

Commentary

A Qualitative Analysis of Physician Humanism: Women's Experiences With Hyperemesis Gravidarum

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OBJECTIVE:

To explore the humanistic qualities of physicians deemed important to women who have experienced hyperemesis gravidarum (HG), thereby, contributing to patient satisfaction.

STUDY DESIGN:

Semistructured telephone interviews were conducted with 96 women who had experienced HG. Content analysis was the qualitative method used to analyze and interpret the interview texts.

RESULTS:

Patient satisfaction was associated with women's perceptions that physicians believed their accounts of their symptoms (i.e., that the woman is neither fabricating symptoms nor overreacting). The perception of being believed by doctors (and other health care providers) was important in terms of feeling validated that their illness was "real," and imperative to women seeking and receiving medical care. Perceived delays in diagnosing and/or instituting treatment were viewed as contributing to unnecessary exacerbations of the illness and hospitalizations, increased emotional strain, and psychological stress.

CONCLUSION:

This study highlights the importance of physicians "believing a patient's story" in contributing to patient satisfaction and possibly health outcomes.

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In the field of medicine, the patient–physician relationship is the heart of the clinical encounter.¹ People consult doctors for a variety of reasons. In general, they perceive an actual or potential threat to the quality of their lives or fear that illness may shorten their lives.² The patient–physician relationship is the arena in which individuals hope to tell their story and assume that doctors will provide an accurate diagnosis, prognosis, and a plan for resolving or managing their distress.

Although medical knowledge and sophisticated technology are used to arrive at a diagnosis and treatment plan, it is interpersonal communication and interaction between patients and doctors that are primary mechanisms for exchanging information.^{3,4} Even in the absence of cure, imparting explanations for the illness in a manner that communicates compassion and respect for the dignity, worth, and belief system of the individual is not only essential as a matter of professional ethics,^{5–7} but may enhance healing⁸ and positively influence patients' physiological health outcomes^{9,10} and psychological condition.¹¹ Moreover, patients who perceive positive interpersonal interactions and humanistic characteristics in their physicians tend to report greater satisfaction with their medical care.^{12–18}

The patient–physician relationship is one of the most complex among interpersonal relationships in that it involves "interaction between individuals of nonequal positions, is often nonvoluntary, concerns issues of vital importance, is therefore emotionally laden, and requires close cooperation."³ In addition, cultural biases and gender stereotypes impact this already complex relationship. Women with reproductive disorders, in particular, experience the impact of gender stereotypes and attitudes, especially when medical professionals are unable to uncover the specific etiology of the condition.^{19,20} Clinical observation and a review of the literature suggest that hyperemesis gravidarum (HG) is an example of such a problem.^{21,22}

HG — severe nausea and vomiting during pregnancy — is a "diagnostic and therapeutic enigma for the obstetrician."²³ HG remains a puzzling condition for both doctors and patients because there is no known cause or cure. Before the use of intravenous (IV) fluids, HG was a significant factor leading to neurologic disturbance and even maternal death.^{24,25} Advancements in IV fluid therapy have greatly reduced the risk of these outcomes.

Unfortunately, health care professionals (HCPs) often view the condition as something of a nuisance. Some contend that patients with HG "garner little attention and engender little sympathy from their physicians."²⁶ Another factor contributing to such a view may be that biologic and psychologic theories about the etiology of HG remain areas of considerable controversy. Although many contend that the disorder is psychosomatic without any supporting scientific evidence,^{21,27–30} the presumption of a psychogenic etiology, at least in part, is pervasive in the medical literature.^{31–41} Although it seems illogical to suggest that HG is never impacted by or a result of psychologic factors, physicians who presume a psychogenic etiology in HG may discount or minimize the severity of symptoms and the full impact of the illness on the woman's quality of life.⁴² This, in

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turn, can contribute to a less than optimal patient–physician relationship, as well as poor maternal and infant outcomes.

