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# Nurses' Care, Doctors' Cure And Patients' Gratification: Therapeutic Relationships In Medicalized Motherhood Practices In Hospitals

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## Abstract

The aim of this study was to understand the doctor-patient-nurses relationship with respect to their therapeutic interaction build up during the treatment process. The medicalization of childbirth has remarkably changed women's experiences of the transition to motherhood. Medicalization has significant influence on women's perceptions of pregnancy and childbirth. The present study employed qualitative research design under which phenomenological inquiry was carried out. Qualitative approach was chosen as the appropriate design to explore the experiences of healthcare services from the users' and providers' outlook. The participants of the study comprise of 20 patients utilizing the outpatients and indoor healthcare services in PIMS and FGPC hospitals in Islamabad. To triangulate the study, the interviews were also conducted two Nursing Superintendents (one from each public hospital), six doctors (three from each hospital) including specialist consultants, medical officers and postgraduate trainee doctors. Thematic analysis technique was used to describe and interpret the information gathered from the field. The study highlighted doctor-patient interaction in three ways; instrumental, expressive and communicational. The findings also illustrated nursing care and their roles have significant impact on patients' experiences and satisfaction with the process of care delivery and health services. It is concluded that the process of measuring healthcare services determines on whether a patient receives ample and efficient care. By highlighting women's energetic contributions to the medicalized nature of care at hospitals, motherhood is perceived as an alternative to analyses of medicalization that is inclined to outlook women either as powerless sufferers or as dynamically opposing medicalization.

**Keywords:** Motherhood, Medicalization, Nurses' care, Doctor's Cure, Health system, doctor-patient relationship

## INTRODUCTION

Maternal health is not the only concern of women but an important component of a nation's integrity. The development of every society, community and state depends on healthy mothers. The ample and efficient investment on maternal health concerns can enhance the advancement of every individual. The growth of the nation relies on sufficient investment in maternal health which in return increases social harmony and economic productivity. Failure to endow on maternal health is not only decadent but also destabilizes the national system of development. In this regard, the role of the health sector is mainly an important ladder to ascend in catering to the development of the nation through investing on women's health. The maternal healthcare in today's world is more medicalized in nature as motherhood includes matters of pregnancy and childbirth which need medical intervention and assistance of medical

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professionals. Childbirth which is considered as a natural and normal birthing process has become more medicalized through the intervention of the biomedical practices of motherhood.

## BACKGROUND

Medicalization is the consequence of re-conceptualizing pregnancy as a medical stipulation which leads towards the acceptance of medicalized childbirth among women. For that reason, ever since women see pregnancy and childbirth as medical domains related to healthcare system, their experiences and expectations exceedingly manipulate the outcome of the care they receive. To measure the outcome of the process of the services delivered at hospitals, patients' satisfaction is an important indicator to be used. It not only provides assessment of the performance of healthcare professionals but also evaluates the availability and utilization of services (Seiler et al., 2012). Effective communication of healthcare providers is mainly the leading cause for the distinctiveness of healthcare for patients (Berhane & Enquselassie, 2015). Although it is based on a short duration (a minimum of 10-15 minutes and a maximum of one hour during one visit), it has high impact on patient satisfaction with health services in various settings.

### Patient-centered Care of Interaction

The medicalization of motherhood at hospitals has a momentous influence on shaping women's experience of childbirth. It shows how the medicalization of postpartum care has affected women's experiences over time. Patients' satisfaction with the services mirrors the quality and continuum of care as well as establishes relationship between providers and patients (Pittrof, Campbell, & Filippi, 2002; Sofaer & Firminger, 2005). Patients' satisfaction with the services is an important indicator to measure the performance of the healthcare services. Patient satisfaction is an important concern in healthcare system to study quality services and provider's competence to meet the patients' expectations. Patient satisfaction is a wide concept based on individual perception and expectations with the services (Bleich, Özaltin, & Murray, 2009). The very subjective feeling is attached to patients' assessment of healthcare services reflected in the individual's reaction towards the services received (Hills & Kitchen, 2007).

Platonova and Shewchuk (2015) explored the patients' level of education and their satisfaction with communication with physician in primary healthcare setting. The findings of the study show that the patients who were dissatisfied with the physicians' interaction and management of care were highly educated and prosperous with respect to their socio-economic status. It reflect that the educated patients may have some critical assessments of doctor-patient relationship and the assessment can be used as guiding principles for health policy makers to improve the guidelines for establishing efficient doctor-patient relationship in healthcare system. Jalil et al's. (2017) study in Pakistan also comprehends that physicians' competence as one of the important indicators to assess patient satisfaction with doctor- patient interactions. Five dimensions of medical interaction such as technical expertise, interpersonal aspects, communication, consultation time and availability were assessed to measure patients' satisfaction. The findings highligh several factors of doctors' incompetence such as inaccurate diagnosis, excessive use of medical tests, non-availability of specialist doctors and experimentation by trainee doctors, all contributing to the patients' dissatisfaction with doctors' communication.

