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The bi-directional adjustment? / L'ajustement bidirectionnel?

Jordan A. Gliedt, DC[1]

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Banking – How I Was Taught to Learn

Unknowingly, much of my life had been lived under the same implicit messaging. I was a student striving to receive a deposit of knowledge so large that I could reach "expert" status. Like those before me, I passively received knowledge from professors, then demonstrated my "expertise" through regurgitation on examinations or imitation of professors' clinical techniques. I was pleased to eventually be given a title of "doctor" indicating my "expertise" and "authority".

As a young clinician I embodied this same model with patients: they were assessed and assigned a diagnosis by the "authority" (me – the "doctor"), and ended with treatment prescribed and performed by me, the "expert". This model was efficient and yielded a dependable technician who could manipulate the spine and soft tissue, prescribe home exercises for the patient to *comply* with, and provide educational information *for* the patient. This model also created hierarchy. Like teachers as "experts" and students as recipients, clinicians were "authorities" and patients were cases. Knowledge and interventions traveled in one direction – from "expert" to learner, from clinician to patient – rarely, if ever, did it travel back. This model was natural, even necessary, I thought. I accepted it, and in fact, reveled in my ignorantly distorted perception of self – the "expert".

Dialogue – How I Experienced Learning

Several years after being made into a clinician, I encountered a classroom that reimagined what "expertise" is. I

[1] Department of Neurosurgery, Medical College of Wisconsin, Milwaukee, WI, USA

Corresponding author:
Jordan A. Gliedt, Department of Neurosurgery, Medical College of Wisconsin, 1155 N. Mayfair Rd. Milwaukee, Wisconsin, USA 53213
Tel: 414.955.7199
Email: jgliedt@mcw.edu

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enrolled in a course that held a different heirloom at its center: Paolo Friere's critique of the banking model of education and his proposal for dialogical, problem-posing pedagogy that embodies co-learning.[1] Instead of passively receiving knowledge from our "expert" professor, we sat in a circle, posed problems from our academic and clinical lives, and co-authored responses through a model of dialogical co-learning. The professor did not bank knowledge into us; he facilitated inquiry, supported thought, and participated as an equal learner in communal dialogue.

This class felt awkward at first. I was accustomed to receiving information or, yet, giving information as a clinical "authority". However, I began to feel humbled and liberated as an active co-learner of knowledge with co-creation of solutions to problems. I realized I previously learned to *speak* with "authority" without appreciating how to *listen* as a member of a communal learning ecosystem that respects every human's inherent lived experience and expertise.

Bringing Dialogue into Clinic

As chiropractors, we commonly engage with patients experiencing pain. Upon exposure to Friere's pedagogy, I started interrogating the traditional clinical encounter in the context of pain. Pain is an experience that, arguably, is dynamically shaped by interactions between one's entire being, including unique bodies, environments, experiences, and contexts.[2,3] Thus, I questioned the value of banking in clinical care in many circumstances. How could I have any clue without *listening* and *valuing* patients' inherent expertise and lived experiences? Could we transform the clinical approach by facilitating dialogical co-learning of an individual's meaning of pain with a co-created plan?

As I began to practice this approach, I worried that inviting patients' input might give the impression I was uncertain and lacking "expertise". I questioned the theory of dialogical co-learning and was afraid patients wanted a clear "authority". Contrarily, I found asking for patients' perceptions and experiences did not undermine trust – it built it. Patients valued being seen as knowledgeable about their own bodies and lives. When asking patient's perspectives and encouraging a space for partnership, many have leaned in and become co-authors of their clinical plans. Many patients have been explicitly grateful for this approach and found it to be empowering.

Dialogue as Practice and Ethic

This approach to care has not come without criticism. As I shared this approach with colleagues, some have openly criticized it as clinically inefficient or unnecessary. I acknowledge and appreciate clinical time demands. Nevertheless, I argue that dialogical practice may be more than just a clinical approach. In some circumstances, could it be an ethical requirement – a stance of humility and professionalism that is centered on patients?[4] A dialogical approach asks the clinician to relinquish the illusion of total knowledge and instead treat each encounter as an opportunity for mutual learning.

In health professions education and clinical practice, the banking model is prominent. Of course there are reasons for this, including the need to establish an intense understanding of information with precision. Friere argues, though, that the banking model can potentially inhibit critical thinking and problem-solving skills and, instead, foster oppressive, hierarchical structures.[1] Friere argues that a dialogical approach can potentially re-humanize the relationship between [clinician and patient], transforming the relationship to *with* instead of *for*.[1]

Pragmatically in a pain-related clinical setting, assuming there are no emergent circumstances with equivocal options available, a dialogical approach includes open-ended questioning, reflective listening, and shared-goal setting with co-development of the meaning of pain. Ethically, it means valuing patients' perspectives as an integral component in the discovery process, shifting focus of "expertise" from an isolated object that can be banked to an essential, integrated source of meaning within the patient-clinician relationship.

The Bi-directional Adjustment?

As a chiropractic student I thought I needed to become an "expert" at adjusting [spinal manipulation]. However, I perceive the most important adjustments I have made have been relational, not manual. The introduction to Friere's pedagogy has allowed me to recognize that clinical care, like education, is often something that is built communally, not merely delivered in isolation.

When I enter a clinic room now, I remind myself that both the patient and I are students of the same body and

worldly phenomena, both searching for understanding. So much of clinical care has traditionally been centered around an "expert" alleviating pain through knowledge translation and intervention, such as the adjustment [spinal manipulation]. So, I ask, does this clinical care approach need to be reimagined? Perhaps, does the most meaningful adjustment occur when two people meet and are simply willing to learn from one another? Maybe, when we transform this approach we see a new adjustment, and its bi-directional.

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