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ASPECTS OF THE DOCTOR-PATIENT RELATIONSHIP IN UNIVERSITY HOSPITAL

ASPECTOS DA RELAÇÃO MÉDICO-PACIENTE EM HOSPITAL UNIVERSITÁRIO

ASPECTOS DE LA RELACIÓN MÉDICO-PACIENTE EN HOSPITAL UNIVERSITARIO

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RESUMO

Objetivo: avaliar a relação médico-paciente por meio do nível de satisfação e percepção dos pacientes. **Método**: estudo transversal e qualitativo com grupos focais constituídos por pacientes provenientes dos ambulatórios de clínica médica do hospital universitário. Os participantes do estudo foram distribuídos em dois grupos focais de oito pessoas, sendo um deles composto por homens e o outro, por mulheres. Um guia padrão de temas foi utilizado para conduzir os encontros de maneira a promover interação e ampla problematização dos temas em estudo. Os diálogos produzidos foram transcritos e organizados em um banco de dados para processamento pelo *software* Alceste, que permite uma análise lexográfica informatizada do material textual e integra métodos estatísticos sofisticados. **Resultados**: a análise dos dados apresentou um número de 247 Unidades de Contexto Elementar (UCE), sendo aproveitadas 199 UCE, correspondentes a 80,57% do total. Foram elencadas quatro classes, segundo a Classificação Hierárquica Descendente. Com base na seleção das palavras isomorfas, com radical comum mais as características de cada classe, como encaminhamento, sala, exame, hora e espera, foram atribuídos nomes definidores: Classe 1, denominada de Acesso aos serviços de saúde; Classe 2 - Acolhimento e autonomia do paciente; Classe 3 - Respeito à privacidade; e Classe 4 - Espera pela consulta médica e pontualidade do médico. **Conclusões**: a interação médico-paciente é complexa e influenciada por diversos fatores direta ou indiretamente relacionados ao sucesso do tratamento e à satisfação do paciente. As políticas públicas e gerências institucionais precisam compreender que as necessidades sociais implicam realidades perversas que contribuem para uma relação dialógica médico-paciente deficiente e, algumas vezes, ineficaz.

Palavras-chave: Aplicativo. Bioética. Clínica Médica. Relações Médico-Paciente. Hospitais Universitários. Serviços de Saúde.

ABSTRACT

Objective: evaluate the doctor-patient relationship using patient perception and satisfaction levels. **Method**: transversal qualitative study with Focal Groups made of patients from the Medical Clinic ambulatories in the University Hospital. Participants were distributed in two Focal Groups with 8 members each, one for male patients and the other for female. A thematic guide was used to conduct meetings, promoting interaction and wide problematization of its themes. All dialog was recorded, transcript and processed in the software ALCESTE, which allows for a sophisticated and up to date analytic lexicography. **Results**: data analysis showed 247 Elementary Context Units (UCE), from which 199 UCE were used, corresponding to 80.57% of the total. Four Classes were listed according to the Descending Hierarchical Classification. Based on the selection of the most characteristic isomorphic words of each class, such as medical referral, room, exam, time

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and wait, definitive names were assigned: Class 1, called Access to health services; Class 2, Reception and autonomy of the patient; Class 3, Respect for privacy; And Class 4, Waiting for medical consultation and punctuality of the physician. **Conclusions**: the doctor-patient interaction is complex and influenced by several factors, directly or indirectly related to treatment success and patient satisfaction. Public policies and institutional managements need to understand that social needs imply perverse realities that contribute to a deficient and sometimes ineffective medical-patient dialogical relationship.

Keywords: Bioethics. Clinical Medicine. Physician-Patient Relations. University Hospitals. Health Services.

