

Clinical Competencies in the Care of Women: Intertextuality and Transversality Between Gynecology and Family Medicine

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Introduction

There is an increasing body of scientific evidence of the differences in the way men and women become ill, in the evolution of disease, and in the way drugs are used. However, the chronic problems presented by women are still considered to be inferior or minor, women are not always included in clinical trials systematically, natural processes such as pregnancy, childbirth and menopause are often medicalized. We do not study the problems that women really suffer and instead create new problems when dealing with pain and discomfort with psychotropic drugs without investigating the underlying causes or pathologies. These facts of the medical field mainly affect gynecologists and family doctors [1].

The reasons for obstetric-gynecological consultation represent an important volume of the daily task of the family doctor/general practitioner. Data from the United States from 1989-1990 reveal that 29% of all primary care visits by women aged 15-44 were obstetric-gynecological. In Spain, it has been reported that they make up 24% of all visits [2].

Gynecology professionals and general practitioners, in relation to care for women, maintain relations of "intertextuality" and "transversality" that affect the quality of care provided.

"Intertextuality" can be understood as the simultaneous presence of two "languages" or two texts, or the actual presence of one language or text in another. In this way, a significant element or set is transferred from one code to another, from one language to another language. The characteristics of the approach to care for women in the field of gynecology translates, in part, to the characteristics of the approach to care for women in family medicine, and vice versa. The patient is a text to be read. Patients are texts that are examined and studied by the clinician. Sometimes they can be read like a book, the text of a newspaper article, or a piece of prose that explains the issue directly. At other times, the stories of patients resemble novels or poems, written with more complicated words, the meaning of which is not always immediately understood. Doctors are readers of these texts [3].

The patient's history is a text produced by the disease. The patient and the doctor are co-authors of that text. The most common form of narrative or biography of the disease is the medical history; it is the official text of the experience of illness. The history occurs in collaboration (albeit explicit or implicit) and is therefore a product of both the physician and patient. There is a continuum of information for understanding the narrative of the disease, including clinical notes, interviews, transcripts of audio-tapes, diaries, video recordings, etc.

Thus the clinical history may seem like a novel by François Rabelais, or by Jonathan Swift, or by Fyodor Dostoyevsky [4]. Clinical histories such as these novels are textual polyphonies where essential dialogic

relationships were established at all levels between ideas, social classes, worldviews, characters, texts and literary discourses, all of them distinct from each other. In the attention to the patient - in the attention to the woman - the doctor knows that the approach to the patient is saturated with foreign words, in the middle of which he is oriented.

The "transversality" refers to the degree of interaction that exists between patients with their doctors (verticality), and in turn between gynecologists and family doctors (horizontality). All depend on each other so that, for example, there is no iatrogeny and to achieve an adequate level of attention to the patient (without errors or contradictions in care). It is a "rhizome".

The "rhizome" is the underground portion of a generally horizontal interweaving of the roots of certain plants. The rhizome branches out and allows a portion of its network can develop other stems, thus stimulating the vegetative propagation of the plant, and its proliferation, sometimes very quickly. It is a system of vegetative reproduction in many plants, such as achimenes, canna, zantedeschia, lily, etc.

A first use of this metaphor is attributed to Carl Jung, the disciple of Freud: "Life always seemed to be like a plant that draws its vitality from its rhizome, the actual life of this plant is not as visible, it lies in its rhizome. What becomes visible above ground does not hold but a single summer, and then it withers (...). What we see is the flowering — and it disappears — but the rhizome remains".

Contemporary knowledge is marked by excessive compartmentalization and gynecology and family medicine should propose its improvement, taking as a basis a new paradigm for the understanding of knowledge: the rhizome and transversality. The concept of transversality has a geometric origin and it means that which is opposite to the longitudinal, that is, to the length defined as the measured distance between two points. We could say that mainstreaming is something that fails to mark or define an area. Transversality is characterized by moving in several different areas without being at all influenced by the identity of each.

