Dynamic Chiropractic

CHIROPRACTIC TECHNIQUES

Point-Counterpoint

Robert S. Francis, DC, DAAPM

Editor's Note: Below is an open letter to the profession from Charles Rollis, B.S., D.C., expressing his concerns over manipulation under anesthesia. Following Dr. Rollis' letter is a response by Robert Francis, D.C., D.A.A.P.M., dean of clinical sciences at Texas Chiropractic College.

Manipulation Under Anesthesia?

Recently I received a brochure for a seminar that I could attend where I would learn how to adjust a patient under anesthesia. Why did this make me pause? What was it that I find foreign about this concept?

After sitting quietly for some moments pondering this uneasy feeling, the following thoughts came to the forefront of my consciousness.

1. I feel as if the adjustment under anesthesia is not allowing the natural healing processes to take place.

There is the artificial environment of the anesthesia and the non-feedback from the patient. I understand that in some instances manipulation must be done under local anesthesia, for a dislocated humerus, and general anesthesia for cervical vertebrae realignment and surgery following severe trauma. Are not these exceptions rather than the rule? Are there individuals attempting to make this the rule? What are the motives?

2. I feel as if I need the feedback from the patient in order to monitor the effects of the manipulation -- be it good, bad or no change.

The artificial environment at least dampens, at worse, or deadens the sensory input/output which can cause a plethora of symptomatology causing further misdirected and unnecessary treatment.

3. I feel as if the anesthesia is short circuiting the flow from above down/inside out.

It seems to me that the flow of life would be interrupted and possibly given an artificial direction in which to flow. This, I find, is a contraindication. I believe in not doing any harm to the patient.

4. I feel as if the rationale and protocol should be held open to the entire profession and not merely a select few who must take special seminars.

By doing this, it won't have the atmosphere of specialty which would further confuse the public at large and other chiropractors. I thought that my specialty was chiropractic.

Is this just another money making proposition? Is this the next phase now that the practice building/office management companies have come under fire?

5. I feel as if we should not be in hospitals.

I know and believe that chiropractic is a specialty of health and not a subsidiary of allopathic

medicine. Am I confused on this? Did I miss a definition somewhere along the way?

Of course, like most of you, in the past I have consulted with other health disciplines to achieve the most good for the patient, but I have never placed foot into their realm, nor do I want to.

I am a chiropractor. My specialty is chiropractic. Through chiropractic care I assist human beings to recapture the above/down/inside out order of things. It is that simple, that true.

I have an unnerving feeling about this direction.

Thank you for your time.

Charles M. Rollis, B.S., D.C.
San Jose, California

A Different Perspective of Manipulation under Anesthesia

I am in receipt of the open letter by Dr. Charles Rollis in which he comments on manipulation under anesthesia (MUA). I would like to address Dr. Rollis' concerns.

I am dean of clinical sciences at Texas Chiropractic College and have a private practice. I am on the medical staff at four facilities where the departments of chiropractic function quite well with the other medical departments and where we perform MUAs of the spine and extremities.

Firstly, Dr. Rollis feels that manipulation under anesthesia does not allow the natural healing process to take place. He perceives the environment to be "artificial" which does not allow "feedback from the patient." He further comments in the same paragraph that there is an "attempt to make manipulation under anesthesia the rule" rather than the exception, and he questions the "motives" of the doctors performing MUAs.

I would like to clarify for Dr. Rollis that the environment is not artificial and the reason for anesthesia is exactly as he states, to eliminate any feedback or attendant muscle spasm as a result of the manipulation. If we wanted "feedback from the patient" we would not perform a procedure using anesthesia. As to his comment regarding the motives and the attempt to make MUAs the rule for manipulation rather than the exception, please understand that only three to five percent of patients ever undergo MUA. Simply because a procedure is relatively new to the profession, and receives a lot of attention, is certainly no reason to assume there is an attempt to perform this procedure on everyone or even most individuals who seek chiropractic care; quite the contrary. This procedure allows the chiropractic physician to provide an intervention to surgery or continued drug therapy. The "motives" are certainly to provide a service that is available to our profession and to our patients in order to alleviate conditions which would otherwise remain unresolved or would go on to medical care.

