ICSC Culture Diversity Module 09
ICSC09 _Section 7_Biopsychosocial Model
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Welcome to the Biopsychosocial Model in Sports to Chiropractors' Role.

Health in sports is all about being ready to compete. That is a little different definition than most of us are used to. Primarily, the one that we all use and the one that most organizations and provider groups, and payer systems use is that health is a state of complete physical, mental, and social well-being. Not merely the absence of disease or infirmity. This was developed by the World Health Organization in 1946.

Some thirty-odd years later, Dr. George Engle, 1977, super bright guy from New York with advanced credentials in medicine, he reasoned that something that we as chiropractors knew from our teaching was that pretty much, health is really a confluence of psychological, behavior, and social connections. This became known as the Biopsychosocial Model. That very model is the one that some would argue was built off of the works Palmer. B.J. Palmer's works, when he originally discussed chiropractors' view of what health is and he referred to it as a Triune of Health that highlights the independent nature of the physical, mental/emotional biochemical, and structural influences on health.

In the Sports Community, health for the athlete is the ability to compete. By and large, most of us have not entertained the concepts of the Biopsychosocial model or the elements as they relate to the athlete. That is pretty much what this lecture is about.

My name is Tom Ventimiglia. I am a graduate of New York Chiropractic College, class of 1980. Professional education through NYCC. Private Practice, almost 40 years in Queens, New York. I retired from the New York Chiropractic College, which is now the Northeast College of Health Sciences as the dean of the Department of Postgraduate and Continuing Education. I am an active member of the American Public Health Association of Chiropractic Health Section, an active member of the Federation of International Chiropractic Sports, and I am a member of the National Chiropractic Mutual Insurance Company-Speakers Bureau.

In the elite sports, which is what most of you will strive to or already are in that community, health problems do not have anything to do with the psyche or the environment. By environment, we are talking about the social environment. If all health problems in our sport can be traced back to either traumatic or orthopedic causes, that is the model that is generally recognized in sports medicine.

Take a moment, think about it, reflect on it. Are all the problems that the patients that you see, whether you are treating the athlete, are they by and large problems that have nothing to do with the psychological or sociological aspect of the athlete's life, and they are pretty much all traced back to some traumatic or orthopedic cause?

Do you Strongly agree, agree, neutral, disagree, strongly disagree.

It is perhaps more important for you to reflect on this question because as you approach this question and as your answer is framed, it pretty much defines how you are going to approach the topic. More importantly, how you are going to approach the next patient that you see who an athlete is.

The purpose of this lecture is to introduce you to the biopsychosocial elements that are unique to the professional and the elite athlete, discuss a self-reflective technique called critical consciousness, and then apply the knowledge and create an empathic, supportive patient encounter that guides the patient athlete towards a greater sense of health and well-being.

The learning objectives will discuss the biopsychosocial model, how it influences, the professional-elite athlete; understand the cultural influences that impact the patient-provider relationship. We are going to begin to leave the biological and enter into the psychosocial. You, the doctor, are a key player in this transition. That patient, that athlete, whether they are professional or whether they are weekend warriors and a whole human being. In the case of the professional-elite athlete, there are forces at play that will impact their ability to become healthy. Finally, we are going to talk about a concept called critical consciousness, cultural awareness of the patients that you are treating. By and large, we have a diverse patient population in the athletic community. How you approach them, how you approach your patience has a tremendous impact on the care that they receive.

The biopsychosocial model of health, which is Engle's model gave us a very broad understanding of the factors that cause particularly non-communicable diseases. It influenced the way we practice. It also created the beginnings of what would become known as the integrated disciplinary teams in health care. You may already do this at your private practice. You certainly do this when you are treating athletes, whether it is in college or high school, or professional, or elite. That integrated disciplinary team is what has evolved from the work of Engle.

This is the general idea of what the biopsychosocial elements are. There is the biological, genetic, physical activity, ability, disability. There is the mental aspect, temperament, self-esteem, coping skills, social skills, family relationships, as you get into the social elements, family circumstances, school, peers. These are elements that all come and mesh together, but they have an enormous impact on the patient-athlete. How do they equate when we are talking about a model of health where health is defined for the athlete as the ability to compete?