RESUMEN

Objetivo: evaluar la relación médico-paciente a través del nivel de satisfacción y percepción de los pacientes. **Método:** estudio cualitativo transversal con grupos focales de pacientes de las clínicas ambulatorias del hospital universitario. Los participantes del estudio fueron distribuidos en dos grupos focales de ocho personas, uno compuesto por hombres y otro, por mujeres. Una guía temática fue utilizada para conducir los encuentros, con el fin de promover interacción y una amplia discusión de los temas en estudio. Los diálogos producidos fueron transcritos y organizados en una base de datos para el procesamiento por el software ALCESTE, que permite un análisis lexográfico informatizado de material textual e integra métodos estadísticos sofisticados. **Resultados:** el análisis de datos presentó un número de 247 Unidades de Contexto Elementar (UCE), siendo aprovechadas 199 UCE, correspondientes al 80,57% del total. Fueron listadas cuatro clases, según la Clasificación Jerárquica Descendente. En base a la selección de las palabras isomórficas con radicales comunes más características de cada clase, como referencia, sala, examen, hora y espera, fueron atribuidos nombres definidores: Clase 1, llamada de Acceso a los servicios de salud; Clase 2, Recepción y autonomía del paciente; Clase 3, Respeto a la privacidad; y Clase 4, Espera por la cita médica y puntualidad del médico. **Conclusión:** la interacción médico-paciente es compleja e influenciada por varios factores, relacionados directa o indirectamente con el éxito del tratamiento y la satisfacción del paciente. Las políticas públicas y la gestión institucional deben comprender que las necesidades sociales implican realidades perversas que contribuyen a una relación dialógica médico-paciente pobre y a veces ineficaz.

Palabras-clave: Bioética. Clínica Medica. Relaciones Médico-Paciente. Hospitales Universitarios. Servicios de Salud.

INTRODUCTION

The doctor-patient relationship, under the anthropometric bias, should be holistically analyzed, in addition to the disease. This is considered, by the biomedical model, a biological variation opposed to normality. Such a conception, grounded in a mechanistic perspective, is the main publicly funded model.[1-2]

In this sense, when considering the patterns of verbal communication or not, as well as fundamental principles such as beneficence, respect for autonomy and the right to information, there are many problems that arise in the doctor-patient relationship, which can result in lack of bond and compromising adherence to treatment, as mutual trust is an important aspect in the relationship with the patient.[1,3]

The phenomenon "fractionation of the human body" aggravates this relationship, as refugees in the specialties, doctors do not consider the patient as a biopsychosocial whole, reducing the consultation time.[1]

The importance of communication through patient input. She reports that some initiatives have been trying to empower patients and broaden their participation in the

consultation. Currently, patients seek a lot of diagnoses on the Internet for easy access, and cultural diversity is a reality in today's medical routine.[4] Thus, disagreement between the patient and the patient regarding the proposed diagnosis and treatment often implies non-adherence to therapy. It does not mean, however, that the physician has to abdicate his technical-scientific knowledge, but rather to reconcile biomedical knowledge with popular representations regarding health-disease, optimizing treatment.[5]

They consider that the doctor-patient relationship is a key element in health care and humanization appears as a principle that increases relational quality, emphasizing the dialogical aspect. A welcoming relationship is also a sign of respect for the dignity of the patient. The figure of the doctor as a human being reliable and available to listen is an essential therapeutic element and, as so often, can define the recovery of the patient, constituting an indispensable tool of beneficence in a treatment.[1]

Often, complaints are received for ethical breach with the Regional Medical Councils, which encourages the teaching of the medical ethics discipline in the course curricula. However, it should be emphasized that the moral training offered in educational institutions and refresher courses does not define character, but enhances and directs physicians whose nature is positive, consolidating their willingness to help others. Medical schools have the opportunity and responsibility to teach and evaluate communication skills to bring about the necessary change in medical conduct.[6]

As this research was carried out in a teaching hospital, it is of fundamental importance to know which problems affect this relationship, since students participate in consultations as apprentices. In their perceptions of humanization during their formation, there is little familiarity with the theme. Therefore, this study aims to evaluate the doctor-patient relationship at the Prof. Alberto Antunes through the level of patient satisfaction and perception, especially regarding communication and the quality of interpersonal interactions. For this, the Focus Group (FG) research technique was used.

