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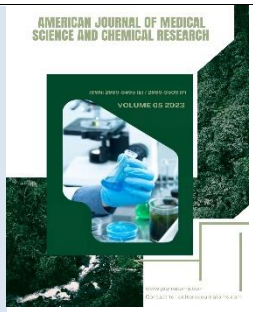

1A thorough examination of Chinese public hospitals with a focus on the diagnosis procedure and patient-physician communication

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ABSTRACT

This study examines the many ways in which patients respond to their doctors' explanations of diagnostic analyses as well as the methods in which physicians explain these analyses to their patients. This study focuses on how patients react to the explanations provided by their physicians. The findings indicate that primary care doctors in China often employ the exclusionary strategy when diagnosing patients. Medical testing (clinical tests) is usually done in primary care consultations to validate the emerging diagnosis. Furthermore, the way in which patients describe their symptoms does not correspond with the views held by the experts. It has been noted that the diagnostic process is dynamic and occurs at almost all levels of the collected consultations. Due to these findings, the diagnosis process is now a continuous process that takes a considerable amount of time to complete (e.g., evaluating the symptoms, elucidating the cause of the symptoms, offering a provisional diagnosis, and

drawing a final diagnosis) rather than a single step
(Byrne and Long, 1976).

INTRODUCTION

This is among the first investigations on the exchange of information between Chinese primary care physicians and their clients. A vast data corpus will be assembled in this study using video-recorded acute-visit consultations from two outpatient clinics of a typical Chinese hospital. The study aims to advance our understanding of the social structure of Chinese primary care medicine by employing primary conversation analysis (CA) to identify moment-by-moment interactional and sequential patterns during primary care encounters. Ethnographic descriptive narratives and CA analysis must be combined if one wants to comprehend the true practice of Western medicine in the Chinese medical system.

Although little research has been done on the subject, the Chinese public and media are very interested in learning more about how primary care medicine is really practiced and applied in China. My research focuses on a single dimension, doctor-patient acute-visit interaction, which may easily and clearly reveal the salient features of Chinese primary care practices. No attempt has been made to address this.

REVIEW OF THE LITERATURE

examination of the body of research on medical contacts, with a focus on primary care doctor-patient interactions, which is the core focus of this study. The current study focuses only on CA investigations of medicinal interactions, albeit not just those studies are. Three themes guide the organisation of the literature: 1) Medical authority 2) Medicine centred on the patient 3) Clinical association studies. It is often acknowledged that the results of healthcare delivery may be significantly impacted by efficient medical communication (e.g., Korsch & Negrete, 1972; Drew, et al. 2000; Maynard & Heritage, 2005; Heritage & Maynard, 2006). Medical results are heavily dependent on doctor-patient communication, including diagnosis accuracy, treatment decisions that are appropriate, patients' adherence to treatment plans, and patient satisfaction.

throughout the consultation. The backdrop of the study primarily focuses on evaluating the CA investigations into doctor-patient interactions in primary care consultation, which is in keeping with the nature of the current research. Three themes are the focus of the discussion: A) the authority of medicine; B) the advent of patient-centered medicine c) CA research on interactions between medicines. I have three goals in mind: 1) To emphasise how important it is to look into practitioner-patient conversations in order to improve communication and healthcare outcomes; 2) To talk about the main conclusions of previous research and how they relate to medicine; 3) To talk about how, after 50 years of research, CA has developed into a strong method of scientific inquiry into medicine and the pertinent major topics and issues. The medical consultation usually takes the form of an interview: The physician asks questions that place the patient in a position to respond, and the patient gives the doctor the floor back. For many professional-client contexts, including trial exams (Atkinson & Drew, 1979) and press interviews (Clayman & Heritage, 2002; Heritage & Clayman, 2010), this Question-Answer turn-taking mechanism seems to be an invariant characteristic.

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The emergence of a consumerist culture in medicine highlighted the weakening of professional authority. This is demonstrated by patients' ability to compare prices and their willingness to question or disagree with medical professionals' diagnoses (Bury, 1997; Coulter, 2002; Freidson, 1986b; Guadagnoli & Ward, 1998; Roter & Hall, 1992). Levinson and Roter (1993) compared various communication styles and discovered that the patient-centered style (e.g., by sharing more bio-medical information, asking more open-ended questions, and paying closer attention to patients' opinions) had a positive impact on the outcome (especially for improving patient satisfaction).

The main source of issues in general practice, especially with regard to misunderstanding, is the overemphasis placed on the doctor's function at the expense of the patient's role (May & Mead, 1999). When clinicians fail to communicate well, it can seriously compromise patients' adherence to treatment programmes. Doctors' unwillingness to provide sufficient medical explanations (Korsch et al. 1968), their incapacity to acknowledge patients' knowledge and experience about their own illnesses (Tuckett et al. 1985), and their failure to obtain the patient's consent before making a medical decision (Stimson & Webb, 1975) are a few examples.

