

New Combinations of Pain Therapies

An Interview with James N. Dillard, M.D., D.C., C.Ac.

Russ Mason, M.S.

James N. Dillard, M.D., D.C., C.Ac., a pain specialist who wears many hats, may be unique among health care practitioners. He received professional training first in acupuncture, then in chiropractic, and then as a physician. Studying these disciplines, in that sequence, shaped his worldview about healing, his approach to wellness, and the way he treats patients.

Dr. Dillard is an assistant clinical professor at Columbia University College of Physicians & Surgeons, New York City, and he is on the medical staff at the New York–Presbyterian Hospitals Columbia Medical Center, New York City. He is also an attending physician at Beth Israel Medical Center, New York City, in the department of pain medicine and palliative care.

Dr. Dillard is also the medical director of the Richard and Hinda Rosenthal Center for Complementary & Alternative Medicine at the Columbia University College of Physicians & Surgeons. This center has been given a grant by the National Institutes of Health's National Center for Complementary and Alternative Medicine for research and education.

Serving as the course director of the Continuing Medical Education (CME) conference on Integrative Pain Medicine, which is now in its sixth year, at the College of Physicians & Surgeons, Dr. Dillard is also the founding and ongoing medical director for the Oxford Health Plans (Trumbull, Connecticut) Alternative Medicine program.

Dr. Dillard has lectured extensively on complementary and alternative medicine (CAM), pain medicine, nutrition and dietary supplements, acupuncture, chiropractic and manual medicine, natural health, and the integration of CAM approaches into conventional medical delivery systems. His clinical practice is focused on integrative pain medicine and general complementary and alternative medicine.

Russ Mason: I think you are one of the few M.D.s whose practice is wholly dedicated to managing pain from an integrative medicine perspective.

James N. Dillard: Yes, pain is an area of medicine I feel strongly about and have a great deal of passion for, because there are a lot of people who are suffering. There are also many practitioners

who suffer, because they have not been given the tools to help the 60 million people who are suffering.

RM: After colds, the number-one reason for office visits in the United States is for pain. And yet, the current medical model does not seem fully equipped to help patients who suffer.

JND: Yes, but it's not that pain control is consciously avoided. It's that in medicine and in medical school, we tend to focus on conditions that kill people. That is understandable, so I am not indicting conventional medicine. But we know that people get sick and die; they have car accidents and die; and they get cancer and die. So we get very focused on those things in medicine, and rightly so. I understand the emphasis, and I am not unsympathetic.

The problem is, along the way, some of the suffering gets neglected, and that is not a conscious decision. I am not alone in this assessment, by the way. It is something that many health-policy advocates have said. As well, the Joint Commission for Accreditation of Healthcare Organizations [JCAHO]—that accredits all 18,000 hospitals in the United States—has, since 2001, mandated pain is the 5th Vital Sign™*

RM: What does that mean, exactly?

JND: It means that every time a doctor or a nurse in a hospital takes a person's blood pressure, temperature, or pulse, the doctor or nurse also must ask the person how much pain the patient is in, on a 10-point scale.

This came about because the Joint Commission decided that hospitals were not doing a good enough job with pain. That is because we, the medical profession—with our 125 medical schools and 18,000 hospitals—were not spontaneously taking

*The American Pain Society created this trademarked phrase. For more information, visit: www.ampainsoc.org/advocacy/fifth.htm The JCAHO has declared that pain should be treated as a vital sign in order to elevate awareness of pain treatment among health care professionals. For more information, visit: www.findarticles.com/p/articles/mi_qa3977/is_200309/ai_n9274424

care of this problem ourselves. So the Joint Commission held our feet to the fire and said, in essence: "You're not doing a good enough job treating pain, so we're going to step in and say: 'You must assess pain; you must reassess pain; you must treat pain; and then you must reassess it again, or you will be on probation as a hospital.'"[†]

RM: The Joint Commission can do that?

