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Original Article

Communications about cervical cancer between women and gynecologists in Serbia

Bojana Matejić[1], Vesna Kesić[2], Milica Marković[3], Lidija Topić[4]

[1] *Institute of Social Medicine, School of Medicine, Belgrade University, Serbia*
[2] *The Institute for Obstetrics and Gynecology, University Clinical Center, School of Medicine, Belgrade University, Serbia*
[3] *School of Psychology, Psychiatry and Psychiatric Medicine, Faculty of Medicine, Nursing & Health Sciences, Monash University, Victoria, Australia*
[4] *The Institute for Social Sciences Research, The University of Belgrade, Serbia*

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Summary

Objectives: The age-standardized incidence rate of cervical cancer in Serbia is 27.2 per 100,000 women, i. e., twice as high as in western European countries. This paper explores the communication which occurs between women and gynecologists in Serbia in relation to cervical cancer screening.

Methods: Our study was conducted in two phases: a qualitative phase (focus group discussions and in-depth interviews with women) and a quantitative phase (community-based survey). This paper reports the findings from both phases, and in particular, the in-depth interviews with 22 women with different socio-economic backgrounds residing in the capital city and a regional town. To illustrate women's experiences and attitudes, we used interview excerpts.

Results: Our findings indicate that there is poor communication between women and gynecologists and an absence of proper counseling. Women's lack of knowledge about reproductive health issues, poor attitudes of gynecologists, and personal barriers that women experience in accessing health care render preventive practices a low priority both for women and gynecologists.

Conclusions: We recommend different educational and organizational strategies that may improve the counseling skills of gynecologists and ultimately reduce the prevalence of cervical cancer in Serbia.

Keywords: Reproductive health – Cervical cancer screening – Physician-patient communication.

Patient-centered care, health promotion, and health prevention are among the main goals of the current reform of the health care system in the Republic of Serbia. The Ministry of Health promotes patient-centered medicine, whereby the relationship between health workers and users is no longer following a paternalistic and hierarchical model[1]. The quality of communication is key to successful counseling and consequently enables patients to achieve their optimal level of health through involvement in decision-making and pursuing healthy behaviors. This paper explores the context of the communication which exists between women and gynecologists in primary (community) healthcare centers in Serbia in relation to cervical cancer screening.

The healthcare system in Serbia is composed of public and private healthcare. In the public system, primary healthcare is delivered through a network of primary health centers at the municipality level, providing basic care and also an array of specialized services. Despite a well-established infrastructure, and importance of providing the "first point of call" for patients, it is well-acknowledged that the healthcare system needs to be more focused on primary healthcare and that restructuring is necessary[2]. Recently, the Serbian healthcare system has been affected by the unstable and difficult social conditions. After 10 years, during which various adverse events occurred, such as the economic crisis and hyperinflation, the collapse of the entire state economy, the war in surrounding countries, UN sanctions, and NATO-led 78-days of bombing, the new democratic regime installed in 2000 inherited a burden of difficult problems. All of these circumstances must be considered as very important determinants of all social relationships in general and the physician-patient relationship in particular[3]. The

transition, so common but equally "painful" for Serbia and all post-communist countries, included the need for reforming the healthcare system. In addition to the problems within the domains of finances, regulations, and management, the emphasis was given to the problematic relationship between health professionals and patients. On the one side, were health professionals with little professional satisfaction and motivation to provide effective and quality health services, and on the other side, the unsatisfied, but passive patients, unaware even of basic patient rights[4]. At the same time, the healthcare system was focused on curative medicine with only formal and non-effective devotion to prevention[5].

