

## Centredanamnesis on the Patient by Negotiated approach in Order to Favor Therapeutic Observance in the Health Communautaire Center of Yirimadio

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### Abstract

**Summary:** The quality of the relationship between the patient and his doctor is one of the major determinants of his success and conditions the success of medical treatment. The history is the essential basis of the diagnosis.

**Objective:** To improve the quality of the patient's history according to a negotiated approach in order to promote therapeutic compliance.

**Method and Material:** this was an action research type study. The study is prospective of the research/action type. The procedure consisted of making an investigation during the curative consultations in the doctors' offices; while the doctor interrogates a patient an investigator fills the investigation paper; to report the findings made with a view to developing a collegial action plan to improve the history. A second survey was conducted to assess the level of achievement of the action plan.

**Results:** The results of this action research showed that almost 2% of physicians did the history summary in the first phase (first survey) while 10% did so after the upgrade. The diagnostic hypothesis was announced to patients by 33% of physicians initially, compared to 48% after the upgrade. And finally, more than half of the doctors did not explain to patients the different treatment options available for his case.

**Conclusion:** Patient-centered history taking is not a common practice at the Yirimadio community health center. More action research is needed for physicians to fully embrace this approach.

**Keywords:** Patient-centered history/therapeutic adherence.

### **Introduction**

The quality of the relationship between the patient and his or her physician is one of the major determinants of success and conditions the success of medical treatment. Medicine is essentially a relational profession where any error in the relationship leads to patient dissatisfaction. More seriously, a poor initial relationship can lead to inadequate management of the patient, which can be harmful to the patient. The history is all the information that the physician gathers by questioning a patient about the history of his or her illness [1]. It is also the information provided by the patient himself or by those around him about the onset of his illness up to the moment when he is subjected to the physician's observation [2]. The history should contain all the information that can be useful to establish a reliable diagnosis and to choose the most suitable therapy for the patient's personality and disorders. During the history, the physician should observe the patient's overall behavior, his or her facial expressions, sincerity and willingness to cooperate. He/she should get a concrete idea of the personality, education, level of culture, economic conditions, social atmosphere, living conditions and habits, professional situation....

The syndromic history is the strategy to gather and integrate the symptoms and eventually the clinical signs to arrive at a syndrome that will finally characterize a more or less complex disease. In some cases, the diagnostic orientation will remain hypothetical but in others the syndromic approach will lead to a caricatured description which will be pathognomonic and will give the diagnosis. The syndromic approach, unlike the analytical approach, is therefore already an exercise in interpreting the data collected. It is therefore more difficult and requires both knowledge and know-how. For example, in the case of differential diagnosis of chest pain, the triad of pain, dyspnoea and tachycardia (palpitations) should lead to the diagnosis of pulmonary embolism [3].

The structured medical interview is essential to gain the patient's trust and to collect all the information necessary for subsequent management. Confidentiality must be maintained throughout the interview. If the patient capable of discernment is accompanied by his or her relatives, it may be wise to ask the patient to have the relatives leave the room during part of the interview, for example for the physical examination. This is particularly important for adolescents, frail patients or in any situation where there is a suspicion of domestic violence (including psychological dependence). Waiting for the patient should be avoided as much as possible; it increases the patient's anxiety and may provoke anger.

In order to achieve adequate patient care, it is essential that a therapeutic alliance be formed between the patient and the physician. This can be defined as "the willingness of the doctor and the patient to work together on a project to achieve common goals" [6].

The interview is the essential basis of the diagnosis. It requires time and availability from the physician. "Listen to the patient, he will give the diagnosis" Sir William Osler (1849-1919) [7]. In view of the important role that history-taking plays in diagnosis, the present study was

conducted at the Yirimadio community health center.

### **Objective**

To improve the quality of the patient's history according to a negotiated approach in order to promote therapeutic compliance.

### **Materials and Methods**

The study is prospective of the research/action type, carried out in June 2017 to evaluate the quality of the anamnesis of doctors in charge of curative consultations at the community health center of Yirimadio. The procedure consisted of conducting a survey initially during curative consultations in the doctors' offices. While the doctor interrogates a patient an investigator fills the investigation paper. Four physicians, worked in center were interviewed by four investigators trained for addressing the questions. Then we measured certain indicators concerning the interview sequences of the doctors. These results were presented to the consulting physicians, and then their leveling in relation to the context of anamnesis according to a negotiated approach for the therapeutic observance. Finally, a second evaluation was carried out to measure the impact of the upgrading on the application of the approach by the physicians.

### **Results**

#### *1. Findings prior to the upgrade:*

- Only 2% of the physicians gave the history to the patients;
- Also, 5% of the physicians verified the patient's adherence to the treatment plan;
- Less than half of the physicians (40%) established the safety net;
- The suspected diagnosis was announced by 33% of physicians;
- The treatment plan related to the patient's problem was explained by 30% of the physicians.

#### *2. Findings after the upgrade:*

- Summary of the history to the patients was done by 10% of the physicians;
- Physicians checked the patient's adherence to treatment in 15% of cases;
- Safety net was established by 40% of physicians;
- The suspected diagnosis was announced by 48% of physicians;
- The treatment plan related to the patient's problem was explained by 36% of physicians.
- Graph I shows that 64% of the physicians did not explain the different treatment options to the patients;
- Graph II shows that 15% of the physicians checked the patients' adherence for the proposed treatment.