METHOD

Participants

Sixteen patients from the medical clinics of Professor Alberto Antunes University Hospital (HUPAA) participated in this study, eight male and eight female. A non-probabilistic, that is, convenience sampling was performed, in which the participants, when invited to participate in the study, voluntarily decided to answer or not the questionnaire. Patients from other sectors of the hospital, such as surgical, pediatric and inpatient clinics were excluded, as well as those under 18 years of age and non-hospital companions.

Instrument

The optimal size for a FG is one that allows for effective participant participation and proper discussion of topics. Thus, each group consisted of eight people within the standards established in the literature. Study participants were divided into two FG divided by gender.

To capture the perceptions of HUPAA users, a standard guide for FG themes was developed based on the new National Curriculum Guidelines of the Medical Undergraduate Course in 2014 for guiding the moderator during FG discussions

1. Evaluate the quality of interpersonal interactions in the doctor-patient relationship

· How do greeting and presentation occur?

· Does the doctor call by name / look straight at you?

· Does the doctor have a conversation during the consultation?

· Do you feel comfortable in consultations?

2. Evaluate communication during consultation and patient understanding of the disease, physical and complementary examination (propaedeutic) and therapy

· Does the doctor hear what you have to say?

· Are you interested in what you say?

· Does the doctor have the physical exam? Do you understand what he is examining?

· Guide the therapy (explains how to use medication)?

· Does the doctor observe socioeconomic conditions (value of medication / treatment)?

· Do you understand the doctor's recommendations?

3. To perceive if the patient feels informed about their prognosis and the continuity of treatment

· Does the doctor explain about the diagnosis (severe or not) and continuity of treatment?

· Do you understand the explanation given by the doctor?

4. Assess patient satisfaction after medical consultation

· Does anything bother you during the consultation?

· Do you leave the consultation easy?

· Do you think any aspect should improve?

5. Understand if the doctor-patient relationship is based on respect and ethics

· Do you feel respected and independent in deciding?

Data analysis

The information contained in the FG dialog transcripts was organized into a database specially prepared for processing by Alceste software (Analyze Lexicale for Context Ensemble of Text Segments, or Lexical Contextual Analysis of a Text Segment Set), developed by Max Reinert.[7] This software enables a lexographic analysis and integrates a large number of sophisticated statistical methods, configuring itself as a textual data analysis instrument that provides criteria for the material in question to be considered an indicator of a phenomenon of scientific value.

Alceste, by means of co-occurrence criterion, divides terms of the text according to similarity and dissimilarity, generating a corpus (text database to be analyzed, in this case, the questionnaire answers), capturing the most frequent and significant words by the coefficient of association [$\chi 2$ (1) $\geq$ 3.84, $p < 0.05$] of the word to its position in the text.[7] Moreover, by means of Correspondence Factor Analysis (CFA), a description is possible, crossing the vocabulary and the classes, through a graphical representation in which the axes allow to visualize the relations and / or oppositions between the classes.[7-8]

To understand the analysis, some concepts must be elucidated. Initial Context Unit comprises the natural divisions of the corpus (answers to each participant's interview questionnaire without questions). Elementary Context Unit (ECU) is the smallest piece of meaningful text; higher semantic weight as a function of text size and punctuation. The Context Unit (CU) consists of the grouping of successive ECUs from the same ICU. The value is calculated by the software, depending on the size of the text to be parsed. The concept of class, which represents a theme extracted from the text, lemmatization, consists of the operation of replacing words with a reduced form, which allows the program to consider and verify the frequency. Descending Hierarchical Classification (DHC) corresponds to an aggregation analysis of objects based on their characteristics.