The age-standardized incidence rate of cervical cancer among the population of Serbian women is 27.2/100000, i.e., twice as high as in western European countries[6]. In 2008, the Health Ministry's Special Working Group for cervical cancer prevention introduced the National Organized Screening Program and its implementation is about to begin in the near future. At the time of conducting our research in 2004, there was no organized cervical cancer screening program in Serbia, including a systematic call, recall, follow-up, and surveillance system. Instead, Serbia employed opportunistic cervical cancer screening. Under this model, spontaneous screening is initiated, either by the women or the gynecologists during presentation to a gynecologist in community health centers and hospitals. Pap smear tests are provided free of charge and performed only by a gynecologist; women do not require referral from a general practitioner. In the past 10 years, on average approximately 12–13 women presented to a gynecologist at a community health care center daily, over a period of 8 working hours. The new standards of care, introduced by the Ministry of Health during 2006, obligate gynecologists at primary health care centers to see about 30 patients (women) daily. This patient load equates to < 15 minutes for each patient. In such circumstances, gynecologists have to be very skillful in communicating with women, and to achieve successful counseling in addition to performing all other duties (e.g., physical examinations, administrative work, prescriptions, and referrals).

A large body of literature and research pertaining to the physician-patient relationship acknowledges and promotes its importance and benefits as the quality of physician-patient communication is positively associated with various outcomes, especially with better patient compliance and satisfaction[7–10]. Given the sensitivity of sexual and reproductive issues and the delicacy of the gynecologic examination, it is not surprising that the relationship between women and their gynecologists is one of the most interesting issues for research[11]. The majority of studies explored the specific relationship between women and gynecologists concerning some issues, such as sexuality, sterilization, and family planning, emphasizing the management of ethically unclear questions[12–14]. Much less attention has been paid to the value of quality communication and counseling in preventive gynecologic practice. To better understand cervical screening experiences of women in Serbia, we investigated women's experiences in their encounters with gynecologists, including counseling, from their own perspective. This paper examines the following research questions:

1. Have gynecologists in public primary health centers routinely discussed the importance and benefits of cervical cancer screening with the women?
2. Have clinicians informed the women about the recommended frequency for a test and stimulated their preventive practices?

Methods

This study was conducted in two phases during 2004. The first phase was qualitative (focus group discussions and in-depth interviews with women), followed by the second, quantitative phase (community-based survey). Women from different social and geographic contexts were recruited from two towns in Serbia: the capital, Belgrade, and a regional town, Smederevo. Network, or so-called snowball sampling, was applied to collect qualitative data. We recruited potential participants through our professional (i.e., a support group for alcoholics anonymous) and personal networks, and also asked participants to refer us to women who may be interested in our research. We applied criterion sampling[15] and recruited women from three age groups (younger [18–34 years], middle-aged [35–55 years], and older [56–70 years]), with and without a (personal or family) history of cervical cancer, and from different socio-economic backgrounds (employed or unemployed and with primary education or less, as well as with secondary and tertiary qualifications). Women volunteered their time to participate in our research and received no compensation, apart from reimbursement for the cost of travel. However, to compensate women for their time, all participants were offered information brochures on cervical cancer screening and where necessary, the research team facilitated their access to screening. Altogether, nine focus groups were conducted, with 62 participating. Each focus group was composed of women with different educational backgrounds, but of similar ages. In-depth interviews were conducted with 22 women (18 interviews with healthy women, 3 interviews with women with a history of cervical abnormalities, and 1 interview with a woman who has had cervical cancer; Table 1). Data collection and preliminary data analysis was concurrent. The interviews were tape-recorded and then transcribed. All

Age		Education		Medical history	
18–34	6	Elementary	7	Healthy	18
35–55	12	Trade	3	CIN3	3
56–70	4	Secondary	7	Cervical cancer	1
		Tertiary	5		
Occupation		**Marital status**		**Residence**	
Professional	6	Single	3	Belgrade	6
Technician-white collar staff	4	Married	11	Outer Belgrade	5
Service industry staff	2	Divorced/widow	8	Smederevo	6
Working class	3			Outer Smederevo	5
Farmer	2				
Retired	4				
Unemployed	1				

Table 1. Summary table, in-depth interviews, N=22.

authors read the transcripts and the team conducted preliminary data analysis together. We developed the coding system and applied it to each transcript. Upon identifying themes arising in one transcript, we coded and cross-checked the themes in other transcripts. Subsequently, hypotheses were developed and modified until data supported our hypotheses and the theory on women's experience with healthcare[16,17]. Thematic analysis of qualitative data was conducted by employing ATLAS-ti software. The analysis informed the survey questionnaire on women's lay understanding and knowledge of cervical cancer and screening.