JND: Oh yes, they can do this every 3 years. If you want to throw a hospital into a panic, just mention JCAHO to an administrator or the chief of the nursing service. Yes, the JCAHO can do that; the organization assesses how a hospital is doing with the treatment of pain.

And, if you read the Guidelines for the JCAHO mandates, they talk about the nonpharmacologic necessities for part of this plan, and they mention that this *can* and *should* include alternative and complementary therapies. This is spelled out in JCAHO's Execution Guidelines.[‡]

So an integrative approach to pain control is not my fancy idea. Yes, I may be one of the few doctors in the country that focuses solely on pain and trains other doctors at academic conferences, and it is the banner I personally wave, but other really smart people—health care policy people and regulators—also came to this idea.

RM: What kind of mandates are health care practitioners who treat patients with pain in a hospital setting obliged to observe?

JND: According to the JCAHO Execution Guidelines for the pain mandates, it is not enough to simply "dial up the morphine." That is not O.K. The hospital must have other pain-control therapies and treatment options, such as physical therapy, psychological therapy, massage, acupuncture, mind-body therapies—they are all in the JCAHO guidelines. So, if you are a hospital system and you want to be in compliance with the JCAHO guidelines, the easiest thing you can do is to say, "O.K., I see that we can't just give everybody morphine. So we will have a pain psychologist available on the floors."



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This is important because with chronic pain—not just acute pain—there are elements of anxiety and depression. . . a sense of catastrophe. There is a mix of psychologic factors that go along with pain, and a good pain psychologist is trained to assess and to deal with these situations. As well, there is an emotional component to pain, and treating that, along with the physical, actually leads to better outcomes for the patient. Therefore, having a multidisciplinary approach to pain yields better results than a single-tool approach.

Another benefit to the multidisciplinary approach is that the program can be adjusted to meet the needs of the patient, since everyone is a little different. And, I might add, many of the various alternative and complementary therapies deserve a place in the toolbox. First, people are using them anyway, and, second, because they really do help people. Inclusion of these therapies helps to round out the overall scope of what can be useful for people who are suffering.

RM: Why do people in pain seek out alternative therapies?

JND: The first reason is that they are not happy with what they have already been using. One reason is that most physicians do not have adequate training in treating pain, or have not done a good enough job in treating pain. The second reason is that, in general, patients are not happy with medical delivery. Again, that is true, in general, in this country at this time. There are a lot of other socioeconomic reasons—47 million Americans are without health insurance of any kind.

Another reason patients seek alternative therapies for pain is that they don't like the answers they have been given. They have sometimes been given powerful, harsh, reductionistic treatments and they are not happy with them. They have been given the "dial up the morphine and inject everything" answer, and they don't like it. They hate the drugs and the way the drugs make them feel.

RM: As an M.D., you have the option to prescribe medications for your patients. Is that something you do?

JND: Yes. I write prescriptions for morphine, for methadone, dilaudid, and all the mixtures of poisons that everybody else in the pain field writes up every day. I've been prescribing these medications for years.

[†]In 2001, the JCAHO initiated new pain assessment and management standards. The standards applied to hospitals, health plans, and organizations that provide ambulatory care, assisted living, behavioral health care, home care, and long-term care. For more information, visit: www.jointcommission.org/AboutUs/joint_commission_history.htm

[‡]Weeks J. C.A.M. Complementary & alternative medicine: JCAHO includes CAM therapy. *Health Forum J* 2002;45(2):33.

What's different about my practice is that I am very judicious about how I use pharmaceuticals, and I take every possible opportunity to do other things to reduce the need to prescribe.

RM: What does research tell us about the effectiveness of integrative therapies for pain?

JND: That is something that has increased dramatically since 1990. There has been a burgeoning of research in alternative and complementary medicine in general. The research in acupuncture has increased tremendously and has been published in peer-reviewed medical journals.