HG also can be an expensive obstetric problem. Despite its low incidence (estimates range from one to three cases per 1000⁴³ to 1 to 10 per 1000 pregnancies³⁷ in the United States and European societies) HG may entail multiple admissions to the high-risk antenatal unit⁴⁴ and utilization of medical treatments such as total parenteral nutrition.⁴³ Moreover, there is some evidence to suggest that women who suffer from severe HG during early pregnancy are more likely to give birth to low birth weight infants,⁴⁵ risking costly neonatal and pediatric treatment. Although technological advances have virtually eliminated death from HG, the condition warrants serious attention because of its potentially severe effects both to mother and in her baby.^{27,46}

This paper reports the qualitative findings from a larger study⁴⁷ that employed both quantitative and qualitative methods to investigate elements of the relationship between physician humanism (e.g., the socioemotional aspects of medical care) and patient satisfaction in the treatment of HG from the perspective of HG patients. Specifically, the focus of the qualitative research question presented here was what humanistic qualities of doctors are deemed important to women who have experienced HG, thereby contributing to patient satisfaction with the medical care received from physicians who treated HG.

METHODS

Subjects and Sampling

The setting of this study was a 529-bed tertiary-care hospital that provides both high-risk obstetric and neonatal intensive care services. The perinatal center, located in a large midwestern city, serves 13 counties, encompassing both urban and rural settings. The study population consisted of all available patients hospitalized for HG from January 1993 through April 1997 who (a) were currently pregnant and had at least one inpatient hospitalization due to HG, but whose HG was resolved and/or (b) had given birth since 1993 and had experienced at least one inpatient hospitalization because of HG during that pregnancy. In cases in which a woman had more than one HG pregnancy since 1993, the most recent HG pregnancy was the specified unit of investigation. Those eligible for the study were either patients or former patients of the hospital who were alert and oriented to person, place and time, had no identifiable diagnosis of mental illness, could speak English, were at least 20 years of age at the time of their inpatient hospitalization, and could be reached by telephone. Ninety-six women met study criteria and were willing to participate in the study.

Procedure

Data were collected in a semistructured telephone interview conducted by the author and a doctoral-level research assistant. The interviews were based on six open-ended questions and were taped and transcribed verbatim. The interview questions focused on

patients' beliefs about the etiology of HG, their experiences regarding the course of the illness, the patient–doctor relationship, and any additional information they desired to share. Respondents were asked to answer interview questions based on their entire HG illness experience, including both inpatient and outpatient medical care. A content analysis of the qualitative data was conducted to delineate major themes and patterns in the data.⁴⁸ Qualitative comments were analyzed according to categories of the operational definition of humanism proposed by Hauck et al.¹⁶ (based on the Physician Humanism Scale by Abbott).⁴⁹ The definition of humanism by Hauck et al. consists of eight components related to physicians' or health care providers' behavior:

1. Respects patient's viewpoints and considers his or her opinions when determining health care decisions.
2. Attends to the psychological well-being of the patient.
3. Regards the patient as a unique individual.
4. Treats the patient in the context of his or her family and social and physical environment.
5. Possesses good communication and listening skills.
6. Engenders trust and confidence.
7. Demonstrates warmth and compassion.
8. Is empathetic.

RESULTS

The findings reported here describe study participants' perceptions of the most salient humanistic characteristics of physicians deemed important by HG patients.

Characteristics of Respondents and Their Physicians

Eighty-three women (86.46%) had already given birth (including four pregnancies ending in fetal demise), and 13 (13.54%) were pregnant at the time of the interview. At the time of their HG pregnancy of interest, the study respondents had a mean age of 27.65 years (range, 20 to 38 years; SD 4.23), a median education of some college/no degree, a median employment status of full time, and a median income category of \$30,000 to \$49,999 (range: <\$10,000 to >\$69,999). At that time, 86 (90%) were married, 8 (8%) were single/never married, and 2 (2%) were divorced. Seventy-three (76%) of the respondents were white, 16 (17%) Black/African American, 6 (6%) Hispanic, and 1 (1%) Asian/Pacific Islander.