That was not Engle's original discussion, that is not what the World Health Organization discussed. This is the definition of health according to scholars as it relates to the professional and the elite athlete.

This is a study that was published in Washington School of Medicine. This study gives you an overview of what the biopsychosocial model is. That is our friend Engle. Simply put, biologically, it is associated with disease and certainly, pathology, genetic disorders. In sports, it refers to traumatic injury, and it refers to pain, and of course, acute and chronic pain and dysfunction. That is the biological element. Keep that in mind as we move on this journey about caring for the athlete.

Psychological speaks about the emotional wellness and mental wellness of the athlete. In this case, we are talking about three things. We are talking about anxiety, depression, and health behaviors. Anxiety, depression, and health behaviors that lead to disease and illness.

The social element speaks about the family relationship. Being an athlete often functions in isolation and how that impacts the individual. I have taken this one step further because this concept of social influences on the patient's health have very much been part of the evolution of organizational and institutional, and very often governmental perspective on the impact social influences have on health. It is referred to as social determinants of health.

I urge you to Google that and get an idea because it is the social determinants of health that started to quiet things that impacting the patient and, in our case, professional or elite athlete. That is family, their education, their economic level, their access to care, health care. Sometimes, the only access to health care the college athlete has might very well be through this sport.

Food insecurity, these are determinants of health that was sociological in nature, and they have a traumatic influence on the patient's outcome. How they impact the athlete? That is what we are going to talk a little bit about.

The concept of the social determinants is being championed by the Centers for Disease Control and prevention. That is the website you want to go visit to get a better understanding of these influences.

This is from Health In the Elite Sports published actually in the German Journal of Sports Medicine. It is interesting because it is a universal view of the patient that we are treating. Health, injury, and illness in the elite sports are closely connected with social factors. We do not think about it that way because all we are thinking about is that football player crashed his head into the other players and now, we have a concussion, we have a severe neck, injury or spine injury.

This is the work of health, injury in sports. First, the term health in the context of elite sports is directly linked to the ability to perform or compete. We need to switch our perspectives a little bit when we talk about heath in elite and professional sports. Secondly, the ability to perform on top level with the highest priority as it relates to health-related decisions.

Is that your priority when you are treating the athlete, to get them back into the game, return to play at the highest level of their performance? That is what this study found. We will go over a little bit about how the study was constructed.

The individual's perception about their complaint such as pain, which is predominantly with the athlete walking off the field, whether walking into your office, is strongly influenced by what is called the culture of risk. If you have never heard of that, you see it all the time. That is where the athlete has a very high pain tolerance. The reason that is not necessarily from a physiological standpoint.

Remember pain is psychological as it is physiological, but it is also the culture of being a professional or elite athlete.

They take higher risks to succeed in their competitions than the average individual might. It is caught in a permanent action dilemma namely between the necessity of risk and taking care of their health. That is the dilemma the patient walks into you. They are walking in with perhaps a shoulder injury, but keep in mind, the underlying psychosocial elements about their healing journey. These are forces at play.

This culture of risk is characterized by normalizing the occurrence of injury and accepting the inherent risk of sports. How does that change your view of the patient's care? Does that mean you endorse this model to be part of the culture of risk? I suggest we all are to a greater or lesser extent because we want to A, please the patient, and B, get the patient back into what is "a normal life".

Keep in mind that if you look at the patient from a psychosocial component, this does not mean that you are going to minimize their desire to get back into the game, but rather you might very well, through exploring the psychosocial components, finding a way for the patient to address A, the injury, and B, compliance with your treatment plan, C, self-care. What a powerful set of clinical tools you have by just stretching out of the biological and looking into the psychosocial.

Question. Physicians and coaches often focus on the biomedical aspects of injuries and complaints, and they rarely try to integrate different understandings of health. The consequence is that relevant factors in the genesis of injuries and complaints are ignored.

Do you strongly agree, agree, neutral. disagree, strongly disagree.

Do we ignore the psychosocial elements in the patient's care? If we do, this creates a disconnect between the doctor and the patient. Your patient is a whole human being physically, mentally, socially, and in cases, spiritually as well.