A cross-sectional survey was conducted with women 18–70 years of age accessing community health centers. The random stratified sample mainly consisted of middle-aged women (35–55 years of age [60.6 %]), who were mostly married (68.9 %) with children (81.2 %). A majority had only a primary high school education (90.6 %) and an average or poor (self-reported) financial status (98.1 %). The response rate was 96.8 % and 776 participated in the survey. The data collection instrument was a semi-structured questionnaire designed to collect self-reported data on women's knowledge, attitudes, and practices in relation to reproductive health, focused on cervical cancer and screening. In this paper, we have analyzed 6 variables according to our objectives: 1) perceived poor experiences with a gynecologist, 2) feelings of shame in relation to the gynecologist, 3) fear of the presentation, 4) women's choice of a general practitioner, 5) gynecologist in regard to gender, and 6) whether the consultation with the gynecologist regarding cervical cancer prevention took place. SPSS software was used for quantitative data entry and analysis.

This paper reports the findings arising from the qualitative and quantitative phases of the study, and in particular, the in-depth interviews with women. To illustrate women's experiences and attitudes, we used interview excerpts.

Results

Relationship with the gynecologist

Poor experience, and feelings of shame and fear of a gynecologist could be important factors in determining the women's relationship with a gynecologist. The results of the survey showed that, overall 73 women (9.4 %) feared presenting to the gynecologist, 52 women (6.7 %) had feelings of shame, and 12 women (1.5 %) confirmed that they had a rather unfavorable experience with a gynecologist. None of these three items were related to the gender of the gynecologist or to the women's level of education. Women from the youngest and oldest groups experienced feelings of shame more frequently than the middle-aged women ($\chi2=6.170$, $df=2$, $p=0.046$); the youngest respondents also feared the gynecologists more frequently ($\chi2=9.955$, $df=2$, $p=0.007$).

The interviews further explored the pattern and determinants of the relationship with the gynecologists from the primary healthcare institutions. In the broader sense, the women emphasized a need for more attention, time, and opportunities to enter into the conversations with their physician. Furthermore, the women were interested in confidentiality and compassion. Nevertheless, their expectations were usually modest, with a focus on the basic human values identified as the most important qualities of a good gynecologist. A "normal" relationship that women wished to have was often no more than the absence of visible hostility they believe some gynecologists demonstrate:

> *I don't expect babbling or something like that-only a normal conversation (Tanja, age 24).*
>
> *I would like to have a normal and calm person for my gynecologist, who would explain things to me without yelling. (Jelena, age 26)*

For Branka (age 58), the main prerequisite for a good relationship with the gynecologist is the respect of the women's privacy during presentation. She still recalls the usual practice she was exposed to during organized screenings at the factory where she used to work in the late 1960s and early 1970s. She strongly believed that the practice compromised the quality of the physician-patient relationship, as the interview excerpt below demonstrates:

> *…It was always very crowded, I remember how we (the women at the consulting room) had waited together, and a few of us holding our panties in the hands- it was very uncomfortable. If you want to talk with the gynecologist about something, everybody can hear you. Disaster… no privacy!*

If they assess the relationship with the gynecologists as very good or successful, participants describe it very warmly and emotionally (*I respect her like God),* drawing on the kinship relationships to describe their gynecologists (*He talked to me as if I were his daughter).* Mirjana (age 65) summarized her good relationship with her gynecologist as follows:

> *I had a very good gynecologist, who unfortunately retired a few years ago. He was not just our doctor, he was like our father. Only that doctor had often advised me to come regularly to check-ups. He knew my soul. For me, it was the main thing, because, I don't come to the physician only to treat my body-the soul is equally important.*