Furthermore, to assess the social interactions in healthcare system, the medical sociology perspective is necessary. Benoit et al. (2005) examined maternity care under three areas covered by medical sociology which are comparative welfare state, the sociology of profession and contemporary social movements. The state, profession and mothers are in a web of interrelations with each other. The state provides policy and structure, in which the sociology of profession is the core aspect to establish relationship with the state and the patients which reflects the social organization of maternal healthcare system. Neiterman (2013) claim that a medicalized view of pregnancy shapes the process of pregnancy and childbirth which shapes women's experiences of becoming mothers. Women's experiences are shaped by the biomedical notions

of pregnancy; women also bring new meaning to the biomedical guidelines. Women view pregnancy as a process of giving birth to a child and sharing their bodies with their children. Burbaker (2007) studies on young mothers' experiences with reproductive healthcare among African Americans and illustrate that reproductive health is socially constructed, managed and controlled by the medicalization of healthcare practices.

Past researches by Berhane and Enquselassie (2015) Coyle et al. (2001) and Hassan and Rehman (2011) focused on the outcomes of healthcare services based on patients' satisfaction about the services. Many of these studies did not focus on the mechanism of the provision of healthcare services. A few studies like Jamas, Hoga and Tanaka (2011), Berhane and Enquselassie (2015) and Ward, Rokkas and Cenko (2015) have been undertaken to investigate the process of delivery of healthcare in terms of the activities performed by the staff and doctors. Various studies demonstrate individual and community level factors for under-utilizing maternal healthcare services resulting in maternal and neonatal mortality in developing countries (Parkhurst, Penn-Kekana, & Blaauw, 2005; Babalola & Fatusi, 2009; Singh, Rai, Alagarajan, & Singh, 2012). There is a gap of service related factors which play a major role in determining the status of utilization of maternal healthcare services. It is determined that maternal mortality and morbidity rates are declining as a result of accessing antenatal care services but studies lack the potential contribution of system and structure of service delivery which the present study intends to investigate. It is a triangulation-based study which investigates the maternal health care services from three perspectives i.e. administration's (structure), doctors' (process) and mothers' (outcome).

## Theoretical perspective

Effective therapeutic doctor-patient relation is the core of clinical process of care in provision of quality services to the patients (Ha & Longnecker, 2010). The doctor-patient communication to deal with the illness exists as a pattern of social interaction which is beyond the biomedical practices of dealing health matters. The finding of the present study applied social exchange theory to understand the nurse-patient, doctor-patient and nurse-physician relationship with each other's. The social pattern of interaction between nurses and patients provide and understanding of establish such relationship to exchange the information, knowledge for the better outcome of the patients. The application of social exchange theory in understand underlying assumption of nurse patient relationship is also supported by Byrd (2006) through highlighting the exchange resources and patterns nurse utilities in order to establish social interaction between them and their clients. The notion of exchange resources is based on vice-versa support from both the partners of social interaction. Such as the information, healthcare services and medical support is provided by the nurse, in return, the patients sacrifice their time, prestige, allowing bodily interaction etc. Social exchange theory is extensively used in understanding social care interaction establishing the providers and the health seekers.

The role of actors in healthcare system can describe under parsons' five pattern variables of interaction. The first pattern affective vs affective neutrality reflects an organize action of the system in which actors such as doctors and staff tries to avoid conflicts and pain in order to maximize the patients' satisfaction. The second pattern self-orientation vs collectivity enforced healthcare providers to act for the interested of the general public not for the individual benefits and prestige. The findings of the study supported the notion by highlighting doctors and nurses actions to save the lives without much considering the benefits they are attaining. Third pattern of particularism vs universalism is the refection of standards determined by social actors in order to deliver the services. In this regard, the findings of the study illustrated although the general pattern of action is based on universalism but many incidents of particularism were also highlighted. The matter of reference, and prioritizing the patients by the providers created dissatisfaction among the general patients. Furthermore, the fourth pattern of social action is quality vs performance which is the core of the present study. The ascribed nature of quality such as doctors' abilities, motivation and interest impacted on their achieved positions and status. The performance of the individual enhances the quality of the care services provided to the patients

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as well as doctors' competence itself. The last pattern is diffuseness vs specificity determined the relationship between the doctors and the patients penetrated in the system within its limited boundaries. Furthermore, Parsons (2011) describe the interaction and communication with doctor and patients by emphasizing that interaction between doctor and patients occurs directly when they face to face talk to each others. On the other hand, communication occurs indirectly through the family members of other medical representative such as nurse as studied in case of maternal healthcare at public hospitals services.

