

# Health Insights Today

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## 21<sup>st</sup> Century Chiropractic Principles and Practice: Interview with Leonard J. Faye, DC

By Daniel Redwood, DC

Leonard John Faye, DC, has been a pioneer in chiropractic theory and practice since the 1960s. Best known for developing and popularizing the dynamic model of the vertebral subluxation complex, Dr. Faye has also played a key role in teaching motion palpation and adjusting methods. He is the co-author of the book, *Motion Palpation and Chiropractic Technic*.

Born and raised in Canada, Faye attended Canadian Memorial Chiropractic College in Toronto and first practiced in rural Ontario. He was among the first faculty at the Anglo-European College of Chiropractic in England and later moved to the United States, where he has practiced for many years in Los Angeles. Dr. Faye recently joined the faculty at Cleveland Chiropractic College – Los Angeles, where he teaches a series of technique courses.

Dr. Faye's website, [www.chiropracticmentor.com](http://www.chiropracticmentor.com), offers video presentations of his palpation and adjusting methods.

*What was your first experience with chiropractic care?*

When I was 17 years old, I contracted rheumatic fever and this put me in bed. All my joints were swollen and I was in excruciating pain. My dad had to build a wooden frame to keep the sheets off me, because even the weight of the sheets and cover were too painful for my joints to withstand that pressure. As you know, we don't get rheumatic fever any more in our society because penicillin kills the streptococcal infections that give you the immune response and give you polyarthritis. I was on aspirin (three every four hours) for two and a half months, which caused me a tremendous amount of digestive problems. During that time, I never put my foot on the floor. Finally, my dad said, "You're just getting weaker and weaker. Let's get a chiropractor in here and see what happens." At the time, medical doctors were telling parents that 42 percent of kids with rheumatic fever died and 75 percent of those that survived had serious heart trouble.

So Dr. Murphy came with a portable table and put it beside the bed. He and my dad lifted me onto the table and he did an adjustment in my mid- to upper thoracics. There were huge audible releases, multiple audible releases, in the upper thoracic region. Then they lifted me back into bed and away he went. The next morning when I woke up, probably 50 percent of my joint swelling was gone. I was able to get up out of bed, go to the toilet and have a bath. It was quite a dramatic change. I had this sense that I was going to heal and get better. My fever broke and in about two to three weeks, when they re-did my sed rate [erythrocyte sedimentation rate is a marker for inflammation], it had dropped from the high 40s (0-10 being normal) to something like two or three. After that, I made a steady recovery and had a few more adjustments with Dr. Murphy and was able to go back to high school in the fall.

*And this led to a major change in your career plans.*

Yes. At that time, I was training to go to the university to become a chemical engineer. I was specializing in math, chemistry, physics, and all the sciences. When I had this experience, I decided that I was going to become a chiropractor so I could help other people experience such a dramatic change in their health. I ended up fully fit again, no heart trouble. Everything was fine.

# Health Insights Today

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November/December 2009, Volume 2, Issue 6

Page 2

*Looking back on that now, what do you think would be the most reasonable explanation for your dramatic response to chiropractic, and the influence of the adjustments on this diffuse and severe joint inflammation?*

It's an interesting thing. In four years at chiropractic college, I never did find out why I responded like that. None of the explanations were satisfactory. And then, upon graduation I was very fortunate that in starting to study and research, in my reading I came across the work of Hans Selye, his book, *Physiology of Stress*. If you read Selye, you'll recognize that all immune and autoimmune responses are controlled by the sympathetic nervous system, which can cause the hypothalamus, the adrenals, etc., to produce pro-inflammatory hormones. Now a hormone can go to every joint and make every joint swell. Examples are the prostaglandins, the kinines and other inflammatory mediators.

I began to realize that the upper thoracic adjustment I had received was in an area where the sympathetics originate. And they obviously were facilitated, which is something I had read about in the work of Irwin Korr [one of the great physiology researchers of the 20<sup>th</sup> century]. I realized that an adjustment can cause a facilitated sympathetic nervous system to relax and no longer be facilitated, thus allowing the parasympathetic system to get control again. The decreased sed rate was proof positive that those proinflammatory hormone levels had been reduced, because sed rate is a measure of inflammation.

*Expanding on this, the functional model of the vertebral subluxation complex (sometimes known as the Faye model) is now widely taught in chiropractic colleges. Could you summarize its perspective and tell us about its main points.*

The *subluxation complex* goes back to 1966, when I was preparing to teach at the Anglo-European Chiropractic College, to start a program there. I was going to be teaching baccalaureate students from Europe who would already have a good basic science background. About that time, I received a paper from the ACA that led me to the conclusion that as chiropractors, we were dealing with neurobiological mechanisms and joint dysfunction. We were also dealing with muscular changes (hypertrophy, atrophy, spasms, and degenerative changes). We also had the inflammatory response occurring around certain joints and in certain nerves. In addition, I was well into reading all of Selye's experiments in his textbook, *Stress*, where he discerned how mammals respond to stress, protecting themselves or healing once there is a disease process.

It boiled down to five components – the biomechanical, the neurological, the muscular, the inflammatory and the stress response. So I put that all together and called it the subluxation complex. I taught at the Anglo-European college that the purpose of the orthopedic and neurological examination was really just to discover what the pathologies were, and that we needed an additional examination component to look at function of the whole locomotor system, because we saw that the spine was part of a closed kinematic system.

