1.1 Difference between the biomedical and social model definitions of health and illness

Introduction:

The process of defining the nature of concepts of physical wellbeing, disability, and pathology extracted from a research-based perspective has engaged much of current health care theory. Some scientists assert and suggest that such conceptions are value-free and elaborated similarly that molecule, material, and rainstorm are. To claim that someone has a sickness or is diseased is to describe them (Nordenfelt, 2007). The medical paradigm, on the other hand, makes full involvement in a society reliant on the removal or 'trying to overcome' of disability – complete engagement in society should only be found through remedy or willpower. It's no surprise, then, how we have placed such a high value on removing debilitating boundaries and have made every effort to dismantle them.

Experience of disability is not always positive, neutral or irrelevant

We reside in solidarity with many other movements of civil rights, so we have acquired information from them. But there is one great disparity between our and other movements that we all cannot bear. Eliminating disability through public health interventions gets barely a fraction of the attention and funding it deserves. The social and economic individual, as a result of an impairment or disability, that limits or hinders the fulfillment of a regular function, varies with age, gender, social, or traditional circumstances' The causes of disability are widely ignored (Organization, 1980). The concepts of prevention are also debatable, in that popular approaches classify fetal monitoring and subsequently abortion as preventative, but in practice, such action is about the eradication of impairment.

Biomedical models of physical health and ailments

The biopsychosocial paradigm was created to both challenges and broaden the traditional biological approach to medicine. In the field of adolescent medicine, one may see the existing difficulties in implementing the biomedical paradigm in practice. We believe that better implementation of recent evidence can help bridge the gap between practice and philosophy. Medical service can be described in the formula of a group of activities utilized by physicians to assist patients who require medical help (such as asking questions, listening, prescribing treatments, and diagnosing). Definition of 'disease' and 'sickness,' two terminologies rooted in distinct perceptions of an individual's poor health,' dethatch clinical endeavor.

The advancement of the Biopsychosocial Model in Medicine:

Across a large number of papers published from 1960 to 1980 (Engel, 1977a, 1981), George Engel illustrated critically a highly impacting questioning regarding a historically important pattern or medicinal model, "the biomedical model". The author effectively summarized boundaries of scan employment regarding it essential for a novel medically important that Engel himself considered a "biopsychosocial model".

According to Engel, the conventional biomedical model of health, which "assumes disease to be completely accounted for with deviations with the norm of measurable somatic (biological) variables," provides no place for the behavioral, psychological and social elements of illness within its particular framework (Engel, 1981).

The Biopsychosocial Model in Medicine: Key Controversies and Criticisms:

Following (Smith *et al*, 2013), pivotal criticisms regarding psychosocial mollies in three extensive and overlapping segments:

The model's scale was much broad, and it couldn't be implemented effectively. Several other authors have pointed ted out that the psychosocial formulation of the model is too extensive in its scope that it delivers slight directions to medical professionals, which brings up the question of implementing the model significantly without having any associated criteria for locating and specifying concerning patient data (Schwartz and Wiggins, 1985; Freudenreich *et al.*, 2010). It may lead to an overabundance of slightly connected biopsychosocial data, for the formulation of the model much time-taking and ineffective to employ to patients during treatment, causing some of them to question "if thin toe can represent a characteristic of diminishing returns in combating reductionism by inclusionism"

A strategy for identifying relevant psychosocial data was not included in the model (Kontos, 2011). The model according to some authors, focuses on the necessity to obtain biopsychosocial knowledge without offering any practical assistance to aid this procedure. Critics raised attention that the model does not specifically inform the analytical level (social, biological, or psychological) to highlight or when, because it is often unclear which factor is ultimately the reason for a certain condition, all analysis levels act synergistically, and physicians remained to select the category that appears for working significantly (Searight, 2016) without having any rationale for why a certain physician moves in one way or another (Ghaemi, 2009). Despite

multiple condemnations since such perspectives time and models entered traditional medical debates, and undoubtedly traditionally irregular utilization of psychological and social conceptions of wellbeing and ailment in studies and practice, the psychosocial model's broad fundamentals have been progressively underscored in guidelines and policy statements.

The social model of health and illness

The social model of impairment has always been crucial in demolishing the old view of disability as a "personal tragedy" and the repression which it entails.

The focus of standard interpretations has always been on disability or impairment as the cause of human circumstances and disadvantages, as well as disability as the target of treatment.