In short, the result is the construction of a hierarchy or tree structure [dendogram - tree graphic representation], which represents the formation of clusters. Similarity between objects can be verified in two ways, namely: (a) a measure of association, with a higher positive correlation coefficient, representing greater similarity; (b) The proximity between each pair of objects may assess the similarity where distance or difference measurements are employed, with the shortest distances or differences representing the greatest similarity.[8] Finally, Correspondence Factor Analysis (CFA) consists of the crossing between vocabulary (taking into account the frequency of words) and the classes, graphically represented in a Cartesian plane, making it possible to verify the opposition between the classes.[7-8]

Finally, this analysis involves four operational steps: Step A: Text Reading and Dictionary Calculation; Step B: Calculation of Data Matrices and Classification of ECUs; Step C: Description of the chosen ECU Classes and Step D: Complementary Calculations. It also enables the triangulation of qualitative and quantitative data.[7,9] For this study, we used the simplified parameterization (paramétrage simplifié), specifically in Step B, with the simple classification option in Elementary Context Units - classification simple sur les Unités de Contexte Élémentaries (UCE).

The results of this study will be archived by the principal researcher for five years and made available to hospital management for analysis without identifying the subjects involved. After this period, they will be incinerated.

RESULTS

The results presented here refer to the content analysis of dialogues among FG participants. Thus, the analysis, constituted by the corpus of 150 ICUs, presented a number of 247 ECUs, in which 199 were used (80.57%).

Four classes were listed (Figure 1A), according to the CHD. Based on the selection of the most characteristic words of each class, names were assigned that function as their descriptors. Class 1, called Access to health services, had 69 ECUs (34.67% of the corpus); Class 2, named Patient Reception and Autonomy, had 43 ECUs (21.61% of the corpus); Class 3, called Respect for Privacy, had 41 ECUs (20.60% of the corpus) and Class 4, waiting for medical consultation and punctuality of the physician, presented 46 ECUs (23.12% of the corpus).

Figura 1A - Dendograma com partições em Classes lexicais

Classe 1: Acesso aos serviços de saúde

69 UCE (34,67% do *corpus*)

Palavras	χ^2
encaminh+	16
diz+	16
ano+	15
consegu+	14
ent	13
dico+	12
posto	10
trabalh+	10
eu	9
diss+	8
nome	8
vontade	8
*s_64	8
tent+	6
no	6
o	6
vai	6
vou	6
jacintinho	6
telefon+	6
dos	6
uma+	5
*g_1	5
que	5

Classe 2: Acolhimento e autonomia do paciente

43 UCE (21,61% do *corpus*)

Palavras	χ^2
sala	37
doutor+	25
est	19
examin+	18
filh+	16
direitinho	15
entend+	11
na	10
coisa+	9
convers+	9
dica	7
a	7
ele	7
uma+	7
outro	6
meu	6
entr+	5
precis+	5
primeira	5
mesmo	5
dess+	4
tir+	4
equipe	4
*s_68	4

Classe 3: Respeito à privacidade

41 UCE (20,60% do *corpus*)

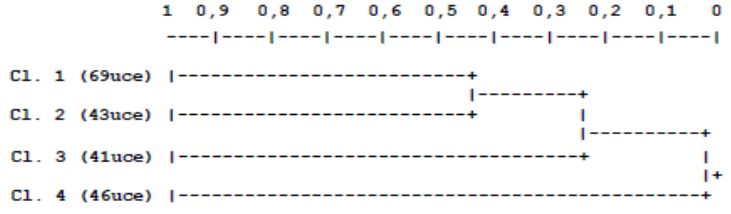
Palavras	χ^2
exam+	80
os	27
faz+	16
fa	11
cil	10
vim	8
teve	8
timo+	8
fazendo	7
dif	7
tenh+	7
meses	6
ginecologista	5
foram	5
rio+	5
meus	4
tive	4
*s_7	4
*s_49	4
tal	3
voc	3
hoje	2
precis+	2
f	2

Classe 4: Consulta médica e pontualidade do médico

46 UCE (23,12% do *corpus*)

Palavras	χ^2
hor+	37
esper+	37
cheg+	30
atend+	30
venh+	28
dez_horas	24
manh	21
da	16
frente	14
*s_3	14
pediatra	13
marc+	12
*sx_1	10
sete_horas	10
oito-horas	10
onze_horas	10
*g_2	10
fiquei	10
cham+	10
mei+	9
*s_6	9
ser	9
ou	9
demor+	7

