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1A Comprehensive Analysis of Chinese Public Hospitals with an Emphasis on Diagnosis Process and Doctor-Patient Communication

FU JING[1]*, DR AFREEN BANU[2a]

[1]Phd. Research Scholar in PhD in Medical Science, Lincoln University College Malaysia
[2]Professor in Lincoln University College Malaysia
Contact Details: afreen@lincoln.edu.my

Abstract

This study looks at how doctors explain diagnostic analyses to their patients, as well as the many ways in which patients react to hearing these explanations from their doctors. The focus of this study is on how patients respond to their doctors' explanations. The results show that when making diagnoses, primary care physicians in China frequently use the exclusionary technique. In primary care consultations, medical testing (in the form of clinical tests) is typically performed to confirm the developing diagnosis. In addition, the descriptions that patients provide of their symptoms cannot align with the opinions of the specialists. It has been observed that the process of diagnosing is an evolving one that takes place at virtually every level of the consultations that have been accumulated. Because of these discoveries, the process of diagnosis is no longer comprised of a single step (Byrne and Long, 1976), but rather a process that is continuous and continues for a significant amount of time (i.e. assessing the symptoms, explaining the symptom cause, providing a provisional diagnosis, and making a conclusion of the final diagnosis).

Keyword: Diagnostic Analysis, Medical Testing

INTRODUCTION

This is one of the earliest studies on the communication between Chinese primary care doctors and their patients in China. In this project, video-recorded acute-visit consultations from two outpatient clinics of a typical Chinese hospital will be used to compile a huge data corpus. Using primary conversation analysis (CA) to discover moment-by-moment interactional and sequential patterns during primary care interactions, the study hopes to contribute to our knowledge of the social structure of Chinese primary care medicine. If you want to understand how Western medicine is actually practiced in the Chinese medical system, you need to combine ethnographic descriptive narratives with CA analysis.

How primary care medicine is really done and implemented in China is an issue that is understudied, but is a topic of significant interest among the Chinese public as well as in the media. No attempt has been made in my research, which focuses on a single dimension that may readily and clearly expose the key characteristics of Chinese primary care practices – specifically, doctor-patient acute-visit contact.

Literature Review

Review of the research literature on medical interaction, particularly on the subject of primary care doctor-patient interactions that is the main concern of this research. In the present study focus is on particularly, though not exclusively, on CA studies of medical interactions. The literature is organized around three themes: 1) medical authority 2) patient centred medicine 3) CA studies of medical interaction.It is widely recognized that effective medical communication can have a profound impact on the outcome of healthcare delivery (e.g. Korsch & Negrete, 1972; Drew, et al. 2000; Maynard & Heritage, 2005; Heritage & Maynard, 2006). Medical outcomes (e.g. the accuracy of diagnosis, the appropriateness of treatment decisions, patients' commitment to treatment regimes, and patient satisfaction) depend significantly on the communication between doctors and patients during the consultation.In line with the nature of the current research, background of the study mainly focuses on reviewing the CA studies into doctor-patient interactions in primary care consultation. The discussion centres on three themes: a) medical authority b) the emergence of patient centred medicine c) CA studies of medical interaction. My aims are three-fold: 1) to highlight the significance of investigating practitioner-patient conversations, for improving the quality of communication and healthcare outcome; 2) to discuss the core findings of existing research, and their implications for medical; 3) to discuss how CA has grown into a robust approach of scientific enquiry into medicine after 50 years of research, and the relevant key topics and issues. The medical consultation routinely follows an interview format: the doctor initiates questions, putting the patient in the position of providing responses, and the patient returns the floor back to the doctor. This Question-Answer turn-taking system appears to be an invariant feature, for many professional-client settings, such as news interviews (Clayman & Heritage, 2002; Heritage & Clayman, 2010), and trial examinations (Atkinson & Drew, 1979).

The decline of professional authority became more apparent with the emerging consumerist culture in medicine. This is manifest in the capacity of patients shopping around and being prepared to evaluate or disagree with doctors' medical judgments (Bury, 1997; Coulter, 2002; Freidson, 1986b; Guadagnoli & Ward, 1998; Roter & Hall, 1992). By comparing different communicative styles, Levinson and Roter (1993) found that the patient-centred style (e.g. by asking more open questions, listening more carefully to patients' views, sharing more bio- medical information) has positive influence on the outcome (especially for enhancing patient satisfaction).

The overemphasis of the doctor's role at the expense of the patient' role is the central cause of the problems found in general practice, particularly regarding miscommunication (May & Mead, 1999). Patient adherence to treatment plans can be largely jeopardised because of a certain communicative failure on doctors' part. For instance, doctors' inability to recognize patients' knowledge and experience for their own illnesses (Tuckett, et al. 1985), doctors' unwillingness to offer adequate medical explanations (Korsch, et al. 1968), and a doctor's failure to seek the patient's consent for a medical decision (Stimson & Webb, 1975).