The rhizome is a descriptive model in which the organization of the elements does not follow a specific structure — with a base or root giving rise to multiple branches as in the familiar model of the tree — but where any element can affect or influence any other. In the rhizome, the knowledge structure is not derived by logical means via a set of first principles, but is made simultaneously from all points under the reciprocal influence of the various observations and conceptualizations. This does not necessarily make a rhizomatic structure labile. In one rhizome there are lines of solidity and organization determined by groups or sets of related concepts. These

sets of concepts define relatively stable territories within the rhizome [3,5-7].

In this context, we intend to outline the clinical competences of the family physician in the field of women's care, in their intertextuality and transversality with the work of the specialist in gynecology.

Discussion: Clinical Competencies of Family Doctor in the Field of Care for Women

The different biological stages in women determine the specific needs and demands of health services. Following the biological stage of the woman, the health needs that health services must respond to are: knowledge and use of contraceptive methods for adequate family planning to avoid unwanted pregnancies and voluntary interruptions of pregnancy, those related to health care of the pregnancy, childbirth and the puerperium, detection and early care of gynecological cancer and attention to the climacteric [8].

Care activities for women

1. Prenatal care: Low-risk pregnancy control is one of the activities whose positive results are well documented when performed by general practitioner. In one year, a family doctor/general practitioner in our setting can follow a minimum of 15-20 pregnancies, which on average generates more than 100 controls. The most important advantages of this activity are the early capture of the pregnant woman, the biopsychosocial approach of the pregnant woman, and the appropriate assessment of obstetric risk.

2. Family planning: Women should have complete and direct access to contraception and contraceptive advice. The family physician/general practitioner is the best health professional to perform this activity. Natural regulation, barrier methods, hormonal contraception, insertion and control of IUDs, sterilization indication and counseling about voluntary termination of pregnancy could be competencies of the primary care physician.

3. Early diagnosis of cancer: Health centers in Primary Health Care can achieve greater coverage and better accessibility for programs for the early diagnosis of breast and cervical cancer. In relation to breast cancer, the role of the family doctor/general practitioner has been summarized in five points: a) preventive and educational advice; B) perform breast examination; C) request mammography; (D) reporting on treatment and assisting their cancer patients in their decision; and (e) engaging in follow-up and palliative care when their patients reach a terminal stage. Regarding cervical cancer, it can be a key piece in the active uptake of patients at risk and continuity in follow-up.

4. Menopause: The treatment of the symptoms of menopause is now controversial. The role of the family doctor/general practitioner in menopause can be defined in three points: a) manage the climacteric discomfort in their consultation, both from a pharmacological point of view and psychological support and advice; B) assess high-risk patients (early menopause, surgical, etc.), and c) control and follow-up of treatments with hormone therapy [9].

5. Obstetric-gynecological diseases in the consultation of the family doctor: Cervicovaginitis, sexually transmitted diseases, prolapses, menstrual abnormalities, breast disorders and abnormal bleeding can be resolved at least initially by the family physician/general practitioner at your appointment. Satisfaction of patients has been demonstrated when their menstrual disorders were treated in primary care.

6. Sexual Violence and protocol of action in primary care: From all the estates involved it is recognized that this problem requires specific protocols. Comprehensive treatment is required with specialized operators and coordinated intervention of all institutions, including judicial, police, health, education and media.

7. Syndromes of the discomfort of women in primary care: We define psychosocial malaise as a suffering that, because it can not be deciphered and expressed in words, appears as mental suffering, pain or somatic symptoms-Including gynecological symptoms-without organic cause.

So, the term "malaise syndrome" in women encompasses a complex set of diverse symptoms. They include nonspecific and general symptoms, psychological disorders and biosocial influences in women who consult the health services, both in gynecology and general medicine. The current approaches to clinical practice are aimed at considering in an integral way, and with a gender approach, all this set of symptoms that the patients consult and who lack an organic justification, and do not usually obtain an adequate response. This situation often makes the patient become a hyper-attendant of the health system, to the same or different medical providers [10-13].