But research has explored alternative medicine for a variety of conditions and a variety of techniques. This covers everything from mind-body medicine to massage, to herbal supplements—so many different areas. Even aromatherapy has got some research on it. Yoga is another option that has been useful for back pain. There are papers coming out every day that justify the use of some form of integrative medicine, which are included in the JCAHO guidelines.

RM: What was it that motivated you to specialize in the treatment of pain?

JND: It goes back to when I was a kid. I had a spinal disorder, and I had a lot of pain. I was treated by a chiropractor, and that helped a lot. At the time I didn't have any particular belief system but this treatment got me interested in treatments that were unconventional.

Then, while attending UCLA [University of California, Los Angeles], a good friend of mine was studying the Chinese language and also acupuncture. I was his "guinea pig," and he actually helped me quite a bit.

RM: Were you in a premedical program at the time?

JND: No, I was studying molecular biochemistry, doing research on monoclonal antibodies. I was a science "geek" and never had any interest in practicing medicine. But when my friend did acupuncture on me, I was surprised that he could push on one spot and I would feel a sensation in a totally unrelated part of the body. What was *that*? So this whole other world opened up to me—that there might be these energetic channels. In terms of the Western science I was trained in, this made no sense. So that piqued my interest in Chinese medicine and I decided to study it, and also chiropractic. This led to establishing a practice in California, which I did for 2 years.

After 2 years of practice, I became more aware of the medicines and surgeries, and I started to become curious about how medications work. I also wondered how a surgeon could cut someone open without killing the patient.

My curiosity in conventional medicine got piqued by being involved with other professions—chiropractic and acupuncture. So, in 1986, I entered medical school. When I got my M.D. degree in 1990, I trained in internal medicine, then in rehabilitation medicine, and subsequently in pain medicine.

In the end, I became a chiropractor, an acupuncturist, and pain physician, and I am on the faculty of the Columbia University Medical Center. I am pretty sure I am the only person in the U.S. with this background. I don't recommend it—it's definitely obsessive-compulsive.

RM: I think your background—especially the sequence of studying healing disciplines—has been significant.

JND: Ninety-nine [99] percent of the physicians who are involved in the CAM world became physicians first; they went to medical school first. So, what was imprinted on their brains—in terms of health care and how people work—was the medical model. There is almost nobody who had rigorous alternative and complementary training first, prior to going to medical school.

I make this point because I think there is an enormous difference in the way one thinks about people, about health and healing.

I have a friend, who is a bit like me, and we both think very differently with respect to our approaches to healing. That person is Tieraona Low Dog [M.D., Tucson, AZ]. She is a Native American healer, a third-generation herbalist, and a nurse-midwife, who practiced for years before going to medical school. She has a unique, extraordinary understanding of health and healing that the vast majority of physicians who are now involved in CAM practice do not have. She is a person I look to as a touchstone for wisdom and understanding.

Therefore, Dr. Low Dog and I both think very differently from most doctors with respect to our approaches as though we perceive health and healing through a unique kind of lens. Also, with chiropractic and acupuncture, the practitioner spends a lot of time touching the patient. . .the hands are a therapeutic component, and that orientation is so completely absent in medical school.

RM: How have you shared your findings with other physicians?

JND: In a number of ways. The PBS special [Chronic Pain Relief, aired from 2003 to 2005 on 107 PBS stations] was helpful to many—including laypeople who suffer. As well, I have a book that provides a lot of information to practitioners and to those who suffer. [See box entitled Resources.] We have conferences on integrative pain medicine, which health practitioners can attend. This is my sixth year of offering conferences on pain.

There are two processes going on. The first is the process within conventional medicine exemplified by the JCAHO process, and there are other educators in the pain field, such as Russell Portenoy [M.D.], at Beth Israel Hospital [New York City] and others around the country. There are professional organizations, such as The American Pain Society, the International Association for the Study of Pain,[®] which is an international group, the American Chronic Pain Association, and other groups. All have been educating physicians and have excellent conferences. These are significant efforts from the conventional medical field. [See box entitled Resources.]

