The biopsychosocial model, which has extraordinary merit for explaining and predicting health and well-being, has had relatively limited acceptance over the past 25 years. There may be a variety of reasons for this, but the forces that shape medical education must be taken into account if the biopsychosocial model is to be more fully accepted than it is currently. Two factors, medical school financing and medical school curricula, that are influenced by powerful forces within medical education are examined. Unless these forces are moved in a direction to benefit from the biopsychosocial model, it is unlikely that this important contribution will be fully acknowledged.

Keywords: biopsychosocial model, family medicine, medical education policy

Cynics, it has been said, are idealists who have met with too much disappointment. Those of us who have a long-standing belief in the power of the biopsychosocial model qualify as pretty major cynics, given the disappointments we idealists have endured over the years. The relative lack of acceptance of the biopsychosocial model, as described by Engel (1977), is a prime example of how idealism can turn to cynicism. Joseph Herman, in an article published in this journal some 16 years ago in 1989, stated several reasons that the biopsychosocial model has not had widespread acceptance. The reasons he discussed included difficulty teaching it, difficulty applying it, and its lack of a “nosological glossary.” All of these reasons may be valid, but, in addition, there are larger and, dare we say, more cynical forces afoot that may impede the progress of implementation of the biopsychosocial model. Idealists are rarely pragmatists, and pragmatism is what is required to promote the acceptance of a philosophical approach to health care. One of the important venues for the acceptance of the biopsychosocial model is the educational system that produces new physicians.

The financing of medical education has changed radically during the past 28 years that the biopsychosocial model has been in existence. Medical schools traditionally have had difficulty changing, but in the last 25 years, money and its influence have shaped medical education like never before. The massive influx of clinical dollars—now accounting for 48% (44.9% public and 50.9% private) of operating reve-
nues of medical schools nationwide—has created a preeminence of high-earning, politically powerful clinical forces that now dominate the medical education landscape (Association of American Medical Colleges, 2005). At one time, prior to the mid-1960s, medical schools were funded primarily as schools, and clinical income was a relative nonfactor in the shaping of curriculum or any other academic enterprise in medical education. But today, there is an undeniable influence of financing on every aspect of medical education, including curriculum. To assert otherwise would be to ignore a vast reality of medical education in the new millennium.

Changes in curriculum—the academic experiences that shape the physicians who graduate and become practicing doctors—are necessary if there is to be acceptance of any worthy philosophical model, biopsychosocial or otherwise. And curriculum change is hard to come by, even under the best of circumstances. Furthermore, curriculum change is rarely achieved by a passion for driving philosophical precepts. Medical schools are inherently practically minded when curriculum reform is undertaken: It is often accomplished for the purposes of meeting immediate needs rather than to satisfy the demands of even the most worthy of scientific models.

In 2005, it is unlikely that a dean of a medical school will find himself or herself in a position of championing curriculum reform for the purpose of promoting biopsychosocial concerns just because it is a good idea. To be sure, some deans have championed curriculum reform, and the results are notable. But it is indeed rare that deans find curriculum reform to be their highest priority, and it is rarer still that they will spend political capital to ensure that curriculum reform is undertaken, and political capital is what is required to influence curriculum committees. More often curriculum changes are conducted within the philosophical confines of curriculum committees, which are composed of faculty who control the makeup of medical school curricula. The curriculum may be driven by the administration, but it is ultimately determined by faculty under Liaison Committee on Medical Education (2003) guidelines.

Medical school curricula are largely determined by political factors and not by philosophical precepts. Anyone who has served on a curriculum committee (as both of us have) knows how they operate. Curriculum “reform” in most medical schools is conducted as a zero-sum game with very few degrees of freedom within a relatively rigid structure. One course may be lengthened, but only at the expense of shortening another. “Another” usually means a course from another department, which may exact its retribution for having had its course shortened at some point. Thus, the curriculum game is played within its own set of rules, with insufficient concern for a guiding set of philosophical precepts such as a biopsychosocial (or any other model). We make the assumption that a politically representative body will reflect the best wishes of the school, but that is often not the case. It simply means that meaningful change is usually averted in favor of incremental change. And, in this context, it is rare that a dean will step in with a strong directive for change unless there is a fabulous reason to do so, such as a true commitment to the biopsychosocial model.

So, in this environment of economic, political, and cynical forces, who are our allies for the establishment of a biopsychosocial model of medicine? They are few, and these allies would be required to be both (a) committed to the biopsychosocial model and (b) politically influential in their schools. This is rarely the case on either count. On occasion, members of family medicine departments have mounted valiant efforts to effect curriculum reform in their medical schools. A recent example was the ascendancy of primary care curricula and the advent of primary care deans within schools to promote a generalist curriculum. Having reviewed numerous curricula from
primary care reform movements, we saw little evidence of biopsychosocial underpinnings to them.