Any limitation or lack of ability to conduct a process in the way or range regarded for an individual (because of an impairment).

Any loss or abnormality of an anatomical physiological, psychological, or structure or function is referred to as impairment.

International Classification of “Disabilities, Impairments, and Handicaps (ICIDH)” of the World Health Organization includes the following definitions:

The contemporary social model of disability:

Impairment refers to how our body systems function and the consequences that this would have on our lifestyles and activities. A new social model of disability is required. This paradigm would deal with two different levels: a better and clear comprehension of impairment and disability underlying social ideas, and an awareness of a person’s bodily experiences. The abolition of impairment does not always mean the abolition of constraints. For instance, a person’s energy and health levels might limit their ability to engage in various pursuits.

2.1 Key aspects of a range of sociological theories concerning contemporary health and illness

Functionalism emphasizes the importance of customs, practices, traditions, and organizations to the smooth running of society as a whole. Using Herbert Spencer's organ analogy, a common analogy presents many social qualities as "organs" that contribute to society's general health When Talcott Parsons (1902–1979), an American sociologist, established the term "structural-functionalism," it became more of a period than a school of thought.

The Sick Role

Medical sociology uses the term "sick role" to describe persons who are sick's rights and obligations. In 1951, American sociologist Talcott Parsons coined the phrase. When a person is afflicted with an illness, he or she becomes a "sanctioned deviant," sociologist William Parsons claims. Functionalists see the sick as a waste of time and resources. The medical community has a responsibility to keep an eye out for this kind of behavior. According to the idea, a sick person has two rights and two responsibilities. Unwell people have certain rights, including the right not to be blamed for their condition and to be exempted from common social roles. An individual must collaborate with medical staff and try as hard as possible for them to help them become better. As a result of his research, he concluded that people can play the sick role in one of three ways: conditionally, unconditionally, or neither (a condition stigmatized by others) (Nordenfelt, 2007).

Critics of the Functionalist Perspective

Functionalist and Parsonsian school of thought dissidents point out several flaws in their reasoning. The concept assumes that the person purposefully plays the ailing person's role to fit in. As a result, it considers that the individual may not comply with expectations of the sick role, may not give up social responsibilities, refuse to rely upon, and may avoid the public sick role if their disease is stigmatized. It also blames the sick in situations where "rights" may not be applicable (Organization, 1980).

During the 1940s and '50s, structural functionalism was at its peak, but by the '60s, it was in rapid decline. Conflict-oriented approaches and "structuralism" superseded it in Europe during the 1980s. Middle-range empirical theories with no overarching theoretical orientation have

replaced criticism as the dominating method in the subject in the United States. In the opinion of the majority of sociologists, functionalist thinking has passed its expiration date.

The Conflict Perspective

A community's social divides, injustices, and conflicts are believed to be caused by economic and political institutions. One of the fundamental purposes of conflict theories in social science is to emphasize the difference in a group's socioeconomic, political, or material status (Nordenfelt, 2007). Marx believed that workers should perceive themselves as part of a greater class that is united in its opposition to capitalism, rather than perceiving social problems as the fault of individuals rather than the system as a whole.

The Interactionist Perspective

For symbolic interactionism, the central tenet is that objects only have meaning in the context of people's interactions with them in their surrounding environment, and this social interaction is what shapes the meanings people attach to objects, which are then continually reworked by people themselves. Individuals' beliefs about what illness is and why they believe it occurs are the primary focus of interactionists. When "bad" behavior becomes "sick," it's a phenomenon known as the "medicalization of deviance." DE medicalization is a process in which "sick" behavior is normalized once again. When a patient is medicalized or de-medicalized, they are handled differently (Organization, 1980).

The Labeling Approach

According to the health and illness labeling school of thinking, psychological disorders are entirely the result of a person's social environment. "Mentally ill" was originally applied to the labeling theory by Thomas J. Scheff in 1966, when he published Being Mentally Sick (Nordenfelt, 2007). Scheff maintained that mental illness is not a sickness of the mind, but rather a result of society's impact on the individual. He argued that society views certain behaviors as aberrant. To understand and come to terms with these behaviors, society classifies people who exhibit them as mentally sick. In an attempt to meet the expectations of others, some people unintentionally alter their behavior. A person diagnosed with mental illness, according to him,

isn't consistent because they all suffer from the same problem. People with mental illness gradually learn that they must act a certain way, and so they do.