A parallel process is going on in the alternative and complementary medicine world, which is something I am spearheading, along with Brian Berman, M.D. [Center for Integrative Medicine, University of Maryland School of Medicine, Baltimore]. Dr. Berman is doing great research, particularly in arthritis and integrative medicine.

We are engaged in convincing the physicians, nurses, and other practitioners who are involved in alternative and complementary medicine that the treatment of pain is a big part of what

they are doing and that an integrative, multidisciplinary approach is best. There are so many other people also treating pain—the massage therapists, the chiropractors, and the acupuncturists. So, as physicians, we need to work hand-in-hand with them, in order to create integrative care plans with our non-physician colleagues.

This is important because, if a patient is on a pharmaceutical, how does this make an impact on his or her acupuncture treatments? If the acupuncturist suggests more “warming” foods, will this interfere with homeopathic remedies? The poor patients! They often get left in the lurch and are confused. Communication is essential.

RM: In your book you state that pain can take on a life of its own.

JND: Yes, that’s right. What often happens with patients who have chronic pain is that there is a dwindling spiral that they experience. It is like the water going down a drain. They have chronic pain, and this leads to anxiety and depression; these factors lead to more discomfort; they gain weight, they become sedentary, stiffer, and weaker. This makes them more depressed and more anxious, and they feel more awful about themselves. And they just spiral down.

So my efforts in education with Columbia University’s Integrative Pain Medicine Conference, and the materials I have produced, are designed to help continue and strengthen the dialogue, the communications, so that the practitioners will talk with each other and so that the patients will talk with the practitioners. In this way, we can arrive at a sensible care plan for those who suffer.

RM: You are varied in your approaches to treating pain. Please describe some of the therapies you use in your practice.

JND: Yes. I have a couple of combinations that I use that I don’t think anybody else is using. I think that, with my background and training, I have tried almost every combination of treatment over the years that you can possibly imagine.

There are certain combinations for certain patients, that I have found work better than other combinations. This makes sense since, if you try various combinations of treatments, for different kinds of patients, over a 25-year period, you arrive at certain therapies.

This is also true of pharmacotherapy. We know that a little dose of certain antiepileptic medications, with a little dose of the tricyclics, with a little dose of an antidepressant, can sometimes make people feel a lot better. But that is not enough. You have to get people back to their exercises and stretching programs. You have to address their psychologic issues, and you have to get them on better diets. That is a conventional combination.

Every pain sufferer should be given relaxation and breathing routines, to be used daily for pain flares; and mind–body therapies are key foundations to the integrative approach to pain.

I use a combination of some hands-on techniques that I have learned from people who are smarter than I am, particularly from some of the “old-dog” osteopaths. I’ve got a few basic stretches that I do, and some digging in—things that I do with my hands. There are also certain acupuncture points, and combi-

nations of points that I have learned from skilled Chinese acupuncturists, and specific ear acupuncture points that I use. I use some very specific injection techniques, on acupuncture points, with a syringe and needle.

Resources

Organizations

American Pain Society

4700 West Lake Avenue

Glenview, IL 60025

Phone: (847) 375-4715

Fax: (877) 734-8758 (toll free)

E-mail: info@ampainsoc.org

Website: www.ampainsoc.org/

Creator of the trademarked phrase “Pain: The 5th Vital Sign,™”

the Society advocates for improving the care of patients with pain by working for such goals as ensuring access to treatment, removing regulatory barriers, and educating practitioners and policy makers about advances and economics in pain management.

International Association for the Study of Pain® (IASP®)

IASP Secretariat

111 Queen Anne Avenue North, Suite 501

Seattle WA 98109-4955

Phone: (206) 283-0311

Fax: (206) 283-9403

Website: www.iasp-pain.org/

Founded in 1973, the IASP is a nonprofit professional organization that promotes research on pain and works to improve care for patients with pain. IASP membership includes scientists, physicians, dentists, psychologists, nurses, physical therapists, and other health professionals actively engaged in pain research as well as individuals who are interested in the diagnosis and treatment of pain.