### **Discussions**

#### *1. Limitations of the study:*

We did not have many articles similar to our study topic. This limited the scope of the discussion. The size of the study does not allow for extrapolation of the results to the entire health district of Bamako's commune VI. 2. General description: In our study, before the upgrading of doctors,

only 2% did the summary of the anamnesis while 10% did it after their upgrading. There was an improvement in this practice between the two assessments, thus helping to address patients' problems. Bass' study showed that the only variable that seemed to be related to the resolution of the symptom or problem was the patient-physician consensus on the nature of the problem [4]. Almost all physicians did not check the patient's adherence to the proposed treatment plan at baseline. However, after their upgrade, 11% did. Safety net establishment was done by 40% of physicians before and after the upgrade.

The suspect diagnosis was announced to patients by 33% of physicians before their upgrades versus 48% after. Initially, 30% of physicians explained the treatment plan to patients in relation to the patient's problem. After their upgrades, this rate was 36%. The vast majority of physicians did not verify patient adherence to treatment.

According to the providers, patient-centered history-taking is very time-consuming and therefore difficult to implement at the Yirimadio community health center because there are too many patients to consult and they are often impatient, so "we have to go fast.

Studies have shown that doctors often interrupt their patients after an average of 22 seconds of expression, whereas the average spontaneous duration is 92 seconds [10]. According to the providers surveyed, patient-centered history-taking is a good technique to satisfy the patient, but difficult for them to perform because each physician sees an average of 35 patients per day.

### **Conclusion**

Patient-centered history-taking is not a common practice at the Yirimadio CSCom, although it is recognized as a good tool by the providers surveyed. A way should be found to reconcile the constraints expressed by the providers and the quality of care induced by the approach.

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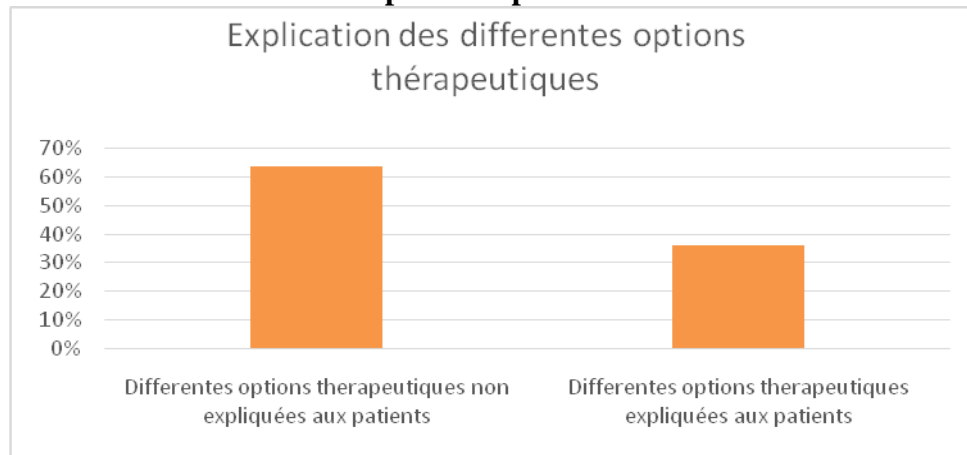
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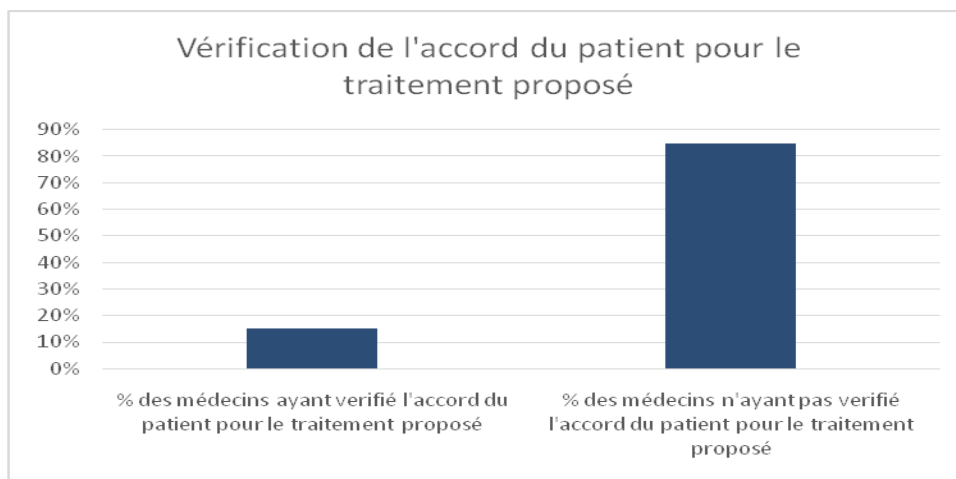
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**Graph I: Distribution of physicians according to the explanation of different therapeutic options to patients**



Physicians did not explain to patients the different treatment options after the upgrade in 36% of cases.

**Graph II: Distribution of physicians according to verification of patient agreement to the proposed treatment.**



Physicians verified patient agreement to the proposed treatment after the upgrade in 15% of cases.