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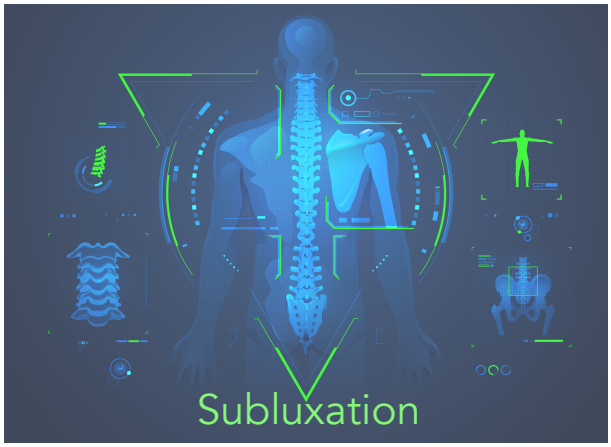

Communication: Subluxation without obfuscation

Greg Venning

Abstract: Since Chiropractors gained regulation in many jurisdictions we have been included in the pathogenic disease management approach. Many of the people who consult with us expect such an approach including diagnosis and therapeutic intervention and Chiropractors may have legal duties to fulfil such obligations.

The diagnosis-therapy interaction between professional and patient is usually a hierarchical one where the patient is dependent on the professional. The salutogenic model is a participatory one in which the person under care is enabled to find and implement solutions.

This paper explores communication of subluxation through a salutogenic lens to allow more empowerment and improve the outcomes of the people we serve.

Communicating subluxation well is a service to humanity and one worthy of the attention, time, skill and energy of the Chiropractic profession.

Indexing Terms: chiropractic; subluxation; salutogenesis; communication

'The single biggest problem in communication is the illusion that it has taken place'

George Bernard Shaw

Vertebral Subluxation Complex (subluxation) is a defining characteristic of the Chiropractic profession and by extension, the Chiropractic Practice. (1) No other profession uses the term. Subluxation is associated with the concept of loss or diminishment of health before disease diagnosis, it denotes a pre-nosological state or state of dis-ease (which is distinct from disease).

Chiropractic then is interested in a salutogenic model (2) originally proposed by Antonovsky in 1979(3) and since developed, validated, expanded and updated. (4) Salutogenesis asks the question '*What explains movement toward the health end of the health/ illness continuum?*' which echoes that of DD Palmer from as far back as 1887. (5)

> *... it is questionable as to whether chiropractic and medical manipulative therapy belong under the same professional label'*

Chiropractic and salutogenesis are focussed on the health ease/dis-ease continuum and positive health outcomes. What it emphasises is the return to or optimisation of health rather than the allopathic focus on cure or management of the disease. This focus paradigmatically separates Chiropractic from the field of allopathic medicine which is driven by a pathogenic model and is, in practical terms, a disease management system.

Without subluxation, we are practising something other than Chiropractic, something more synonymous with medical manipulative therapy. This therapy certainly has validity and value in the marketplace, however it is questionable as to whether the two approaches belong under the same professional label.

A focus on subluxation opens the Chiropractor to a non-therapeutic paradigm. Herein lies a challenge: Since Chiropractors have actively sought regulation in many jurisdictions, we have been included in the disease management political-industrial complexes, systems, regulations and laws. Many of the people who consult with us expect a disease management approach including diagnosis and therapeutic intervention and Chiropractors may have legal duties to fulfil such obligations.

This is a challenge in communicating Chiropractic. People consulting Chiropractors may be familiar and habituated with a disease care model and may present with the expectation of receiving a diagnosis and a therapy directed at this diagnosis. The diagnosis-therapy interaction between professional and patient is usually a hierarchical one where the patient is dependent on the professional. The salutogenic model is a participatory one in which the person under care is enabled to find and implement solutions.

Labels

It has been said that you cannot not communicate. The labels we apply to people under our care communicate our ideological stance far more powerfully than we realise.