Women who see private gynecologists, and the majority of other women who wished to be able to do so, had very high expectations related to private gynecologic practice. Notwithstanding a better organizational practice, the predominant advantage is possibly a different, egalitarian, and from the women's point of view, a better relationship with the gynecologists. The women assumed to be more respected and more listened to, as Jelena (33 years of age) explained:

> *I went to the private gynecologist to be treated as a human being. I could spent with him an hour, asking him what I need to know, from A to Z.*

However, Violeta emphasized two sides of this issue. First, it is logical and desirable to expect a better position in the relationship, describing it simply by stating: "*When you pay the private gynecologist, you pay for the time to ask questions.*" But, a level of distrust was mentioned in interviews a few times, as illustrated by this participant:

> *I suspect, sometimes, that they (in the private office) want to frighten us, (tell us) to come more frequently, so, they can take more money"*. Violeta (41 years of age)

In contrast to the high expectations, the experiences are not always as patients wanted. Accordingly, some women believed that it would be much better and more affordable to address organizational issues (e. g., waiting time and privacy) and allow necessary time for women to receive counseling in the public primary healthcare gynecologic departments.

Analyzing the data from the quantitative phase of the research, we wanted to examine the women's choice of general practitioner and gynecologist in regard to gender (Table 2). Our respondents had more often consulted with female physicians, but it is not so surprising, given a higher proportion of females in this profession. Currently, in Serbia, the total proportion of female physicians is 63.5 % (61.4 % among general practitioners and 76 % among gynecologists)[18,19]. Nevertheless, the age groups and education determined the attitude toward the gender of the gynecologist; the women from the oldest group, as well as the women with less education, more often avoided male gynecologists ($\chi2 = 20.27$, df = 6, $p = 0.002$, $\chi2 = 15.46$, df = 8, $p = 0.046$).

Women participating in the focus groups, as well as interviewed women, raised the issues of preferences with regard to the gender of the gynecologist. The majority of them had no gender bias when selecting a physician, suggesting that several other factors are more important *("I want a kind person, no matter the gender"; "I believe that they are both, female and male physicians, equally competent").* Only one interviewed women from the rural background, who explicitly said: "*I am very shy, I cannot deal with that…so, I prefer the female gynecologist*". Two of our youngest interviewed women emphasized being disappointed with a poor relationship with their female gynecologists. They stated that they had believed that female gynecologists were more understanding and sensitive. However, their experiences were different to their expectations, as Jelena and Tanja revealed:

> *She (the gynecologist) was rushing me and commenting about how slowly I was dressing off (unfortunately I was in jeans). I think that she was not tolerant. Afterwards, she talked with me in a hurry. (Jelena, age 26)*

Table 2. Women's chosen general practitioner and gynecologist in relation to gender.

Gender of gynecologist	General practitioner		Gynecologist	
	No	%	No	%
Female	455	65	412	57.9
Male	56	8.1	88	12.3
Sometimes male, sometimes female	188	26.9	213	29.8
Total	699	100	713	100

I remember a female gynecologist was very hostile during our conversation and extremely rough during examinations. When I remarked that it was hurting me, she asked me sarcastically how I manage the same thing during the intercourse. (Tanja, age 24)

Do gynecologists provide cervical cancer prevention information?

Our survey confirmed that women rarely talked with the gynecologists about cervical cancer prevention. Only 18.2 % of the respondents remembered a conversation and consultation about that topic (Table 3). A very striking finding is that >77 % of women from the youngest group (>34 years of age) had never talked about cervical cancer prevention with their gynecologists. The women from the middle-aged group, as well as the women with the highest level of education, had significantly more consultations about cervical cancer prevention than other groups ($\chi2 = 20.003$, df = 4, p = 0.000, $\chi2 = 39.2$, df = 8, p = 0.000). Also, male gynecologists significantly more often consulted women about this issue ($\chi2 = 14.007$, df = 4, p = 0.007), suggesting gender differences in counseling practices.