A key point here was that the spine couldn't be treated individually but had to be evaluated as a component of the locomotor system. And then, of course, we taught about inflammation at a really high level. We also attempted, without having a huge physiology department, to show how you determine whether a patient is under stress and in a stress response or a failed stress response. So now we had a way of determining what surgeons call the constitution of the patient. But rather than determining whether our patients were strong enough to respond to surgery, we had to determine whether they were ready have a general healthy adaptive response to what we were doing.

*What would be some of indicators of the presence or absence of this ability to respond to chiropractic treatment?*

# Health Insights Today

A SERVICE OF CLEVELAND CHIROPRACTIC COLLEGE

November/December 2009, Volume 2, Issue 6

Page 3

There are a number of them. If the patient perspires really easily, if they're very jumpy when they hear a noise or a shout, if they pace because they're unable to stand or sit still, if they don't sleep very well, and if the digestive system is really upset. *Those are all signs of being in a state of fight-or-flight.* Your blood pressure rises, your heart beats faster. There is a hyperesthesia to "skin rolling" by the spine or to pinprick in areas of spinal irritation. Spine dysfunction produces facilitation, as Irwin Korr's extensive research in this area demonstrated.

*I have a question about the relation of theory and practice. As any health science evolves, the best explanation for how a particular treatment (such as a chiropractic adjustment) works will naturally change and develop over time. What happens, then, when some doctors still cling to the old explanatory model? This would apply to chiropractic, medicine or any other healing art.*

What you're saying is that if you're using some sort of chiropractic system, and you obviously get good results, how does that interface with the possibility of having a new system that also would get the same results? With regard to the subluxation complex, if you don't understand these components and you're not interfacing with them, you will not have the same ability to predict whether a patient is going to respond or not respond. You do what you do and you see whether the patient is going to respond. I strongly believe that the chiropractor's work becomes way more predictable when we monitor the five components of subluxation complex, with regard to how many visits the patient will need, for how long, and what to expect from visit to visit. That's the benefit of understanding what you're dealing with.

*To what extent do you believe that chiropractic adjustments have a preventive effect?*

I believe that a manipulation, an adjustment, that causes an audible release, is therapeutic only if the joint is dysfunctional when it receives the manipulation. So to practice prevention, we have to be able to identify a manipulable lesion, or a dysfunctional joint, and do a manipulation that actually improves the dysfunction. Then, it will prevent the body from having to adapt to that dysfunction in ways that could eventually lead to inflammation, degenerative changes, etc. But to just take every patient, lie them on the table, do two lumbar rolls, a thoracic crack, and two cervical cracks, will not, I believe, result in a preventive experience...

We need to be treating patients in the early stages of losing their health. We're not disease managers like medicine; they're excellent at doing that. We're involved in prevention and health promotion, at least we should be.

*So you would generally subscribe to the adage, "Chiropractic first, drugs second, surgery last"?*

Absolutely. It's one of the few slogans I illustrate in my practice.

*You are now teaching at the Los Angeles campus of Cleveland Chiropractic College. What does your work there involve?*

I'm very fortunate. I'm teaching the Tri III class in learning manipulation skills, along with the technique courses in Tri IV, Tri V and a Tri VI review class. So what I'm able to do is teach students methods of thrusting – recoil, body drop and impulse. We've put together about 180 different manipulations of the spine and extremities, and we've put out a workbook describing how to perform each of them. The goal is that the students attain a level of "conscious competency" by the time they enter clinic in Tri VII. So instead of learning something in one course and then losing that knowledge for lack of review, each class builds on the previous classes and includes review of what was learned in the previous classes. We're seeing a high level of skill development. It's very exciting.

# Health Insights Today

A SERVICE OF CLEVELAND CHIROPRACTIC COLLEGE

November/December 2009, Volume 2, Issue 6

Page 4

*That sounds very satisfying. Looking forward, in an ideal future, how do you see chiropractic developing over the coming generation?*

I think there's going to have to be a standardization of care. I see our technique programs melding, so that there will be no such thing as the "guru system." The focus will be generic manipulation, by which I mean that the student will know how to do upper cervical recoil, the student will know how to do the placement of the blocks for SOT [sacro-occipital technique], the student will know a wide variety of manual manipulation methods, but it won't be called Upper Cervical Specific, it won't be called SOT, and it won't be called Gonstead. And the techniques that say, for example, that one finger is positive while another is negative, or the techniques that "talk to the feet," will be dropped.

We will have a rational integration of techniques that are taught with the foundation of biomechanics, the foundation of muscle assessment, recruitment order, feed-forward mechanisms and more. So we will have generically trained, evidence-based chiropractors that the rest of the world can talk to, and we will be able to talk to the rest of the world. People will learn to respect our field.

*Is there anything else you'd like to add?*

What I'd like to say in closing is that I look to the day that students read extensively, including going outside the box a little bit, and really start to comprehend the philosophy of a drugless therapy. And that they understand that we are going to help society to be much healthier starting with our work with younger patients, from childhood onward. We can adapt a healing philosophy that helps society and get away from a philosophy where we come first and the patient comes second.

Chiropractic must be evidence-based, not faith based. There's a transition that has to occur at the student level, so instead of students trying to pick a technique to become a disciple of, they instead will develop individual knowledge in the fields of biomechanics, inflammation, Selye's stress model, adjusting skills and more. We will have, if our students will adopt this kind of philosophy, a very strong profession. Because we graduate something like seven or eight percent of the profession every year, we can change the profession in ten years.

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