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*“Whether we should stray from just meeting health needs is a debate that strikes at the core of what it means to provide holistic care, but perhaps each GP needs to know their limit.”*

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### Do our consultation models meet our patients' needs?

I've had to learn that I can't usually meet the social needs of my patients, even when I was working as a GP registrar near a charitable neighbourhood scheme that uses a network of volunteers to offer friendship, guidance, advice, and practical support to anyone in the local community.<sup>1</sup> So when one patient told me that she needed swabs because she had started working in a brothel, to earn money to pay back her debtors, my heart broke because my ability to help was so limited. No-one told me how to cope with that brutal situation at medical school and I'm sure it isn't covered by the RCGP curriculum. In fact, I'm not sure if anything could have prepared me for someone disclosing what she did.

I have slowly realised that the biopsychosocial model isn't perfect and, increasingly, it seems to be back-to-front as it gives precedence to the medical, or biological needs of the patients. I quickly reconstituted a sociopsychobiological model, where the assessment of social needs consisted merely of sympathetic, non-judgemental listening. She already knew that there was nothing I could do to help with her debt or awful situation; I just needed to come quickly to the same conclusions. Next, psychological assessment and support was offered; I was 'there' or 'here' if she needed to talk about 'things'. This left me focusing, paradoxically, on her biological needs, though it was obvious these were the least of her problems.

I was lucky that she was clear about how I could help. Since then, though, plenty of patients have expected their social, psychological, and even existential needs to be met by me and I have had to, hopefully gently, disappoint both them and myself. Which leads to the consideration of a different model for reflecting human needs.

In 1943, a hierarchy of human needs was proposed by Maslow.<sup>2</sup> These needs are often represented as a pyramid, with a base of 'physiological' needs (including food and warmth), followed by 'safety' (including health), then 'love/belonging', next 'esteem', topped off by 'self-actualisation'. One aspect of the theory is that you can't

meet higher needs if the lower ones aren't being met. This explains why it is pointless trying to convince my patient who survives on a weekly budget of £17.50 to take his medicines. As he often goes hungry, his more basic physiological needs preoccupy him and take priority over his health and safety.

Predictably, this model also has its limitations in practice. It doesn't need to be turned inside out, but perhaps it is simply too much to aspire to, because as a doctor I generally try to meet a narrow band of need, towards the bottom of the pyramid, which depends on physiological needs (food/warmth) being met by society and the patient not looking to drag me up their pyramid to meet their 'higher needs' of belonging, esteem, and self-actualisation. I can try to give them respect (part of the penultimate esteem level), or even have empathy and compassion towards them, but in the context of a 10-minute consultation this is likely to be ineffective if they have unmet needs at the lower level of love/belonging.

Maslow's model is a useful reference tool when things don't go to plan. It highlights that we should be signposting patients to other agencies to meet their pressing basic needs before, and as well as, trying to meet their health needs. Whether we should stray from just meeting health needs is a debate that strikes at the core of what it means to provide holistic care, but perhaps each GP needs to know their limit.

So, one model appears back-to-front, at best, the other merely serves to demonstrate my limitations as a GP. Neither explain how I can help a patient who has to work in a brothel.

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