

The Biopsychosocial Model in Academia: Philosophy or Best Practices?

Like the concept of the 'subluxation,' the meaning of the biopsychosocial model of healthcare can be disputed. Generally, however, it embodies the idea that a milieu of biological, chemical, emotional, behavioral, social and personal factors all intertwine to determine human functioning in the context of dis-ease or wellness. When discussing the application of this model, it is generally contrasted with the traditional reductionist biomedical model of medicine which intimates that every disease can be explained by an underlying biological process (1). Dispute over the model arises not from the concept itself, but rather from its related philosophical paradigm. Some, particularly those involved in complementary and alternative medicine (CAM), prefer to interpret the model as epitomizing the mind-body connection (2); others view this model as a logical extension of the biomedical model to include non-traditional psychosocial factors that either arise from, or result in, biologic effects (3,4).

The psychosocial aspect of the biopsychosocial model has been incorporated, in varying degrees, into many healthcare professions. Psychologists, for example, work almost entirely from these concepts. Only recently has the concept formally gained any ground in the chiropractic profession. In 2005, the World Federation of Chiropractic unanimously agreed on a definition for the identity of chiropractic, which included supporting statements claiming that chiropractic doctors employ a "patient-centered and biopsychosocial approach, emphasizing the mind/body relationship in health, the self-

healing powers of the individual, individual responsibility for health, and encouraging patient independence” (5). While some institutions, such as that of the World Health Organization (6), do not include a holistic patient approach in their definition, others such as the Association of Chiropractic Colleges acknowledge that chiropractic “emphasizes the inherent recuperative power of the body to heal itself without the use of drugs or surgery” (7).

George Engel, a psychiatrist, brought this concept to the forefront of the collective healthcare world in 1977 when he intimated the need to both embrace a broadly inclusive “systems”-based intellectual framework and to train a new generation of “biopsychosocial” clinicians (1). However, medicine has not traditionally embraced these views... but this is changing, as evidenced by an increasing number of recent studies employing either psychosocial or biopsychosocial approaches to low back pain classification (8). As a further example, Kaiser Permanente has recently launched a massive campaign stressing their “Thrive” message, emphasizing their commitment to total wellness, offering a wide range of holistic services to their members. These services include programs to monitor total health, manage chronic conditions, lose weight, improve eating habits, quit smoking, reduce stress and manage pain (9). Few could argue that Kaiser’s approach conflicts with the primary tenet of healthcare, *primum non nocere*, however the reasons for their embrace of whole-body medicine are unclear. Could it be that the public demands a more holistic approach to their medical experience? Or perhaps it is simply more cost-effective to address the entire person,

with the end result being fewer office visits per patient. Either way, it could be argued that the patient receives better, if not more complete, care at each doctor visit.

It is for this very reason that chiropractic academia must embrace the biospsychosocial model. Healthcare is not about the philosophies, the models embraced or the bottom line of the practitioner; healthcare is about the best possible care for the patient leading to the best possible outcome of health. This is analogous to education being about student learning and not the act of teaching itself. In order to promote complete patient health, it is important that chiropractors be “patient health” practitioners. The completeness of the biopsychosocial model addresses the patient in many contexts, allowing the doctor a wide-lens view of the world in which the patient lives, in turn providing a wealth of information from which the doctor can make appropriate diagnoses and treatment plans. Thus, the rank and file academic foot-soldiers must do everything possible to graduate quality “patient health” providers.

It can be argued that chiropractors and chiropractic academia should embrace the biopsychosocial model to help construct and maintain a professional identity separate from medicine. Although the chiropractic relationship does not necessarily engage the psychosocial aspect of a patient’s life, the very nature of chiropractic practice necessitates an intimacy with patients that most medical doctors cannot, or will not, forge. Thus, it could be stated with some certainty that the chiropractic identity (as varied as it is!) is already more geared toward promoting complete patient health than

most other medical healthcare professions. The biopsychosocial model, then, can be viewed simply as an extension of a philosophy already embraced by the profession.

The role of chiropractic academia is multifaceted; there are responsibilities to the student, the institution, the profession and the public. The student is owed quality education, truth and a vision. Would it not be considered an error of omission to ignore the psychological and social context of patients and focus solely on neuromusculoskeletal complaints? The reader is challenged to imagine a chiropractic program in which students are not taught to record a patient's activities of daily life in a patient history, but instead to focus only on the objective measurable complaints.

Undoubtedly, such a program would graduate doctors with less compassion for patients and a lessened context in which to understand complaints. Together, this would result in less specific and less functional patient care with poorer outcomes. On the other hand, employing the biopsychosocial model in the curriculum opens students' eyes to the context of the patient experience allowing for better care through patient-specific functional outcome measures.

The responsibility of chiropractic educators to the institution, the profession and the public are similar in that there is the expectation that only quality healthcare professionals are produced. Specifically, educators should not only mold technical practitioners, but also critical thinkers. Training students to employ all available information, using the tools provided in school, to properly diagnose and treat patients is truly the crux of the educational experience. Should the biopsychosocial model not be

given as a tool to the students through education, the skill set of the new doctor would be, by definition, limited.

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Word count: 1006