I want to spend a little time about the methodology and conclusions that were reached based on the study that we are discussing. They looked at 1138 young athletes. There were male and female. They had a 61% response rate to their service, which is very good for a survey study.

The survey looked at their health status, their health-related behavior, representation from outside of the sports community, their understanding of nutrition, social network, socio-demographics. The study also looked at specifically, for Olympic disciplines. Artistic, gymnastics, biathlon, handball, and wrestling. They did interviews on the athletes. They observed health-related behavior of the athletes, coaches, and medical staff during training and competition, and they analyzed Olympic Training Center. This is an interesting study that was done.

This was predominantly one example of Klaus Schneider who happens to be not the patient athlete's name, but this is a handball player. These are the physical injuries that he sustained as being an elite athlete. As you can see, infraspinatus strain, lacerations, splintered thumb bones, hamstring muscle strains, meniscal lacerations, quad strains plantar fascitis. Physical ailments that the athlete sustained particularly in this case, and you will find as you know, depending on the sport, different injuries for the sports.

This is the result of the study. The athlete's complaint does not necessarily correspond with the injury or how much time they need to take off. There is a disconnect immediately. You may see this as an acute sprain or acute sprain strain perhaps in this 2 or 3 gradings, which you know is approaching surgery. That is not how the athlete is going to communicate the amount of pain because remember, the culture of risk, I have to deal with pain. It is part of being an athlete.

Of course, the subjective complaints decrease with increased therapy and reduced competition, less therapy. Most of the injury history is ignored, it is trivialized, and in many cases, it is masked with pain medicine. That is the findings of the study.

Social function for the athlete is the ability to compete. Remember, they are part of a team or they have achieved a certain level of expertise recognized by coaches and the individuals, whether it is NCAA, whether it is professional. Once they hit that level, they are part of a society. Most athletes maintain their social functionality, despite being diagnosed, and of course, this can lead to greater injury or more severe injury, greater complaint.

They do not want to be placed in a category as not having stamina or endurance. This becomes part of that socialized culture of risk. Very often, they will transfer the responsibility of their health to their coach and/or you as to healthcare provider. They do not take that responsibility on themselves. "Doctor said" that is the key. You play it a pivotal role in moving this athlete toward a state of health. That does not mean, you are not moving them towards a state of being competitive. It simply means you are taking a different approach than many, many other healthcare professionals do.

Who do we serve? These are our patients. There is multi-cultural, there is multi-gender, different sports. We are treating all the athletes. It is different abilities, different levels of trauma. This is what we need to understand as we move forward.

This is a look at the psychological aspect of the patient's care. This study was about the mental health of elite athletes, and this was a narrative systematic review. We will move from the biological into the psychological. The physical impacts of elite sports participation have been well documented but quite frankly, nobody has done any studies on them. The studies are very, very few. Most of them have not been interventions, but they are simply overviews and surveys.

Based on the evidence, they found that broadly speaking, athletes have the same level, comparable risk of high-prevalence mental disorders relative to the general population. This occurs as they approach retirement, or they are experiencing performance difficulty. Think about that, your patient is an older patient, perhaps coming to the final stages of their career. You might want to think more about the mental health of this individual, but also, if they are struggling with performance levels. That is when the mental health component comes in.

The intense mental and physical demands on the athlete are unique aspect of their career, and that makes them susceptible to mental health problems and challenges and taking higher risks. You need to know that. They tend to not seek support for mental health problems for all the reasons that people usually say, "I am not going to see anybody in the mental health field" because in this case, it is a perception of weakness.

While it is well-established that physical activity contributes to the well-being of the individual, in the case of the elite-professional athlete, it often compromises their well-being, their approach to the mental health. It increases the symptoms of anxiety, depression, overtraining, which is a behavioral issue. Of course, injury and burnout.

This study took a look at a few different athletes and see what we came up with from the mental health perspective. This is a Rugby team in Italy. The players experienced a moderate frequency of anger symptoms, interpreting these as facilitative rather than debilitative. In other words, their anger as a good thing. It facilitates their skill sets and makes them more competitive. By and large, anxiety is a significant predictor of anger.

