

# The Biopsychosocial Model, Patient-Centered Care, and Culturally Sensitive Practice

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In a rigorously conducted qualitative study in this issue of the *Journal*, Robert Bartz<sup>1</sup> provides a glimpse into the practice of a family physician caring predominantly for urban Native Americans. We read the physician's thoughts about treating some of her patients with diabetes, and in one case we learn the parallel thoughts of the patient. The study, limited as it admittedly is, gives us much to ponder as we face the challenges of teaching and practicing culturally sensitive and culturally competent medical care.<sup>2</sup>

In his abstract, Bartz states that "biopsychosocial models of disease may conflict with patient-centered approaches to communication." I would propose instead that the 2 models are somewhat different in focus and ought to be viewed as complementary.

The biopsychosocial (BPS) model was originally proposed as a scientific paradigm<sup>3</sup> and as such, aims to be ethically neutral to the extent that any scientific model or theory can be. The BPS model teaches us that if we want to understand diabetes among Native Americans, we need to understand the social and cultural environment and the psychological impact that environment has on the individual, just as much as we would need to study the genetics and the biochemistry of the disorder in that population. This model goes on to suggest that in caring for any patient with diabetes, we ought to inquire into the psychological, social, and cultural factors in that person's life, as well as examine the retina and monitor glycohemoglobin levels.

The BPS model, as a scientific paradigm, speaks peripherally to the issue of physician-patient communication, but solely in instrumental fashion, similar to the utilitarian approach that Bartz's physician, Dr M, seems to adopt. That is, since science begins with accurate observation, scientific medical practice must begin with an accurate and thorough history. But the patient will, as a rule, provide a detailed, thoughtful, and accurate history only when the physician enters into an open, interested, and facilitative relationship with the patient. That sort of communication becomes a critical scientific tool, without which medical work could proceed no further.<sup>4</sup>

Various patient-centered methods, such as the model of sustained partnership, constitute different model types.<sup>5,6</sup> Unlike the BPS model, they include both scientific and eth-

ical aspects, and claim to help integrate those 2 elements of good medical practice. In an extreme case, a physician could use the BPS model as a superior way to manipulate or coerce patients, since knowing more about the patients' emotions, cultures, and so on could render them more vulnerable to the physician's machinations. The patient-centered models suggest that the physician ought to use this integrated knowledge of the patient as a whole person within a particular ethical framework that respects the patient's basic rights and dignity, and takes very seriously the patient's own life goals and projects.

## ONE PHYSICIAN'S APPROACH

How does Dr M stack up in relation to these various models? I ask this question not to criticize Dr M, who deserves great praise for having dedicated her career to the care of an underserved population and for trying hard to understand the lives of her patients. But Dr M may serve as an exemplary representative of a physician who does things that all of us do in our own practices, even when caring for patients of similar cultural backgrounds, so the analysis of her methods may be of general benefit.

First, it is worth noting that while Bartz describes Dr M as having a "sophisticated biopsychosocial approach," her own description shows at least one way that this is not true. Many of her patients came to her wanting to talk about stress, and Dr M agreed that under the BPS model there was a direct relationship between emotional stress and the course of diabetes. But then her "medical perspective" caused her to "[direct] the patient away from problems like stress and toward issues like exercise, diet, and medications." If the result was a group of patients with well-controlled diabetes, no one could criticize Dr M's strategy. But she admitted that too often the result was a series of time-consuming repeat visits with the patient being no more compliant with the medical regimen at the end than he or she had been at the start. Apparently Dr M never asked herself whether talking to her patients more about stress and less about diet, exercise, and pills would actually in the end have been a more efficient way to secure their sympathetic cooperation and their compliance.

Turning next to patient-centered care, Dr M's most important deviance from ideal practice seems to be what Bartz describes as her adoption of an instrumental rather than a dialogic mode of discourse. This is illustrated best in Table 5, a transcript of an encounter with Patient C. Patient C has just given Dr M a gift: She has admitted openly that she has never taken any of the oral medication for diabetes that Dr M prescribed. Admittedly, most of us do not especially enjoy receiving this type of information

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from our patients and are at least momentarily at a loss for words when it happens, but it is a gift nonetheless. It usually takes patients a lot of courage to admit this, and the disclosure often signals a heightened level of trust in the relationship on the patient's side. If the physician responds appropriately, she may learn critical new facts about the patient's belief system, and a much more effective and collaborative treatment plan may then emerge.

How does Dr M respond to Patient C? She very appropriately and wisely asks why, and the patient responds with a pivotal further disclosure: "Because I'm scared." Dr M then charges on: "You know, that's interesting that you are scared to take the medicine. Some people are scared not to take their medicine; they worry that if they don't take it they might get sicker."

This depicts the instrumental mode that infects most of us at least some of the time, and some of us almost all the time. Dr M has very little *curiosity* about what scares Patient C. Instead she is simply looking for the best angle to preach to the patient about why compliance with the prescribed regimen is so important. This robs Dr M of any opportunity to explore the fears in detail and perhaps do something positive to reassure Patient C.