Since Chiropractic is distinct from the practice of medicine it is useful to explore communicating subluxation by beginning by questioning the lexicon in use. 'Patient' is defined as:

- a person who is receiving medical treatment, especially in a hospital (6)

It may be argued that the term patient is not the best term to use in a Chiropractic Practice. It has been said that the term is overly reductionistic and even dehumanising through de-individuation. (7)

A more appropriate term in a Chiropractic setting is 'person' defined as:

- a human as an individual (8)

A patient receives 'treatment' defined as:

- something that is done to cure an illness or injury (9)

So, we may look to use the more expansive term 'care' instead, defined as:

- the process of caring for somebody/something and providing what they need for their health or protection (10)

Toward a state of coherence

A key part of the salutogenic model is empowerment and effective communication which would help the person under our care to discover the three internal factors that contribute to a state of well-being or coherence:

1. Meaningfulness: the demands and challenges of your life situation are worthy of investment and engagement;
2. Comprehensibility: confidence that the stimuli deriving one's internal and external environments through life are structured, predictable and explicable;
3. Manageability: the resources are available to one to meet the demands posed by the stimuli.

Since this model is congruent with the Chiropractic worldview, it seems useful to use these three factors in proposing a model for communicating subluxation.

Meaningfulness: What problem does your care solve for them?

The essence of this factor would be to answer the question, '*Why is this important to the person?*'

The art of education is to relay new information in a way that relates to previous information that the person already knows. The person is actively engaged in the process and not a passive receiver. '*Here, knowledge is not passively received; rather, it is actively built up or constructed by students as they connect their past knowledge and experiences with new information*.' (11)

To do this, the Chiropractor would take time to gather information from the person and calibrate their communication within that context. The Chiropractor may ask themselves the question '*what is the meaning and significance of the complaint for this person?*'

The search is for something deeper than the surface issue of pain, maintenance or desire for health optimisation that may be presented. What does the complaint mean to the person? Does it represent a threat or potential threat to one of their roles in life? Does it limit or threaten to limit their function in daily life? Does it affect or threaten to affect their sense of identity through one of the above?

The deeper meanings are the drivers that bring a person into care and motivate them to be actively engaged in their well-being. They give the person reason and motivation to bring their resources to bear on their health. They give meaningfulness.

When you have an understanding of the deeper meanings a person is carrying as they present to you, you can communicate more effectively and recommend and provide more person-centred, evidence-based care.

What is health to the person?

A potential way forward is to build on meaningfulness and to find out what health means to the person we serve. We begin with their explicitly stated and implicitly inferred values, desired level of function and their sense of identity. From this desired outcome, we may begin by helping the person to question how their past circumstances inform their present state through biographical history taking including pre-birth, birth and childhood circumstances

A systems review, while helping the Chiropractor get a more holistic picture of a person's past and present health status, also allows the person to revisit the terrain of their past and begin to make links between their health status now and what has gone before. In this way, the Chiropractor would have helped the person connect to the notion that their problems of today did not just start yesterday and that there may be more going on than they initially thought.

What does subluxation represent to the person?

With this new understanding of a person's meanings, we can now begin to ask the question, 'What does subluxation represent to the person?' This is a key distinction in creating a participatory and not a dependent relationship, a salutogenic and not an allopathic one.

Far from being an opportunity to tell a person about the biomechanics and neurology of the brain-spinal-dural-neural interactions, this is a conceptual space. Here the Chiropractor allows the person to make their own meanings of the concepts in the health ease/dis-ease continuum and the effects subluxation process may have on it. I stress that at this level, we are dealing in the realms of the conceptual.

Stories, analogies and metaphors are useful tools to help a person orientate themselves to the salutogenic view of the continuum of health. At a very fundamental level, we can build on the concept that structure affects function and any aberration in structure will have a negative effect on function. Subluxation as the aberration in the structure will have negative effects on the function of the mind-body. Here we can communicate that subluxation leads to a loss of health, to a state of dis-ease.

By helping a person to create links between the structural distortions and the functional deficits that clinical objective evaluation may show and the effects of those on their quality of life, we are creating the platform for a more empowered process of informed consent and a more participatory role in their care.

Our outcome here is that the person feels the demands and challenges of their situation are worthy of investment and engagement. They feel inspired to take action.

Comprehensible: Structured, predictable and explicable

The essence of this factor is, '*What is happening to me?*'

With the professional understanding that subluxation is a process and not an event and that it is relational (systematic) and not only locational (segmental), we are not dealing with a straightforward cause-and-effect relationship such as 'bone on nerve' (though this does not negate the segmental process of subluxation nor us using that analogy as a stepping stone to comprehension) though complex multi-factor causation is certainly at play.

We are dealing in the realms of non-linear complexity and not simple linearity. The challenge we face when communicating subluxation then is in relaying the complex in simple ways without the loss of nuance.