American Chronic Pain Association (ACPA)

P.O. Box 850

Rocklin, CA 95677

Phone: (800) 533-3231

Fax: (916) 632-3208

E-mail: ACPA@pacbell.net

Website: www.theacpa.org/

The ACPA facilitates peer support and education for patients with chronic pain and their families so that these patients can make their lives more full despite the presence of pain. The organization works to raise awareness in the health care community, among policy makers, and in the public about issues of living with chronic pain. Patients can be directed to the ACPA for support and to obtain information.

Book for your patients

The Chronic Pain Solution:

Your Personal Path to Pain Relief

The Comprehensive, Step-by-Step Guide to Choosing the Best of Alternative and Conventional Medicine

By James N. Dillard, M.D., D.C., C.Ac.

with Leigh Ann Hirschman

New York: Bantam Books, 2002

Conferences on pain and integrative medicine

For information about the next pain conference, contact: The Richard and Hinda Rosenthal Center for Complementary & Alternative Medicine listed in the box entitled To Contact Dr. James Dillard.

RM: Can you explain a little more about that?

JND: I often inject a local anesthetic, but I sometimes also inject vitamin B₁₂. But the injections are always in combination with other treatments. As I said, I have been at this for 25 years and I am still trying new things to make people feel better. I make mistakes every day, and I get it wrong, and that is O.K. Because, if I get it right a reasonable part of the time, then I feel like I am helping people. So I have to stay honest with it.

If people want to find answers regarding their chronic pain, they need to just try things—a little bit of this, a little bit of that. If a patient can find a combination that makes him or her feel better, then maybe the patient can get back in the pool or go for a walk, or start stretching and strengthening. Maybe a patient will not be as depressed because he or she is no longer as helpless as previously.

The point is, when one finds an effective remedy for chronic pain—even partially—that leads to healthier habits, and that leads to improved sleeping, better diet, and so on. This reverses the downward spiral I mentioned earlier. Patients become a little more active, because they have put together their own chronic pain solutions.

I know this probably sounds Pollyannaish but I have seen it happen too many times to discount the process. My book is a collection of stories about the patients I have treated over the years, and their stories explain what they did and what the results were. So many got better, that I felt compelled to write down their stories.

In some cases, people were able to use therapies that I didn't even know about, but which I was glad to learn of, and which are also included in my book.

RM: How do assess the future of pain management?

JND: I don't want to discount how tough it is for some people. I have seen people who have had horrendous things happen to them—car accidents, fibromyalgia, chronic Lyme disease, and multiple cancer surgeries. These people need to be taken seriously.

However, even in the darkest hour for the pain sufferer, there are still things that have not been tried that can help and make a difference. I have seen patients who wanted to kill themselves because they were at the end of their ropes—and there are thousands of people like that. What is worse is that many have been told that there's nothing that can be done, that they just have to learn to live with it. This is a myth. They just need a smart, caring doctor to troubleshoot about what's already been done and to consider additional options.

Another myth is that pain is always equal to tissue damage. . . always equal to something being terribly wrong in the body. As we know, pain can take on a life of its own, in the body and nervous system and overwhelm the life one used to have. It can become amplified and persistent in the nervous system. But there is hope, even for those who have reached a deep level of despair. And part of that despair comes from the fact that their doctors have been telling them the wrong things. And that is a tragedy.

Does this mean that the people are going to become pain free? No, often not. But it does mean that they can get better.

I believe in realistic, incremental hope. And that this can be accomplished by leaving one's mind open to having other options and other things to think about. That is the message I seek to bring to patients who suffer, to the medical community, and to the complementary medical community. □

To order reprints of this article, write to or call: Karen Ballen, *ALTERNATIVE & COMPLEMENTARY THERAPIES*, Mary Ann Liebert, Inc., 140 Huguenot Street, 3rd Floor, New Rochelle NY 10801, (914) 740-2100.