Here is where I want to go with this, self-confidence was a significant predictor of control of anger. Self-confidence. One of the things that I am going to move towards as we go through the rest of this lecture is how we doctors can facilitate the patient's, the athlete's sense of self-confidence, self-efficacy.

That is more than treating the biological now, is not it? It is guiding them and what tools we need to do then. There is a wonderful book, I will mention at the end, about motivational interviewing that will help you frame communication technique that will help the athlete move towards a sense of higher confidence. High and low-level competitors did not differ in their frequency and interpretation of anger symptoms.

This is various sports in Norway. Females have higher level of concentration disruption and somatic anxiety than males. The perception of performance climate predicted performance worry. Perceived ability predicted less performance worry for females and males, perceived ability. Here we are again, self-confidence, perceived ability. There is no secret here other than the fact that we, by logic, ignore these issues. How can we get the patient, the athlete back to that place of understanding their level of confidence and their performance and skill, and what they can do without hurting themselves, without overtraining? That is part of the job of addressing the psychosocial components of the athlete.

These are swimmers. Greece facilitated perceptions of anxiety symptoms related to more adaptive cognitive and behavioral outcomes. Different sports, different approaches to the issues of anxiety and depression that plagued many of the general population, but also plagued many athletes. They perceived anxiety as a facilitator, and they had less avoiding coping strategies. They did not perceive anxiety as a debilitative issue. They saw it as a facilitative issue. Think about that when you are speaking with your patients. Has anxiety become part of their norm, lack of sleep, use of alcohol when you are not performing or not competing, other drugs?

Guide the conversation. We are not talking about being mental health specialists. Do not misunderstand me. That is when you need to make that referral. I am just talking about, how you develop a relationship with the athlete that expands the skills, but also expands the relationship that you have with the individual.

These were various sports. Self-esteem based on respect for self is associated with more positive patterns of perfectionism. Their self-esteem. Negative patterns of perfectionism were related to higher levels of cognitive anxiety and lower levels of self-confidence. These are behaviors things that you could focus on that build the confidence of the athlete.

By the way, this all happens very quickly during the care of the patient. You do not have to spend one hour with the patient. You do not have to have a separate consultation. While you are examining, while you are adjusting, while you are overseeing the rehabilitation, have a planned conversation that addresses these issues, and suddenly, the relationship changes. Be more than a therapist, be their doctor.

One of the interesting things is that mental health challenges for the athlete are often related to a lack of social support and/or recent life events. This is something that keep in mind for the professional athlete or the college, just high school athlete, the elite athlete particularly. We will talk about this. The social networking that gives support to the athlete is related to the activity, but the family stressors and the other issues that most of us ignore because simply, this is not part of the athlete's life. There are also issues that play. I suggest, probably a good thing to find out from the patient, how are things going at home? Remember, doctor build a relationship. The athlete, regardless of their level, really would like to have a relationship with you. Somebody who can guide them on health issues

Here is a various Sports in Australia. Results suggested that athletes have a higher prevalence of eating disorders, especially in sports, emphasizing thin shape, leanness, or low weight eating disorders were higher among female athletes, competing emphasized the importance of a thin body. Keep in mind, when you are treating this patient population, ask the question, discuss their eating habits.

I am going to add, and again, this would be part of the motivational interviewing work if you decide to pursue it and I urge you to, it will change the way you communicate with your patients. Find out a little bit about their healthy eating patterns. Just giving them a diet does not work. Although, it is important if they do not have an understanding of nutrition. More importantly, is the health behavior. I will say it again, more important is an acknowledgement on their part of their health behavior.

Let us look at social determinants of health, particularly in the athlete. These are access to healthcare education, economic stability, social, and community support. Within that context, neighborhood and their environment.

Athletes are people coming from different walks of life. Negative social determinants preclude development of positive health over time and lead to health disparities. They have a tendency to have the greatest impact on adolescent. If you are treating high school, athletes and young men and women, particularly in college who are moving through the system as a gifted athlete but suddenly, they are not moving with the maturity that the average individual might, this has an impact.

