# LETTERS TO THE EDITOR

*The Journal welcomes Letters to the Editor. If found suitable, they will be published as space allows. Letters should be typed double-spaced, should not exceed 400 words, and are subject to abridgment and other editorial changes in accordance with Journal style.*

## THE BIOPYSCHOSOCIAL MODEL

To the Editor:

Dr Urberg's[1] commentary on Dr Medalie's[2] essay on the biopsychosocial model illuminates starkly the difference between two world views that exist within family medicine. One is the positivist (reductionistic, epidemiologic) world view, the other is the naturalistic (hermeneutic, phenomenologic, interpretive), which includes the biopsychosocial model.[3,4]

Inherent in Dr Urberg's argument that the naturalistic world view fails to address "the central question of patient care" and that "it is not a valid medical model" is the positivist assumption that a patient is only a scientifically describable collection of molecules. In other words, he reaffirms the reductionist assumption.

I do not interpret Dr Medalie as having rejected "strong antireductionism," but rather infer that Dr Urberg is so reductionistic that he is blind to the simultaneous truths of molecular biology, psychology, and sociology that Dr Medalie sees. Dr Urberg begs the question of the relationship of various types of knowledge, insisting on a superiority for biochemistry and epidemiology. Positivism is well founded, but it is not necessarily universally correct to the exclusion of other knowledge. The only people who have been "disappointed" by the biopsychosocial model are positivists who need *P* values to believe anything.

I see things quite differently. I see patients who are on the one hand a collection of molecules, cells, tissues, etc, but who are also persons with a history and a culture. I know their families and communities. Their personalities are indispensably relevant on a day-to-day basis. Dr Urberg asks us "to accept therapeutic medicine as the primary goal of medicine." I point to the *Doctor, His Patient and the Illness* by Michael Balint as evidence that the biopsychosocial community has been focused on this goal for almost 40 years.[5]

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### References

1. Urberg M: Biopsychosocial model (letter). J Fam Pract 1990;31: 13–14
2. Medalie JH: Angina pectoris: A validation of the biopsychosocial model. J Fam Pract 1990; 30:273–280
3. Stoller D, Dozor R: Meaning and the politics of experience, a progressive agenda for family practice. Family Systems Medicine, Summer/Fall 1988:249–254
4. Kuzel A: Naturalistic inquiry. Fam Med 1986; 18:369–374
5. Balint M: The Doctor, His Patient and the Illness, Edinburgh, Churchill Livingstone, 1957

## GENITAL CHLAMYDIA INFECTION

To the Editor:

Ferris et al[1] presented two very important points in their recent article on test of cure for genital *Chlamydia trachomatis* infections in women. An indirect method of analysis for *Chlamydia trachomatis* can be used as a test of cure. It was also found when it is appropriate to retest following treatment of *Chlamydia* infections.

We used the fluorescein-conjugated monoclonal antibody test as a presumptive test of cure 2 weeks following initiation of treatment in 1986.[2] We found all compliant patients to have a negative test 2 weeks following initiation of treatment. This finding is comparable with the findings of others.[1,3]

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