Figura 1B - Dendograma com a intersecção das classes



The relationship between the classes can be seen in the dendogram of figure 1B. Classes 1 and 2 are closely related due to their proximity and correspondence to the semantic aspects listed. Although they have some degree of relationship, Classes 3 and 4 are more independent of Classes 1 and 2, because they are more distant in terms of relation (Figure 1B) and have semantic aspects that differ from the others.

DISCUSSION

Class 1 – Access to health services

As shown in Figure 1A and Chart 1, Class 1 is characterized by significant words and ECUs that refer to the difficulties of access to health services, referral between medical specialties and the referral system and fundamental counter-reference in contributing to integrality in health.

Chart 1: Description of ECUs plus Class 1 characteristics.

χ^2	Text tracking
13	#ent o #diz que passa #anos, #vai para secretaria e n o #consegue.
11	#ent o o m #dico olhou e #disse: oi, eu n o fa o isso mais n o, mas #vou #encaminhar o #senhor para o hu.
10	#ent o eu #pergunto #senhora: #at quando isso #vai acontecer no #hospital aqui?
7	A pessoa tem medo de responder #at o #nome. quando um m #dico assim, n o d #vontade nem de #dizer a idade.
7	A #senhora concorda em ser examinada por eles? eu acho o certo, porque se ele tivesse #feito essa #pergunta eu #ia #dizer que n o, eu fui porque n o me #perguntaram.
5	nas vezes que eu fui atendida ele #deixa. ele #fala: meu #nome fulano, #pergunta meu #nome, eu digo. #ent o a_gente #fica conversando e #daqui a pouco desabafa tudo.

Although the Brazilian Constitution guarantees health as a universal right to be guaranteed by the State, despite the advances made, it still lives with the unequal and exclusionary reality of access to the Unified Health System (UHS).[10] Unfortunately, the testimonials of users in FG point to a disappointing picture of access to health services.

Differences in access to hospital care according to income group are still observed in Brazil, indicating social inequality in the use of these services. The groups with the most health needs are those that have the greatest difficulty in accessing and using health services. And when they access them, the poorest people tend to look to health services more for disease problems, not for prevention or routine checkups, as observed in the contingent of the highest earners.[10]

> *I pay health insurance is not because I can afford it, I pay because I need it [...], I really need medical care. If I come here only, there is no condition because it is very difficult and takes too long the doctor.* (Patiente 3, Group 2).
>
> *The person who is not aware here [in the hospital] cannot make an appointment.* (Patient 6, Group 2)

My doctor here is a good professional [...], but since last year he sent me a paper from the hospital itself and I never got the appointment. (Patient 1, Group 2)

The person tries to make an appointment and is always stopped by the hospital bureaucracy. (Patient 2, Group 2)

In line with the reports, inequalities of access stand out as one of the main problems to be faced in order for the UHS to function effectively, which requires a constant struggle to strengthen health as a public good.[10]

Class 2 – Patient reception and autonomy

As noted in Figure 1A, Class 2 is characterized by meaningful words that reflect the importance of medical reception and patient autonomy. Selected text following (Table 2) also describes beliefs related to the physician's own therapeutic functions and the patient's own relationship.

Chart 2: Description of ECUs plus Class 2 characteristics.

