Rycerz Genca Justyna, Węgorowski Paweł, Michalik Joanna, Domżał Drzewicka Renata, Stanisławek Andrzej. Women's expectations regardings medical outpatient implemented in gynaecological. Journal of Education, Health and Sport. 2018;8(9):738-755 eISNN 2391-8306. DOI http://dx.doi.org/10.5281/zenodo.1413444
http://ojs.ukw.edu.pl/index.php/johs/article/view/5933
https://pbn.nauka.gov.pl/sedno-webapp/works/876862

The journal has had 7 points in Ministry of Science and Higher Education parametric evaluation. Part b item 1223 (26/01/2017).
1223 Journal of Education, Health and Sport eissn 2391-8306 7

The authors declare that there is no conflict of interests regarding the publication of this paper.

Received: 02.08.2018. Revised: 18.08.2018. Accepted: 11.09.2018.

Women's expectations regardings medical outpatient implemented in gynaecological

Oczekiwania kobiet odnośnie opieki medycznej realizowanej w poradni ginekologicznej

Justyna Rycerz–Genca[1], Paweł Węgorowski[2], Joanna Michalik[2], Renata Domżał-Drzewicka[2], Andrzej Stanisławek[2]

[1]Independent provincial specialized hospital name of Jana Bożego in Lublin, Poland
[2]Chair of Oncology and Enviromental Health, Faculty of Health Science, Medical University of Lublin, Poland

Corresponding author:
Joanna Michalik
Katedra Onkologii i Środowiskowej Opieki Zdrowotnej
ul. Staszica 4-6
Collegium Maximum
20 -081 Lublin
Tel. 600 065 151

Streszczenie

Wstęp

Podstawowa opieka zdrowotna jest pierwszym szczeblem profesjonalnej usługi medycznej, do której zgłaszają się pacjenci ze swoimi dolegliwościami oraz problemami zdrowotnymi. Dostęp do świadczeń podstawowej opieki

zdrowotnej winien być wolny od jakichkolwiek barier fizycznych, organizacyjnych oraz finansowych ze względu chęć korzystania z usług różnych pacjentów.

Cel pracy

Celem pracy było poznanie oczekiwań kobiet odnośnie opieki medycznej realizowanej w poradni ginekologicznej. Do realizowania celu badań wybrano zagadnienia dotyczące między innymi poziomu zadowolenia kobiet z funkcjonowania i oferowania usług medycznych w poradni ginekologicznej jak również oczekiwania kobiet podczas wizyt w poradni ginekologicznej.

Materiał i metody

Do badań wykorzystano metodę sondażu diagnostycznego używając kwestionariusza ankiety standaryzowanej, która była skierowana do kobiet korzystających z usług poradni ginekologicznej.

Wyniki

Z przeprowadzonych badań wynika, że najczęściej ankietowane chodziły do lekarza ginekologa raz na trzy lata, (49,33%, n=74). Analiza statystyczna wykazała istotnych związek pomiędzy aktywnością zawodową ankietowanych kobiet a częstością wizyt u ginekologa, (p=0,004). Przeprowadzone badania wykazały, że najczęściej podczas wizyty w poradni ginekologicznej ankietowane oczekiwały: wykonania badania ginekologicznego, (93,33%), cytologicznego, (83,33%) oraz badania piersi, (69,33%).

Wnioski

Oczekiwania kobiet podczas wizyty w poradni ginekologicznej dotyczą przede wszystkim uzyskania informacji na temat badań i leczenia. Kobiety korzystające z poradni ginekologicznej są zadowolone z oferowanych usług medycznych i sposobu funkcjonowania poradni. Kobiety w wieku 30-41 lat z wykształceniem wyższym stanu wolnego są istotnie bardziej zadowolone z poradni ginekologicznej aniżeli kobiety w wieku do 30 roku życia i powyżej 40 roku życia oraz posiadające wykształcenie podstawowe bądź zawodowe i zamężne.

Słowa kluczowe: opieka medyczna, poradnia ginekologiczna

Abstract

Admission

Primary health care is the first level of a professional medical service, to which patients with their ailments and health problems apply. Access to basic health care services should be free from any physical, organizational and financial barriers due to the willingness to use the services of various patients.