The physicians of the respondents were 80 (83%) male and 16 (17%) female. Of these, 86 (90%) were white, 9 (9%) Black/African American, and 1 (1%) Hispanic. Obstetrician-gynecologists represented 81 (84.4%) of the physicians; 9 (9.4%) were perinatologists, 3 (3.1%) were in family practice, and 3 (3.1%) comprised other specialties (e.g., nutrition and nurse midwife). The median length of relationship (range: <1 week to >2 years) between the respondents and their doctors before being treated for HG was more than 2 years (43 respondents); 11 women were under their doctors' care for 1 to 2 years, 1 for 7 to 11 months, 22 for 2 to 6

months, 11 for 2 to 4 weeks, and 8 had known their doctors 1 week or less.

General Findings

Physician humanism was found to be associated with patients' satisfaction with the medical care received from their doctors in the treatment of HG based on the qualitative data. This is consistent with the quantitative findings ($r_s = 0.60, p = 0.0000$) in the larger study from which these data are excerpted.⁴⁷ The findings presented here further enrich our understanding of this relationship.

QUALITATIVE ANALYSIS OF INTERVIEWS

The qualitative comments by study participants revealed particular aspects of physician humanism that were helpful and not helpful throughout the course of their illness that affected overall satisfaction. Examples of themes pertaining to physician humanism include, but are not limited to "works as a team," "provides information and education," "taking time to listen," and "tries hard/sincere effort." Of the eight humanism categories that framed the analysis and the numerous themes within each, one particular theme, coded "believes patient's story," emerged as a powerful pattern that served as an overarching theme in these data.

"Believes patient's story"

Based on the qualitative comments, satisfaction with physicians in the treatment of HG was strongly associated with women's perception that their doctors believed their accounts of their symptoms. Believing in what the women told them indicated that the doctors took the illness seriously, and created an atmosphere of trust and respect, which has been identified as an essential component of physician humanism. Some examples follow:

The most helpful thing was just acknowledging that I was sick enough to be admitted to the hospital, that I couldn't go on anymore at home. That this was really happening, and I couldn't control it. And that I wasn't making it up. I knew I wasn't [making it up] but [it helped] that someone believed me.

If you feel comfortable knowing that your doctor believes in you, not understands, but tries to understand what you're going through, that is going to relax you a little more. You are going to relax and put yourself more in their hands and let them treat you. I think that's a stress reliever right there. If you think someone's not quite buying what you're saying, you know, you get a little up in arms.

The context

The data reveal that physicians' believing a patient's story occurred most often within three contexts: (a) when the physician

maintained a biologic etiology, (b) when the physician was the doctor who took care of the women most often during the illness (not necessarily their primary care physician), and (c) when the physician made the actual diagnosis of HG.

Respondents perceived doctors who attributed the etiology of HG to a "real" condition (e.g., biologically- versus psychologically-based) were more likely to "believe" patients' accounts of their symptoms. Ninety-three of the 96 respondents expressed dissatisfaction when physicians demonstrated a belief in psychogenesis. One respondent explained, "He made me feel that there was really nothing wrong and that it was in my mind. And it was like I shouldn't call him or bother him for such a minor thing." A satisfied respondent reported:

Well, for one thing, he took it seriously. He didn't treat me like a hysterical female. In talking to some of my friends, other doctors are like, 'Of course you're sick, you're pregnant.' You know, pat you on the head and send you home. My doctor took me very seriously. . . . He seemed to understand that this is a very real problem, and that I certainly had it.

In comparison to "other doctors," the data showed that women felt the physician who took care of them the most during their HG illness experience was more likely to place credence in what the women told them about their condition than were other doctors who also cared for them during the pregnancy. Other doctors who saw the women included partner(s) of the doctor who took care of the women the most, doctors from practices whom respondents had changed due to dissatisfaction, interns and residents, emergency room doctors, and other specialists. The women perceived that other doctors were more often not seriously concerned about them, that they gave punitive messages, that they were misinformed about HG and treatment strategies, and they delayed intervention. Respondents attributed these factors not merely to a lack of knowledge, but as a result of doctors' beliefs that HG patients overreact and/or that HG was psychologic and, therefore, did not require medical attention.

