years?

David Hanscom: More. So my route is a little different. So I went through that phase you're in right now, and I think as you go along that you'll probably go a d- a little bit different direction also, but that's my entire... So I did not quit my practice to manage chronic pain. So I wrote the book 'cause I got tired of explaining it, plus I couldn't do it.

Mm-hmm. And people read the book and nothing would happen. Then I developed a website, and then a course, then as people go through the course and learn the skills to calm their body down, pain results. So I've evolved into teaching people the skills to calm it down or reroute the nervous system. And over three to six months with repetition, the brain really does go away.

So my practice has evolved to hopefully interact with even with yours to say, "Look, okay, surgery's not an option." But the reality is with the pain science, this is not a theoretical solution, it is a definitive real solution. The pain really does resolve. So the problem is I used to feel guilty about not offering surgery, 'cause I'm held up as a definitive answer.

I have nothing to offer. Mm-hmm. To really say that you get to live with pain the rest of your life. And in the Family Practice Letter in 2002, this term came up called medically unexplained symptoms, MUS, which means- Mm-hmm ... we believe you have the pain, there's not, not much we can do. We can help you along, but you're really stuck with pain the rest of your life, which is a disastrous diagnosis. MUS is not a helpful diagnosis So I still want to come off this one for a second because I, I just want to talk about one more thing surgically, and I think we should have another podcast expanding on what you do as far as alternatives. But I really admire you for just being real distinct, really clear, not tossing people on, I call it the surgical scrap heap, that you do a failed surgery, they're on the scrap heap.

So when surgeons think the same way, I did my job, I did the surgery, it didn't work, have a good life, right?

Scott Phillips: Yeah.

David Hanscom: Huge problem. So we both talked about this before, surgeons often don't see the patients postoperatively. I follow all my patients indefinitely,

including the failures. So I like to address the fact that, and I'm became really fired up about this because often patients are seen by a PA, maybe the surgeons, then the postoperative care is done almost completely by PAs or nurse practitioners.

If I see you as a patient, nerve symptoms, see the scans, do the surgery, but don't know how it turned out, how do I get-- how do I improve my decision-making as a surgeon? I don't see my patient afterwards to see all these decisions resulted in this. I don't care what the research shows. If I don't know how you did as my patient based on all my data, how do I get better myself with my decision-making?

Scott Phillips: You're absolutely right, but that, that doesn't, from a business model standpoint, that's not very efficient. I mean, the most efficient way to make money is to see as many patients as possible and do as many surgeries as possible, and if you don't have to see all of them, the PAs can quote, "screen them."

And I've heard people use the term “work them up,” and work them up just means check boxes like they failed this, failed that, failed this, ordered a bunch of X-rays, and then they finally meet the surgeon. So yeah, it's not a good, not a good business model and it really is not, not good care. I mean, and not, not all surgeons do that, but you know, they do care about their patients, but sometimes the, in a busy practice, you don't get that.

You know, speaking of the business part, I mean, I, you know, because I explain to patients, uh, very well what the problem is, very often m- the best candidates for surgery, um- end up getting better. And sometimes it's a radiculopathy, which is a nerve root irritation, and those do resolve, and usually... Well, they get better, and they can sometimes resolve.

But when I explain to them exactly what it is, exactly what's causing it, telling them that it probably will improve and we don't know how much, but if it's still there and you don't like it, there's a surgery, so then they're not trapped. They realize that the tingling is not a sign that they're gonna be paralyzed.

And so I don't know what happens. Well, we know what happens, but, you know, sometimes I think that lowering the defcon level actually makes it to where

maybe they feel it, but they're just kinda not bothered by it, and so they don't call me back to, to do the surgery. I mean, sometimes they do, sometimes they don't.

But I think by explaining it well, lowering the threat level, I'm actually helping the symptoms and helping the recovery and, and almost shortening or, or lowering the number of patients that I can take to the operating room.

David Hanscom: What happened in my practice in doing exactly what you said, normally surgeons operate almost 20% of the patients they see.

Um, the s- this historical average was about 10%, but in modern day it's about 10 to 30%- I'm sorry, 20 to 30% of people get surgery when they walk into a surgeon's office. And what happened to me is that I was operating on less than 5% of my patients, and a lot of them were surgical patients that get better with time.

So my hospital actually literally hated me. It's a long story. We can talk about that a different time.

Scott Phillips: We don't get paid nearly a much to talk and explain things to patients as we do to do something to them or order something for them

David Hanscom: And I had three administrators tell friends of mine inadvertently how happy they were glad to see Hanscom retire. It was unbelievable. So for me personally, though, I mean, it w- became financially awkward, but as you know, there's nothing more rewarding to see a patient get better with surgery or without surgery.

I would say, "Look, we're trying to get you better with or without surgery. It doesn't really matter to me. And if they get better without surgery, great. If they get better with surgery, great." So the business model in surgery particularly has really distorted our spine care.

We can tell dozens of str- I, I mean, I just had a friend of mine from the Midwest show me his scans after neck surgery. Mm-hmm. And he's actually in the medical world, and the surgeon, he's 70-some years old, and- Mm-hmm ... his scan looked like he was 30 years old. A completely dead normal neck MRI scan.

Completely normal.

Scott Phillips: So minimal degeneration for a 70-year-old?

David Hanscom: No degeneration.

So, I mean, it happens all the time. So that's what makes me nuts even talking about this, is just seeing so much... First of all, he's probably not gonna have a major complication, but think of the money society just spent on operating on a completely normal spine for any age.

