

Patient-centered care and biopsychosocial model

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Editorial

One of the crucial elements of medicine, mainly general medicine, is the combination of patient-centered care (PCC) and the biopsychosocial (BPS) approach with the effectiveness of medical intervention in the context of evidence-based medicine. In reality, these two theoretical poles have governed the analysis of scientific action [1]. And in this context, at present, quantitative procedures are considered superior to qualitative ones [2].

However, it happens that according to the doctor it becomes better clinician, he becomes aware of the subjectivity and the “soft” technology that is used in the attention in the consultation. And on the other hand, as the doctor becomes a better researcher, more “scientific”, he becomes aware of the “hard”, mathematical and “objective” methods used in research. This means a gap between points of view that seem irreconcilable, and that produces discomfort to the doctor [3].

But, in reality, any approach to research is inherent to its qualitative nature. Decisions about the research line, the definition of the problem, the selection of the instruments to be used, the decision of the methods of data collection, and the interpretation of the data, are subjective processes that are determined by the context of the researcher. The “quantitative” is a “particular case of the qualitative” [4].

The problem is not whether one is better or worse information, but what type is required to solve the clinical problem and how we increase the effectiveness of medical actions and research. The efficiency of medical care has been studied extensively and factors such as resources, organization and management, equipment, resolution capacity, technology, clinical guidelines, clinical history, etc. are cited. However, in order to develop or increase the effectiveness and efficiency of clinical medicine, it is necessary to remember the crucial thing that is not usually expressed: “to understand” patients and ourselves in the respective contexts [5,6].

In this scenario, the importance of PCC is highlighted, which is consistent with the biopsychosocial model (BPS). George Engel introduced the BPS model as an alternative to replace the biomedical model reductionist [7,8]. The BPS model incorporates the qualitative: thoughts, beliefs, behaviors, the social context and interactions with biological processes, to better understand and manage disease and disability. In this model the biological, psychological and social processes are integrated and inseparable. For example, thoughts and feelings can not be separated from the biological processes that occur in the brain [9]. It must be borne in mind that the characteristic of clinical medicine is the understanding of the patient and his or her illness based not only on symptoms and signs, but on the psychological and social factors that relate the patient to his or her context [10-12].

It is important that the doctor be aware of accepting the patient’s offer of symptoms and organizing them by including himself in the

dynamic field that is configured. The knowledge and understanding of the symptom-its diagnosis-depends on the doctor-patient relationship, and it is this relationship that signals (such as road marking) the clinical setting [13].

As the person in context is the center of medical interest in PCC and in the BPS model, naturalist methods-observing, understanding, reflecting-are needed to enable us to truly see patients as people, apart from See the mechanisms of the disease. It is not to see the disease and “something of the patient”, but to put the patient-context first and the pathophysiology behind. The practice of medicine is an interpretive activity: it is the art of adjusting scientific abstractions to the individual case [14].

All these elements are in the BPS model. There is considerably strong evidence on the importance of the BPS model to determine the disability associated with health problems. The BPS model, in the first place, allows us to understand the patient’s beliefs about his illness and, consequently, coping strategies, including compliance with treatments and advice. And second, it allows understanding, through the emotional reactions of the patient, its consequences on health [9].

In fact, PCC and the BPS model call our common sense, our humility and resignation. The consultation of general medicine is an observatory for many events: simple characters full of complexities, a review of the crazy attitude of the human being who is anguished by the small, the trivial and temporary, while he is able to ignore the big. It is a place where the GP interest is not directed towards the rational, but towards the irrational and emotional: the maternal feeling, the animal intuition, the shortcut to the exit door. The GP gets hooked on his mystery; he is infected by the patient’s anxiety, by the imbalance and the terrors that dominate those characters. The PCC and the BPS model are a point apart. In fact, they are more a station of arrival: a set of great part of the obsessions and, mainly of all the looks, of the patients. The GP feels the sensation of observing his daily work in the consultation with the same anguish with which a landscape is contemplated from the edge of a precipice: one can enjoy the views, yes, but with a knot in the pit of the stomach.

The language of individuals (and perform the clinical history) is nothing more than the study of a person in a context, performed by another person in another context, ie a qualitative activity) is

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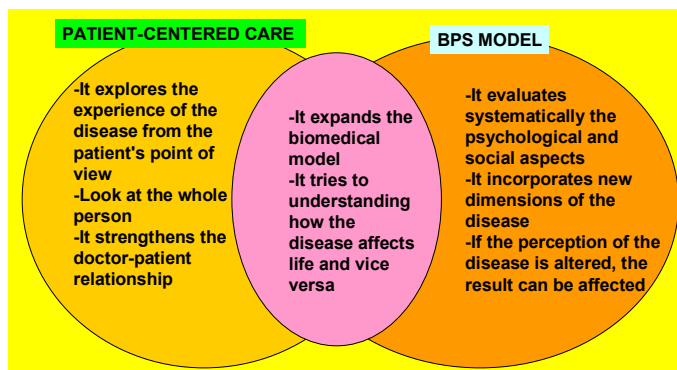


Figure 1. The biopsychosocial model (BPS) and the patient-centered care (PCC) overlap

qualitative and modifies the quantitative. The kind of information that doctors need to meet people is subjective - born of the subjectivity of the patient and the doctor. All decisions in medicine are subjective, qualitative. We increase the effectiveness of medical actions and research contextualizing: "understanding" patients and ourselves in the respective contexts. By first knowing people in their contexts we are able to be more effective with our "objective" instruments [15,16]. That is, we increase the effectiveness of medical actions when we use the PCC and BPS models.

In short, for medicine focused on the patient and for the investigation of effectiveness - that is, for medicine - it is necessary to go back to basics and stimulate reflection on elements not considered in conventional textbooks on clinical and research: emotional reactions of doctors and patients to the problems that arise and their implications. Becoming a doctor is more than simply learning a set of knowledge, skills and attitudes, including research; Medical training not only forms a body of knowledge but also changes the person. The BPS model is the framework where PCC is included. The BPS model and the PCC overlap (Figure 1). To improve the assistance of people, especially with chronic diseases, GPs need to be trained to examine their own beliefs and consequences of communication with patients. This should occur in the environment of an integrated understanding of the bio-psycho and social.

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