Some women explained, "only my doctor really understood." These women felt affirmed and understood primarily by their physician. One woman said: "He was really the only person I felt could understand everything I was going through the most, other than my mom." Respondents attributed this quality as something inherent in the professional role of physician (e.g., Doctors "deal with patients and see how patients really feel"), and as a result of doctors' personality (e.g., "He's a good person"), and that obstetricians, in particular, are the most apt to provide the support and understanding necessary to women experiencing pregnancy complications such as HG.

Finally, women's perceptions of doctors' believing a patient's story also occurred in the context of doctors' taking action. One woman commented that her physician "believed me and took measures to help me." Physician actions perceived as helpful included verbal

instruction and recommendations, explanations regarding why taking no action at a particular point was an appropriate intervention, and/or aggressively treating the illness at home or in the hospital, medication, IV therapy, and in some cases, TPN. However, the action most frequently noted by respondents that resulted from being believed by one's doctor was making the diagnosis of HG.

Making the diagnosis. Women's confusion surrounding the mysterious and unfamiliar physical symptoms of HG dissipated when they and their doctors mutually constructed a definition of the experience. Before being diagnosed with HG and with no previous knowledge of the term, many respondents explained their inner sense that "something was not right." Even women pregnant for the first time and uncertain about what nausea and vomiting of pregnancy (NVP) should actually feel like reported that they "knew deep down" that what they were experiencing went beyond NVP. Thus, the act of giving a name to their somatic experience provided relief and comfort for the women in this study.

Two other patterns emerged from the data in addition to doctors' believing the patient's story and diagnosing the illness. Even the most satisfied respondents believed that the diagnosis could and should have been made sooner than it was, that doctors had downplayed the symptoms for several weeks before making the diagnosis. Although some women acknowledged the physician's difficulty in distinguishing between NVP and HG, they voiced frustration regarding how long it took their doctors to confirm the diagnosis of HG. One respondent experienced four weeks of HG before she was diagnosed. She reported that she got the impression from her doctor through the office staff that "You're pregnant, and this is a part of being pregnant. Some women get sick, and you need to get up, and you need to deal with it." She noted, however, that once her doctor made the diagnosis the condition was treated seriously. Other women perceived that delayed diagnosis contributed to delays in receiving appropriate and timely medical intervention. One woman said:

I guess in some circumstances maybe don't wait so long for the IV therapy. . . . I think they held out a little too long before I got serious treatment that I am sure I needed a little sooner.

Some of the women who reported having experienced previous HG pregnancies believed their doctors were more responsive with subsequent HG pregnancies; HG diagnosis and treatment was instituted earlier in subsequent pregnancies. Women discussed how it took less effort to "prove themselves" compared with the first pregnancy, in which doctors had treated their physical signs and symptoms as more suspect. One respondent recalled:

The third time he was a lot more compassionate. He was so different the first time around because I think they [doctors] think the first time around, "Oh, she

just doesn't know what it's like to have morning sickness."

Women's responses to being believed

The women in this study reported both psychologic and physical responses to being believed by their physicians. Respondents were comforted when their doctors were knowledgeable about HG (e.g., "she knows what it is and knows what to do"), and reported feeling validated when their doctors' believed their symptoms to be a "real, medical" condition. Moreover, women reported enhanced self-confidence and ability to stand up against the skepticism of others as a result of physician validation. Finally, numerous women felt that being believed enhanced both their physical and psychologic processes, thereby positively influencing their course of recovery. Enhanced self-esteem was reported as a result of being believed: "When the doctor is working for you, you feel good about yourself. And I think when you feel good about yourself, you're maybe going to get better quicker." Others reported that perceived expedient medical intervention (e.g., "he put me right in the hospital," "he started me on I.V.s") contributed to a quicker recovery.

