Experience Report

Rethinking patient's chief complaint, research contributions developed by medical students to person-centered care

Repensando a queixa principal do paciente, contribuições de pesquisas desenvolvidas por estudantes de medicina para o cuidado centrado na pessoa

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ABSTRACT | INTRODUCTION: Traditionally, anamnesis, or medical interviews, have been the main tool in diagnosing health issues and indicating therapeutic intervention. Medical interviews perform clinical methods and hence medical theory. **OBJECTIVE:** In this paper, we will present a learning experience process gained during an introductory course on research. **METHODOLOGY:** Based on a clinical report designed for the purposes of investigation, a group of students and an advisor analyzed the role of the chief complaint in providing healthcare. **RESULTS:** Students noticed the case did not express the chief complaint of the patient. In addition, there was difficulty in articulating social and biological data in the report. Such findings were discussed by the group considering the literature on medical interviews and the medical anthropology framework in order to broaden their understanding of subjective and sociocultural aspects of illness. **CONCLUSION:** Group discussions about the case and the literature made it possible to expand the students' understanding. We argue that taking into account the main complaints can reveal a complex range of sociocultural meanings and webs relevant to understanding the health concepts and practices of patients and their microsocial groups. In doing so, we hope to contribute to the debates around medical education and the appreciation of sociocultural aspects in health practices, thus, enrich the caregiver-patient relationship toward person-centered care.

KEYWORDS: Medical education. Education, premedical. Medical anthropology. Patient-Centered Care.

RESUMO | INTRODUÇÃO: Tradicionalmente, a anamnese, ou entrevista médica, é a principal ferramenta para se chegar ao diagnóstico de saúde e à intervenção terapêutica. As entrevistas médicas operacionalizam métodos clínicos e, portanto, uma teoria médica. **OBJETIVO:** Neste artigo, apresentaremos uma experiência de ensino e pesquisa dentro de uma disciplina de introdução à pesquisa. **MÉTODOS:** A partir de um relatório clínico elaborado para fins de investigação, um grupo de alunos e orientador analisou o papel da queixa principal para a assistência à saúde. **RESULTADOS:** Os alunos perceberam que o caso não expressava a queixa principal do paciente. Além disso, houve dificuldade em articular dados sociais e biológicos no relatório. Tais achados foram discutidos pelo grupo considerando a literatura sobre entrevistas médicas e o referencial da antropologia médica, a fim de ampliar a compreensão dos aspectos subjetivos e socioculturais do adoecimento. **CONCLUSÃO:** As discussões do grupo sobre o caso e a literatura possibilitaram uma ampliação do entendimento dos alunos. Argumentamos que levar em conta as queixas principais pode revelar uma complexa gama de significados e teias socioculturais relevantes para compreender os conceitos e práticas de saúde de pacientes e seus grupos microssociais. Ao fazê-lo, esperamos contribuir para os debates em torno da educação médica e valorização dos aspectos socioculturais nas práticas de saúde e, assim, enriquecer a relação cuidador-paciente em direção ao cuidado centrado na pessoa.

PALAVRAS-CHAVE: Educação médica. Propedêutica médica. Antropologia médica. Assistência centrada na pessoa.

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Introduction

The clinical method based on the biomedical model takes as central objects the identification and intervention of the disease. In this model, following linear logic where we search for the cause of action in a single way, the disease is understood as an abnormal biological variation that is measured and classified into groups in an abstract way.[1,2] Thus, the psychosocial features of the health-disease process are considered peripheral and of little clinical relevance, as the predictive power and taxonomic language of this method are related to its possibility of abstraction, which depends on figuring out common factors, not the particularities of the personal experiences.[1]

Even though biomedicine keeps pushing onward, sustaining the mechanistic metaphor and linear logic engenders hurdles to health care in real settings. Many conditions are complex and multifactorial, so linear logic does not capture them satisfactorily. Furthermore, the use of new technologies and medications relies on patient's acceptance and motivation, which means adopting a different lifestyle and changing lifelong habits.[1,3,4]

In health care that takes place in real life, what we see is the confluence of different facets of reality interacting systemically and inducing the way a person works. Understanding the interactions among causal, triggering, and/or aggravating factors in the health-disease process requires a way of thinking that considers the complexity of the intertwining of biological, socioeconomic, cultural, and political dimensions.[1,4,5] In this sense, developing a refined sensitivity to grasp the phenomena related to the experience of illness, suffering, and care is a challenge and needs to be faced from the beginning of health training.[3,5]

Thus, medical training practices which favor and assess the interrelationships that shape health issues may be useful to target the limitations observed in healthcare contexts. The integration between teaching, research, and care may help in this process by supporting the reflective and critical approach essential for quality health care practices.[6,7]

In this article, we will present the learning experience gained in an introductory course on research held at the medical school at the Faculty of Medicine of Estácio de Sá University (Rio de Janeiro). Departing from a triggering clinical case, the group constructed a research question – what is the role of the chief complaint in medical anamnesis?– and sought to think about its object applying medical anthropology framework, especially the anthropologist Eduardo Menéndez's views.

