

WEEK 1 MODELS OF HEALTH CARE

Health: A positive state of wellbeing

Illness: Regarded as the health problem for the persons own subjective point.

Disease: objective state of the body

Impairment: a physical or functional loss

Disability: a variety of social processes where external barriers prevent people with impairments from participating fully in their chosen occupations and in the life of the community.

BIOMEDICAL MODEL

- Health is the absence of disease or injury.
- Focuses on understanding body structure and function.
- Neglects peoples subjective experience of ill health

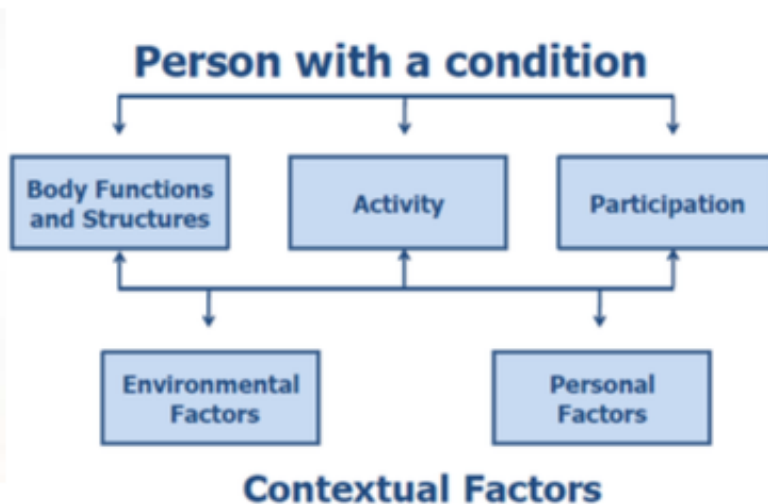
BIOPSYCHOSOCIAL MODEL

- Looking at the patient as a whole
- Health is a positive state of wellbeing.

SOCIAL MODEL

- Emphasises on the role of social and environmental barriers to participate in valued activities

ICF Framework



- BODY FUNCTIONS are physiological functions of the body systems.
- BODY STRUCTURES are anatomical parts of the body such as organs, limbs and their components.
- IMPAIRMENTS are problems of body structure or function such as significant deviation or loss.
- ACTIVITY is the execution of a task or action by an individual.

- ACTIVITY LIMITATIONS are difficulties that an individual may have when completing activities.
- PARTICIPATION RESTRICTIONS are problems that an individual may have in involvement in real life situations.
- ENVIRONMENTAL FACTORS make up the physical, social and attitudinal in which people live and conduct their lives.
- We mainly test body functions and structures but still look at everything else.

What is the aim of an examination or an assessment?

- to establish a relationship with the patient.
- to make a clinical diagnosis
- identify goals or outcomes of physio management.
- get baseline measures.
- establish any precautions or contraindications.
- identify the most appropriate intervention strategy.

Process of assessment is:

- Interview > observation > tests of function and structure > goals > Plan of treatment.

Interview

- Subjective assessment gathering information through interview.

Objective assessment (observation)

- Objective assessment to find a specific diagnosis, prognosis, any existing disorders and to plan care based on patient goals.

Tests of function and structure.

- We will be measuring any impairments, activity limitations, participation restrictions, quality of life.

Goals and plan of treatment

- The plan is based on your judgement and diagnosis considering the clients individual goals.
- physios can manage an individual through making referrals, providing intervention, conducting re-examinations and as necessary modifying interventions.

The Structure of the history assessment.

- Current history (when, which symptoms, how, progress of symptoms, any treatments so far)
- Body chart
- Behaviour and symptoms (24 hrs, aggravators/ eases)
- Irritability of symptoms (what aggravates it, intensity, duration).
- Past history (first episode, subsequent episodes)
- Contraindications and precautions (special questions) (any unexpected weight loss, xrays, medications, steroid use)
- Social history (age, gender, employment, self care? dependant? leisure activities.
- Special questions