Women's responses to *not* being believed

Like their responses to being believed, women perceived both psychologic and physical ramifications of *not* being believed. Women's responses to not being believed included reports of anger, diminished self-esteem, and confusion between their own inner sense that something was not quite right and their doctor's expert opinion. Some respondents perceived that their physical symptoms were intensified and recovery prolonged as a result of either no action or delayed action by their physicians. For example, one woman described that she "got behind the eight-ball" as a result of what she perceived as delayed medical intervention; she believed she became much sicker than was necessary and that it was "more difficult to get on top of it [illness]." Still others disregarded negative aspects of the patient-physician relationship and focused on the positive aspects (e.g., "I didn't care for what he said, but I think he is smart"), seeking socioemotional support from other sources. As a result of not being believed some respondents changed physicians in the midst of their pregnancy, and some did not go back to that physician with their subsequent pregnancies.

Delay in seeking medical care as a strategy. The data also suggest that some women may wait longer than necessary in seeking medical attention to ensure that they will be taken seriously. Women employed unique strategies for interacting with their physicians and tried to manage their symptoms independently when they perceived it was pointless to contact their doctors, or when they sought to avoid the perceived possibility of physician rejection (e.g., verbal and nonverbal messages that the patient is overreacting and not *really* sick). Some women delayed contacting their physicians because they felt it was pointless based

on previous experiences with doctors who took little action and minimized the symptoms. For example:

I suffered a long time [with this pregnancy] before I was willing to admit that I was beaten. Because with my first two, nothing was really done about the hyperemesis. I remember my doctor at the time saying, 'Be glad you can keep down the chicken noodle soup because otherwise you would be in the hospital.' So that was the attitude she had. I would just on my own do what I could to keep from being hospitalized. So when I went into my third pregnancy I did the same thing. I did what I could or what I thought I could to keep from having to ask the doctor about it or having to be hospitalized. And then when that didn't work I felt like I was the failure, that I didn't do enough. That is why I am grateful that I had a new doctor [this time].

Even in cases in which respondents were extremely pleased with the understanding and reassurance from their doctors that HG was "real," there were enough self-doubting internal and external messages about the validity of the illness, prompting women to strategize ways to protect themselves psychologically. Some women waited until their symptoms got "really bad." For example, one patient who was satisfied with her doctor echoed the strategy of others stating, "I wasn't one to call every day either. I kind of just waited until it got so severe that he knew it was that bad." It may not be unusual for individuals to delay seeking medical care to avoid the event of "going to the doctor." The distinction here is that some HG patients delayed care not to avoid going to the doctor, per say, but because they perceived they would have a better chance of being *believed* by their physicians; so they would receive medical treatment.

Patients and self-doubt. In addition to physician-related factors, two subthemes coded "patients and self-doubt" and "other health care professionals" emerged from the data shedding further light on why some women delay seeking medical care for HG. Even though women had an inner sense that something was not quite right, many described a tendency to "second-guess" or disbelieve themselves. Without a clear diagnosis explaining their symptoms some women had thoughts such as, "Why am I so sick? Why can't I handle pregnancy?" Self-doubt occurred for many women even after the diagnosis of HG was made: "Why can't I get over this? Maybe it is psychological; women get pregnant every day." Although women were more likely to doubt themselves in their first HG pregnancy experiences (which parallels their perceptions of their doctors' responses), a few noted self-doubt in subsequent HG pregnancies as well. Lastly, second-guessing oneself particularly occurred in the context of receiving "all in your head" messages from other HCPs, family, friends, and coworkers. One woman discussed how helpful it was for her doctor to provide ongoing reassurance that she was not to

blame for getting HG, and that her doctor understood just how "mentally draining" the HG was for her:

Enough people tell you it is all in your head, you almost start to believe it yourself, and that makes it even worse because you don't choose to throw up 25 times a day. You don't choose not to have a social life, to get up and share in regular things like going outside and smelling fresh air. You don't choose to be on your back for that long and just watch TV, especially if you are how I am, I am always on the go. And not being at work and being separated from people and being isolated was an awful thing for me.