**Methods**

The aim of this study was to understand the importance of doctors and nurses in healthcare, the present study explored their relationship with the patients in medicalized domain of motherhood. The study is describing care Interactions under subthemes of patient-centered care, interactive and communicative relationship doctors' power and patient's experiences & satisfaction. The study was carried out at two public sector tertiary level teaching hospitals in the capital of Islamabad. The study was conducted from January 2016 to August 2016.

As research ethics is essential to be followed by researchers at all phases of the study, initially, permission was obtained from particular hospitals for data collection, then informed consent was achieved through direct contact with prospective participants through face-to-face interaction at the hospitals. To obtain the permission from the hospital, the formal letter from my supervisor was addressed to the hospitals. The case was then presented at research ethical committee recently constituted in the public hospital which was granted an approval to conduct the study. The confidentiality of the data was assured to the hospital authorities not to use the name of the hospital in highlighting critical matters of the hospital. Pseudonyms of the participants are used in reporting the findings.

Before the commencement of the interviews, the researcher assured the confidentiality of the information to the respondents. The informed consent was provided to the participants enclosing information related to the researcher and intention of study. The researcher used digital recorder to record the interviews which was also informed to the respondents and assured them to keep the information safe and will be used for study purpose only. No one else other than researcher will have access to those interviews. It was also assured them that the recording will be destroyed after the completion of the study. They had also given the opportunity to say no to respond to any questions and can ask the details of any question if they feel any ambiguity. The researcher guaranteed utmost confidentiality of the information to the participants. The names appear in this study are the pseudonyms of the respondents.

**Data and methods**

The teaching hospitals with separate maternal and child unit equipped with common technological equipment and essential staff were selected. On the basis of the abovementioned characteristics of the hospitals, Pakistan Institute of Medical Sciences (PIMS) and Federal Government Polyclinic hospital were selected for the study. Both hospitals are considered as public hospitals funded under Ministry of Health Pakistan, which provides financial resources as well as formulate guidelines and procedures. Both hospitals have separate department for maternal healthcare.

The research adopted purposive sampling methods, in which required criteria were preselected to choose the appropriate sample from the population. The purposive sampling enables to select small bur representative sample which incorporate the essential characteristics of the study requirement which also reflected heterogeneity of the population. The participants of the study was consisted of two administrators (one from each public hospital), six doctors (three from each hospital) including Medical Officers, General Practitioners and Specialist Consultants and twenty patients (ten from each hospital) used the hospital services for at least two days and willing to document their experiences regarding the healthcare services.

**DATA COLLECTION TECHNIQUES**

For the conducting in-depth interview, the researcher used self designed interview guideline

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based on open-ended questions without giving any direction or required answer to know the real response of the participants. Lots of probing was required for getting more information which was the most difficult task, as participants used to give shorted response. The primarily designed interview guideline was verified by doing pilot study before commencing the final study.

The study also engaged in participant observation to make the data more reliable by examining the actual behaviour of the doctors and patients with each other as well the staff of the hospital with the patients. Participant observation is the widely accepted and used method in anthropology which is now accepted and utilized in sociology too. Two types of observation checklist is used i.e.; structured and un-structured. The selection of either type depends on the nature of study. Structured observation is usually preferred by positivist research and un-structured by interpreters. To verify the availability of the services, pre-designed structured observation checklist was used which was not exhaustive in nature. Therefore additional information was noted down and wherever allowed some snapshots were also taken as evidence.

**Data Analysis Procedure**

The data in this study was analyzed by developing themes and sub-themes. Reporting and interoperating the qualitative data is a very meticulous task. The present study employed three interrelated concepts of assessing maternal healthcare services i.e. structure, process and outcome. Thematic data analysis technique was used by following the process of immersion, coding, categorization and theme generation. Initially, the researcher aimed to draw a broad-spectrum description of women's experiences of healthcare services Interviews provided more data than expected. Number of times the transcriptions were read to extract more comprehensive information related to the specific purpose of collected data. Various themes come forward from the data which were placed in a variety of different categories by using ATLAS.ti software. After organizing data in ATLAS.ti, themes were generated and by adopting phenomenology technique, thematic analysis was preceded. By employing constant comparative method, the information obtained from three different types of respondents as well as the data collected from interviews and observations were compared and contrasted with each other.

