

Contextualization of Clinical Care in General Medicine

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Theoretical developments in general medicine have gone beyond the classic meanings of doctor, patient, and pathology, but have not yet delved deep enough to clarify what constitutes and differentiates the general practitioner (GP). Contextualization is one of its basic and differentiating pillars [1,2].

Let's look at a clinical case: "John, 55 years old, with post-polio syndrome from childhood, which requires him to walk with a crutch, presents with headaches and chest pain; later, anxiety appears. He goes on long-term sick leave... He says he is going to leave his job as a salesman for a company. The family tells the GP that they have to take care of him, which poses an additional problem on top of caring for his two elderly parents and Juan's sister with Down syndrome..."

This clinical vignette allows us to reflect on the fact that, in order for the GP to make a diagnosis, provide treatment, and establish a prognosis in general medicine, it is essential to consider the overall context. To fully understand the impact of illness (neurological, cardiological, etc.) on an individual, it is essential to consider the context. Illness is the result of a complex interplay of symbolic networks and biological processes [3,4].

Thus, the impact of an illness on the individual, in terms of symptoms, loss of capacity, productivity, healthcare and social costs, can be immense. However, these impacts multiply when considering the repercussions on the family, which can be measured in terms of limitations on social and work roles related to time spent caring for the ill member, negative emotional reactions, economic costs, social stigma, the need to make important decisions such as institutionalizing the ill family member, increased stress within the family system, and so on. This impact is further amplified when other relevant community influences are taken into account: peers, colleagues, teachers, etc. (social expectations, social demands, culture, etc.) [5,6].

Considering this multidimensional and comprehensive contextual model is valuable for diagnosis, treatment, and predicting prognosis (the outcomes of health-disease situations). In diseases with a "biological or organic" basis. Psychosocial factors play a role in the etiopathogenesis, evolution, and management of these diseases, and psychosocial symptoms may frequently be present. In diseases with a "functional or psychosocial" basis, "somatic" symptoms often accompany the psychosocial and pathological manifestations.

In other words, the etiopathogenesis, evolution, and management of all health problems—cardiovascular conditions (myocardial infarction, angina, hypertension, heart rhythm disorders, etc.), respiratory conditions (pulmonary tuberculosis, bronchial asthma, etc.), digestive conditions (peptic ulcer, ulcerative colitis, etc.), nervous system conditions (migraine, stroke, etc.), psychiatric illnesses, endocrine system conditions (diabetes mellitus, hyperthyroidism, menstrual disorders, etc.), sexual disorders, etc.—involve biological factors, but also psychosocial factors (contextual, relational, community-based) [7].

There is a recognition that physical and mental health constitute a common field of study, such that while physical factors predominate in some illnesses and psychological factors in others, for the vast majority of health problems, physical and mental elements coexist in their etiology, symptomatology, and treatment [8-11].

There is no individual without context, nor context without individual. One creates the other and vice versa, and they co-evolve. Intervening on the individual (without considering the context) is not possible (it can only be done unconsciously or without information); there are no individuals, only individual-plus-contexts. And conversely: intervening on the context (as if it were not co-dependent on the individual) is not possible. Furthermore, contexts are local. The totality of the world is the juxtaposition of specific and distinct individual-contexts [1].

Since the person within their context is the center of medical interest, it is necessary to learn the methods of the naturalist: Understand, Observe, Think, Reflect. These methods allow us to "truly see" patients as people, apart from seeing the mechanisms of the disease. It is not about seeing the disease and "something" about the patient, but about putting the "patient-context" first and the disease and its pathophysiology second. The kind of information that physicians need to understand people is subjective—it arises from the subjectivity of both the patient and the physician. But subjectivity becomes objective when it becomes an object of reflection and contextualization/social construction.

The GP's clinical task is to recognize that the common denominator of illness is that it occurs or arises in "situations." When seeing a patient, one thinks in terms of diseases—headache, chest pain, anxiety, or pneumonia, etc.—these are useful concepts that contain a wealth of knowledge about etiology, course, prognosis, and treatment. But at the same time, one always knows, deep down,

that illness is a process inextricably intertwined with the untold history of that particular patient. To give value to these symptoms, they must be considered within their context. The identification and diagnosis (of some diseases, such as Alzheimer's) are more related to certain social/contextual factors than to specific pathological factors. The course of the disease is influenced by the concurrent psychosocial factors. Family structure (family stress, roles and relationships, family resources, etc.) affects the manifestations of illness in its members [5,12,13].

The treatment of illness must address not only the sick individual but also the family. Family. Illness (e.g., neurological, cardiac, etc.) impacts the cognitive, affective, and sensorimotor aspects of the individual patient, but also family and social functioning, and this family functioning influences the neuropsychological functioning of the ill individual. Individual illness produces an increase in family dysfunction and stress (caregiver stress, family tension, family breakdown, relationship problems –separation, divorce–, family incompetence or irresponsibility, changes in family communication styles, overprotection, authoritarianism), which can lead to greater decompensation of the patient (biologically and psychologically: glycemic or hypertensive decompensation, anxiety, depression, cognitive and sensory changes, lack of support, reduced social contact).