In accordance with our previous findings based on the qualitative analysis of focus groups discussions[20], the focus groups and interviews confirmed the strong attitude and belief that the main reason for any contact with healthcare professionals, including gynecologists, is mainly of a curative nature. Keeping that fact in mind, it is not surprising that counseling about cervical cancer prevention is not a frequent topic between women and their gynecologist in the primary health care context:

I was never told about the importance of check-ups. I was never asked if I had had a Pap test…. They had never explained that my behavior-lack of presentation to screening, is risky. (Jelena, age 33)

Sometimes, the women were counseled about the importance of cervical cancer prevention, but discontinuity of care was strongly related to non-compliance. Julijana, at the time when she was a government department employee, had access to organized annual gynecologic check-ups; she had the same gynecologist for years and was satisfied with the relationship and counseling. But, after she was forced to change occupations and work in the private sector, she lost the opportunity of having organized check-ups. Consequently, she had never taken the initiative to develop a similar relationship with a gynecologist at a community health center. She did not present to the gynecologist for years, although, she remembers the recommendations and advice about cervical cancer prevention that she was given before.

Based on the analysis of qualitative data, we found that gynecologists from primary healthcare institutions do not stimulate women to come only for the reason of check-ups *(They ask me immediately what is my complaint...)*. The women interviewed were convinced that any attempt to contact the gynecologist without presenting with symptoms, merely for consultations and advice, would be misunderstood as a less important reason:

I believe that if I came only for a check-up, they would consider it as a luxury. Like I don't have anything more important to do (Vesna, age 41)

Sometimes, the interviewed women recognize the physician's advice as actually insincere and formal:

They always advise us to come for the check/-up, once a year, or more frequently... But… if they (gynecologists) were a little bit kinder, if they wanted to answer the questions I asked, then I would go (Slavica, age 51).

Similarly, Svetlana (age 53) believes it is not enough to tell women to present for the Pap test if the gynecologist does not explain the purpose of the test.

The women mainly "read between the lines" that the formal physician-patient relationship should not be questioned. They often mentioned some non-verbal signs (*She glanced to her watch*) and expressions (*He was frowning*) that came from their gynecologists, which the patients understood as resistance and refusal to offer counseling. Branka stated: "…*I have a feeling that they look at me as if I am preventing them to do something more important"*.

Furthermore, respondents gave the examples when they had been, in a way, even "punished" for the initiative of visiting

Table 3. Consultation with gynecologist about cervical cancer prevention.

	Age groups, number (%) of participants			
	18–34	35–55	56–70	Total
I had a consultation	18 (11.9)	103 (21.9)	20 (13.0)	141 (18.2)
I didn't have any consultation	117 (77.5)	286 (60.9)	100 (64.9)	503 (64.9)
I don't know (I don't remember)	16 (10.6)	81 (17.2)	34 (22.1)	131 (16.9)
Total	151 (100.0)	470 (100.0)	154 (100.0)	775 (100.0)

the gynecologist without symptoms or complaints. The following statement is from the woman who rarely went to the gynecologist:

> *Once, during a very hot summer day, when the doctor saw me, she asked why I came only for a check-up, without any alarming signs, in that heat. I was so uncomfortable and embarrassed and became thoroughly rattled, that I left the surgery in the slippers that I got for the presentation. Since that, I have never gone back to the gynecologist again (Jelica, age 44)* .

After the interview with us, Jelica had decided to do the Pap test, and unfortunately, the result was positive (CIN III).

Few of our interviewed women who failed to achieve a satisfactory relationship with the gynecologist handed over the important role of gynecologic consultations to friends or relatives who are general practitioners or gynecologists. Nevertheless, these consultations were not about preventive practices as they had happened in the situations when the problem had already occurred.

