Dynamic Chiropractic

CHIROPRACTIC (GENERAL)

The Last Holdout

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In our hospital, chiropractors have enjoyed a high level of acceptance from the other medical physicians and nurses of the emergency department (ED). Only one nurse has remained openly skeptical. In the beginning, she liked to tease. She even expressed her doubt in front of patients. She became a little more accepting of chiropractic after overhearing a conversation between two patients in another hospital. One patient told the other that if the ambulance had brought him to our hospital, he could have seen by a chiropractor. She commented that there must be something to "this chiropractic," but she still wasn't sure.

Her skepticism has not been entirely objectionable. She has questioned chiropractic in a way that has given us the opportunity to have an intellectual discussion, even if in the end, she has maintained her position.

Once, after helping a patient to achieve full cervical mobility and total relief of pain, the nurse asked what treatment I had rendered to obtain such dramatic results. After an extended explanation of our department's protocol, which includes patient education, peripheral neurofacilitation, and a stepwise, ultra-safe approach to spinal manipulation, she still didn't appear to be impressed.

I explained our theory of the body's defense mechanism, whereby the body produces pain, spasm, and joint fixation in an attempt to splint the perceived injury. I discussed how sleeping too close to an air conditioner or an open window could provide the irritation that could fool the body into reacting as if there were actual trauma. I went on to describe how I would hold the patient's head while instructing him or her to turn toward the restricted side while I prevented movement.

While instructing the patient to relax, I would relax my grip so the patient would turn just a little more. After repeating this procedure several times with progressively increasing mobility, I would move on to a relaxation/traction procedure. While standing behind the seated patient, I would hold the occiput in the heels of my hands, with my thumbs pointing to the posterior and my other fingers pointing cranially. My forearms would be pressing down on the patient's shoulders as I instructed him/her to elevate the shoulders while holding a deep breath and concentrating on the tension. I would then instruct the patient to exhale and breathe normally while relaxing the shoulders. As the patient relaxed, I applied gentle traction to the patient's cervical spine.

After performing these two procedures, the patient usually demonstrates near-normal ranges of motion and is able to tolerate chiropractic cervical adjustments. The patient will then typically have near-full range of motion and report near or full relief of pain. It was a long, detailed explanation. The nurse listened intently - appearing to understand the explanation, only to comment, "So, it's all just psychological!" My heart dropped.

Almost one year after giving up hope on this last holdout, I was called to the ED to see a young man with complaints of severe occipital headache. The patient was the nurse's own son. The attending physician, who called me, is best described as conservative, intellectual, and extremely traditional in his approach to injury and disease. His professional history includes service as a

military physician, many years as an oncologist/hematologist, and previous employment as the assistant director of a busy inner-city ED.

The attending physician advised that he had already medicated the patient with the narcotic Percocet to block pain and the muscle relaxant Flexeril. He went on to explain that the patient complained of tenderness to palpation of the cervical and occipital areas. He said the patient's neck felt very tight. He also described the patient's lifestyle, which included working as a baker and enjoying video games - both activities that cause prolonged alteration of posture, placing additional stress on the neck.

The patient additionally informed me that he had a four- to five-year history of almost-daily migraine-like headaches. He had been under the care of a neurologist, who prescribed various medications with less-than-adequate results.

My evaluation concurred with that of the attending physician. The muscles were very tense. I performed a supine version of cervical motion palpation. The motion palpation findings were much worse than just stiff end feel. As I challenged each joint from posterior to anterior, the whole spine moved as a unit, demonstrating severe fixation. Treatment consisted of chiropractic adjustments. The patient tolerated treatment without complication.

I conferred with the ED attending prior to discharge. The ED attending typically writes a prescription for analgesic medication to be taken by the discharged patient. This time, the attending surprised me by suggesting, that since the problem was by nature so mechanical, medication was not indicated. He suggested that the patient would be better served by following up with chiropractic care instead.

The patient stopped at the nurse's station to say goodbye to his mother. By coincidence, the entire ED staff as well as a consulting cardiologist and a couple of visitors were in and around the nurse's station. The ED attending said to the patient, "As a point of reference, you rated your pain as a 7/10 when you first arrived. How did you feel after the Percocet and Flexeril, but before [you saw] the chiropractor?" The patient replied, "There was no change." The attending then asked, "How are you feeling now that you've seen the chiropractor?" To which the patient answered, "Oh, it doesn't hurt at all now." His mother (the last holdout) responded to his report by turning to me and saying, "When can you see him in your office?" She then turned to her son and commanded, "You are going to follow-up with Dr. Cerf!"

Working in the ED gives us the opportunity to treat patients who might not have otherwise been exposed to chiropractic. The medical staff enjoys having chiropractic as an additional treatment option. Our medical staff knows that chiropractic can offer their patient relief at times when traditional medical care is unable to help or would be excessive for the presenting condition. The ED is an excellent environment in which to observe the responses patients experience to medical vs. chiropractic treatment for various conditions. Both the medical and chiropractic practitioners have an opportunity to learn when to select medical or chiropractic treatments and when to suggest a combination approach. Best of all, the medical staff has an opportunity to witness the great results with which we are already familiar in our private offices.

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