χ^2	Text tracking
19	quando v que algo muito grave, fica_enrolando a #pessoa, n o d diagn stico exato. eu #acho isso #uma falta de respeito para-com o paciente, porque eu #preciso #saber o-que #est acontecendo comigo
15	A #doutora, ela #conversa mesmo, #a_gente desabafa, como_se_fosse_uma_terapia. minha m #dica me recebe e depois come a a #conversar comigo. como_se_fosse_uma_terapia mesmo-que eu fizesse com ela. e ela me #examina todinho, tudo #direitinho.
12	acusou que eu estou com #uma mancha no meu rim. ent o ele #conversou comigo tudo #direitinho, ia passar para minha m #dica e a minha m #dica ia #explicar tudo #direitinho.
10	O meu neto faz #tratamento aqui, mas a m #dica n o_examina nada. A #primeira m #dica #tirava a roupinha e #examinava do dedinho do p cabe a, que o correto, que eu #acho.
10	pra mim at de #primeira, um m dico que chega, #conversa mesmo, dialoga mesmo com a #pessoa para #saber o-que a #pessoa #est #sentindo.
7	es_vezes tem tr s, quatro, cinco ali na #sala e todos eles t m que #examinar a mesma #pessoa.
6	certo. quem #examinou? outro, n o foi ele. certo que ele tamb m estava na #sala, #entrava e sa a, ent o deixa #a_gente encabulado porque #est l a #pessoa aprendendo, #quer dizer, voc passa a ser #uma cobaia e n o um paciente

It can be said that "the process of establishing human relationships with patients contributes to developing the physician's sense of responsibility, as well as improving outcomes and adherence to treatment, increasing patient satisfaction".[1:651] This aspect was evident in the speeches of the patients participating in this study, who emphasized the importance of medical reception and interpersonal relationships in satisfaction with care.

The doctor really talks, we vent, it's like a therapy. My doctor welcomes me and then starts talking to me. It's like therapy even if I did it with her. (Patient 5, Group 2)

Another characteristic feature of this class was respect for autonomy, especially in relation to information. The Code of Medical Ethics, in its article 34, prohibits the physician "to fail to inform the patient about the diagnosis, the prognosis, the risks and the objectives of the treatment, except when direct communication can cause harm, and in this case, should communication to your legal representative".[11:17] The disrespect for this autonomy puts doctor and patient in different planes, resulting in an asymmetrical relationship in which the doctor has a body of knowledge that the patient usually does not have.[3]

> *There are some doctors who do not inform the exact diagnosis to the person, they get tangled up [...] I think this is a lack of respect for the patient because I need to know what is happening to me.* (Patient 4, Group 1)

Patient autonomy clashes with therapy when information about the diagnosis and its consequences is poorly passed. Thus, it is clear that, to organize efficient health services, it is necessary to consider the respect of the patient's subjective values, cultural diversity and the promotion of their autonomy.[3]

Class 3 – Respect for privacy

Figure 1A shows that Class 3 is characterized by meaningful words that refer to beliefs related to the need to respect patient privacy. The selected text segments (Table 3) follow the same line.

Chart 3: Description of ECUs plus Class 3 characteristics.

χ^2	Text tracking
27	eu pago plano se sa£de, n o porque eu posso pagar, pago porque preciso. #tenho seis h rnias de disco na coluna, problema_de_vista, eu #tenho que me cuidar de 6 em 6 #meses, estar #fazendo ultrassom, bi psia do f gado, #fa o muito #exame de sangue e eu realmente preciso de cuidados m dicos.
14	se eu vier para aqui n o tem condi o, porque muito #dif #cil e demora demais o m dico. mas #os m dicos aqui s o #timos, eu gosto muito daqui.
13	quando aquele-que calado, que s olha ali #os #exames, s pergunta sua idade e essas coisas assim, #voc se sente inibida de dialogar.
13	assim, o caso dela, n o_me_incomodo #tamb m. O #ginecologista l muito novinho, mas #faz #exame #tamb m.
10	para quem j #teve filho n o tem essa vergonha toda, mas quem nunca #teve. eu #tenho.
7	fica mais f #cil de #voc ser atendida, marcar_uma_consulta no caso.