The rates of psychological alterations of any kind are higher than previously thought and are increasing and affecting almost half of the population. Differences by sex occur particularly in the rates of common mental disorders: depression, anxiety, psychological alterations and somatic complaints; these disorders affecting 1 in 3 people occur twice in women than in men. And, moreover, depressive episodes are among them longer, the recurrences more frequent and with a greater tendency to chronicity than among males. Women's greatest impact is due to psychological as well as social and gender factors, as the traditional role of women in societies exposes them to more tensions, while depriving them of the ability to modify their stressful environment, As well as the high rate of domestic and sexual violence to which they are exposed.

The syndromes of the discomfort of women are marked in primary care by a split of the demand. Although biological complaints are heard, the implicit demand that can be supported in the psycho-social and gender context is usually split and not taken into account. In the consultations the only legitimate expressions are the somatic ones and the omission of the personal experiences and their meaning is omitted. Patients with malaise syndromes are perceived as difficult, unsatisfied, frustrating to the doctor, and there is a tendency towards a medicalized management of the psychic malaise. In practice it is observed that the therapeutic behavior is, most frequently, the prescription of psychotropic drugs, paradoxical performance with the absence of diagnosis, but that participates in the high frequency product of prescribing tranquilizer among adult women. This fate is of great importance because if the self-perception of the malaise is invisible, which causes the symptoms, it facilitates the chronification of the problems through the non-specific reassuring medication. A generic final destination in which this line ends, is this chronification in symptomatic passivity with a rather lethargic pre-disease state. Psychosocial gender factors that influence women's forms of illness and which are factors associated with discomfort are those related to the impositions of the social consensus of gender and the overload they produce [14].

Model of attention based in a strategy of approach of gender

The model is based on the integration of the biological, psychosocial and subjectivity including the gender determinants. The method would

be a sensitive listening to the biographical psychosocial elements that are significant for the patient. It will try to locate those significations that produce the symptoms, to indicate the locations and to return to the patient its meaning to produce effects that allow to her to be responsible for its change. It is necessary that this process is performed through an integrated physician-to-patient relationship capable of producing the sought-after effects (Table 1) [10,13,15-19].

Principles of women's health care	Strategy for symptoms without medical cause
Consideration of the personal and social situation of the patient	Recognition of symptoms as a source of medical knowledge
Consideration of the gender identity of the patient and gender roles	Challenge to the relationship between power and gender and professional authority
Respectful to the patient	Communication strategy that invites the patient to use her knowledge and daily experience, maintaining the role of the patient as a source of knowledge
Route the patient to face their health problems and encourage selfresponsibility	Make emerge the meanings of gender and power interactions as meaningful explanations of the patient for her symptoms
Avoid medicalization	Possibility of treatment in groups of women

Table 1: Model of attention in a strategy of approach of gender [10].

Conclusion

Based on intertextuality and transversality, it is necessary to look for spaces of collaboration between gynecologists and family physicians on topics such as uncomplicated pregnancy controls, basic family planning, treatment of menopausal symptoms, early diagnosis of cervical cancer, approach to sexuality, and approach to syndromes of the discomfort of women, which can only result in improvements in the accessibility of the users, increase in the collection of health programs, reduction of waiting lists, hospital decongestion and better quality of care.

From family medicine, it is possible to provide, in the care of women, what the specialized level of the gynecologist can offer with more difficulty, such as biopsychosocial approach, continuity of care, primary and secondary prevention activities, council Health, and integrality.

From gynecology, can be offered to family medicine a highly qualified medicine, a global vision of women who surpasses care for organs, and a location in the health system that facilitates the integration of preventive activities and health promotion along with

curative care, and a model that can avoid medicalizing or psychologizing the transitions moments in the woman's life cycle such as menarche, pregnancy or climacteric [20].

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