Another explained:

[It was helpful] for the doctor to say it's not in your head. . . . As a nurse, I knew it wasn't 'in the head'. . . . But it's just nice to have that reaffirmation. When you're real miserable sometimes your focus can be kind of blurred because you're so miserable, and you think, 'What's wrong with me? Why can't I just get up and feel better?' So it helps to have that understanding.

Other health care professionals. Although the primary focus of this study was the patient-physician relationship, numerous respondents noted the important role hospital nurses and physician office staff (e.g., nurses and secretaries), in particular, played in the treatment of their HG. These individuals were frequently viewed as an important, positive support network for women with HG. However, respondents discussed the gatekeeper role of nurses and secretaries as integral for patients either receiving or not receiving medical care. Some of the women viewed "getting past" the secretary and/or the nurse to the physician as a major feat:

I didn't find that [I had to prove that I was sick] as much with my doctor or even his personal nurse, but it was with the office people, the people who answered the phones. It was them that you had to really sell yourself that you were sick. I mean, they're the ones that get you through to either the nurse or doctor.

As was the case with physicians, negative interactions with "gatekeepers" influenced some patients' decisions to delay seeking medical attention. Furthermore, echoing reports of their doctors' altered responsiveness from the first to subsequent HG pregnancies, women described how the office staff were more supportive during "the second time around," as if the symptoms were now more "real" because of their established record of getting HG.

DISCUSSION

Women's lived experiences with HG that helped to shape their perceptions were analyzed as a first step to giving voice to this patient population. Although this study is not generalizable beyond the population in this setting, the data generated provides information useful for future studies about physician humanism, its impact on the patient-physician relationship and patient satisfaction. Research designs that provide broader generalizability of findings could prove beneficial for affirmation of these data. The qualitative findings have enhanced our understanding of the relationship between physician humanism and patient satisfaction found in the quantitative data,⁴⁷ and are consistent with other studies that have examined empathic determinants of patients' satisfaction with the patient-physician encounter.⁵⁰⁻⁵²

The distinguishing quality of this study, however, is the delineation of particular elements of physician humanism perceived as important by women who have experienced HG. The majority of respondents in this study expressed satisfaction; strong and positive relationships between women and their doctors exist for HG patients. This demonstrates that the patient-physician relationship worked most of the time for most of these women. However, when it did not work, the experience was unforgettable, contributing to patients' reports of diminished self-confidence, delayed recovery, and discontinuation of their doctors' care. The most powerful and overarching theme that emerged from the qualitative data presented here was patients' perceptions regarding the phenomenon of doctors' "believing the patient's story." Moreover, it is most salient to the quandary many women with HG experience — namely, the pervasive, yet unsubstantiated, presumption that HG is primarily a psychogenic disorder. In particular, the study has shown that patients' perceptions of being believed by one's doctor (and other HCPs) has numerous ramifications for quality health care. Two subthemes, validation of the illness experience by doctors and doctors' taking action, were crucial to reported patient satisfaction of the patient-physician relationship.

Respondents expected that doctors would respect their integrity (i.e., that one is neither fabricating symptoms nor overreacting about minor symptoms). This finding is consistent with other literature suggesting that in addition to expecting expert medical care, generally, patients prefer doctors who take their symptoms seriously, listen, and ask questions about their symptoms.⁵³ The perception that doctors who acknowledged a mostly biologic versus psychogenic etiology of HG were more likely to believe patients' stories is also significant in light of the extensive literature on gender bias and female medical conditions.^{21,54-62} Although an assessment of both physical and psychosocial events should occur in most cases of illness, erroneous beliefs and assumptions about sex-roles may lead to misdiagnosis and ineffective or even dangerous treatment.⁶³