2.2 Evaluate the sociological theories summarized above as applied to contemporary health and illness

The Functionalist Approach

A society's ability to function depends on its inhabitants' ability to retain good health and have access to adequate healthcare, according to Talcott Parsons (1951). When a big number of people are unable to carry out their duties because of illness, society suffers. Premature mortality has a "poor return" to society since it prevents people from completing all of their social responsibilities due to the high costs of pregnancy, birth, childcare, and socialization. Medical care inadequacies harm both those who are sick and those who are healthy. When they recover, sick persons are labeled as "malingerers" or "fakers." William James' concept of the sick role is more closely related to the acute (short-term) disease. Long-term illness makes it difficult for persons who are chronically ill to abandon their duties as caregivers and suffer from their illnesses.

The Conflict Approach

The conflict approach focuses on differences in health care quality and access as a source of conflict (Weitz, 2013). The quality of health and health treatment varies greatly around the world and inside the United States. Social class, color and ethnicity, and gender differences are all reflected in our health and health care. There is an increased chance of disease and a more difficult recovery for those who fall ill because of social poverty and poor health care. There is a mountain of research pointing to disparities in health and healthcare. According to the authors, physicians' quest for a broader range of practice has been both positive and detrimental. Doctors' motivations are viewed as cynical in some controversial approaches to medicine and health care, they argue (Organization, 1980).

The Symbolic Interactionist Approach

Symbolic interactionists argue that health and disease are socially produced concepts. This means that only society and its members can decide what constitutes a healthy mental or physical

state (Buckser, 2009; Lorber & Moore, 2002). To illustrate how the symbolic interactionist theory is concerned, Ritalin's introduction led to a shift in the way ADHD was perceived, from being a disorder to an illness.

Dissertation
Help Services

References

Crow, L. 2010. Including all of our lives: Renewing the social model of disability. In: Equality, Participation and Inclusion 1, Routledge, 136–152.

Engel, G.L. 1977a. The care of the patient: art or science? Johns Hopkins Med. J. 140:222–232.

Engel, G.L. 1977b. The need for a new medical model: a challenge for biomedicine. Science (80- .). 196:129–136.

Engel, G.L. 1981. The clinical application of the biopsychosocial model. In: The Journal of Medicine and Philosophy: A Forum for Bioethics and Philosophy of Medicine, Oxford University Press, 101–124.

Foss, L. 1987. The second medical revolution: From biomedicine to info medicine.

Freudenreich, O., N. Kontos and J. Querques. 2010. The muddles of medicine: a practical, clinical addendum to the biopsychosocial model. Psychosomatics. 51:365–369.

Ghaemi, S.N. 2009. The rise and fall of the biopsychosocial model. Br. J. Psychiatry. 195:3–4.

Ghaemi, S.N. 2010. The rise and fall of the biopsychosocial model: reconciling art and science in psychiatry, JHU Press.

Kontos, N. 2011. Perspective: biomedicine—menace or straw man? Reexamining the biopsychosocial argument. Acad. Med. 86:509–515. Laidler, E. 1979. Definitions of health and illness and medical sociology. Soc. Sci. Med. Part A Med. Psychol. Med. Social. 13:723–731.

Malmgren, H. 2005. The theoretical basis of the biopsychosocial model. Biopsychosocial. Med. An Integr. Approach to Underst. Illness; White, P., Ed.:21–35.

McLaren, N. 1998. A critical review of the biopsychosocial model. Aust. New Zeal. J. Psychiatry. 32:86–92.

Nordenfelt, L. 2007. The concepts of health and illness are revisited. Med. Heal. Care Philos. 10:5–10.

Organization, W.H. 1980. International classification of impairments, disabilities, and handicaps: a manual of classification relating to the consequences of the disease, published by resolution WHA29. 35 of the Twenty-ninth World Health Assembly, May 1976, World Health Organization.

Schwartz, M.A. and O. Wiggins. 1985. Science, humanism, and the nature of medical practice: A phenomenological view. Perspect. Biol. Med. 28:331–361.

Searight, H.R. 2016. The biopsychosocial model: “reports of my death have been greatly exaggerated.” Cult. Med. Psychiatry. 40:289–298.
Smith, R.C., A.H. Fortin, F. Dwamena and R.M. Frankel. 2013. An evidence-based patient-centered method makes the biopsychosocial model scientific. Patient Educ. Couns. 91:265–270.