**Results & Discussion**

**Nurses-patient relationship**

Nurses are the backbone of the healthcare system. The word "care" in nursing definition has four meanings; face to face working with patients, dealing with patients as a whole person, open-ended nature and commitment to her work (Ratcliff, 2002). From providing continuity of care to patient to managing administrative tasks of handling patients and record keeping, they are responsible for various healthcare matters. The nursing care by women has deep rooted in the ancient history to serve the humankind. The nursing skill was initially learned from through apprenticeship at home or at community level. The formal nursing care training for the newborn was originated in 1799 in United States started by Valentine Seaman, a New York City physician. The formal nursing care trainings were delivered by following a manual of nursing care published in 1800 which is being followed till today with certain addition and advancements of medical world. In today's world of technology oriented medical profession, the nursing care practices has evolved in relation to societal demands and increased knowledge of the patient's needs.

On the contrary, it is found very common by patients and attendants to behave badly with the nurses almost every day. The following is one of the staff's views:

> *Because of the over burden of our work, nurses and staff cannot fulfill the demands of each and every patients, due to which they complaint and very rudely behave with us. Obviously when patients irritate us and want to fullfill all their demands which is not possible for us, we also become angry towards them which shows our negative attitude to them. Let see now you come for the interview, but*

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> *we are giving you time along with doing our own work, but patient's demand is to just treat them individually on urgent basis. We changed the bed sheet daily in the morning but after some time there is again requested from the patients to change it again because their children or attendant poured tea on it. So now this is very ridiculous, patients need to take care of this by themselves. So we have our own limits and capacity to deliver the services, but patients again and again asked for the same thing, then its natural they we some time become aggressive.*

The above extract form the interview depicted that it is humanely difficult for the staff to fulfill all demands of the patients every time. Patients attitude also become harsh because of not having treatment date as per their ease and not finding bed in ward, so their attitude and behavior also become rude towards the staff. But patients never understand the problems and limitation of the hospital's services, they just think individually. On the limitation of having free beds, furthermore the staff mentioned that they allocate beds according to the severity of patients' condition. She explained as:

> *If we have 30 patients and three beds, the priority will be given to those patients who need the services most urgent due to their critical situation. And the remaining 27 will give the remarks that why they given chance to these three patients and not us. Although they are right, but we are also not wrong, we have limited facility and according to the available services we have to admit the patients.*

The observation of the researcher also supports the responses of the doctor and staff, within the limited resources doctors and staff are struggling hard to fulfill their responsibilities by accommodating all the patients. Additionally the data revealed that many of the doctors and staff do their best to realize the patients about the limitations of the hospital services. But on the other hand, patients do not want to sacrifice their time to come again and again for the normal checkup. Therefore number of cases of patient's misbehavior was reported in OPD due to not getting the number or having long waiting hours. As the misbehavior between patients and staff is vice versa, hence one staff reported that they learned and expert now to deal with such patients. Number of times the language barriers make the situation more complex when patient unable to understand and communicate in Urdu language. The patients who were illiterate belong to different tribes such as "Pashtun" or "Afgani"[1] only speak and understand in their regional language. The staff (Anum) reported their engagement with multilingual and multiethnic patient as:

> *Yes, all the time, most of the pashtoon patients do not understand our language, and we do not know how to speak in Phustoo, it is very complex situation for us to inform the health matters to those women, and also they are uneducated, so they don't know about the treatment and what we are saying. The uneducated even don't understand the language. All the time we have to call their male members if they come with them because males have frequent interaction with the people outside the home so they learn and*

[1] **Pashtuns** also known as ethnic **Afghans in Persian language and Pathans in Urdu language.** The Pashtuns are mainly recognized by their usage of the Pashto language. The vast majority of Pashtuns are residing in their indigenous traditional Pashtun locates in south of Oxus River in Afghanistan and west of the Indus River in Pakistan. Due to the fact Pakistan has open its boarder for Afghan refugees, they are scattered in all parts of the country. Majority of its population settled in Khyber-Pakhtunkhwa, Federally Administered Tribal Areas (FATA) and Balochsitan (Tarzi, & Lamb, 2011).