HG patients responded to "not being believed" in a variety of ways. For example, the strong influence of "expert power"⁶⁴ created confusion for some and anger for other patients when their inner

sense of what was actually happening was incongruent with their perceptions of their doctors' beliefs. Alternatively, when patients felt the backing of their doctors (e.g., "on the same wave [length] together"), they were able to acknowledge the illness experience that they intuitively knew to be true. Moreover, other literature has shown that some women tend to devalue their own insight and do not listen to their inner voice, in part, due to gender socialization. Women who believe that they are "receivers" of knowledge defer to others, especially to those in authority.⁶⁴ The pattern of "second guessing" oneself further establishes the importance of doctors' providing continual education and reassurance because some patients may blame themselves either for causing HG or for their supposed slow recovery, and may, themselves, delay treatment.

In addition, being believed as one element of physician humanism was viewed as helpful especially in the realm of social support in coping with HG. Women's struggle to "prove themselves" to their own doctors could be averted. Also, the patient-physician relationship served as a protective shield of sorts; the perception that "my doctor believes I'm *really* sick" armed patients with the confidence necessary to defend themselves against the skepticism of others. This was especially true for women who had a limited and/or a nonexistent social support network. The essence of many of the qualitative comments was such that "if my doctor believes me, that's all that really matters." This finding is consistent with scholarly works advocating the value of professional support as an important form of social support.⁶⁵ Thus, although important for patients in general, doctors' believing patients suffering from HG is critical as the authenticity of the illness was sometimes questioned by the women themselves and often questioned by other HCPs, family and friends.

Furthermore, the theme "only my doctor really understood" was a compelling dimension of the patient-physician relationship central for some respondents. Viewing their own doctors not only in terms of the key medical role, but also as key psychosocial support is an important finding in light of the pervasive literature that suggests physicians historically have demonstrated insufficient appreciation and understanding of women's experience with illness, and about HG in particular. "Only my doctor really understood" speaks to the unique importance of the patient-physician relationship because women experiencing pregnancy complications may be especially vulnerable, both physically and emotionally,⁶⁶⁻⁶⁸ and may, thereby, place a greater emphasis on the importance of the relationship with their doctors.

Respondents perceived that their doctors were more likely to take action if they believed the patient's story. Doctors' action to diagnose the somatic experience as HG, and to resolve and/or medically manage the HG, was a desperate need and expectation reported by these respondents. Practice and policy implications are apparent. In light of diminished health care financing, it would be beneficial for physicians and insurance providers to develop and/or review established medical protocols for HG patients. There is some evidence

in this study to suggest that delayed diagnosis and treatment of HG occurs, particularly during first HG pregnancies compared to patients' subsequent HG pregnancy/s. Whether this occurs as a result of the inherent difficulty in making the differential diagnosis between NVP and HG or that HG continues to raise suspicion about the primacy of psychologic factors is not clear. What is clear, however, is that delayed diagnosis and treatment affects patient satisfaction; it also may contribute to the exacerbation of HG symptoms affecting both maternal and infant outcomes, thereby necessitating expensive invasive home health care and/or hospital services.

In addition to biomedical competence, developing innovative medical education programs that emphasize attitudes and values about the patient-physician relationship,⁶⁹ reexamine stereotypical attitudes about women and health,⁷⁰ train doctors to evaluate their own psychologic responses to patients,⁷¹ teach humanistic interpersonal and communication skills,⁷²⁻⁷⁷ and emphasize patient satisfaction as a major outcome measure of psychosocial training programs in medical education are warranted.⁷⁸ Similarly, the results of this study can assist the perinatal health care team (including physician office staff) in reconsidering their own ideologies about HG patients. A reevaluation of the ways in which a HCP's interaction with HG patients may, in and of itself, be a psychosocial stressor that contributes to exacerbating symptoms and impeding recovery will be valuable in promoting better patient care.²²

In conclusion, in addition to medical treatment, the natural course of the disease process and the spontaneous recovery from illness, the interpersonal interaction of the patient-physician encounter contributes to the healing process and should be regarded as a primary therapeutic tool.⁷⁹ This human relationship remains even when technological interventions aimed at combating illness and disease fall short or fail.

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