Objective of the work

The aim of the work was to get to know the expectations of women regarding the medical care provided in the gynaecological clinic. In order to achieve the research objective, the issues concerning, among other things, the level of satisfaction of women with the functioning and offering of medical services in the gynecological clinic as well as the expectations of women during visits to the gynecological clinic were chosen.

Material and methods

The research was based on the method of a diagnostic survey using a standardized questionnaire, which was addressed to women using gynaecological outpatient services.

Results

The research shows that the most frequent respondents visited the gynaecologist once every three years, (49.33%, n = 74). Statistical analysis showed a significant relationship between the professional activity of the surveyed women and the frequency of visits to the gynecologist (p = 0.004). The study showed that most often during the visit to the gynecological clinic, the respondents expected: gynecological examination (93.33%), cytological examination (83.33%) and breast examination (69.33%).

Conclusions

Expectations of women during a visit to the gynecological clinic concern primarily the obtaining of information on research and treatment. Women using the gynecological clinic are satisfied with the offered medical services and the way the clinic operates. Women aged 30-41 with higher education are significantly more satisfied with the gynaecological clinic than women under 30 and over 40 years of age and with basic or vocational and married education.

Key words: medical care, gynecological clinic

Introduction

Primary health care is the first level of a professional medical service, to which patients with their ailments and health problems apply. In this facility, the healing, nursing and preventive needs of the recipient are met. Access to basic health care services should be free from any physical, organizational and financial barriers due to the willingness to use the services of various patients. Care that is exercised in POZ-tach takes into account the needs of patients as well as their families and not just focusing on a given disease entity. [1,2,3,4,5]

The concept of primary care was presented through the World Health Organization. WHO for the first time showed the importance of PHC in shaping public health in a document from 1978, the so-called Declaration from Almaty. In Poland, as in other industrialized countries, the burden on the health care system is increasing. This is related to the process of life extension and age-related diseases. One of the important elements is also the need to meet the expectations of patients in codecision about their health and the growing requirements and legal regulations

regarding the observance of patients' rights. The reform of the healthcare system in 1999 had the greatest impact on the current appearance of POZ in Poland. In the second half of the 1980s, we had to deal with difficult access to services, low prestige of POZ doctors and constantly decreasing patient satisfaction. Problems of the health care system were so significant that they became one of the issues discussed during the Round Table discussions in 1989. In the early 90s of the last century a new POZ model was developed based on family medicine - a new specialty for physicians, with competences similar to those of physicians in countries with stable and strong POZ (Great Britain, the Netherlands, Scandinavian countries, Canada, Australia). Thanks to taking into account the needs and expectations of each of the beneficiaries, we are witnessing changes taking place in health care at the turn of the last several decades. [1,6,7]

By the concept of organizational structure, we understand the layout of workstations, cells and organizational divisions, as well as the definition of interrelations between them (hierarchical, functional and informative). [3]

According to the resolution approved at the end of the seventies by the European Region of the World Health Organization, the healthcare system should be centralized on primary health care. To POZ we include: medical and social care, which is exercised in an accessible, continuous, team-oriented way, focused on the individual, family and society, regardless of age and gender. By the concept of permanent, we understand continuous access to health services which is reflected in the patient's health needs. [4,8]

The quality of the service is combined with the time that we devote to the patient and his problems, the effectiveness of treatment and the organization of work on various groups of diseases. The most important task of primary health care is to promote and strengthen health - non-specific prophylaxis, as well as disease prevention - prophylactic prophylaxis. Another important task is diagnostics, treatment to prevent the development of disease, rehabilitation and medical and social care. The most important role in the organizational structure of primary medical care is played by local clinics and health centers. The care they provide for counseling includes children as well as adults, it consists in preventive actions as well as providing health services. [9,10,11] The provider of services in the field of primary health care is obliged in particular to act in accordance with the scope of tasks set out in the regulations for the physician, nurse and midwife of primary care. [12]

According to the principles of providing PPE benefits, the service provider entrusting services in the field of basic health care provides the beneficiaries with the costs of their own business access to:

1. outpatient care, including care at the patient's home,
2. diagnostic tests.

