



Leonard J. Faye, D.C. ¹

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1. Private practice of chiropractic.

Submit correspondence and requests for reprints to:

Leonard J. Faye, D.C.
10780 Santa Monica Blvd, Suite 400
Los Angeles, CA 90025
E-mail: ljfaye@earthlink.net

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THE SUBLUXATION COMPLEX

In the last issue of this journal, criticism arose about the scientific validity of the subluxation complex. A topic that I have written and lectured about since 1967 (1). At the heart of this debate are two philosophical views about the nature of measurement. On the one hand are the realists who believe that measures are either accurate reflections of reality, or close approximations. On the other side are the conventionalists who argue that measures are simply heuristic devices about which there is a consensus. The concept of the subluxation complex was always intended as simply a heuristic device, a convention. The idea was to get the future chiropractors to think more complexly about a complex problem. It forced the integration of much wider areas of information and knowledge.

The goal was to free the chiropractor from finding the magic button (subluxation), and to consider a normal, healthy, mobile, inflammation-free spine as only one of the essentials for maintaining

and regaining health.

A little historical background may help to reveal how I came to propagate the dynamic paradigm through the SC model. I adopted the term from an A.C.A. sponsored article jointly written by Drs. Janse, Homewood and Weiant in the early 1960s. I have not seen a copy of this article since, and I can not say much more than it denounced the bone-out-of-place theory and described some of the complexities of the subluxation. It was still considered a thing to be adjusted. At the time I was practicing in England, and I had just completed a three-year, in-office study (not published), looking at pre and post radiographs of my patients that had greatly improved after a series of full-spine, diversified, chiropractic adjusting. The results finally convinced me that I was not re-aligning a vertebra that was slightly misaligned, when I adjusted and relieved patients of their symptoms. No significant realignment occurred.

The subluxation, per se, did not exist as described by the classic chiropractic texts of the time. At the same time it seemed to me that the progressive Swiss chiropractors were much closer to the truth of what we did to influence the return to health of our patients.

Every fall for five days, the Swiss Chiropractic Association held a post-graduate symposium that gave those developing the dynamic concepts of chiropractic a place to present their research and conceptual papers. These works by Illi, Sandoz, and many others were published in the Swiss Annals. This work challenged the concept of subluxation and the static definition of the time, as a dogmatic idea, too simplistic to explain how chiropractors helped patients recover from multicausistic conditions.

In the 1960s, the chiropractic profession was divided and wasting its' energy trying to justify the different modes of practice. X-ray marking systems gave contradicting listings on the same patient from the same radiographs. To outsiders it appeared nobody in the U.S.A. seemed concerned as college students were asked to choose the system they wanted to follow and encouraged to plod on, regardless of the facts at hand. Critical thinking was discouraged and subluxation was supposedly

the common demoninator. No randomly picked, let alone any prospective studies, only retrospective studies were published to show misalignments were re-aligned. In fact many patients that got well were measured as more misaligned, as confirmed by a Danish student thesis conducted by Dr. Bjarne Halvorsen et al, which was made available to me in private correspondence, in 1985 (2).

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The loss of the subluxation left a large conceptual void to fill. Since there was no specific "thing" to adjust, in my opinion we needed a more complex theoretical model to form a paradigm that would help us co-ordinate our research efforts, organize the existing body of literature, and our collective eclectic, clinical observations, along with our treatment methods. There is no subluxation complex, per se, any more than there was a

subluxation.

The subluxation complex working model was an attempt to allow scientific investigation of our tenets and methods. Many years ago, holistic vitalism was labeled unscientific by the medical and supporting scientific community. This myth had to be eradicated by chiropractic research; and we needed to correlate these efforts under some umbrella. The complex, as I described it, included the pathogenesis of stress as pioneered by Hans Selye M.D., and in my opinion added rational explanation as to why some of our patients were observed to gain health benefits after suffering organ disease. These responses occurred not because of a simple relationship between a spinal nerve and the organ, but for much more complex reasons tied to the physical, mental and chemical causes, reducing the effects of stress and gaining the patients' confidence that instilled hope; all had a role to play.

