EDITORIALS

The Biopsychosocial Revolution

Interviewing and Provider-patient Relationships Becoming Key Issues for Primary Care

George Engel proposed the biopsychosocial model in what soon became a landmark event for understanding medicine as a science.[1,2,*] The model prompted a revolution in medical thinking by providing an argument and rationale that better linked medicine to science. Following the revolution in physics at the turn of the last century, science gradually moved away from previous linear, cause–effect thinking. To that point, understandably, medicine's guiding biomedical model focused only on diseases. Beginning with Engel's model, medical thinking has slowly evolved by incorporating and integrating psychosocial components. The biopsychosocial model stems from what many consider the modern articulation of science, general system theory.[3–5] Engel's model prescribes a fundamentally different path from the still-guiding biomedical model: to be scientific, a model for medicine must include the psychosocial dimensions (personal, emotional, family, community) *in addition to* the biological aspects (diseases) of all patients. By integrating these multiple, interacting components of the subject of our science—the patient—we also become more humanistic. We link science and humanism. While this revolution/evolution in medicine has not yet supplanted the biomedical model, the biopsychosocial model now is taught in most medical schools, and most practitioners are familiar with the term and its meaning.[6] But the problem we now face is that the model itself does not address the intricate process needed for achieving relevant biopsychosocial understanding of the patient.

Identified by the Western Ontario group, "patient-centered" medicine developed as the approach (process) for implementing or operationalizing the biopsychosocial model.[7–10] This new approach puts the patient's needs foremost (e.g., interests, concerns, questions, ideas, requests) but continues to include disease issues. Applied to the interview, we always integrate the patient-centered process with 'doctor-centered' interviewing (for disease details).

By enhancing communication and provider-patient relationships (PPRs), patient-centered interviewing produces the relevant biopsychosocial reality of each patient at each visit. It changes the model from an intellectual construct to a practical means for a more scientific understanding of every patient. Patient-centered interviewing is the flip side of the biopsychosocial coin; they go hand-in-hand, process and content.

Encompassing the dyadic patient-centered approach, newly described "relationship-centered" care (RCC) goes one step further.[11,12] RCC extends the person-centered process to the remainder of the medical system, encouraging communication and relational principles at all levels, e.g., among administrators, nurses, doctors, and unions.[13]

This issue of the *Journal of General Internal Medicine* highlights the PPR and communication (and, therefore, the biopsychosocial model) in primary care research. For example, the work of Forrest et al. concerns the better understanding of some determinants of the PPR.[14] They found that HMO patients rated the PPR lower when required to select a physician from a list and/or to get authorization for referral. The authors avoided the common pitfall of criticizing managed care and urging a change in its rules. Rather, while the HMO is doing its job to control continuously escalating costs,[15] the authors acknowledge that the focus could profitably be upon the PPR itself (and, inextricably related, communication). This laudable position recognizes that the exigencies of managed care have increased already strong demands upon physicians to establish effective relationships and communication. The wisdom of focusing upon the PPR and not recommending simple administrative change can be found in a literature replete with the health outcome benefits of being patient-centered, many of which studies were randomized controlled trials; see reviews.[16–18] The authors caution rightly that study other than their cross-sectional work will be needed to place their findings in proper perspective. For example, we do not know if administrative changes will have any impact on health without simultaneously addressing communication/PPR.

Heisler et al. did not directly study the PPR but evaluated closely related communication-based predictors: patients' perceptions of participatory decision making, informing patients, and understanding.[19] They found that self-reported, improved outcomes of diabetes self-management were closely related to informing patients and, not surprisingly, to patient understanding. Informing and motivating patients are key patient-centered interviewing skills. But understanding alone is not sufficient, particularly where the patient may need to

make unwanted changes, such as to begin a diet or quit smoking. For example, the following additional factors, among others, can also affect outcomes: specific PPR variables (e.g., empathy, open-ended inquiry), self-efficacy, satisfaction, compliance, cognitive ability, stress level, autonomy, and readiness to change. While the authors' caveats about a cross-sectional study are germane, we applaud their addition to the increasing body of research indicating that patients benefit from being informed. We may think we provide sufficient information, but patients typically disagree[20–22] and, perhaps with the stress of their illnesses, they often forget information they do receive.[23]

These papers, and several others in this issue, underscore the central role of communication and PPR in primary care and, therefore, the need to train students and physicians in patient-centered interviewing methods. While it is encouraging that more training now occurs, we need much more teaching for both students[6] and residents.[24] Although we have effective patient-centered interviewing methods, the need to teach them remains, especially for those beyond residency training, who often have had little previous exposure. For continuing medical education and faculty development, a wonderful resource has evolved (nurtured by the Society of General Internal Medicine) over the last 2 decades and has been a unique, valuable dissemination mechanism: The American Academy on Physician and Patient (AAPP) (www.physicianpatient.org). AAPP provides week-long training at its annual meeting (June) and also frequently conducts 1- to 2-day training sessions throughout the United States, always tailored to the needs and interests of those who invite them.