African Americans and black athletes are particularly vulnerable. This is disproportionately represented in sports. They rely or have families relying on them for financial stability. Knowing that, talking about that is gaining a better understanding of the social influences that the individual is dealing with.

Underserved athletes, involved assessing social determinants of health because you want to get a better understanding of their needs, the health disparities that impacted and of course, the influences such as their family.

Sports Medicine Physicians. They represent the only clinicians with whom athletes would engage for health care. You may be the only doctor who is taking care of them. Broaden your perspective. Do not just look at the injury. Be the whole doctor and as chiropractors, I know, we are trained to be more holistic. One of the ways that you can screen for social determinants of health is ask, how are you doing, are you stressed, how are you handling stress, how are things going with the family.

One of the things that I found as a chiropractor, that really worked beautifully for me, in this relationship, in this conversation, while I was treating the patient, while I was administering the adjustment. I was talking to the patient about these topics. I am caring for you, biologically, we are having a conversation and I am learning a little bit about any mental stresses that you are under and I am getting a better understanding of who you are as a person from your social determinants. Have a plan when you are caring for your patient. That is more than logical.

The athlete according to this particular study, often just like the doctor, the healthcare professional, is concerned about their well-being. By you participating in this conversation, you can better facilitate them on the playing field because they have somebody to work with more than the coach. While you are doing the physical exam, follow up. I said earlier, while you are doing the treatment. Many of us believe that we understand the emotional problems that our patients are dealing with. We can deal with the non-injury psychological issues. We just need to step into that role. Do not miss the opportunities. Take time. Have a plan, work with the patient, look at the intake information, maximize the time you are spending with them.

Question. I feel confident discussing psychosocial issues with my athlete patients.

Do you strongly agree, agree, neutral, disagree, strongly disagree.

We talked about the biopsychosocial model, the biological aspects of it, about the psychological aspects that like anxiety, depression, about health behaviors that are influenced by the lifestyle that the professional and elite athlete have. We talked a little bit about these social support systems, about the culture of risk, the life as it relates to health and well-being of the athlete is not exactly the same as it is for the general population.

I want to take this conversation a little further along. How we develop as people, our values, our belief systems, that is what we bring often to the doctor-patient relationship. Unfortunately, one of the things we bring is our bias, whether they are implicit or explicit. We also bring our stereotype. It is inevitable.

Kahneman wrote in a really great book called “Thinking Fast and Thinking Slow”, wonderful book. Think, read, and learn about the cognitive bias that we all experience. When this bias appears into our consciousness, they translate into our behaviors. Here is the thing, our purpose as healthcare professionals, specializing in sports, is to help the athlete achieve optimal performance naturally. That is Chiropractic. That is the purpose that is articulated by the American Chiropractic Board of Sports Physicians.

FICS purpose is articulated as to provide equitable access to sports chiropractic care, education, mentoring, and research to all athletes regionally, nationally, and internationally. We have an opportunity to fulfill a mission that is clearly well-described by expanding our skill sets and including the psychosocial elements in the care of our patients to promote equitable access to healthcare for all athletes.

Here is where we are starting. This is a quote by Anais Nin. If you would like to Google her, she is an author, writer early 20th century "We do not see things as they are. We see things as we are." That is a very profound statement because when we are dealing with our patients, our athletes do not look anything like us. Keep in mind, no matter what religion you are, no matter what gender you are, race, ethnicity, socioeconomic level, even if the athlete was born in the same house as you or in the same neighborhood and looked identical to you, chances are you have different value systems. Think about any members of your family.

We engage with our patients through our lenses and I am asking you to not be blind. Be conscious. Maya Angelou said, "We are only blind as we want to be."

Cultural humility, how do you effectively and respectfully deliver health care to an increasingly diverse population of elite- professional athletes, and it starts with a self-reflection and humility.

Critical consciousness. That is how we overcome our biases, stereotyping, and prejudice. It is not easy. It is a lifelong experience. You will know it when you feel it. When you look at somebody who is obese, and you have a thought about their obesity, you look at somebody who has a different sexual orientation, and you have a thought about that.