> *speak Urdu language, but female as they don't go outside, they do not know how to speak and understand Urdu language. Even there are lots of Christian patients comes in, but we never discriminate them on the basis of any class and religion. Our duties are to just provide the treatment irrespective of their ethnicity.*

A study by Tammentie et al. (2009) supported the above mentioned argument that due to lacking resources, nurses cannot provide the ample information and time to one patient. Therefore the families also need to play their role in order to facilities the postpartum time of motherhood to avoid any mental or physical illness. It is analyzed that there must be holistic relationship for maternal care by the families and the care providers. Sauls (2002) found that supportive care during childbirth resulted in better outcome for the mothers and newborns. The evidence supported the findings of the current study mentioned that collaborative care by the health professional impacted on healthier outcome of care. It is analyzed that mother's satisfaction with the services has profoundly influenced by the nature of care interaction they have with the doctors and nurses.

The researcher was informed by the patients about provision of basic education to the mothers such as; breast feeding, cleaning of newborn, abruption etc. The observation taken by the researcher also found few evidences of such practices in the hospital. The nurses usually teach the new mothers how to breastfeed the newborn, how to take care of the baby and what types of sign and symptoms should be taken care etc. this shows the process of care delivery at public hospital follow the in-hospital educational and counseling program which is given importance in public health. In addition mothers also want to gain more knowledge and information in terms of any booklet and written document which remains with them for long period of time and also easy to recall the information. Barbara et al. (2010) mentioned that doctors and nurses must develop some educational booklets to provide some rich information to the mother about basic healthcare concerns of newborns. The educational booklet will enhance the continuum of care to accomplish better outcomes.

In addition, mothers also want to receive consistent information from their health-care providers. A comprehensive education booklet may promote consistent education from nurse to nurse. Although the focus of our quality improvement project was on postpartum education during hospitalization, perinatal educators and postpartum nurses should collaborate to develop educational materials that provide consistent information throughout the continuum of care. In concise, nursing care and their roles have significant impact on patients' experiences and satisfaction with the process of care delivery and health services? In order to fulfill their responsibilities in a proficient conduct, nurses must be equipped with the expert knowledge and advancement in the field of healthcare. The authoritative nature of nurses-patient relationship is influences by the health condition and place of the care process performed. The nature of mothers' health condition and nurses' working matters established the reciprocal relation between them which varies from patients' knowledge and their social-economic status. The place also plays an important role where the interaction took pace. Usually at nursing workstation they have more control and power over the patients, while at patients' home or private ward and VIP rooms, patients are more in position to direct the nurses according to their need.

**Nurses-Physician Relationship:**

Many researches (Kaissi et al., 2003; Fewste & Velsor, 2008; O'Leary et al., 2010 & Thomas et al., 2003) identified teamwork, collaboration and communication as important indicators to study the nurse-physician relationship. The purpose of the team work and collaboration between nurses and the physician enables them to attain the healthier results for the patients. Tschannen (2004) determined collaborative nurse-physician relation by identifying the teamwork which is also supported by another study by Rosenstein and O'Daniel (2005) that mentioned doctor's hostile manner provoke nurses to work as a team. The collaboration and support from the doctors also enhance the nurses' satisfaction with their job and

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workload (Vahey et al., 2004). The collaboration and teamwork is the reflection of good communication between nurses and doctor which is also supported by social exchange theory. According to the perspective of social exchange theory, interactions are based on the balance of relationships in the negotiation and exchange of resources. D'Amour et al., 2005 stated that negotiation process involves the conurbation of the providers and the receivers in a very collaborative manner in exchange of resources. The collaboration also leads to the quality of relationship between the supervisor and subordinate can have negative or positive impact on quality of care services (Covey, 2006).

The analysis of social exchange theory reflected that the hierarchal nurses doctor relationship not only beneficial for the better outcomes for the patients but also benefited the hospital and healthcare system. Getting access to the healthcare services and receiving efficient care services is the fundamental right of patients which become institutionalized. The patients' rights are exercise under the structured pattern of healthcare delivery services. Ojwang et al., (2010) mentioned that patients' right in Kenya is administered by Ministry to Health to improve the outcomes. A study conducted in Kenya to examine the nurses' vs patients' interaction found the impolite utterances by the nurses impede the patients' rights of dignity and respect. It was also highlighted that when patients' rights are violated, patients' also violate the dignity of the nurses as retaliation.