Benefits in the field of PEP are 24-hour benefits, which are provided in designated facilities and at specific times.

In counseling, the recipient is entitled to basic medical care from 8.00 to 18.00 on Monday to Friday.

In counseling, the recipient is entitled to basic medical care from 8.00 to 18.00 on Monday to Friday. In the remaining time from Monday to Friday from 18.00 to 8.00 and round the clock, as well as on weekends and public holidays, the patient has the right to outpatient and night-time and holiday doctor's advice as well as nursing and midwifery services. [12,13]

The health care provider is obliged to provide beneficiaries with information about the rules and organization of nightly and holiday health care, by placing information in the place where healthcare services are provided and the service providers' premises. For the provision of night and holiday health care by a doctor, nurse and midwife, the branch of the Voivodship Health Fund concludes an additional contract, if it is necessary to ensure continuous and appropriate provision of services. A person providing healthcare services behind a healthcare provider's center and organizational units benefits from legal protection provided in the Penal Code for public officials. The minister competent for health matters, after consulting the President of the Supreme Council of the Medical Council and the Supreme Council of Nurses and Midwives, will specify in the ordinances the scope of tasks of the primary care doctor, taking into account the need to ensure comprehensive services and patient's well being. [3,7,10]

Choosing a midwife and primary care nurse is certified by a written statement of intent known as "declaration of choice" in written or electronic form. The declaration contains the following information:

1. Data on the recipient:
2. Specification which choice is made once a year,
3. Health insurance card number - for insured persons,
4. The branch code of the voivodship Fund,
5. Data on the doctor, nurse and midwife in primary care
6. Date of making the choice,
7. Signature of the beneficiary or his legal guardian,
8. Signature of the person accepting the declaration of choice.

The model of the selection declaration is determined by the President of the National Health Fund. The service provider is obliged to provide the model of the selection declaration and

verify its correctness after having checked the entitlement of the beneficiary to use the health care services specified in the Act.

Completed declarations are kept at the healthcare provider's premises, ensuring at the same time the availability of beneficiaries who submitted them in compliance with the requirements of the Act of August 29, 1997 on the Protection of Personal Data (Journal of Laws of 2002 No. 101, item 926 and No. 25, item 219, No. 33, item 285, No. 25, item 219 and No. 153, item 1271 from 2004). [12.14]

Objective of the work

The aim of the work was to get to know the expectations of women regarding the medical care provided in the gynecological clinic. In order to achieve the research objective, the issues concerning, among other things, the level of satisfaction of women with the functioning and offering of medical services in the gynecological clinic as well as the expectations of women during visits to the gynecological clinic were chosen.

Material and methods

The following work was written using the diagnostic survey method using a standardized questionnaire, which was aimed at women using gynecological outpatient services.

The research was carried out in the Gynecology and Obstetrics Clinic of the Independent Public Health Care Center in Bychawa from June 2015 to April 2016. The study group consisted of 150 women between the ages of 16 and 67. The examined women were informed about the anonymity of the study, as well as the use of the information provided solely for scientific purposes.

The obtained results were subjected to statistical analysis. A 5% error of inference and associated significance level $p < 0.05$ indicating the existence of statistically significant differences or dependencies were accepted. Statistical research was carried out based on STATISTICA 12.0 computer software (StatSoft, Poland).

The study included 150 women aged from 16 to 67 years. The average age was 38.43 ± 13.27 years. The respondents aged up to 25 years accounted for 17.3% (n = 26), while 17.3% (n = 26) were aged between 26 and 30 years, 25.34% (n = 38) in aged 31-40 and 40.00%, (n = 60) over the age of 40.

Results

The research shows that the respondents most often went to the gynecologist once every three years, (49.33%, n = 74), while 24.00% (n = 36) were at least once a year and 26.67% , (n = 40) only when there were any ailments.