Drip-feeding vs drowning

Encoding new information into short-term memory has bandwidth limitations and going beyond those limitations by giving too much information at a time creates challenges. (12) One challenge this creates in the context of this article is that the person receiving the information cannot retain all the information transmitted to them while the Chiropractor giving the information assumes it has been received and will be remembered. This could lead to any number of sub-optimal outcomes for both the person and the Chiropractor.

A common theme here is one of uncalibrated expectations: a person under care is expecting rapid relief while the Chiropractor expects a longer recovery process. If Chiropractor's expectations are not communicated clearly enough, the person may be unhappy that their desired outcome is not being met while the Chiropractor assumes they understand each other. This leads to the person discharging themselves from care and the common grumbling in Chiropractic circles '*They just don't get it.*' A more accurate description would be '*You just didn't communicate it effectively*.'

Many cases of professional complaints or litigations are attributed to communication issues, especially informed consent. Here again we can see the pattern of unmet expectations that are derived from ineffective communication.

In relaying information about subluxation in the context of the person's health journey, it is useful to think of watering a plant. We would do well not '*drown the plant*' by giving it a week's worth of water all at once. A more effective strategy is to '*drip feed*' information over time.

Miller described the process of '*chunking*' information into manageable bits (13) to avoid the trap of overloading the encoding systems of short-term memory. Though the idea has been revised and details updated over the years, the basic concept remains sound. (12, 14)

Here the professional, with their jargon and layers of information, is often at a disadvantage. We tend to vomit jargon-filled information at people. It comes out in torrents and leaves them with greater confusion instead of clarity. This makes us think we are communicating effectively while, in reality, we are holding a monologue with too many chunks of information being relayed at a time, and we don't even know it.

As an example, when a Chiropractor considers the term 'spine' we have layers of understanding and data based on thousands of hours of study and possibly many years of experience. Consider what comes to mind: Osseous structures and their shapes; myofascial attachments, actions and innervations; biomechanics; central and peripheral neural elements, their pathways and functions to

name but a few. We have built these layers of knowledge one chunk of information at a time over years.

The layperson considers the same term, 'spine' and thinks only of dinosaur-like bones. The chunks of information in the gulf between the two understandings are immense. If we allow this void of understanding to remain between us and the person when we are communicating, we risk having them feel like they are operating in the dark.

Jargon, with its Latin and Greek origins and many layers of information has a very limited place if any in this space. Plain words, spoken plainly can illuminate the void and bridge the gulf. If jargon is useful, it is used minimally and explained in simple ways.

With chunks of information, delivered with repetition over time, we can help a person create new knowledge and come to new understandings. We can build on the conceptual understanding achieved in the first stage and apply it to some of the person's particular findings.

Our outcome for comprehensibility is confidence that the stimuli deriving one's internal and external environments through life are structured, predictable and explicable. Our job here is to create this experience. Too much information too fast overwhelms. Too little information or poorly structured delivery leaves a hole. Either of those extremes does not create confidence.

Using questions, we can gain an understanding of what a person does and does not know which helps us calibrate our communication and drip-feed information appropriately. This is an interactive dialogue that provides for continuous empowerment and ongoing informed consent and person-centred care.

Manageable: Available resources and practical long- and short-term options

The essence of this factor is, *'How will we accomplish this?'*

When we propose a way to address subluxation that is based on the person's meanings and done in the context of their comprehensibility, we can now co-create manageable solutions for the person.

If manageability is about a person feeling they have the resources needed to meet their needs, we can address four main resources:

1. Hope - A person without a sense of hope that their life situation can improve is not likely to feel that change is possible. This would make any approach to solving an underlying problem unmanageable. A belief that improvement is possible is a prerequisite for the formation of manageability. Here the healing ability of the mind-body is a primary driver, knowing that regeneration can occur, even without knowing the limits of that change.
2. Time - here we deal with time as a subjective matter. What seems too long to one person may seem just right to another person. The greater the meaning of the future outcome, the greater the time likely to be devoted to attaining it. The second dimension of time is if a person can comprehend that the state of their current health is the culmination of their past events and behaviours, then they are likely to be open to a more holistic approach to health and healing rather than short-term biomedical relief care. Having this journey mapped out and broken into steps (chunking) helps a person orientate themselves to where they are and where they want to get.
3. Trust - a sense of confidence in the practitioner to deliver the interventions necessary and work within the regenerative capacity of their mind-body is necessary for them to take on care with the specific practitioner. If this is absent, they may seek care elsewhere or doubt that anyone has the requisite skill to deliver the change they hope for.
4. Energy - this resource is as much about physical energy as it is about inspiration to follow the path. The greater the meaning the person has for their desired outcome (this is inspiration), the more energy they will be motivated to devote to it.