Number of researches (Kramer & Schmalenberg, 2003; Boyle, 2004; Fung et al., 2005; Kindeke & Sieckert, 2005; O'Mahony et al., 2007; Latte et al., 2008; Latimer et al., 2009) supported the nurse-physician collaboration and coordination for the better outcomes for the patients. As the patients-doctors and nurses interaction is for very limited time period, Harrison (2004) emphasized on higher level of coordination between the service providers. Similar findings were reported by Estabrooks et al. (2005) in which low mortality rate was reported as a result of excellent nurse-doctor relationship to execute the services at the hospitals. As a result of doctor-nurse positive and good relationship, patients' satisfaction with the services also increases ((Vahey et al., 2004). Similar study by Meterko and Young (2004) elaborated the culture of teamwork in the hospitals flourish the doctor-nurses and patients relationship in positive way. Teamwork enhances patients' satisfaction as it minimizes the internal conflicts among employees and focused on better outcome for the patients. The findings of the Meterko and Young (2004) study illustrated positive relationship between teamwork culture and patients' satisfaction with the services and process of care. On the other hand, the significant negative relationship was found between bureaucratic culture and patients' satisfaction.

The finding of the present study highlighted that doctors also work as team; the senior doctors like medical officers and consultants are responsible for supervising the work of junior doctors and give training of all doctors in their team. All doctors have some come personal qualities such as commitment to caring for others, resourcefulness and stamina, willingness to accept responsibility, the ability to priorities workload and work under pressure, motivation and perseverance, the ability to communicate well with people, demonstrating empathy and team work. So in this way they deal with any emergency situation but it doesn't mean that whoever will do any mistake will be covered up. No if any doctor did any mistake there is mechanism of check and balance and on serious offences they are terminated as well. But all doctors and staff work like team and family. In emergency situation they support each other and share their work.

**Doctor-patient relationship**

The hierarchal doctor-patient relationship has long history in the domain of public health. Due to specialized knowledge and medical expertise, doctors have some power and control over the patients (Hearn, 2009; McGuire et al. 2005). Medical treatment usually begins with interaction and discourse. The efficacy of interaction relies on the ability to understand each other (cockerham, 2012). The study highlighted doctor-patient interaction in three ways; instrumental, expressive and communicational. Instrumental reflects the doctor's competency to deliver efficient care, expressive interaction established thorough emotions and feelings toward the patients' illness. While, communicational feature of care reflected

the behavioral aspect of the doctors and the way they interact with the patients.

Evidently, one of the doctors (Sadaf) verbalized her relationship with the patients as;

> We try our best to treat patient well, we talk with them in good manner so they may understand what doctor is asking and advising them. If our behavior remains good with patient, they also behave well. In my ten years of job what is my assessment that if we politely talk and behave good with patients, they never do any misconduct with us. If we act well, patient will not mad to behave in violent way.

McGuire et al (2005) study on doctor patient relation also supported the findings of the current study mentioned doctor's perspective in educating the patients through their knowledge and expert opinions. Taking consent from the patients make the doctor's role as decisional priority and patients' role as decisional authority. Similarly, (Breen et al., 2009; Levinson et al., 2010; Butalid et al., 2012) reported that with the rise of patient-centered care initiatives taken globally in last ten years patterned the physicians' communication style in a way to enhance patients' decisions regarding meticulous treatment.

The common factors figured out by the staff and doctors about patients' compliant are not giving ample time to them, long waiting hours etc which are not under the control of doctors. As the system is like that one doctor in her normal eight hours of study have to treat more than fifty patients, so they cannot spend more time on one patient. With the limited time but heavy load of patients doctors still fulfill their responsibilities and do their best to provide comfort to the patients as reported by the doctor (Rubina);

> I am working in OPD and needs to attend fifty patients in just six to seven hours, so it's natural that I will become tired and feel myself exhausted, but still as I am a doctor I ignore the patients' attitude as many times patients do misbehave with us for not giving them priority and ample time.

Another doctors' respondent (Masooma) added;

> We provide our services at the best, we don't want to disgrace the patients, but some patients irritate us by asking one question again and again, their attendant especially do not understand what we are advising them, in wards and emergency usually we interact less with the patients because she is in very critical situation at that time, but attendant irritate us badly.

Similar information was provided by another doctor (Faria) as;

> Normally, we inform and advice them one thing, after some time they will come back again and ask the same thing again. Some time one family member came and asks one thing, and after sometime either forgets it when go outside or intentionally send another family member to ask the same thing again. So we don't have much time to inform one thing to every person again and again. We want only those attendant come and discuss the matter that may understand things properly and provide care and medicines to their patient, because if they do not understand us they can give wrong medication as well. As patient's situation is not like that to understand each and very thing, it's useless to talk with her, so we inform all matters to their attendants.

Regarding compliant majority of the patient mentioned that they never complaint against the doctors and staffs because they know the system and culture. When one's complaint against the staff and doctors, their attitude towards patient become worst. The researcher also observed the situation of doctor's shouting on the patients during performing normal delivery by threatening the patient to slap them as they are not putting their efforts to deliver the baby. It was very shocking for

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the researcher how doctors behaving with patients who are already in pain and instead of providing their emotional support they were increasing her fear and pain.