You put it aside. You are a doctor. You are there to take care of them. It creeps into your mind. Unless you are critically thinking about that and reflecting, and it is a lifelong process. It will always be there. Sometimes it will cause, as Kahneman said, an unhealthy reaction, even you doctor in the care of that patient.

Just some definitions. Bias is the action of supporting or opposing a particular person or thing in an unfair way, allowing personal opinions to influence your judgment. This can be unconscious or implicit or conscious explicit. It shows up when you are challenged, when our way of approaching an issue, especially as doctors, is not followed, the patient is not compliant, the patient is not getting better. That is when these intelligent and then explicit bias begin to show up.

Equitable access to healthcare. Everyone is entitled to health and health care, regardless of their background. It is an egalitarian approach to health. We need to approach every patient from that perspective. Equitable health care includes healthy food, safe living environment, the ability to be well across all aspects of life from work home, life to medical care. What is health equity in sports medicine and how can we address health equity?

Stereotyping involves associating a characteristic with a group as a preconceived idea. Now, I know these terms are familiar to you. I am just telling you, urging you to think about when they are sitting in the room with you and your patient. Your job is to be self-reflective

Some studies I found that I thought were interesting relative to provider bias, in this study, they found that healthcare professionals who are white had a preconceived notion of pain assessment and pain tolerance than patients, who are of color. This led to unequal treatment related to pain.

These are the bias that are prevalent in healthcare, sexual identity, sexual agenda, education, socioeconomic status ableism, age, overweight and obesity, racial bias, geographic location. You think then though none of these plays into part of my role. I have a very open understanding and consciousness of people. Keep in mind, we are all human and under stressful situations, we want to make sure that we keep the patient's well-being and welfare in mind.

There is cultural awareness with your patients. Studies have found that patients from lower socioeconomic levels, the doctors had less conversation about alcohol and drug addictions than from highest socio-economic levels. Thinking about your athlete, an athlete comes sometimes from a lower socioeconomic level, sometimes from a higher socio-economic level. There was a study that showed that most white athletes were coming from who were professional or elite were in private universities.

Talk to some more dominant in conversation with African American patients. Nonverbal unconscious biases are observed that healthcare professional makes less eye contact with minority patient, especially with a weight status or sexual orientation. Medical Physicians prescribe less analgesia for Latino patients, for no other reason other than the fact that they are Latino. This cognitive bias is prevalent in sports medicine, and they cloud our decisions.

Our patients, on the other hand, have an expectation from the healthcare provider that somehow you are going to fix everything for them. We must learn that cognitive bias and mitigating strategies in our schools slow down decision-making and consider alternate diagnoses can be effective and know your own cognitive bias and how it impacts your decisions.

Here is the top five unconscious bias in healthcare: race, ethnicity, age bias, gender bias, weight status, and socioeconomic level. This encompasses all of us. If you are 35 years old and you are taking care for an athlete who is 5 or ten years older than you, be conscious of the fact that you might default to an age bias. Be conscious of the fact that you may have an objection to people who do not manage their health by virtue of their diet. As I mentioned, there are false beliefs about the biological differences between blacks and whites as it relates to pain.

One of the areas I had like us to be very conscious of, in over the next few slides, is how we approach our patients who are different than we are. This is so important, not only in private practice. It is equally important when treating the elite-professional athlete. We need to bring an open mind, I refer to as an egalitarian approach, to our patient's care. I want to give you some examples of biases and prejudices that occurred various groups and perhaps you can identify with them, perhaps you find them disconcerting. More importantly is that to you they are there, they exist, and we need to do our very best to mitigate them.

Women and gender bias. Research have found that in some counties, it takes significantly longer for emergency medical personnel to get women to the hospital who are having heart attacks compared to men. Doctors are more likely to believe that heart problems for women are stress-related, whereas for men is always organic. Women of color, especially, are subject to inferior care as it relates to heart medicine, EMS travel.

Women endure a higher levels of intimate partner violence, accessing mental and family health services. Clinicians underestimate pain in women, which prevents them from receiving appropriate care. Now, while biology plays a role for sure, it is also important for us not to misidentify based on women or gender.