The amount as well as the quality of research about PPR/communication in this issue can encourage us. These works provide testimony to our increasing focus upon the psychosocial aspects of primary care and to moving beyond an isolated interest in disease. Continuing to painstakingly generate sound evidence for psychosocial medicine fosters a needed maturation of this newer aspect of medicine—a prerequisite for the blossoming of a more scientific medicine. — **ROBERT C. SMITH, MD, ScM,** *Michigan State University, East Lansing, Mich.*

* *Of historical note, in a letter to the editor in 1961, Engel first used the term ''bio-psycho-social-cultural.''[25] For simplicity, the name was shortened. Engel viewed the social domain of the model as encompassing cultural, spiritual, and other broader issues (personal communication).*

REFERENCES

1. Engel GL. The clinical application of the biopsychosocial model. Am J Psychiatry. 1980;137:535–44.
2. Engel GL. The need for a new medical model: a challenge for biomedicine. Science. 1977;196:129–36.
3. von Bertalanffy L. General System Theory: Foundations, Development, Application. Revised Ed. New York, NY: George Braziller; 1968.
4. Weiss PA. The Science of Life: The Living System–A System for Living. Mount Kisco, NY: Futura Publishing Co.; 1973.
5. Brody H. The systems view of man: implications for medicine, science, and ethics. Perspect Biol Med. 1973;17:71–92.
6. Novack DH, Volk G, Drossman DA, Lipkin M Jr. Medical interviewing and interpersonal skills teaching in US medical schools. JAMA. 1993;269:2101–5.
7. Levenstein JH, McCracken EC, McWhinney IR, Stewart MA, Brown JB. The patient-centered clinical method. 1. A model for the doctor-patient interaction in family medicine. J Fam Pract. 1986;3:24–30.
8. McWhinney I. The need for a transformed clinical method. In: Stewart M, Roter D, eds. Communicating with Medical Patients. London: Sage Publications; 1989:25–42.
9. Levenstein JH, Brown JB, Weston WW, Stewart M, McCracken EC, McWhinney I. Patient-centered clinical interviewing. In: Stewart M, Roter D, eds. Communicating with Medical Patients. London: Sage Publications; 1989:107–20.
10. McWhinney I. An Introduction to Family Medicine. New York: Oxford University Press; 1981.
11. Inui TS. What are the sciences of relationship-centered primary care. J Fam Pract. 1996;42:171–7.
12. Tresolini CP. Pew-Fetzer Task Force: Health Professions Education and Relationship-Centered Care. San Francisco: Pew Health Professions Commission; 1994.
13. Suchman AL, Botelho RJ, Hinton-Walker P, eds. Partnerships in Healthcare: Transforming Relational Process. Rochester, NY: University of Rochester Press; 1998.
14. Forrest CB, Shi L, vonSchrader S, Ng J. Managed care, primary care, and the patient-practitioner relationship. J Gen Intern Med. 2002;17:270–7.
15. Pear R. Propelled by drug and hospital costs, health spending surged in 2000. New York Times. January 8, 2002: A14.
16. Williams GC, Frankel RM, Campbell TL, Deci EL. Research on relationship-centered care and healthcare outcomes from the Rochester Biopsychosocial Program: a self-determination theory integration. Families, Systems and Health. 2000;18:79–90.
17. Stewart MA. Effective physician-patient communication and health outcomes: a review. Can Med Assoc J. 1995;152:1423–33.
18. Williams S, Weinman J, Dale J. Doctor-patient communication and patient satisfaction: a review. Fam Pract Res J. 1998;15:480–92.
19. Heisler M, Bouknight RB, Hayward RA, Smith DM, Kerr EA. The relative importance of physician communication, participatory decision-making, and patient understanding in diabetes self-management. J Gen Intern Med. 2002;17:243–52.
20. Calkins DR, Davis RB, Reiley P, et al. Patient-physician communication at hospital discharge and patients' understanding of the postdischarge treatment plan. J Gen Intern Med. 1997;157:1026–30.
21. Waitzkin H. Doctor-patient communication: clinical implications of social scientific research. JAMA. 1984;252:2441–6.
22. Waitzkin H. Information giving in medical care. J Health Soc Behav. 1985;26:81–101.
23. Ley P. Doctor-patient communication: some quantitative estimates of the role of cognitive factors in non-compliance. J Hypertens. 1985;3:51–5.
24. Merkel WT, Margolis RB, Smith RC. Teaching humanistic and psychosocial aspects of care: current practices and attitudes. J Gen Intern Med. 1990;5:34–41.
25. Engel GL. To the editor. Psychosom Med. 1961;23:426–9.