The critical research strand (e.g., Barry et al. 2000, 2001; Mishler, 1984; Fisher, 1984) demanded that lay knowledge and patient autonomy be given more credence. The 1990s saw a shift in the focus of contemporary medicine towards the promotion of a patient-centered approach to healthcare, which emphasises the agency of patients and their choices in managing their own illnesses. This type of clinical practice can be held accountable to the patient's experience as an individual (Gardner, 2017; May & Mead, 1999; Mead & Bower, 2000).

PROBLEM DESCRIPTION

The purpose of the proposed study is to present the ethnographic contextual elements of primary care delivery in China, which are essential to comprehending the interactions that will be gathered for this investigation. To make some of the activities that could be typical of Chinese medicine easier to grasp, the researcher will explain the pertinent social contexts and organisational framework. 1) An overview of primary care services provided by hospitals is one of the study's main points. 2) The difficulties facing Chinese primary care 3) the standard hospital visits by patients.

THE STUDY'S OBJECTIVE IS TO INVESTIGATE

the pertinent social circumstances and structures in order to make some of the practices that may be typical of Chinese medicine easier to grasp.

RESEARCH ISSUES

• Which social contexts are there?

RESEARCH DESIGNATION

The naturalistic and qualitative approaches of CA were applied as a result of this study (Drew & Heritage, 1992, 2006). In accordance with Goffman's theory, social interactions signify a certain institutional order that is connected to social organizations' normative obligations and rights (1955, 1983). According to Garfinkel, "ethno

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techniques" are employed to create social bonds (1967). In light of this, interactional behaviour practices—which make up institutional order—are studied via CA approaches. CA is able to recognise patterns by comparing data examples with comparable patterns. Through this process, CA ascertains whether the pattern is cumulative or recurring (Sacks, 1984; Schegloff, 1992).

DESIGN OF RESEARCH

For five months, the fieldwork for this project will be carried out at two public metropolitan hospitals on the Chinese mainland. The majority of people in China receive their medical treatment mostly from hospital outpatient clinics. The researcher abandoned the original goal to gather data from community-based primary care centres in light of this discovery. The primary care interactions data from a typical mainland Chinese hospital will be gathered.

EXAMINATION OF DATA

Putting a large volume of data into categories that make sense is the first step in handling it. I meticulously documented every session, including the video's title, the data number, the demographics of the participants (age and gender), whether it was a first-time or follow-up consultation, the main complaint, any follow-up complaints, the outcomes of any physical exams, the prognosis, and the length and calibre of the session.

Heritage and Clayman (2010) identified "known" and "unknown" medical conditions as potential primary care concerns. 'Known' concerns fall under two different categories: 1) Frequent ailments, such as those pertaining to the respiratory system 2) Recurrences of illnesses that have already been identified. "Unknown" illnesses are ones whose aetiology and symptoms are unknown. causes that the patient has never come across before. These three categories of problems are considered primary care concerns only when they appear unexpectedly and severely, either at the first appointment or in later follow-up visits. Afterwards

I decided to narrow my focus to two types of primary care visits: 1) follow-up visits, where patients report having the same chronic or persistent symptoms but with an abrupt worsening of those symptoms, and 2) initial visits, where patients report experiencing symptoms for the first time.

CONCLUSION

The proposed study focuses on the sequence in which physicians get information about their patients' diagnoses from their responses and physical characteristics. If there is a pattern in the data that does not match the typical symptoms of a disease, then potential diagnoses can be ruled out in favour of null hypothesis. Nonetheless, the doctor will consider it and carry out further investigation if the symptoms align with a likely diagnosis.

Both inquiries inquiries made by physicians and the responses provided by patients will be used to support claims of exclusion. Here, the researcher suggests including three more examples of how doctors intentionally structure their history-taking discussions around the four-component process to subtly rule out a diagnosis.

RESTRICTIONS OF THE RESEARCH

The approach, choice of topic, and data collection all have several shortcomings.

Considering that the results are based on consultations from a single hospital, care should be used when interpreting them. Given China's large population and vast region, my transcriptions may contain some dialect-specific features. Even though the researcher plans to gather a fairly large corpus (660 consultations) (e.g. rural,

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sparsely populated and so forth), 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. Time constraints necessitated focusing on a particular specialty of medicine (a four-year course). Presently, the study was is restricted to the diagnostic exercise and activities. Activities connected to treatment in which patients participated heavily have to be improved. Though they emerged only in the last stages of my study, techniques of coding and quantification—which have become more prevalent in CA studies of medicine—could undoubtedly be included into any further analysis of my data. I was unable to statistically examine my findings.

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