Sexual orientation. How do you address the individual? This author is saying, "If you do not know, just ask." Instead of saying, "Are you married, or do you have a boyfriend or girlfriend", consider asking if you have a partner, are you in a relationship, what do you call your partner? Members of the LGBTQ community are more likely than their heterosexual counterparts who experience difficulty accessing health care. There are less employer health-sponsored insurance benefits for same-sex partners.

We can make changes to the clinical encounter that can enable us to improve the health and well-being of our transgender individuals, communities. Soliciting and using the patient's preferred name and pronoun, including sexual orientation/ Include gender identity questions on the intake forms. Include

assessment of known risk factors among transgender populations. Consider some of our patients who are transgender might be taking hormone therapy or have postural alteration to conceal sexual characteristics, binding practices, which impacts the musculoskeletal system. The greater our awareness and sensitivity to our patients, as individuals, the greater our capacity to help facilitate their healing process.

Individuals with weight status problems. Obesity, bulimia nervosa, anorexia nervosa. This is not, in fact, only women. Trying to approach it from a person being lazy or just stop the thoughts and get a handle on your situation does not work. Imagine if you were consumed with the idea of food all the time. It is important and I had pointed this out to those athletes where leanness or body type is an essential part of the athletic activity. That you had to be conscious of the sport of the individual, and how that might play on their body size and eating disorders.

Critical consciousness. It is about human dignity. We can champion this. Doctor, we have an obligation and a moral responsibility to champion human dignity. In private practice, practice for care of the athlete, or will you call the pain to go by another country, or take care of a world-class elite-professional athlete? Remember, human dignity transcends everything.

Automatically activate an egalitarian approach. Equal concern, equal care, equal access to healthcare resources. Find common identities. It is still easy to see how we are different, but doctor, it is so much more important to find out how we are the same. We all have similar family traditions and values and beliefs.

I am suggesting to you as I have numbers of patients over decades of private practice, this all happens while rendering, chiropractic care because it is a plan that you have. If you have a plan for the physical, have a plan for the psychosocial. Take the perspective of the patient. There are fears, expectations, illness centered communication.

Illness is what the patient believes is wrong with them. The disease is what the name of something you give them. There is a story that says the patient in our case, it might be the athlete walks into your office with an illness. There are all the influences that are impacting this symptomatology.

They got hurt and in pain. Are they going to lose their position on the team if they lose their scholarship? Are they going to lose the support of their family or going to stay on the team? Those are the things that craft and create the illness. They come to our office, and we give them the name of something and now, they have a disease or disorder or dysfunction. When they leave your office, they have an illness again. Try to remember that and try to bring them into one continuum so that you are always conscious of the illness as well as the disease.

Cultural humility: Addressing inequities, providing a better health care experience for the athlete, professional, or elite. It is a lifelong commitment. Continue to evaluate yourself, take a breath, take a moment. Chances are, you have come from a station in life and chances are, you are in a station of life that is higher than the average. That bring the humility that comes with that level of success.

Understand your implicit and explicit bias. Keep it in check. There is a power in balance that is inherent in the provider-patient relationship. Remember that. That sensitivity allows you to have a much more authentic conversation.

Develop mutually beneficial and non-paternalistic partnerships with the patient. Non-paternalistic. Yes, you must inform and direct, but you can also guide. Here in this is the key to great communication, being a guiding force in the patient's care.

Understand your patient's health, their beliefs, their life experiences, socioeconomic level, their dominant language, race, ethnicity, sexual orientation, age, gender and their health literacy. Even if they are exactly the same as patients yours, chances are, your patient's disorder or disease is different. Cloak your relationship in humility. It ensures the patient feel safe. Safe enough to tell this story, our story, his story of illness and wellness.

Here are a few final thoughts. Gain a better understanding of the biopsychosocial model. Incorporate psychosocial assessment into your patient encounter. Take time to reflect on your personal bias, implicit and explicit. Develop communication skills that will enable you to contribute to the athlete's journey.

I urge you, take one more step with this one book that you read in the next month or two. This is the book you should read, Motivational Interviewing in Health Care. It is applicable to private practice. It is applicable to the care of your patients, who are athletes and professional athletes, and elite athletes. It is applicable to your role not only a doctor but also as a coach, as a mentor, and as a healer.

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