As a result of the statistical analysis, it was found that the respondents aged 31-40 slightly more often went to the gynecologist at least once a year, (34.21%) compared to those under 30 (21.15%) or above 40 years, (20.00%). The differences found were not statistically significant (p = 0.38).

The conducted research shows that respondents with higher education received visits to the gynecologist at least once a year significantly more often (35.29%) compared to the respondents with secondary education (25.88%) or primary or vocational (6.45%). The differences found were statistically significant (p = 0.001), (Table 1).

Education	Frequency of visits			Altogether
	Every three years	At least once a year	In the case of ailments	
	n %	n %	n %	n %
Basic education	13 41,94%	2 6,45%	16 51,61%	31 100,00%
Secondary education	42 49,41%	22 25,88%	21 24,71%	85 100,00%
Higher education	19 55,88%	12 35,29%	3 8,83%	34 100,00%
Totality	74 49,33%	36 24,00%	40 26,67%	150 100,00%
Statistical analysis: $Chi^2 = 17.97$; p = 0.001				

Table 1. Frequency of visits to the gynecologist with regard to education

The study showed that respondents living in rural areas were slightly more likely to visit a gynecologist at least once a year (31.43%) than those from the city (17.50%). The differences found were not statistically significant (p = 0.11).

Studies have shown that free respondents visited the gynecologist at least once a year (31.43%) compared to married women (21.74%). The differences found were not statistically significant (p = 0.38).

Statistical analysis showed a significant relationship between the professional activity of the surveyed women and the frequency of visits to the gynecologist (p = 0.004). It was found that

those surveyed who worked professionally went to the gynecologist at least once a year (31.76%) than those who did not work (13.85%) (Table 2).

Professional activity	Frequency of visits			Altogether
	Every three years	At least once a year	In the event of ailments	
	n %	n %	n %	n %
Working	43 50,59%	27 31.76%	15 17,65%	85 100,00%
Does not work	31 47,69%	9 13,85%	25 38,46%	65 100,00%
Totality	74 49,33%	36 24,00%	40 26,67%	150 100,00%
Statistical analysis: $Chi^2 = 10.97$; $p = 0.004$ *				

Table 2. Frequency of visits to the gynecologist, including professional activity

There was also a significant relationship between economic conditions and the frequency of visits to the gynecologist ($p = 0.0004$). The respondents who had very good or good economic conditions were more likely to visit the gynecologist at least once a year (25.81%) than those under the average conditions (15.35%) (Table 3).

Economic conditions	Frequency of visits			Altogether
	Every three years	At least once a year	In the case of ailments	
	n %	n %	n %	n %
Very good/ good	67 54,03%	32 25,81%	25 20,16%	124 100,00%
Average	7 26,93%	4 15,38%	15 57,69%	26 100,00%
Totality	74 49,33%	36 24,00%	40 26,67%	150 100,0%
Statistical analysis: $Chi^2 = 15.53$; * $p = 0.0004$				

Table 3. Frequency of visits to the gynecologist, including economic conditions

As a result of the conducted research it was found that the respondents who had two children slightly more often used visits to the gynecologist at least once a year (27.08%) than those who had one child (22.92%) or three or more years , (23.23%). The differences found were not statistically significant ($p = 0.12$).

Statistical analysis showed that the respondents who had gynecological operations in the past were slightly more likely to go to the h = gynecologist at least once a year (38.89%) than those

who did not have surgery (21.97%). The differences found were not statistically significant (p = 0.25).

The research shows that most often when choosing a gynecological clinic, the respondents took into account such factors as: the fact that the doctor was recommended by another person (88.67%), providing a sense of intimacy, (86.00%), the possibility of telephone registration , (86.00%), providing reliable information on health status, (84.00%), doctor's relation to the patient (84.00%), and less frequently: doctor's gender, (74.67%), modern medical equipment, (66.67%), seniority (59.33%), and most often not taken into consideration: male gender, gynecologist, (90.00%), doctor's degree, (53.33%).

The research shows that the most frequently interviewed as the reason for the visit to the gynecologist were: control (32.67%), cytological (25.33%), pain (16.67%) and bleeding from the genital tract (13, 33%), and rarely pruritus, (9.33%), malaise, (3.33%), intrauterine insertion, (2.67%) or other reasons, (2.67%), (Table 4).