An anamnesis based exclusively on a biomedical perspective limits understanding of the phenomenon of health-disease. Thus, developing a critical stance regarding the role reserved for the chief complaint in traditional medical literature[8,9] revealed a nuanced understanding of the patient's demand along with the intertwining of the socio-sanitary conditions that configure it, enabling a broader awareness of the health-disease phenomenon and the improvement of care.[10] Medical schools may benefit from teaching interviews focused on people's experiences.

Methodology

A Medical training report

At Faculdade de Medicina of Estácio de Sá University, the Integrated Seminars (IS) are taught during the four initial years of the course over a period of six months (a term) each and aim at the teaching and research integration. The IS are formed by an active learning component and an investigation component, both oriented by the supervisor professor. Each semester, small groups of students perform different projects regarding themes, research methods, and final results presentation. Those IS particularities are related to the other disciplines which make up each academic period following professors' scientific backgrounds and preferences. It focuses on attuning knowledge and skills expected for the related training phase and dialogue with students learning experiences in health services.

In the fourth term, students start semiology training in a hospital setting. Here, the IS seeks to emphasize a clinical approach (from now on, named IS-IV). A clinical case report is prepared by the group of professors that make up the IS-IV, and it is the trigger for research reasoning among students and tutor in small group sessions. Questions are raised based on the case discussion, evolving into methods and investigation strategies which are explored together for building a manuscript developed by the IS-IV students.

IS-IV approach rests on Case-Based Teaching (CBT). Such methodology consists of the application of clinical cases as a teaching method for students in the health field. Unlike lecture-based teaching, which is centered on a person (teacher), case-based teaching involves interactive exploration of specific, real-life situations. Cases are based on facts, or complex situations, written to encourage discussion and collaborative analysis. Therefore, CBT is a guided approach based on prior knowledge of the topics, in which contextualized discussions enable better assimilation of knowledge.[11,12]

This manuscript will introduce the research results developed by a group of IS-IV students within the 2021 second term.

From the beginning, the group read the case report and immediately realized that the anamnesis did not present the patient's chief complaint. Considering the clinical interview as a method to understand the patient's health-disease experience, the group sought to reflect on the role of the chief complaint in medical anamnesis.

For this purpose, we divided the students into pairs. Each pair sought references that addressed the research question raised in the first meeting. Initially, the group agreed to search for publications that addressed the medical interview process. Each pair read, prepared, and presented their findings over the next few weeks. All group members and the supervisor discussed the pairs' results during follow-up meetings. The limited role of the chief complaint observed in the most common references in medical education led the supervisor to recommend reading medical anthropology texts.

Finally, the students' notes and observations made during the meetings were collated in a shared document (Google Docs) that was edited by the group and formed the basis of the final manuscript.

In the next section, the case report and the results of the bibliography review and discussions carried out in the seminar meetings will be presented.

Results

Case report - a brief presentation

IS-IV Anamnesis introduced Mrs. Ilda, 60 years old, a widowed mother of 4 who lives in the neighborhood of Lapa, in Rio de Janeiro. Currently, she is monitored at Lapa Family Clinic, where the team noticed numerous physical symptoms associated with diet-related chronic diseases (DRCDs), such as type 2 diabetes, hypertension, cardiovascular disease (CVD), and obesity. Moreover, the anamnesis revealed a patient with a history of family problems: an alcoholic father, a mother in need of continuous care, and offspring with health and financial problems. All of which are probably a reflection of both the physical and emotional suffering of the patient. However, all this data fails to present the details of the concerns and challenges faced by the patient. Therefore, the complexity of the experience is neglected, hindering better understanding of patients' realities.

A review of the medical interview process

Afterward, the group worked on the role of chief complaint in conventional anamnesis. With this in mind, we reviewed and discussed the chief complaint definition within the main semiology reference books.[8,9] Furthermore, references from "Person-Centered Medicine"[1,2] contributed to discussions on anamnesis, providing a broader understanding of the clinical case approach.

Comparing person-centered and conventional medical interviews made it clear there was a devaluation of chief complaint in the latter practice. As discussions on the relevance of the chief complaint deepened, the group embraced the diversity

of possible approaches based on the patients' speech and its consequences for the doctor-patient relationship and an in-depth understanding of the health-disease-care seeking phenomenon.

The chief complaint has a polysemic character, related to patients' symptoms perception and understanding of it. Likewise, the chief complaint portrays patients' most urgent concerns about their health status and functioning. Furthermore, the chief complaint may disclose the entanglement of socio-sanitary conditions that configure it.[5,10]

In the following section, we will introduce medical anthropology contributions to a nuanced semiology training and its impact on comprehensive and situated healthcare practices.