Scott Phillips: So quite frankly, people-- no one wants to have surgery, but they go in, in, in a last resort, end of the line kinda mode. You, you know this. If you wanted... Nobody wants surgery, but if... I mean, I, I, I've made the comment before that, if I wasn't, um, you know, following my Hippocratic Oath and being ethical, I could probably talk 90% of patients into surgery.

Absolutely. I'd just say, "See this disc? This disc- Yep ... is what's causing your pain. It looks horrible. It's a small surgery. We'll be in and out, just gonna clean things out," and just be vague. And I, and, and nobody wants it, but people, people sign up. People become desperate

David Hanscom: So I agree about the desperation part of it.

I really did not understand for a long time if, when I said no to surgery... Well, I... first thing, you said something that triggered my thinking here is that as a surgeon, the way we think is that they come into my office for surgery, that they really want surgery. I learned - Nobody wants surgery ... that even if the surgical problem, they didn't wanna jump right into surgery.

They wanted to see what happens. So you're correct. Nobody really wants surgery. They wanna get better. Correct. And when you take away that hope, of course, things get desperately worse. It's a problem. So we only have a couple minutes left here. Um, do you wanna just briefly mention the upscaling of surgery, which is a huge problem?

Scott Phillips: Yeah, and this is, you know, there are some, there's some other doctors, like primary doctors that, that kind of see through it, but most don't because it's really been such a convention that we just get surgery, and if the MRI has a bunch of findings, they end up getting surgery, and no one really reads the notes to see what the symptoms are.

So your, your book really defines like what are good symptoms and what are good matches. But the bottom line is, is that someone might have an isolated nerve that's being irritated or pinched or whatever term you wanna use, and a small surgery to create space on the one side of the body, right or left, would make that pain go away.

But sometimes the surgeons will find reasons to do more. Like instead of just a one-sided surgery, they might do a whole fusion and create space on both sides and do instrumentation of the segment. Now coming out of the back end of that surgery, the patient's gonna say, "Great, my leg pain is awesome." And they will never know that they could have had the same result with a much smaller, less risky surgery, and the doctors don't know that either.

And then I, I'd love to hear your comments on this. You know, if you, if there is a reason to do a, a fusion or a instrumentation, very often I've seen even, even people that I love and adore, um, colleagues, you know, make an argument that, well, we're gonna do two levels or maybe the above and below because, this one looks really bad and it's just gonna be a matter of time before this, this adjacent segment disease, uh, or degenerative disc disease.

And so then a one-level fusion becomes two or three levels. And if the one level, again, was the symptomatic level and the outcome is gonna be great, like less back pain, the patients and the doctors will never know that they could have had that same outcome with a lesser surgery. So it's almost like doing a shotgun and hitting your target, but nobody knows that you could have sniped that with a much safer, smaller surgery.

David Hanscom: I mean, the problem is- It is prophylactic ... there's a bunch of things happening. First of all, you, you have a bigger operation than you need, which is a higher complication rate. Um, second- secondly, the longer the fusion,

the longer the lever arm, the higher the chance the spinal will break down within three to five years.

It just flat-out mechanics break down. So what seems like, quote, "prophylactic surgery" is actually creating a whole nother set of surgeries that never needed to be done. So Scott, we're sort of out of time. Well, I know we're just getting warmed up. I think we're gonna do another few podcasts here over the next few months to sort of keep rounding this out.

I don't get to talk to surgeons very often that have your same viewpoint. There's a few. So in my world, the more I put this non-operative stuff out there, which has been consistently good, um, there's more and more resistance in the surgical world. So we're making progress in the whole medical world in general about the neurophysiology of pain and the pain science, but I don't know about you, but I see the surgical world digging their heels in even more.

Scott Phillips: Well, yeah, I mean, it's an infrastructure that's been there and it's a convention. And quite frankly, I'm not trying to criticize other surgeons. I mean, sometimes that's just what they're trained and, um, they're doing maybe, what I would say is the wrong thing, but they're doing it for the right reason.

David Hanscom: Well, they just don't... They might not know.

Scott Phillips: I agree. And I would love to talk more surgical topics, especially with you, who's, like, a complex spinal surgeon and understands everything. But yeah, a book club would be great for y- for your book. I think your book deserves more attention. I think more doctors and patients should read it.

David Hanscom: That's a great idea. So Scott, um, you are in North Texas. As you mentioned, we can find you on Google, uh, but you have a website. What's the website name, Scott?

Scott Phillips: Yeah, my practice is called Excelsis, like Gloria in Excelsis. It's Excel, S-I-S... E-E-X-C-E-L-S-I-S, and it's excelsis.life, L-I-F-E, as in to live a good life.

So excelsis.life or search Google for Dr. Phillips neurosurgeon.

David Hanscom: Okay. Scott, thank you. It's always a lot of fun. We have a lot more things to come in the next few years, so it's great to talk to you.

Scott Phillips: Okay. Goodbye. Thank you, David.

Tom Masters: I'd like to thank our guest, Dr. Scott Phillips, for being on the show today and explaining how he shares the principles of pain science with patients in his own practice to help them better assess the risks and benefits of back surgery.

I'm your host, Tom Masters, reminding you to be back next week for another episode of Back in Control Radio with Dr. David Hanscom. And in the meantime, be sure to visit the website at www.backincontrol.com.