Interventions based solely on biomedical data, without considering the context, can have negative consequences. Working in general practice without a contextual orientation deprives the patient of reality, isolates them from everyday life as if they existed in a material void, strips them of their multiple determinants, and deprives them of the continuity of their history, their biography [14]. For decision-making in general medicine, context is the final arbiter [15]. The more severe or complex a health problem is, the more necessary it is to contextualize it [16].

Furthermore, therapeutic adherence is more related to the doctor-patient relationship (trust, etc.) and family influences than to biomedical factors such as pathology, types and number of drugs, dosages, duration, etc. Finally, the severity and prognosis of the illness (such as depression, etc.) can be predicted more accurately from the context, the loss of social and family roles and activities, than from clinical findings alone [17-21].

In summary, contextualizing in general medicine means adapting scientific evidence to the patient's life and situation. Its key importance lies in transforming: 1) a theoretical diagnosis into a realistic one, distinguishing between overlapping symptoms by understanding the patient's history, social environment, culture, and lifestyle, and reducing the need for unnecessary tests by gaining a comprehensive view, thus optimizing resources; and 2) a theoretical treatment plan into a realistic, effective, safe one adapted to the patient's context, such as their economic capacity, understanding, family support network, and daily routines (e.g., work schedules). This avoids prescribing treatments that, while scientifically correct, are inapplicable or ineffective in the patient's context, facilitating shared decision-making by exploring the patient's beliefs and values about their illness. Without context, general medicine becomes "mechanical" and prone to errors.

References

1. Turabian JL, Perez Franco B (2003) Individualized medical care with a community orientation - Contextualized care: the figure is the background. *Electronic Clinical Journal in Primary Care*. https://ddd.uab.cat/pub/rceap/rceap_a2008m9n16/rceap_a2008m9n16a8.pdf.
2. Turk DC, Kerns RD (1985) Health, illness, and families. A

- life-span perspective. New York: John Wiley and Sons. <https://search.catalog.loc.gov/instances/7f361911-4538-57c0-b400-8286d5906fad?option=lcen&query=84025655>.
3. Turabian JL, Perez Franco B (2001) *Community Activities in Family Medicine and Primary Care*. Madrid: Díaz de Santos. <https://editdiazdesantos.com/wwwdat/pdf/9788479784744.pdf>.
4. Turabian JL, Perez Franco B (2007) Big Mysteries. Can You See the Loch Ness Monster? The Biopsychosocial Model and Community Activities. *Aten Primaria* 39: 261-264.
5. Charles ST (2010) Strength and vulnerability integration: a model of emotional well-being across adulthood. *Psychol Bull* 136: 1068-1091.
6. Turabian JL, Perez Franco B (2015) Models of care centered on the patient's "companion." The family and the context: at the edge of the doctor-patient relationship in family medicine. <https://www.amazon.es/Modelos-atenci%C3%B3n-centrada-acompa%C3%B1ante-paciente/dp/3659097756>.
7. Turabian JL, Perez Franco B (2006) The Doctor with Three Heads. *Aten Primaria* 38: 570-573.
8. Borrell-Carrió F, Suchman AL, Epstein RM (2004) The Biopsychosocial Model 25 Years Later: Principles, Practice, and Scientific Inquiry. *Ann Fam Med* 2: 576-582.
9. Balint JA (1999) Brief encounters: speaking with patients. *Ann Intern Med* 131: 231-234.
10. Engel GL (1980) The clinical application of the biopsychosocial model. *Am J Psychiatry* 137: 535-544.
11. Engel GL (2012) The need for a new medical model: a challenge for biomedicine. *Psychodyn Psychiatry* 40: 377-396.
12. Haggerty JJ (1983) The psychosomatic family: An overview. *Psychosomatics* 24: 615-623.
13. Minuchin S, Rosman B, Baker L (1978) *Psychosomatic families*. Cambridge: Harvard University Press. <https://es.scribd.com/document/274437126/Familias-psicosomaticas-Salvador-Minuchin-Bernice-L-Rosman-Lester-Bake>.
14. Turabian JL (2017) Stories Notebook about the Fundamental Concepts in Family Medicine: Context and Contextualization, The Fable of the Seagull, The Dove, The Crow and the Albatross. *J Gen Pract* 5: 1-2.
15. Turabian JL (2017) For Decision-Making in Family Medicine Context is the Final Arbiter. *J Gen Pract* 5: e117.
16. Turabian JL (2018) Contextual treatment: a conceptualization and systematization from general medicine. *Int J Fam Commun Med* 2: 137-144.
17. Feibel JH, Springer CJ (1982) Depression and failure to resume social activities after stroke. *Arch Phys Med Rehabil* 63: 276-277.
18. Gresham GE, Phillips TF, Wolf PA, McNamara PM, Kannel WB, et al. (1979) Epidemiologic profile of long-term stroke disability: the Framingham study. *Arch Phys Med Rehabil* 60: 487-491.
19. Hayman MD (1972) Social psychological determinants of patients performance in stroke rehabilitation. *Arch Phys Med Rehabil* 53: 217-226.
20. Labi MLC, Phillips TF, Gresham GE (1980) Psychosocial disability in physically restored long-term stroke survivors. *Arch Phys Med Rehabil* 61: 561-565.
21. Fuller J (2017) The new medical model: a renewed challenge for biomedicine. *CMAJ* 189: 640-641.

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