

The Interview with the Pregnant Woman

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Editorial

In a recent Editorial [1], we began a reflection on the doctor-patient relationship and its specificities in obstetrics and gynaecology. In this Editorial, second part of the subject, a little deepening on this special doctor-patient relationship will be done [2,3].

Keywords Communication; Communication training; Physician patient relationship; Patient satisfaction; Obstetrics and gynecology; Psychological interview; Clinical competence

Types of doctor-patient relationship

As previous research has displayed, a physician's communication style is an essential factor predicting patient satisfaction and compliance [4-6]. Furthermore, a good physician-patient relationship and high communication quality seem to be crucial elements fostering the activation of patients' self-healing powers [7].

Types of doctor-patient relationship according to degree of interpersonal relationship

Doctor-patient relationship distinguishes two types of relationships according to whether the interaction between the doctor and the patient is directly interpersonal or mediated by the diseased organ [5-7]. That is, focusing on the organ "that does not working well" and the patient acquires connotations of client that requests the repair of the same. It is a more pragmatic, operative and functional relationship, aimed at obtaining information on the alteration of the organ and the type of restoration that is intended. If this model is exaggerated, it runs the risk of ignoring the personality or even parceling the physical body of the patient, treating the diseased organ, as if it were an authentic object. Either the disease is considered as a whole, or the disorder is part of the patient, resulting in personal involvement in the relationship, since it is established directly between two people understood in their affective-intellectual global. The doctor not only sees the diseased organ, but the whole patient, the somatic and the psychic. The attitude of the therapist resonates with that of the patient, so that "one goes from one person's medicine to two person's medicine". It is the relationship that is used in psychiatry and even more in psychotherapy. No doubt both models complement each other. Thus, a pattern of doctor-patient relationship can be described that comprises two elements:

- An interpersonal relationship that is used in psychiatry and psychotherapy.
- A technical model, which pretends to be a repair service (the relation of the specialist to the object of care; a more impersonal type of relationship).

Of course, there may be fluctuations in the behavior of the doctor-patient relationship, sometimes dominating the psychological perspective, which amplifies the interpersonal relationship, and in others the independent study a sick body in the perspective of the more impersonal specialist technician. The aim is to balance these fluctuations in the medical profession, although the primary purpose of the relationship may vary, depending on the time in question [8]. The physician should pay attention to the symptoms and the laboratory tests, but without neglecting the relationship with the patient, which is the one that will provide the understanding of both the symptoms and their psychological development as well as the patient as a whole [9,10].

Types of doctor-patient relationship according to the control exercised by the physician or the patient

When the doctor dominates the relationship by making the decisions that he deems most convenient for the patient, it is a "paternalistic" relationship. The patient cooperates with the physician; that is, to do what is commanded. This is the traditional form of doctor-patient relationship and is still very common in our environment. It works best with patients of lesser education and who willingly accept authority. In contrast, younger, more educated and more skeptical patients tend to be more demanding. They exercise more control than the doctor and give the impression that they "consume" health services when they are in front of the professional ("consumerist" relationship model). During the time that the requests of these patients are considered reasonable by the doctors, the relationship works perfectly, although the doctor always has the doubt as to whether the patient really trusts in him or he is only used. In the model that highlights coparticipation ("mutual" relationship), control and power in the relationship are balanced between doctors and patients; each one endeavors to contribute and take responsibility as far as possible. This is the model that is most invoked when it comes to achieving mature relationships with patients. Finally, sometimes patients or physicians do not exercise sufficient control, so the relationship is considered to be "absent" and patients may drop out of treatment thinking that they have not been given proper attention or that the doctor is incompetent or insensitive [11].

Is there a single type of doctor-patient relationship for all diseases, patients, and circumstances?

Probably "one size fits all" - a single model - does not fit all circumstances, and the physician should be expert in several of these models and learn to adjust their style of communication to the context in which they provide care. Doctor-patient relationship cannot be seen outside the context where the interview takes place, and must conform to it. There are different approaches that derive from different schools, but many of them are complementary or are juxtaposed. A serious

problem with models is that the "active ingredients" of each are not known. On the other hand, medical interview cannot be understood as a single encounter. The physician and the patient develop ongoing friendly relationships, which have historical precedents and expectations of continuity. Most medical interview research has been done, however, on visits to new problems rather than on tracking of known problems. Nor is there much research on the effect of the organization of health systems on the doctor-patient relationship, which is probably a crucial factor.

Medical behavior at each stage of the interview with the pregnant woman

Reception: Before receiving the patient, the doctor who systematically cares for their professional relationships, has in their favor the respect and admiration of other pregnant women, who in the neighborhood and in the waiting room, condition positively, with their comments, to the woman that initiates its specialized attention, since the affability and compassion of the professional are among the qualities most appreciated. Affectionate and respectful reception plays a reinforcing role in these popular perceptions, and in the event that these comments have not taken place, it ensures a positive "first impression", which is very important in interpersonal relations.

Identification: During this stage, the origin of the pregnant woman, her socio-cultural level and her occupation will be collected, data that will facilitate her integral attention. Occasionally the doctor receives, at this time of the interview, information as relevant as the reference to the marital status that can express the separation or death of the partner in the early stages of gestation.

Interrogation: It must always be done while maintaining the usual ethical standards; the physician will explore if there are determinant conflicts of anxiety, whose management in a relationship of mutual participation would immediately enter into the individual care program. In the same way we will investigate the personal conceptions about pregnancy and childbirth, information whose importance is not necessary to highlight. Finally, the attitude of the couple to the future child and their criteria regarding family planning should be investigated.

Physical exam: It should be done with the utmost gentleness, taking into account the ethical significance of respecting the modesty of the pregnant woman and avoiding any painful maneuver that would reinforce the frequent popular conceptions about pain in childbirth. The doctor should strive to achieve the qualification of "doctor of soft hands" in the appreciation of the pregnant woman and the woman. Indications of complementary examinations will always be argued in order to reduce anxiety, otherwise they can be a starting point for concerns.

Information: It plays a very important role in the care of a pregnant woman, and together with persuasion it is a fundamental element of the psychoprophylactic method, which eliminates the negative conditions established socioculturally in relation to childbirth. Never the health team can ignore the orientation to the pregnant woman about the harmful effects of the toxic ones; this can be emphasized during psychoprophylactic training.

Therapeutic Indications: Medical prescriptions must always be argued; in cases where surgical attention is required, this information will be made with the best anxiolytic technique.

Farewell: It should be considered as an important element of the interview, and during it will use phrases like "everything goes very well" as well as small messages of high relevance suggestive. It is important to insist on the significance of the personality patterns of the pregnant woman and the doctor, as well as on the relevance of the sociohistorical context where the relationship takes place, for its good development.

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