

## **EDITORIAL**

### **A BIOPSYCHOSOCIAL-SPIRITUAL MODEL IN HEALTH**

Next year, the biopsychosocial model will reach her 40th birthday!

Engel<sup>(1)</sup>, in 1977, took a major step in favor of the health personnel and their patients, when he advocated that the dominant model of disease, the biomedical model, was insufficient. He proposed a biopsychosocial model useful for research, teaching, and health care.

Nevertheless, even today, its advocates do not implement this model routinely, much less universally. Mc Inerney<sup>(2)</sup>, in 2015, emphasized that “medical professionals will need to be familiar with the research identifying the health risks associated with different behavioural and social conditions and not just the biological illness itself. Therefore, it is no longer sufficient for clinicians to state that treatment is successful in terms of its effect on a specific biological illness, but it is now also necessary to know whether the treatment gives significant improvement over the way in which a person lives.”

Analyzing the biopsychosocial model, Borrell-Carrió, Suchman and Epstein<sup>(3)</sup> argued that “it may be that the content and emotions that constitute the clinician’s relationship with the patient are the fundamental principles of biopsychosocial-oriented clinical practice, which then inform the manner in which the physician exercises his or her power”. They added that “the physician’s skills should be judged on their ability to produce greater health or to relieve the patient’s suffering—whether they include creating an adequate emotional tone, gathering an accurate history, or distinguishing between what the patient needs and what the patient says he or she wants”. “Mindfulness, the habits of attentive observation, critical curiosity, informed flexibility, and presence, underlies the physician’s ability to self-monitor, be vigilant, and respond with compassion”.

One criticism to the biopsychosocial model is that it is not an adequately guiding: “reminding us to pay attention to three aspects of illness. Then the question becomes: how do we choose? How do we prioritise one aspect versus another? .... The biopsychosocial model, as classically advanced, does not guide us on how to prioritise. Consequently, prioritisation happens on the run, with each person’s own preferences, and the model devolves into mere eclecticism, passing for sophistication”<sup>(4)</sup>.

Sulmasy<sup>(5)</sup>, in 2002, presented a more comprehensive model of care and research that takes account of patients in the fullest possible understanding of their wholeness—as persons grappling with their ultimate finitude. One may call this a biopsychosocial-spiritual model of care. In other words, this biopsychosocial-spiritual model is not a dualism in which a soul accidentally inhabits a body. Rather, in this model, the biological, the psychological, the social, and the spiritual are only distinct dimensions of the person, and no one aspect can be disaggregated from the whole. Each aspect can be affected differently by a person’s history and illness, and each aspect can interact and affect other aspects of the person. Consequently, when caring for people at the end of their lives, this new model suggests that the patient comes to the clinical encounter with a spiritual history, a manner of spiritual/religious coping, a state of spiritual well-being, and concrete spiritual needs.

Katerndahl e Oyiriaru<sup>(6)</sup> developed and validated an instrument to assess each dimension in terms of its specific symptoms and functional condition in primary health care users and obtained promising results.

If these brief notes suggest that there has been no stagnation around the biopsychosocial-spiritual model, it is important, however, to stress that there is a long way to go and much to be done. It is worthwhile to continue exploring the potentialities and limitations to this model in a critical way, which is not always the case. Only by knowing the model limitations, we will be able to train health personnel with a holistic and spiritual view. By any means and wherever we go, we do not walk in the direction of words attributed to Leonardo da Vinci: “Poor is the pupil who does not surpass his master”. We must collaborate daily to improve the model that has been shaping our practice in the last 40 years ...

### Referências

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