More than 40 years ago, George Engel, a University of Rochester–based physician and scholar, confronted the biomedical community of his time. He posited the inadequacy of viewing patient problems through only a biomedical lens and suggested that inclusion of psychosocial determinants as relevant to understanding disease states was more scientifically sound. He argued persuasively for the replacement of a dogmatic biomedical “folk model” with a more inclusive “biopsychosocial model” that stressed not only physicochemical, molecular, and biological numerics but also individualized psychological and social descriptors.1 His trenchant argument included the following:

An examination of the correlations between clinical and laboratory data requires not only reliable methods of clinical data collection, specifically high-level interviewing skills, but also understanding of the psychological, social, and cultural determinants of how patients communicate symptoms of disease.1

Since those decades past, Engel’s name and model have faded from the awareness of many in the biomedical world. It has taken a pandemic to remind us again of his insights and their continued relevance. In this issue of Mayo Clinic Proceedings, latter-day colleagues of Dr Engel from the University of Rochester revisit “the tradition of the biopsychosocial model” while addressing the “psychosocial costs” of the present pandemic that “parallel the biomedical ones.”2 They focus primarily on the biopsychosocial dynamics of 3 groups: those secluded in the community by virtue of disease exposure or disease itself, those isolated in hospital settings for more attentive care, and clinicians caring for and interacting with all these patients on a day-to-day basis.

The article’s distilled message is that regardless of group, a continuum of emotional and physical responses may be expected in the wake of the pandemic’s stresses, whether those of social isolation, illness experienced, illness anticipated, moral quandaries over resource triage, or death. Prepandemic medical and psychiatric comorbidities, basic demographic characteristics, substance abuse, and previous experiences of trauma and loss are among specific psychosocial variables that act as determinants of how patients and providers respond to the situations faced.

The variety of potential responses is obvious. So also is the need for tailored interventions to meet individual needs. These interventions may vary from structured telemedicine interviews, to peer support groups, to close monitoring for mood and cognitive fluctuations, to being watchful for any initiation or rekindling of a post-traumatic stress disorder. One intervention should not be expected to fit all. Discriminant, discerning care is the charge.

Among the practical therapeutic interventions available is the adoption of an attitude of trauma-informed care in relating to patients and peers.3 This intervention entails maintaining a focus on patient-centered communication, holding an understanding of trauma effects on overall health, using active professional collaboration, seeking and understanding one’s own history of trauma and loss, and acquiring an ability to explore trauma and loss issues with patients and colleagues without causing even greater distress.

Undoubtedly, the most challenging of these elements is that of a clinician considering his or her own history of trauma and loss and how this might impact their ongoing care of patients. Outside psychiatric practices, we clinicians are rarely inclined toward or encouraged in these explorations. It is an aspirational goal to which Dr Engel would undoubtedly accede.
More than a year with coronavirus disease 2019 has passed. It has had an undeniable human ecological impact beyond the tents, wards, clinics, and intensive care units where its victims are treated. There is widespread societal loneliness, unemployment, and uncertainty as to the future. Just as there are fewer hospital beds and more professional burnout, there are also fewer available outpatient appointments and more delayed responses to routine patient queries. To work in any medical venue now is to know some element of this multidetermined biopsychosocial chaos.

Imagine an isolated elder who forgets the directions for her weight-adjusted diuretic regimen and is readmitted with decompensated heart failure. Imagine a diabetic teenager who lives with the stress of being quarantined from her friends and then succumbs to impulses for self-mutilation, thereby being placed on a 72-hour inpatient hold with suicide precautions. Or, imagine a lone, sedentary veteran living with only his nine cats and a barely controlled combat-related post-traumatic stress disorder who is reluctant to see an unfamiliar doctor for his progressive dyspnea of several months until eventually calling 911 with acute on chronic pulmonary emboli and severe pulmonary hypertension.

The time of coronavirus disease 2019 is one calling out again for Engel’s biopsychosocial lens in our efforts to generate and sustain solutions in moments such as these. But it must also be acknowledged that many among us now carry our own histories of loss and unalterable change from this scourge. We have come to realize different identities, intentionally or not, as increasingly fatigued healers feeling mostly called to the duty of our professions, not as heroes, but as individuals trying repeatedly to just do the right and decent thing. In this doing, we find ourselves face to face with the prospect of limping forever, like the biblical Jacob, after our own fated wrestling with a malevolence that has strained body as well as spirit. Though healers, we stand now also among the wounded.

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