The healthcare professionals at public hospitals work as a team, where each member's role and responsibilities are clearly defined in written documents. As the job description is provided to the healthcare providers therefore everyone know their job task and collaborate with each other for the smooth process of delivery healthcare services to the mothers and newborns. To upgrade their skills and performance, in-service training programs are established and encouraged the doctors and nurses to attend the program to learn innovative techniques and methods of care. The healthcare providers' performance is monitored and through recording maternal deaths or unexpected prenatal deaths which is audited with the aim of identifying weaknesses in the systems. The monitoring mechanism enables the system to improve the performance as a whole rather than blaming one another.

The findings of the present study also highlight such patterns of interaction between doctors and mothers as patient. As pregnancy and childbirth process is itself challenges for the mother especially the first time mother, therefore both the mothers and the doctors try to establish reciprocal relation between them to facilitate each other in more effective way. One of the consultants (Sadia) convoluted the doctor patient relationship as;

> I think our profession is all about the doctor patient relationship, as we all the times are dealing with patients in various capacities. We continually need to communicate with each other, physicians, nurses. Clear communication is so important. When you have good relationships it is easier to review and discuss the treatment administered. Many times we came across with such patients who are arrogant, and in-controllable, we made agreements about how to approach and handle this patient. I think good relationship helpful in the communication with the patient and his family. I always involve the patient's family to diagnose the real problem, I believed the discussion should be very friendly and in comfortable environment.

Frequency of interaction between the healthcare providers and patients enhances the quality of care as well as patient's satisfaction with the care (Gabe, Bury &Elston, 2004). Literacy is another important factor highlighted by **(**Bennett et al, 2006) which determine level of communication between doctor and patient. The study explored the relationship of high and low literacy and doctor-patient communication among African Amercian Women. Findings of the study illustrated that women with both low and high level of literacy had poor utilization of prenatal care due to weak communication with healthcare providers. Most of the women reported inability to communicate and understand the patient's perspective and if patient are unable to understand their perspective they do not clarify the problem to the patients. Therefore, poor utilization of prenatal care not solely associated with the patient's level of literacy but the doctor's communication skills need to be upgraded according to the patient's level of understanding.

Berhane and Enquselassie (2015) mentioned six attributes to investigate the effectiveness of the healthcare services from patients' perspective such as waiting time for consultation, doctor-patient communication, nursing communication, availability of medicines in the pharmacy inside the hospital, continuity of care and diagnostic and treatment facilities. Patient selection and preferences of healthcare are associated with their willingness to wait, patients' focused treatment and the value of services delivered by the hospitals. Communication with doctors and nurses as well as availability of drugs and other diagnostic services contribute to the patients' satisfaction of healthcare services leading towards the preferences to access particular hospital.

**Patients' Compliance**

Compliance necessitates indulgent by the patients which is also the reflection of doctor-patient

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relationship (Lutfey, 2005). In most of the cases found in the study regarding patients' compliance depicted that patients have trust on doctors' advice and follow the treatment procedure and instructions. Particularly the patients with low level of literacy never questioned the doctors' choice for meticulous treatment and comply with the guidance of their physicians.

Patients' trust on doctor competence and advice make the doctor-patient relationship in a positive way. As reported by one patient;

> I have trust on doctor to whom I ever go. I always ask form other patients about the particular doctor and after getting some satisfaction with them, I choose my doctor. Although I have also taken my decision on people's perception abut luckily my own experience is good with my doctor as she is very competent and very vigilantly perform her job tasks. . I have trust on her skills and ability to perform every task in very humble way. After my 2nd DNC I was in fear, but she explained me all the process and performed all the procedure of DNC by herself. She herself did my ultrasound, checked all my reports and even contacted with diagnostic center and directed her about the precaution measurements and detail scan. I feel that she is very competent therefore many people knows her very well and consultant her for any maternity related mater.

The researcher's observation also supported the patients' perspective in a way; most of the services are provided by the young junior doctors who are at their learning stage. Who themselves don't know how to take proper care of the patients and what type of treatment is required, many times they are asking from each other's what to do next. It is the system to give them opportunity to learn and enhance their skills, but they should have limit to treat with the patients. Many times, the experience and educated patients started quarelling with them what they were doing, as they already gone through with the stages and when feel that the doctor is doing something wrong, they asked to call senior doctors. Sometime the situation arises conflicts among doctors and patients.