Looking through the keyhole - medical anthropology's contributions to medical education

Medical anthropology emerged in the United States out of the belief that it was important to examine the medical system of a society to understand the sociocultural context in which it belongs. The notion of culture which guided early examinations of this school of thought was a fixed and homogeneous system understanding. Interestingly, the emergence of medical anthropology in the United States initially aimed at implementing health education programs but ended up expanding the scope of anthropological work and triggering critical movements and new medical anthropologies in other national contexts.[13]

For instance, from the 1960s onwards, under the influence of Geertz's interpretive anthropology, culture came to be understood as a dynamic construction in which social actors give meaning and organize their existence. Accordingly, culture is embodied in the dimensions of human biology and lived experience, as we are social beings, and the ways in which we live shapes our brains and bodies. This definition of culture would encompass environmental features – including material aspects, knowledge systems, and institutions – which are based on shared agreements or social conventions. Thus, culture involves not only cognitive models or representations but also contextual knowledge, discourse, and practice, which may be inscribed in patterns of interaction and social institutions.[14] In this framework, illness understood as an experience immersed in a sociocultural process, allows us to analyze some issues, among them, how people explain their illnesses and the search for care.[5]

There are also other understandings of culture influencing health care practices. Medical anthropology helps us to become aware of them. The "difference" conception, for instance, is casted by the idea of culture in which a group or community is distinguished from others, whether by some shared lineage, geographic origin, or other characteristics, e.g. language and religion. This meaning of culture includes the notions of ethnicity, race, and religion.[14]

Another definition of culture relates to the notion of cultivation, meaning that societies evolve and reach, through civilizing processes, greater sophistication of language, social etiquette, science, and the arts. Historically, in European societies, this understanding of culture justified hierarchical status systems and reproduced itself, through colonization, to other peoples and nations, ultimately justifying slavery and the establishment of discriminatory relationships with those considered subordinate.[14]

Even today, these ways of understanding culture resonate. For biomedicine, the values of individualism and autonomy, rooted in Western cultural traditions, have shaped diagnostic systems and therapeutic interventions with major repercussions for clinical practice and the health status of populations.[3,14]

Eduardo Menéndez, an Argentinian anthropologist based in Mexico, is an important author in LatinAmerican critical medical anthropology.[13] In his work, he advocates that diverse forms of understanding illness and care that currently operate in a given society have cultural roots – of a religious, ethnic, political, and scientific nature – configuring themselves in different forms of biomedicine. Although these differences exist, they are usually registered and analyzed through social and ideological representations and much less at the level of social practices, reinforcing a dominant conception of antagonisms rather than interactive articulations amongst the different forms of care.[10]

Illness and different forms of care might be understood as experiences in which symbolic processes articulate the social context and psychobiological reality of the patient, whether by the patient's perception of the disease (illness), by the professional (disease), or by the observation of the interaction/negotiation (sickness) that permeates the episode's social legitimation process.[15] There are several ways to express concern. These modes are culturally constituted in the sense that they relate to certain types of interaction and are associated with values and norms related to health in specific social contexts.[5]

Thus, what is observed is that, under the umbrella of the biomedical perspective, an array of health beliefs and assistance activities are denied, ignored, or marginalized, despite being frequently used by different sectors of the population. Among the elements to examine the process of marginalization, there is the negative character attributed to culture, related to backward folkloric knowledge and behavior, interfering in the results of (biomedical) health interventions.[10]

Eventually, such knowledge is included in the planning of health actions, in primary care strategies, or in contexts of expansion of low-cost coverage and for marginal populations.[10] Nonetheless, the silencing of culture updated by health professionals and services remains a habit and engenders withdrawal from patients.[3]

Universalizing strategies, necessary when we think in terms of health services and systems, or valuing subjectivity, important in the daily life of services, but often individualizing, may be very distant from the real experience of the sick, making it essential to consider sociocultural dimension in all its complexity. Aware of such limited incorporations, health systems and institutions responsible for training health professionals must promote a positive perspective of the sociocultural particularities of the communities followed. Medical anthropology has been encouraging (and instrumentalizing) the process of medical education in order to value the patients' narratives and teach physicians to decode the cultural and medical meaning of such narratives.[5,10]

It is important to assess the sociocultural restrictions of an individual and their community, what are the opportunities for expressing their difficulties and suffering, what other modes of expression would be accepted in their context, and what are the personal meanings of their health situation.[5] Asking about the chief complaint allows further investigation.

Final comments

This report seeks to indicate possible lines of future research, given the discussion on a clinical case presented here. The review points to the potential for more in-depth interviews in medical education. However, further research is needed in order to better understand the Brazilian situation.

What we have learned by paying attention to the absence of chief complaint was that entanglement of meanings and worries would make itself clear if we cared for the patients' words. Instead of closing the possibilities of investigation with the proposition of a definitive medical diagnosis, an attitude of openness and curiosity toward the patient's universe may improve the exchange of knowledge and the negotiation of care and, therefore, person-centered care.

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Authors' contributions

Antunes MSMM, Lyra PPO, Mattos JP, Ferreira DS, Catharina LB, Machado J, Lourenço MWR, Silva LLV, and Ximenes VHP have made a substantial, direct, and intellectual contribution to the work and have approved it for publication. Müller MR guided the elaboration of the reported experience and the article's writing.

Competing interests

No financial, legal or political competing interests with third parties (government, commercial, private foundation, etc.) were disclosed for any aspect of the submitted work (including but not limited to grants, data monitoring board, study design, manuscript preparation, statistical analysis, etc.).

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