

Prevention Works. Emergency Medicine Alone Won't.

— *A reactive-only healthcare system is failing patients with back pain, diabetes, and heart disease*

By Robert B. Sheely, DC

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As a chiropractic physician, I have treated patients who arrived at my office after years of failed prescriptions, cortisone shots, and finally, a surgery that left them no better than before. I have also worked alongside emergency medicine colleagues who are extraordinary at what they do. But what I see every day in practice has convinced me of something the medical establishment is slow to admit: we cannot surgicalize and medicate our way out of a chronic disease crisis.

Consider the patient with low back pain. He hurts. He can barely get out of bed in the morning. He goes to his doctor, who orders imaging, refers him to a specialist, and eventually schedules a lumbar fusion. The waiting list stretches six months. So he sits. He takes opioids to get through the day. His core weakens. His posture deteriorates. And when he finally gets the surgery, the outcome is uncertain — because no one addressed the underlying biomechanical dysfunction, the sedentary lifestyle, the poor nutrition, or the postural strain that created the problem in the first place.

Now ask yourself: why wouldn't we intervene earlier?

The same logic applies to the patient with type 2 diabetes who receives a prescription but no lifestyle guidance. Or the cardiac patient who survives a heart attack and is discharged with five medications and a follow-up appointment, but no structured program to address the stress, diet, and inactivity that contributed to the event. Emergency medicine saved their life — and we are deeply grateful for that. But emergency medicine is not a health strategy. It is a rescue operation.

We are rescuing people from crises we could have prevented, over and over again.

For years, low back pain treatment in the U.S. has followed a familiar and expensive path: wait for symptoms to worsen, then escalate intervention. The result? Low back pain is now the leading cause of disability worldwide, affecting 619 million people globally in 2020 alone,¹ and costing the U.S. economy more than \$100 billion annually — two-thirds of which stems from lost wages and reduced productivity, not direct medical care.² Yet landmark research — including the Spine Patient Outcomes Research Trial (SPORT), published in the *New England Journal of Medicine* — consistently demonstrates that conservative care produces outcomes comparable to surgery for most non-emergency spinal conditions,³ at a fraction of the cost and risk. A separate NEJM study found that 90% of sciatica patients improved with conservative care alone within four months, without ever going under the knife.⁴ Researchers at Duke Health put it plainly: “Patients who receive early conservative care have better outcomes and are less likely to develop chronic low back pain.”⁵

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We know what works. We have the evidence. And yet the system continues to pay for surgery while chronically underfunding the prevention and conservative care models that could make surgery unnecessary in the first place.

The parallel with chronic disease is equally stark. The landmark Diabetes Prevention Program, published in the *New England Journal of Medicine*, found that lifestyle intervention — diet, exercise, behavior change — reduced the incidence of type 2 diabetes by 58% in high-risk individuals, outperforming metformin alone.⁶ A 2022 meta-analysis confirmed that structured lifestyle interventions reduce diabetes incidence by 25% and measurably improve blood sugar control.⁷ Yale School of Medicine researchers state plainly: most cases of type 2 diabetes can be prevented through lifestyle interventions.⁸ And yet we continue to build our healthcare system around managing the disease after it arrives, rather than stopping it at the door.

Heart disease is no different. The evidence that diet, exercise, stress reduction, and metabolic health management prevent the majority of cardiovascular events is decades old and irrefutable. Regular physical activity, sound nutrition, and weight management have all been demonstrated in rigorous studies to significantly reduce the risk of cardiovascular disease.⁹ The PREDIMED trial — one of the most cited randomized controlled trials in cardiology — showed that a Mediterranean-style diet significantly reduces major cardiovascular events.¹⁰ Yet our healthcare expenditure remains overwhelmingly weighted toward acute cardiac intervention rather than the community health programs and preventive care that keep people off the table entirely.

This is not a criticism of emergency physicians or surgeons. Their work is irreplaceable. In fact, from a personal experience, 18 years ago, I slipped on some ice and twisted my tibia and fibula into a perfect spiral fracture. I had the option of having pins placed in it to better align the fracture. The healing time would be about the same. So, with my minimal invasive philosophy, I elected for it to heal without the pins. It healed perfectly, as it was suggested. However, it also healed with a 15-degree right-foot outward angle. Barely noticeable, but I wore out my right shoes very differently from my left over the years. The biomechanics and the kinetic chain in my right leg were all under constant stress, and 18 years later, I had massive arthritis in my right hip and nowhere else. I should have thought of this - I did not. So, I ended up finding an excellent orthopedic surgeon, Dr. Welker, who did my right hip surgery in March of 2026. I am now Dr. Rob 2.0. The relief was amazing and just exactly what I needed. So, just so you are clear, I work with medical professionals on a daily basis. They are clearly the best at what they do.

But consider this: 90% of the nation's \$4.9 trillion in annual healthcare expenditures go toward people with chronic and mental health conditions.¹¹ Preventable illnesses alone cost the U.S. an estimated \$730 billion per year.¹² And yet, as the Trust for America's Health has documented, decades of underfunding have left our public health and prevention infrastructure ill-equipped to address the very conditions driving that spend.¹³

A healthcare culture that treats emergency medicine as the primary answer to back pain, heart disease, and diabetes has made a catastrophic category error. It has confused rescue with care.

Prevention is not passive. It requires active investment: in community-based wellness programs, in conservative care providers, in patient education, in nutrition counseling, and in the kind of longitudinal, relationship-based medicine that actually changes behavior. These programs are not glamorous. They do not generate the drama of a bypass surgery. But their results, measured in avoided hospitalizations, reduced disability, and improved quality of life, are undeniable.

In my own practice, I see patients who were told surgery was their only option — and who recovered fully through a structured program of chiropractic care, therapeutic exercise, and nutritional support. I see pre-diabetic patients who reverse their trajectory with clinical weight loss programs rather than a lifetime of escalating medication. These outcomes are not accidents. They are the result of using the right tools at the right time — before the crisis becomes irreversible.

We are finally having a national conversation about value-based care, about bending the cost curve, about meeting patients where they are. But that conversation will remain incomplete as long as we treat prevention as an afterthought and emergency intervention as the gold standard.

The evidence is clear. The tools exist. What we need now is the will to fund, prioritize, and expand the conservative care models that keep people healthy in the first place — before the ambulance has to come.

Our friends, our neighbors, our families are waiting for us to get this right.

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Respectfully,



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