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Editorial OMICS International

Physician-Patient Relationship in Obstetrics and Gynecology

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Editorial

Concept of communication and doctor-patient relationship

The doctor–patient relationship has been and remains a keystone of care: the medium in which data are gathered, diagnoses and plans are made, compliance is accomplished, and healing, patient activation, and support are provided [1]. The doctor-patient relationship is a topic evaluated from multiple perspectives. The transcendence of the permanent study of this relation is given by the fact as evidenced by its influence on health care outcomes [2]. The doctor-patient relationship is a complex phenomenon comprised of several aspects, among which we can point out physician-patient communication, patient participation in decision-making and patient satisfaction.

The style and level of communication between doctor and patient is a fundamental fact that determines the quality of their relationship.

The clinical interview is a technique and place of communication, where the doctor-patient relationship is produced and developed. Communication, in the doctor-patient relationship points out - signalizes (like signalling a path in the forest, so that we can focus our field study on the natural values of the place) - the clinical setting. The "General Law" of medicine refers to integrating the human and technical approach in the communication and clinical reasoning. That is to say, connect the biomedical and psychosocial aspects of clinical care. This is basic to achieving the ultimate goal: it is about achieving "good decisions"; those that reduce or manage uncertainty of medical impact [3]. The doctor's relationship with the patient is the true nucleus of clinical praxis. This requires a contextualized clinical interview; the physician-patient-context interview is thus a learning experience. It is a communication that helps the patient and the doctor to learn [4].

The physician-patient relationship appears historically during pregnancy and delivery

The earliest doctor-patient relationship, speaking historically, appears during the care of the pregnant woman and the woman in childbirth. Multiple evidences of mesolithic culture, allow us to infer that the phenomenon of reproduction drew the attention of man from the stages very remote and that, with many possibilities, one of the most ancestral manifestations of what we know today by doctor-patient relationship occurred precisely during gynecological care. From that time until now, women have received -with varying degrees of quality, according to the historical stage - the benefits derived from a successful relationship with those who in every moment of human development played the role of medical aid provider [5].

There is a high awareness of the great importance of achieving successful professional relationships with women during their confrontation with experiences as significant as pregnancy, childbirth and the puerperium. Pregnancy and childbirth are decisive moments for the life of every human being, and both the previous and the subsequent period are decisive for the emotional, intellectual and social development of the child, with a central influence of the mother, the father and the family.

The reproductive process not only constitutes a high biological and emotional demand for the woman, who undergoes substantial changes in her body and even deeper in her life, especially if she responsibly assumes the demands of gestation, childbirth, postpartum and upbringing. The reproductive process must also be understood as a fundamental call for the strengthening of the bonds of couple and family, interweaving a network that will provide protection to the child.

Beliefs

It is necessary to remember the importance of the negative conditions that have been formed since childhood through the socio-cultural influences transmitted from generation to generation. Together with the fears and fantasies engendered by these mechanisms, there are important motivations implicit in the happy expectation of a desired child, and the latter should be used by the health team as a first-order resource to develop in the pregnant woman her potentialities, So that it can successfully face one of the most important physiological manifestations of women: childbirth.

General aspects of the doctor's relationship with the pregnant woman

The adequate care of pregnancy and the prevention of complications during childbirth are undoubtedly the fundamental objectives pursued by the pregnant woman from the earliest stages of her pregnancy, but there is also the psychological need to establish a positive interpersonal relationship with the health team and very especially with the physician, as a resource to increase their safety and ensure such significant emotional support during childbirth.

Historically the pregnant woman has assumed, for socioculturally determined reasons, a totally passive role in the relationship with the doctor, and a position of absolute dependence has long been considered as a main characteristic. However, the evolution of obstetric care has modified this model, and more and more emphasis is placed on the active participation not only of the woman, but also of her partner.

Pregnancy is a natural process of women where they can influence different factors causing anxiety, even in normal gestation. The doctor must adequately manage the peculiar sensitivity of the woman and the demand for support in situations that can generate anxiety. An assessment of the affective state of the pregnant woman, where

irritability may occur, is essential. This includes understanding, empathy, and willingness to help.

It is necessary to take into account that in the woman an ambivalent attitude towards pregnancy is frequent, and a threshold of excitability of the nervous system is reduced, so that along with the gratifying factors implicit in that state there are also annoyances derived from the vegetative changes, aesthetic affection, urinary discomfort, or reduction of hemoglobin level, etc.

The planning of communication with the pregnant woman must take advantage of all the possible ways to transmit security, optimism, affection and availability to the relationship of help. Another important aspect of tactile communication is the training to perform exploratory maneuvers with the greatest of kindness, since this increases the safety of the pregnant woman when she appreciates the concern of her doctor to avoid causing any discomfort during your attention.

Three types of doctor-patient relationship that are frequently used with the patient:

1. A type of relationship is "active-passive": the patient, because of his pathology, participates very little in the relationship [6]. The doctor behaves with the patient as a father would with his child of a few months of age. The doctor totally manages the situation. It may be adequate in the acute stages, especially if there is some degree of decreased consciousness.

2. The most frequently used is the one of "guided cooperation": the patient can receive orientations and cooperate in its treatment. The doctor behaves like a father in front of a teenage son. It pursues ties that guarantee the accomplishment of the appropriate treatment. It may be adequate after the acute phase of the diseases.

3. Finally, in the chronic phase, a relationship of "mutual participation" may be adequate. The physician should discuss with the patient her management of the disease and anxiety-creating situations.

The usual doctor-patient relationship during pregnancy is guided cooperation and sometimes mutual cooperation; In the delivery phase, guided cooperation, and in surgical cases, the active-passive. In the puerperal stage, guided cooperation or mutual participation is used in case there are specific conflicts [5-7].

The medical-patient relationship can be different according the psychosocial aspects or factors of diseases. But, what is a psychosocial factor? It is a measure that potentially relates to psychological phenomena and social contexts with pathophysiological changes.

Table 1 presents a list of psychosocial and contextual factors. Psychosocial problems constitute between 3-13% of the main reasons for consultation in general practice, but they are present in a much larger proportion of patients. Some study has found them between 20-60% of the patients who consult for an organic reason, depending on the type of problem.

Really, all health problems are biopsychosocial. The symptoms and diagnoses of the disease (cough, dyspnea, hemorrhage, pain, palpitations, epigastric burning, vomiting, diarrhea, cancer, myocardial infarction, asthma, ulcer) symbolize certain psychosocial aspects in people (disability, death, social isolation, anguish, cultural rejection).

Loneliness
Demands in your private life (caring for family ...)
Fear
Violence
Relation with substance abusers
Difficulty or conflicts with people close to you
Dysfunctional family
Unemployment
Work (physical or mental)
Pain, sorrow, sadness...

Table 1: Some psychosocial and contextual factors (stressful life events) that affect the doctor-patient relationship.

In "biological or organic" diseases, psychosocial causes are involved in their etiopathogenesis, evolution and management, and psychosocial symptoms can frequently occur. In "functional or psychosocial" diseases, "somatic" symptoms that accompany psycho-sociopathological manifestations frequently appear. In health problems (both "organic" and "psychosocial" basis), psychosocial aspects are sometimes more important in etiopathogenesis or sometimes in management or rehabilitation [8-10].

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