Our outcome in manageability is for the person to feel that the resources are available to meet the demands posed by the situation.

Education and Informed Consent

In an evidence-based construct that truly subscribes to a biopsychosocial model, communication would be taken seriously. It would be taught to the professional with great skill and would form an essential part of their tertiary level education and training as well as their continuing professional development. Sadly, this seems not to be the case in practice. In some jurisdictions the topic is not considered worthy of recognition for continuing professional development.

An example of this is the process of informed consent. As is common practice in an allopathic model, a person is presented with an often-complex form, written in legalese, which contains potential risks of a procedure that a person has to sign. This is a defensive medico-legal and practitioner-centric practice that does not fulfil the person-centred obligation.

In a true evidence-based practice model with informed consent at the core of the person-centred approach, a healthcare professional would make explicit their place within the healthcare system, provide context to their encounter and provide the person under care with options for care based on their values and discuss potential positive and negative effects. In that context, a simply worded medico-legal form is entirely appropriate.

Conclusion

The fundamental aspect of communication is that its outcome is not what information has been transmitted, but rather what information has been received and successfully encoded. What you say matters less that the meaning the person ascribes to what they heard.

While our very environment communicates our values to the people we serve from the colours on our walls to the posters they hold, words and how they are spoken are an important part of the clinical encounter. They have a powerful effect on the outcomes we get with people.

Vertebral Subluxation Complex is a rich and valuable term that has survived many attempts at lexicon cleansing. (1) This survival, never-mind the scientific evidence base, is a self-evident display of the merit and utility of the term.

Communicating subluxation well is a service to humanity and one worthy of the attention, time, skill and energy of the Chiropractic profession.

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References

1. Senzon, S.A., *The Chiropractic Vertebral Subluxation Part 1: Introduction.* J Chiropr Humanit, 2018. 25: p. 10-21 DOI 10.1016/j.echu.2018.10.002.
2. Kent, C., *Proposed Neurobiological Processes Associated with Models of Vertebral Subluxation: Dysafferentation, Dyskinesia, Dysponesis, Dysautonomia, Neuroplasticity and Ephaptic Transmission.* Archives in Neurology & Neuroscience, 2019. 3(1) DOI 10.33552/ann.2019.03.000555.
3. Antonovsky, A., *Health, stress, and coping.* New perspectives on mental and physical well-being, 1979: p. 12-37.
4. Mittelmark, M.B., et al., *The handbook of salutogenesis.* 2022.
5. Senzon, S.A., *The Chiropractic Vertebral Subluxation Part 2: The Earliest Subluxation Theories From 1902 to 1907.* J Chiropr Humanit, 2018. 25: p. 22-35 DOI 10.1016/j.echu.2018.10.009.
6. *"patient"*, in *Oxford English Dictionary*. Oxford University Press.
7. Haque, O.S. and A. Waytz, *Dehumanization in Medicine: Causes, Solutions, and Functions.* Perspectives on Psychological Science, 2012. 7(2): p. 176-186 Available from: http://www.jstor.org/stable/41613554.
8. '*person*', in *Oxford English Dictionary*. Oxford University Press.
9. '*treatment*', in *Oxford English Dictionary*. Oxford University Press.
10. '*care*', in *Oxford English Dictionary*. Oxford University Press.
11. Santrock, J.W., *Educational Psychology*. 2 ed. 2004: McGraw-Hill.
12. Norris, D. and K. Kalm, Chunking and data compression in verbal short-term memory. Cognition, 2021. 208: p. 104534 DOI 10.1016/j.cognition.2020.104534 Available from: https://www.ncbi.nlm.nih.gov/pubmed/33360054.
13. Miller, G.A., *The magical number seven, plus or minus two: Some limits on our capacity for processing information.* Psychological Review, 1956. 63(2): p. 81–97 DOI: https://doi.org/10.1037/h0043158.
14. Thalmann, M., A.S. Souza, and K. Oberauer, *How does chunking help working memory?* J Exp Psychol Learn Mem Cogn, 2019. 45(1): p. 37-55 DOI: 10.1037/xlm0000578.