Dr. Rollis continues in his letter to emphasize "short circuiting the flow from above down/inside out." While I am not certain exactly what he intends by this comment, I do recall my chiropractic philosophy courses taught in chiropractic college. My understanding is that to remove nerve interference is the end goal and objective of our treatment and that manipulation accomplishes that goal. It would seem that if manipulation is not possible due to severe antalgia or due to chronic intra-articular adhesions and fibrosis of supporting soft tissues, this objective of removing nerve interference and allowing the innate healing homeostatic mechanisms, which we all recognize, to function normally would not enable us to achieve this goal. It would follow, then, that

if we are unable to achieve our purpose, the patient will seek care elsewhere. Our goal is to heal the patient with chiropractic adjustments and not have them seek care from other physicians.

Dr. Rollis asks that the protocol and rationale for manipulation under anesthesia "be held open to the entire profession and not merely a select few." I will remind Dr. Rollis that the entire protocol with indications and contraindications was published in the ACA Journal in 1989 and included a case study. It was again published in Dynamic Chiropractic a few months later with additional cases by Dr. Stephen Capps, a pioneer in the procedure at the first hospital in the country to develop the protocol for our profession. As I am certain Dr. Rollis is current with the journals of our profession, he may want to refresh his memory of these publications. The only college to offer a certification course in manipulation under anesthesia is Texas Chiropractic College (TCC). TCC has a 36-hour didactic course and hands-on proctorship program leading to certification of manipulation under anesthesia. This is a state-of-the-art program and many physicians across the country attend this certification training. Therefore, not only has the college and the profession published protocol and rationale and made this available to the entire profession, but has encouraged chiropractors from all over the country to take advantage of the training available at Texas Chiropractic College. The training is essential to ensure a standard of care that is not arbitrary and that the profession can implement anywhere in the country, at any hospital.

Dr. Rollis further says that the "public at large" will be confused about chiropractic and the specialty of chiropractic. If anything, this activity in the hospital sets us apart as specialists and provides us with an excellent avenue and environment to promote chiropractic. I know from my personal practice. I receive many more medical referrals than I did prior to practicing in the hospitals, and so do my colleagues. It certainly has not confused the "public at large" in any way at all, rather it has informed more of the public about chiropractic.

Lastly, Dr. Rollis feels we should not be in hospitals. I feel we should be in hospitals. All Texas Chiropractic College graduates are required to participate in a hospital rotation as a graduation prerequisite. By practicing in hospitals, as I mentioned above, the medical staff not already familiar with chiropractic care can see firsthand what results we get with chiropractic. The co-management and referrals increase, thereby exposing more and more patients to chiropractic care by practicing outside the orthodox health care delivery system. We are no longer perceived as less than a real doctor. While some chiropractors would like to remain isolated in their practices with only their staff and their patients aware of what they do, chiropractors who participate in the hospitals make a much larger group of health care providers and patients aware of chiropractic. This results in more acceptance of chiropractic and integration into the mainstream of health care delivery in this country. If we continue to isolate ourselves in private clinics, we limit our exposure to the public and deny chiropractic care to millions of potential chiropractic patients.

Dr. Rollis, in closing his letter, asks the question, "Am I confused on this?" Yes, Dr. Rollis, you are confused and misinformed as to the effectiveness, research, protocol, and rationale of manipulation under anesthesia for our patients. We chiropractors who practice in the hospital setting are not a "subsidiary of allopathic medicine" as you indicate we may be; rather, we remain a very distinct and separate discipline with our own identity that continues to be accepted by medical staffs all over the country.

I hope this information and the references mentioned herein will answer Dr. Rollis' questions.

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