Dynamic Chiropractic

CHIROPRACTIC (GENERAL)

In Defense of the Audible

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1995 was certainly the year of the audible. One group of researchers established that the popping noises that accompany the modified rotary break adjustment usually come from the side of the neck contralateral to the contact hand.[1] Another investigator produced a comprehensive review of the scientific literature on joint cavitation and its possible reflexogenic effects.[2]

Although interesting and clinically relevant, this type of mechanistic approach to interpreting audibles is necessary, but not sufficient. The theories of the audible that I have seen are surprisingly mute on what amounts to what it essentially is: the basic unit of exchange between the chiropractor and the patient (even the office visit fee is less fundamental). Great injustice is done it by regarding the audible as a mere sound, a phenomenon which could be characterized by a purely scientific investigation. Detached from its sociological and interactive ramifications, the audible is not merely banal, but deliberately banalized. It's like defining a Cadillac as merely a "car," without mentioning that historically, the Cadillac has functioned primarily as the expression par excellence of spectacular American opulence, a means of communicating class distinctions among the haves and have-nots.

The audible is much more than a sound produced by gas coming out of solution when a joint is suddenly distracted, or a sound resembling that of a glass being lifted off a wet counter top. The audible remains the basic entity through which the doctor and the patient communicate and exchange perceptions. The experience of hearing an audible establishes through its immediacy that something was in fact accomplished by the HVLA thrust. This experience is the distinctly chiropractic equivalent of a cornerstone tenet of modern physics, which replaces the Newtonian concept of mysterious forces (that somehow accomplish action at a distance) with a quantum mechanical model in which bodies interact through the exchange of particles (photons, pions, etc.).

Virtually all chiropractic techniques by necessity employ some means of furnishing instantaneous sensory experience to the patient that something has happened. The audible, which happens to invoke the sense of hearing, remains the outcome measure of choice, possessing the twin advantage of having been there from the beginning of chiropractic, and also being blessed with an unsurpassable immediacy, following the adjustive thrust within a very few milliseconds.

Nevertheless, other confirmatory means employing other senses have also been utilized. The visible invokes the sense of sight: thermographic printouts showing "heat breaks," and pre/post-x-rays alleged to show something, etc. Visibles can be very effective, but are inherently vulnerable when the doctor is confronted with questions like, "Are you trying to correct the graph (x-ray, etc.) or the patient?" Audibles of course are prone to a similar onslaught ("Are you interested in the pop or a correction?"), but derive a certain credibility from an important property. The likelihood that an adjustive thrust will be accompanied by increased discomfort is inversely proportional to the clarity of the tone which accompanies it. There is no credible way to explain to the wincing victim of a deafeningly silent or raspingly inharmonious osseous adjustment that, even though the audible was dirty or even absent, the vaunted "correction" was somehow made ... the joint is moving better ... the spasm is reduced ... there's less inflammation now.

And then there are touchables, like muscle testing in AK and arm fossa testing in SOT. Supposedly, it is possible, by means of subtle reflex phenomena, to derive diagnostic information about the body and perform therapeutic maneuvers accordingly, all based on indications derived from the strength or weakness of indicator muscles. I know from personal experience that patients are often impressed by such wizardry, but rarely believe deep down that I am pushing with equal enthusiasm from one muscle test to another.

I of course share that same skepticism. After all, since I usually have a vested interest in the outcome of any one muscle test, maybe I produce whatever outcome I expected in the first place.

Palpation of tender and trigger points, another commonly employed touchable, lacks some degree of credibility for the same reason. Neither the doctor nor the patient can be sure that the locations tested are exactly the same and the pressure uniform from trial to trial. There are, nonetheless, studies showing fairly good interexaminater reliability for tenderness testing,[3] and better yet, the continuing development of soft tissue algometry technology.

[Among the traditional five senses, this leaves only smell and taste unrepresented as a vehicle of doctor-patient exchange. The medicolegal climate being what it is, this is almost certainly a good thing. Nonetheless, any readers who are aware of smellables or tastables in current use by chiropractors as outcome measures are asked to contact the author.]

One can always assess the significance of an entity by the quantity and the quality of the effort expended by detractors to establish its insignificance. In short, there is a concerted effort within chiropractic to drive a wedge between the audible and the so-called correction. Whenever the subject comes up, which is surprisingly and revealingly often, the audible is contemptuously dismissed as a tacky and occasional accouterment to the vaunted correction, or what's worse, buried beneath a pile of extemporaneous mumbling concerning its purely acoustic existence.

It has become fashionable for technique gurus to self-righteously declare themselves above the audible even as they swoon with all the rest before the volume of the legendary "deep set." Even as they minimize its inherent importance, they pound away with fearless abandon, and even turn the patient over on the other side, if repeated maneuvers fail to evoke the "therapeutic click" (Grieve).

Once, at an extremity seminar I attended, one of the participants asked the instructor to adjust her neck. Having unexpectedly failed in his first three attempts on the left side of her neck, the instructor (who happened to be a big and beefy guy and appeared sort of frustrated and even embarrassed) declared that he would approach the subluxation by "pulling it from the other side." Three failed attempts later on the right side of the neck, during which the patient was almost decapitated, the instructor was compassionate enough to declare that, despite his having failed to produce an audible, the correction had taken place. The patient knew better.

I understand why chiropractic students, should they happen to get some audibles while positioning the patient, nervously proclaim, "It went on the set-up. No thrust is required." They often take cheap facet rattling for an adjustment. The case of experienced clinicians, who observe on a daily basis that good HVLA adjustments tend to make noise, and yet pretend that audibles don't matter when push comes to shove, is far more complex. Why are we so ashamed of our tradition? The obligatory and ritualized denunciation of the audible is an obvious manifestation of an organized if unconscious schizophrenia. It equates to the dishonesty of the Little League coach who insults his vanquished ball players by stupidly reminding them: "It doesn't matter whether you win or lose, it's how you play the game." They, like the patients, know better.

References

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