Somewhat surprisingly, given the way that Dr M has snubbed her, Patient C actually makes another effort to tell her story and describes how the medicine man told another patient with diabetes not to take *her* medicine. But this hint that the patient is seeking a way to treat diabetes that is perhaps more in concert with traditional tribal practices is unheeded by Dr M, who simply rejects the idea that a medicine man would tell a patient with diabetes not to take medicine.

A sustained partnership with a diabetic patient requires finding out the patient's goals and preferences, warning the patient of possible mismatches between their personal agendas and what is known medically about the optimal management of diabetes, and finally trying to negotiate a treatment plan that will best preserve the patient's other life commitments and sense of autonomy, while at the same time preventing complications in both the short and long term. But to do this requires, first of all, that the physician be sufficiently curious about the patient's life goals and beliefs. Dr M seems notably lacking in this curiosity. She just *knows* that if a patient has diabetes, the most important things in that patient's life become proper diet, exercise, and compliance with medications. If the patient does not happen to think this way, then Dr M does not really want to know why. She will simply spend each visit continuing to repeat why she is right and the patient is wrong. The reasons not to practice this way, sadly, are the same as why (as the popular saying has it) a person should not try to teach a pig to sing — it does not work, and it annoys the pig. An additional reason, as Dr M's own case proves, is that it also annoys the physician.

A physician does not have to engage in a so-called cross-cultural medical practice to run into these issues. I have plenty of these sorts of problems trying to provide good care for my white, middle-class patients with dia-

betes. Actually, to be more accurate about it, every encounter with a patient is a cross-cultural exercise. But the need to embrace both the BPS model and a sustained partnership model are driven home by dramatic examples from practice among patients whose belief systems are even more clearly at odds with the medical mindset. A recent book<sup>7</sup> describing a case of epilepsy in a Hmong child, leading eventually to a near-persistent vegetative state, is illustrative. The author began by asking who was to blame: Did stubborn, ignorant parents engage in non-compliance amounting to medical neglect, as it seemed to the competent and caring physicians? Or did the child in fact get sicker each time the Western medicines were employed and seem to improve only when traditional Hmong remedies were given, as the parents insisted? In the end, the author concluded that the question of blame is unanswerable, but much could be done to prevent such an impasse from occurring.

## SUCCESS STORIES

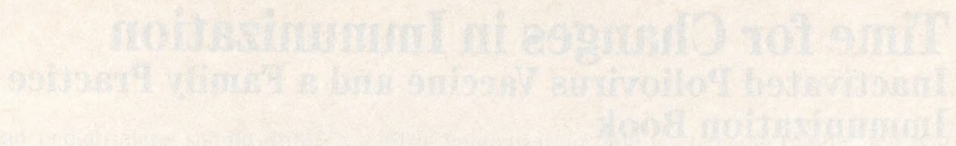
The following are 2 minor success stories from practice among Southeast Asian patients.

A middle-aged Hmong male (from a community that avoids all contact with Western medical institutions whenever possible) had severe, recurrent right-upper-quadrant pain. A Western physician diagnosed gall bladder disease and recommended cholecystectomy. The patient underwent a healing ceremony in which a shaman bestowed magical powers on water that was then used to cleanse the abdomen. When the pain persisted after the ceremony, the patient accepted the conclusion that the pain was not of spiritual origin and consented to surgery. He had an unremarkable postoperative course and reported that he was cured of the pain.<sup>7</sup>

An older woman from Southeast Asia (ethnicity not further specified) presented to the intensive care unit with hemorrhage into a highly anaplastic carcinoma of the liver that had previously proved unresponsive to radiation or chemotherapy. She requested aggressive life-prolonging therapy, which seemed totally unrealistic to the medical staff, and consideration was given to denying her request on the grounds of medical futility. Further discussion with the patient revealed that she fully accepted her terminal prognosis. Her religious beliefs convinced her, however, that if she died during the present lunar cycle, a curse would fall on her family for the next 5 generations. She requested aggressive therapy only to the extent that it could help her survive a few more days until the change in the lunar cycle. Once this request was understood in context, the staff agreed and were able to keep her alive for the requested period.<sup>8</sup>

These success stories depend in large part on someone having sufficient curiosity to want to know why the "other" is acting in a seemingly inexplicable manner. Dr M, sadly, has a lot of labels to pin on her noncompliant patients, but very little curiosity about them.

As Engel<sup>4</sup> would remind us, the activity of science starts



with curiosity. Most of us ended up going into the medical profession because as children we loved to take things apart and put them back together. (Or, in some cases, we just loved to take things apart.) Curiosity was probably the first impulse that prompted us toward a medical career. The first step in becoming excellent patient-centered and culturally competent physicians might be as simple as recapturing that basic sense of why we became physicians in the first place.

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