Many practitioners in family medicine have unfortunately abandoned biopsychosocial approaches as a direct response to perceived pressures from medical school administration and faculty. Or, perhaps they did not subscribe to them fully to begin with. This is another dilemma in effecting curriculum change: Someone has to believe in an approach to be a champion of it and attract allies to make it happen. If students are not steeped in the biopsychosocial model, where does that process begin? A critical mass of faculty has yet to develop in most medical schools.

One of the most worrisome facets of the involvement of practitioners of family medicine in the promotion of a biopsychosocial model is their own tendency to disown this potentially powerful foundation of care. The most recent example is the report released by the Future of Family Medicine Project Leadership Committee (2004) of the Academy of Family Physicians with participation from other organizations throughout the family medicine community. In this report, practitioners of family medicine are shown to overlook its own value system. Although the “core values” of a family physician are articulated at the opening of the report, they are subsequently ignored in favor of concepts such as a “market basket of services” and administrative structuring of practice models. If this is the future of family medicine, it is one in which delivery of care is emphasized over the basic principles on which that care is built. Perhaps there were too many committees involved in the construction of the report for it to have retained a philosophical point of view, but it is truly unfortunate that an opportunity was missed to articulate the dimensions of a model on which family medicine is based.

Family medicine has such a rich inclusive history—having been established by political forces far beyond the medical school—that it seems to have become almost too inclusive, engaging in “visioning by committee.” Have we now arrived at the point at which we wish to be everything to everyone and, in so doing, become nothing to anyone? Some of the original framing documents of the field of family medicine are notable for their insistence on biopsychosocial approaches to medicine, but what is their current role? The name family medicine was created for a combination of philosophical and political purposes, but has the philosophical been dropped in favor of the political? Today, the identity of family medicine must be asserted with the conviction it was born with but has rarely been seen in the past 25 years.

Family medicine still offers the greatest hope of implementation of the biopsychosocial medicine in medical schools. But to do so will require that we adopt a far more assertive posture than we have been willing to in the past. We must understand the political forces that work within medical schools. We must see medical schools as more than merely a source of medical students whom we recruit on an annual basis into our residency programs, but for what they are: the engines that power the entire multibillion dollar operation that is the American medical care system, educating the physicians of tomorrow. We have an enormous opportunity to fuel these engines and affect the students who graduate from our medical schools. Although we have made tremendous inroads in gaining curriculum time, we must bring more to the curricular equation: We must bring our values of biopsychosocial medicine as well. Are the values of the biopsychosocial model compatible with medical school curricula? Yes, they are, but only if we say so and are willing to take the risks necessary to make them happen.

It is of substantial concern that members of few departments of family medicine truly stand for the values of biopsychosocial medicine. It is indeed difficult to promote a model about which we are ambivalent. Herman
(1989) refers to the “split model” of care with “one ear tuned to the organic and the other to the psychosocial.” This allows the practitioner flexibility and reduced guilt for not applying the biopsychosocial model to every patient encounter in a given day. He suggested this approach as a transition until we became “always” able to use the full model. An alternative and more productive approach may be that the biopsychosocial model is applied over time in a continuous doctor-patient relationship. On one occasion the emphasis may be on a biomedical symptom or illness and on another the focus may be psychosocial, but the context of the biopsychosocial approach is the framework and guiding process for all encounters. And it appears that we remain ambivalent about the biopsychosocial approach. Where, for example, is our biopsychosocial research agenda? What departments have established themselves as biopsychosocial strongholds? There are few.

To be sure, funding agencies have not helped the equation either. Biopsychosocial dimensions of care are seen as an add-on at best. The bulk of research funding in the United States comes from the National Institutes of Health, where institutes are focused on disease or organ system entities. Even the National Institute of Mental Health is focused on DSM–IV diagnoses and biomedical treatments. Research into the processes of care and the influences of psychological, social, cultural, and economic factors is rarely funded and largely regarded as “soft-science”—not the purview of the National Institutes of Health. With this perspective on research, the National Institutes of Health can never really live up to this last word in its name, for without researching the application of the biopsychosocial model to all diseases, the goal of maximum health can never be achieved.

If we are to achieve the promise the biopsychosocial model has held for the past 28 years, we must accomplish far more than we have thus far. Thomas Kuhn (1970), in his legendary and often-misunderstood book, *The Structure of Scientific Revolutions*, asserted that a scientific paradigm is useful only for as long as it is capable of describing, explaining, and predicting phenomena. We have an innate sense that the purely biomedical model may be insufficient to accomplish its paradigmatic task in medicine. However, the biopsychosocial model has yet to take full root. The responsibility remains ours to test this model for its full capability to describe, explain, and predict health and well-being. Short of that, it will continue to be largely ignored.

References