Discussion

The results presented in this paper are not dissimilar to some previous studies in which it became clear that only the combination of curing and caring for women makes gynecologic services sought after and desirable[21]. This study elucidated the very complex, intimate nature of relationships between women and a gynecologist, more than in any other contact between a patient and a physician. The qualitative methodology of interviews was very useful to study the diversity of women's experiences and attitudes. Interviews clearly illustrated problems in the sphere of relationships with patients. Women expected trust, kindness, sympathy, and understanding from their gynecologists but, at the same time, assessing these qualities as mainly unfeasible goals, they were satisfied with much less. In every respect, the expectations were shaped by the various assumptions and previous poor experiences. Very often, women demonstrated an understanding of difficult conditions in primary healthcare, blaming the organizational policy for the shortage of time with the gynecologists and discontinuity of care. At the same time, they did not have any doubts about the quality of expertise available at the primary healthcare level. This attitude was also confirmed when analyzing women's expectations of private gynecologic practice. They did not seek a better qualified physician and the opportunity to present to an expert, but sought a better position in the relationship with the private physician, much more as a client than a patient. Under these circumstances, they could avoid a subordinate role and ask for more time for counseling.

Although, it is the accustomed belief that that women prefer a female gynecologist, our results were similar to studies that revealed that the gender of the gynecologist is not an important predictor of the quality of the relationship and communication with the patient[22]. Women expect certain "gender advantages" in their contacts with female gynecologists and were more disappointed with insensitive attitudes and misunderstanding than in the case of a similar experience with male gynecologists.

The most striking finding from this study is the lack of counseling about preventive practices on behalf of gynecologists from primary healthcare institution. Women understood counseling to be a "less important" reason to visit gynecologists. Furthermore, not only did gynecologists fail to stimulate the women and suggest periodic presentations for screening for cervical cancer, but some of them demonstrated repulsive attitudes toward women's initiatives.

There are several practical implications of our findings. It is important to assess potential for change, appreciating two positions in the relationship of gynecologists and of women.

In the relationship with patients (women), our findings suggest poor communication and absence of proper counseling. First of all, the communication skills need to be taught and improved during undergraduate training and subsequently through continuing medical education. There are already some signs that this goal will be achieved through a new curriculum for undergraduate students, established two years ago. The Module, «Physician in the Community», in the second year of medical education, introduces the basic theoretical principles and practical skills necessary in a quality physician-patient communication. We recommend organizing similar workshops for gynecologists from the primary healthcare institutions. It is equally important to educate and stimulate the gynecologists to use the existing "National Guidelines for Primary Health Care Physicians – Prevention of Malignant Diseases", for preventive activities performed by general practitioners, gynecologists, and nurses at the primary level, authorized by the Ministry of Health[23]. The guidelines emphasize the importance and obligation of counseling the women about preventive practices. Also, the first visit to the gynecologist should provide an important and unique opportunity to develop a successful and lasting relationship with the women, as outlined in some existing recommendations[24]. Furthermore, new possibilities for counseling the women about the preventive practices arise this year, by establishing 25 Centers for Preventive Health Services (CPHS), as part of the Serbian Primary Health Care Institutions[25]. The concept and the organization of CPHS allows, for the first time outside

the gynecologic department, counseling about cervical cancer prevention and, in some institutions, having PAP tests.

This study gave insight about women's perspectives of the relationship with gynecologists and made it possible for us to perceive their position and to assess some specific needs. Periodic assessments of women's satisfaction with the service may be a valuable source of improvement in the gynecology departments. Furthermore, the promotion of patient rights would empower women to seek and receive what they have the right to obtain from the healthcare system in Serbia. The public system still has advantages compared to the rising private sector, whereby the trust can be used to improve the professional satisfaction for gynecologists in primary healthcare.

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Address for correspondence

Bojana Matejić, MD, PhD,
Assistant Professor of Social Medicine
Institute of Social Medicine, School of Medicine, University of Belgrade,
Dr Suboti a 15 (Silos),
11000 Belgrade, Serbia
Tel: +381-11-2685-451,
Fax: +381-11-2659-533
E-mail: bojana_boba@yahoo.com