I formulated this working model so that the Anglo-European Chiropractic College students I was teaching in 1967 would be able to correlate the academic courses with the chiropractic clinical sciences, and not be faced with conflicting information. The emphasis was on rational reasoning from scientific evi-

dence, as opposed to passing along chiropractic dogma, rituals and religious fervor. "It works" and "you better believe it works" were not part of the program.

3 The SC model allows a chiropractor to examine a person in a classic ortho-neurologic manner, as well as biomechanically and chiropractically, and arrive at a double diagnosis; one, to assess the state of the pathological tissue changes and determine the prognosis, the other, to determine the therapeutic procedures and treatment schedules. It covers our paradigm and limits our scope of practice to what we are the best equipped to do. From prevention to supportive maintenance care, the model is rational and accommodates our traditional practices. At the same time it allows for falsifiable questions to be asked, and thus expand and clarify our pertinent knowledge. It primarily was a method of bringing research evidence to bare on our clinical practice.

For example lets look at a chronic tennis elbow patient: the history is typically of some incident or repetitive strain that leads to a pain on the lateral side of the elbow. Instead of healing in 72 hours or so, the pain persists for many months, worsening with use and easing with rest and over-the-counter N.S.A.I.Ds.

Examining the area of chief complaint confirms the diagnosis of lateral epicondylitis. Now if one follows the outline of SC, we need to determine the neuropathological component. A sharp pin would probably elicit an area of hyperesthesia in the dermatome of C5-6 on the side of the tennis elbow; other tests are likely normal. The kinesiopathology examination would reveal the blocked flexion and anterior to posterior rotation at the level of C5-6. Since the dysfunctional area is part of a closed kinematic system, all other parts of the system need to be assessed for biomechanical insults, starting with the feet and including the shoulder girdle. Let's stop here and examine our rationale. Bausbaum and Levine were able to demonstrate that chronic inflammation is driven by a facilitated sympathetic nerve releasing norepinephrine at the site of the inflammation (3). My clinical experience shows that when my treatments cause improved movement at the level of C5-C6 in flexion and anterior to posterior rotation, the local tenderness clears and soon after the patients epicondylitis heals. Two questions arise 1) Can cervical dysfunction cause facilitation to the cervical sympathetic ganglion chain or post-ganglionic neurons?

2) Can restoring cervical function to normal, remove the facilitating stressor and allow the inflammation to act like acute inflammation and resolve in a few days? This then leads me to ask why Dr. Nelson does not think SC attempts to explain existing phenomena and observations; also, why he does not feel SC can be testable or falsifiable. He says a tautology is irrefutable and useless. Clearly the questions above are falsifiable every step of the way. I think it gives our researchers a guide as to what the most important research questions are that we need next investigate. It also provides a paradigm from which to interpret the past research.

Clinically, SC is a conceptualization for organizing the essential information relevant to treatment with which a chiropractor needs to be familiar. It provides a paradigm from which to assess the scientific literature, and this is not the medical paradigm. The human sciences are common to medicine and chiropractic. While it may be our holistic, vitalistic approach to the prevention and treatment of health problems that sets us apart, we still need to know as much as we can about biomechanics, neurobiological mechanisms per manipulation, inflammation of joints and soft tissues, stress physiology, nutrition and exer-

cise as they are related to our type of practice. Knowing what you are not isn't good enough. With the SC, I can weave the scientific information into a drugless fabric and feel I am being rational and reasonable, and not just a believer or a disciple of a technique guru.

The subluxation complex represents one attempt to provide a rational approach to holistic, vitalistic healing; i.e., chiropractic.

I wish to thank Dr. Ian Coulter a friend and mentor who has helped me understand the philosophy of science, and our professions' efforts to achieve a place in the scientific community of the healing arts. I also thank Dr. Craig Nelson for caring enough to be critical, as criticism leads to progress.

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