Regarding the doctors' competence and patients' trust there are some differences between the junior and senior doctors highlighted by most the patients. Some of the patients mentioned that junior doctors are not competent enough as most of the cases they have mistreated, and when unable to control the situation, then they called senior doctors which also depends on the availability of the senior doctor. Usually the process of healthcare organized in a way to perform the normal task such as OPD, normal delivery and case taking in emergency is performed by the junior doctors and consultant are referred only is emergency cases.

> I always own what doctor says, because I trust on my doctor and she always advice me in such a convincing manner that I feel this all about my health. And as her behavior is too authoritative which I think good to some extent, some time I feels that her attitude should be soften, so I want to ask something about the medication or treatment procedure I may able to ask.

Similar findings were also reported by one of the patient;

> When I asked the junior doctor to call the senior doctor to perform my delivery, she argued with me and said "if you don't want to have treatment here, why you came here, you should better go to the doctor in her private clinic"

The experiences of having education and teaching by the doctors vary from patients to patients, as one patient (Mehwish) remarked;

> After the operation when baby was handed over to me than one doctor came and teach me how to carry the baby for feeding and help me for first time feeding the baby. Other general information regarding taking care of baby, when to take bath and when to get

vaccination was also informed to me, they also issues baby card on which vaccination dates and general instruction to handle the baby were mentioned.

Overall, majority of the patients were satisfied with the treatment provided by the doctors and if there are some loopholes, some patients ignored by realizing that doctors are also humans and not possible to deliver their 100%. Patients' feel satisfaction when they got treatment regardless of having limited resources.

## DISCUSSION AND IMPLICATIONS

This papers reflects the findings of the study presenting doctor-nurse-patient relationship in the musicalized domain of motherhood. The above mentioned findings of the study illustrated that doctor-patient relationship is more the behavioral matter rather than built on structural possessions. In this manner, the findings linked with the exchange theory of Georage Homans which reflected upon the individual actions and behaviors in establishing and exchanging relation. Homan asserted that every action is necessary to analyzed under it unique exchange of relation between two actors which are institutionalized as well. A basic assumption of exchange theory is the actions performed or exchange to get the reward which is not only in terms of financial benefits but also the recognition, sentiments and prestige. Scott (2012) further enlightens the notion of gaining profit through exchange relation in way of getting equal profit by all the actors. Such as with respect to doctor-patient exchange relation both are getting benefits in terms of satisfaction and better outcomes. Similarly Daldiyono (2007) also supported the Scott (2012) statement and Homan impression of getting benefits form exchange relations. The doctor-patient relationship is moreover considered under the religious obligation to serve the patients who are in need to seek care from the doctors. This nature of paternalistic relationship provokes the exchange relation between doctor and patients in more positive way.

In addition to parsons' views of social interaction between patients and doctors Freidson (1988) describe the Szasz and Hollander interaction model based on three modes of interaction; activity-passivity, guidance-cooperation, and mutual participations. In first stage of patients' interaction with the doctors, they are in passive position due to their illness and seeking cure from the doctors. In guidance-cooperation patients are willing to take the advice from the doctors and act upon them in order to get rid of their illness. Therefore patients are likely to obey the instruction and collaborate with the providers. The third mode of interaction established thorough mutual understanding between doctor and patient about the treatment of the particular health matter. Both the doctors and the patients accept each other authorities and concerns to find the better and easy solutions for the problem.

As an outcome of mounting medicalization of childbirth, rather than only physiological activity, gynecologists are persuaded to deal with pregnancy as more pathological and social interaction with the patients. Healthcare providers in hospitals are the prime agents of delivering services to the patients which are based on the interaction and communication between them and the patients. The patient's cure from the illness is the greatest achievement of the doctors is not possible without providing the ample and efficient care by nurses. Both the doctors and the nurses are the backbone of the delivering healthcare services in medical industry. One endow with consultancy and treatment while others offer their services to accelerate the process of diagnosis and care for the patient.

## CONCLUSION

. Healthcare providers in hospitals are the prime agents of delivering services to the patients which are based on the interaction and communication between them and the patients. The patient's cure from the illness is the greatest achievement of the doctors is not possible without providing the ample and efficient care by nurses. Both the doctors and the nurses are the backbone of the delivering healthcare services in medical industry. One endow with consultancy and treatment while others offer their services to accelerate the process of diagnosis and care for the patient. This papers reflects the findings of the study presenting doctor-nurse-patient relationship in the musicalized domain of motherhood. As an outcome of mounting medicalization of childbirth, rather than only physiological activity, gynecologists are

persuaded to deal with pregnancy as more pathological and social interaction with the patients.

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