The critical strand of research (e.g. Fisher, 1984; Mishler, 1984; Barry, et al. 2000, 2001) called for a greater recognition of the legitimacy of lay knowledge and patient autonomy. As the reaction to medical dominance, contemporary medicine (since the 1990s) witnessed a changing focus to promote a patient-centred approach to healthcare – the sort of clinical practice which can be accountable to patient-as-person experience, and which underlines the agency of patients and patients' choices in managing their own illnesses (Gardner, 2017; May & Mead, 1999; Mead & Bower, 2000).

Statement of the Problem

The proposed study aims to provide the ethnographic contextual features of Chinese primary care provision, that are necessary to understand the interactions to be collected for this study. The researcher shall explicate the relevant social settings and structure, for facilitating the understanding of some of the practices which may be characteristic of Chinese medicine. The key points for this study are 1) the overview of hospital-based primary care service 2) the challenges to Chinese primary care medicine 3) patients' routine visits to an ordinary hospital.

Objective of the Study

- To examine the relevant social settings and structure, for facilitating the understanding of some of the practices which may be characteristic of Chinese medicine.

Research Questions

- What are the social settings and structures for facilitating the understanding of some of the practices of Chinese medicines?

RESEARCH METHODOLOGY

As a result of this research, the naturalistic and qualitative methodologies of CA were used (Drew & Heritage, 1992, 2006). According to Goffman's theory, social interactions represent a particular institutional order, which is linked to normative rights and duties of social organizations (1955, 1983). "Ethno techniques" are used to build social relationships, according to Garfinkel (1967). With this in mind, CA techniques study practices of behavior in interaction, which constitute institutional order. Comparing data instances with similar patterns allows CA to identify patterns.

If the pattern is cumulative or recurring, CA determines if it is through this process (Sacks, 1984; Schegloff, 1992).

RESEARCH DESIGN

The fieldwork in this study will be conducted in two Chinese mainland public urban hospitals for five months. In China, the outpatient clinics of hospitals have been the most prominent facility for delivering medical care to most people. In view of this observation, the researcher did not follow the initial plan to collect data from grass-roots primary care facilities. The data to be collected of primary care interactions from an ordinary mainland Chinese hospital.

DATA ANALYSIS

When dealing with a big amount of data, the first step is to organise it into meaningful categories. I kept detailed notes on each session, noting the name of the video, the data number, the participants' demographics (gender and age), whether it was an initial or follow-up consultation, the primary complaint, any secondary complaints, the results of any physical examinations, the prognosis, and the session's duration and quality.

Two types of medical issues, "known" and "unknown," were presented by Heritage and Clayman (2010) as possible primary care concerns. There are two distinct classes of 'known' issues: 1) Ailments that occur often, such as those affecting the respiratory system 2) recurrences of previously diagnosed disorders. Illnesses labelled "unknown" are those whose symptoms and causes the patient has never encountered previously. Only when all three types of issues manifest suddenly and severely, either on the initial visit or during subsequent follow-ups, are they regarded to be primary care concerns. Following

I chose to focus on just two types of primary care visits: 1) initial visits during which patients report experiencing symptoms for the first time, and 2) follow-up visits during which patients report experiencing the same persistent (or chronic) symptoms but with a sudden worsening of those symptoms.

CONCLUSION

The suggested study focuses on the order in which doctors collect clues about their patients' diagnoses based on the patients' replies and the patients' outward appearance. Possible diagnoses can be reduced to null hypotheses if the data trends in a direction that looks incongruous with (the usual symptoms of) that diagnosis. However, if the symptoms match those of a probable diagnosis, the doctor will take it into account and continue looking into it.

Both the questions asked by doctors and the answers given by patients will play a role in providing evidence of exclusion. Here, the researcher recommends adding three more instances in which clinicians routinely plan their history-taking conversations around the four-component sequence in order to implicitly rule out a diagnostic hypothesis.

LIMITATIONS OF THE STUDY

There are a number of flaws in the strategy, topic selection, and data collecting.

The findings should be interpreted with caution, given they are based on a single hospital's consultations. My transcriptions are likely to include some dialect-specific characteristics due to China's huge population and broad territory. It is difficult to know how representative my findings are for Chinese primary care medicine throughout so many provinces, including so many ethnicities, and so many different area types, despite the fact that the researcher proposes to collect a rather large corpus (660 consultations) (e.g. rural, sparsely populated and so forth).

It was necessary to focus on a specific area of medical practise due to time restrictions (a four-year study). The current research was limited to the diagnosis activity and practise. Treatment-related activities, where patients took a significant part, should be further developed. I was unable to investigate my findings statistically, and methods of coding and quantification, which have grown increasingly common in CA studies of medicine, arose only in the last phases of my study - they could definitely be included into any future analysis of my data.

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