Although it is a teaching hospital, student co-participation was not the cause of privacy complaints. These were mainly related to gynecological consultation and the performance of more invasive procedures, such as specular gynecological examination. Some women characterize the examination as a procedure that leads to invasion of privacy and bodily integrity or exposes them to a painful, embarrassing and unpleasant experience.[12]

> *I know this is a school, but it bothers you: you are in a room, in my case, the problem is gynecological, and there is a lot of academic there [...]. This is very annoying, you understand?* (Patient 3, Group 1).
>
> *That's why I often wonder whether or not I take the exam here.* (Patient 2, Group 1).

Female embarrassment was reported when the professional performing the gynecological exam was male:

> *I bother because I even get nervous about getting a gynecological exam with a man because I always did a woman. When a man comes, I did it myself here and I was shaking.* (Patient 6, Group 1).

Thus, to ensure comprehensive care for women, it is important to look at her without prejudging attitudes and conceptions, welcoming her so as not to see only the technical procedure, aiming at the least embarrassment during the procedure.[12]

Class 4 – Wait for medical appointment and punctuality

Figure 1A shows that Class 4 is characterized by meaningful words that refer to beliefs related to dissatisfaction with the physician's lack of punctuality and the waiting time for the consultation. The selected text segments (Table 4) also reveal punctuality as a form of respect for the patient.

Chart 4: Description of ECUs plus Class 4 characteristics.

χ^2	Text tracking
24	#demora muito, a n o ser que a_gente #venha logo cedinho, o-mais cedo poss vel para ser o primeiro, porque se n o. eu, por_exemplo, a minha #consulta estava #marcada para as #sete_horas #da #manh, eu vim ser #atendida agora de #dez_horas.
19	veja, voc #chega de #sete_horas #da #manh para ser #atendida de #dez_horas. E j teve vez de eu #chegar de #sete_horas #da #manh e quando #venho ser #atendida j duas_horas #da tarde.
19	O #problema dessa #espera porque a #consulta #marcada para tal #hor #rio e sempre ela #come a a ser #chamada uma #hora, duas #horas depois.
18	A m dica sempre muito bem atenciosa na #hora #da #consulta. O ruim mesmo por #causa s #da #espera.
16	O m dico tem_que_ter_pontualidade. em qualquer servi o a pessoa tem_que_ter_pontualidade no seu servi o. ent o o-que que acontece: #marca o #hor #rio #da #consulta #dez_horas e #chega dez_e_meia, isso n o ser pontual.
14	#marca para #oito_horas e quando vem #come ar a #atender a_gente nove_horas, nove_e_meia, #dez_horas.
9	O #problema mais a #demora para #marca o e a #espera.

Hospitals and school outpatient clinics often require longer service hours, as the teacher must advise students and resident physicians during consultations. Despite this prerogative, the waiting time factor should be considered when studying patient satisfaction, as it is generally one of the main reasons for complaints by service users.[13]

The doctor is always very attentive at the time of the consultation [...] the bad thing is just because of waiting. (Patient 1, Group 2)

The doctor has to be more punctual. In any service, the person must be punctual in their service. (Patient 4, Group 2)

A very long wait is reported as the main reason for complaints. The delay is understandable, as in teaching services, the teacher is constantly requested by the student or resident doctor and can hardly keep up with the pace of arrival of patients.[14]

CONCLUSION

The study of the doctor-patient relationship through the use of the FG technique showed four important classes when analyzed by the Alceste software. The classes called "Access to health services", "Reception and autonomy of the patient", "Respect for privacy" and "Waiting for medical consultation and punctuality" contribute with fundamental subsidies for the improvement of the doctor-patient relationship, the main objective of this research. The difficulty of access to the doctor and hospital care, the precariousness of reception and respect for autonomy, as well as the lack of patient privacy, especially during the gynecological examination in a teaching location where students are present, were the more salient aspects than the quality of the doctor-patient relationship itself. The speeches of the patients suggest that the mere fact of getting a medical appointment, given the reality of public health and after long periods of waiting and difficulties, causes these dissatisfactions to be relegated to the background.

The results obtained will be made available to the executive board of the hospital, maintaining the confidentiality of the subjects, so that, from what was observed, the services are improved. There is a need for further research that will contribute to the expansion of this.

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