Grounds	n	%
Control tests	49	32,67%
Pap smear	38	25,33%
Pain	25	16,67%
Bleeding from the genital tract	20	13,33%
Itch	14	9,33%
Bad mood	5	3,33%
Insertion of an intrauterine device	4	2,67%
Other	4	2,67%

Table 4. Reasons for a visit to a gynecologist

Values do not add up to 100% due to multiple responses.

The research showed that most often during the visit to the gynecological clinic, the respondents expected: gynecological examination, (93.33%), cytological examination (83.33%) and breast examination (69.33%) or ultrasound examination (52, 67%), while most often they did not expect a medical exemption (81.33%), blood pressure measurement (78.00%), referral for additional examination (66.00%), pH assessment of vaginal discharge, (64, 00%), prescription, (58.67%) or education (51.33%).

As a result of the conducted research it was found that the respondents were most often satisfied with the choice of gynecological clinic, (49.33%, n = 74), and 21.33% (n = 32) were definitely satisfied, and 27.34%, (n = 41) of the respondents admitted that they are rather unhappy and 2.00% were definitely dissatisfied women.

As a result of the statistical analysis it was found that the respondents aged 31-40 significantly more often assessed that they were definitely satisfied with the choice of gynecological clinic,

(34.21%) in comparison with the respondents aged up to 30 years (25.00%) or over 40 years, (10.00%). The differences found were statistically significant (p = 0.04), (Table 5).

Age	Assessment of satisfaction with the selection of a gynecological clinic			Altogether
	Definitely yes	Rather yes	Definitely not / rather not	
	n %	n %	n %	n %
Up to 30 years	13 25,00%	26 50,00%	13 25,00%	52 100,00%
31-40 years old	13 34,21%	13 34,21%	12 31,58%	38 100,00%
Over 40 years	6 10,00%	35 58,33%	19 31,67%	60 100,00%
Totality	32 21,33%	74 49,33%	44 29,34%	150 100,00%
Statistical analysis: $Chi^2 = 10.15$; p = 0.04 *				

Table 5. Assessment of satisfaction with the selection of gynecological clinics with regard to age.

As a result of the statistical analysis it was found that the respondents with higher education were significantly more often definitely satisfied with the gynecological clinic selection (41.18%) in comparison with the respondents with secondary education (16.47%) or primary or vocational (12 , 90%). The differences found were statistically significant (p = 0.0003), (Table 6).

Education	Assessment of satisfaction with the selection of a gynecological clinic			Altogerher
	Definitely yes	Rather, yes	Definitely not / rather not	
	n %	n %	n %	n %
Basic / vocational	4 12, 90%	12 38,71%	15 48,39%	31 100,00%
Average	14 16,47%	53 62,35%	18 21,18%	85 100,00%
Higher	14 41,18%	9 26,47%	11 32,35%	34 100,00%
Totality	32 21,33%	74 49,33%	44 29,34%	150 100,00%
Statistical analysis: $Chi^2 = 21.35$; * p = 0.0003				

Table 6. Evaluation of satisfaction with the selection of a gynecological clinic with regard to education.

The statistical analysis carried out did not show any significant differences in the assessment of satisfaction with the choice of gynecological clinic between the respondents from the city and from the village (p = 0.64).

The research showed that the free respondents were significantly more often satisfied with the choice of gynecological clinic (42.86%) compared to married women (14.78%). The differences found were statistically significant (p = 0.002), (Table 7).

Marital status	Assessment of satisfaction with the selection of a gynecological clinic			Altogerher
	Definitely yes	Rather, yes	Definitely not / rather not	
	n %	n %	n %	n %
Married	17 14,78%	62 53,92%	36 31,30%	115 100,00%
Unmarried	15 42,86%	12 34,28%	8 22,86%	35 100,00%
Totality	32 21,33%	74 49,33%	44 29,34%	150 100,00%
Statistical analysis :Chi^2=12,66; p=0,002				

Table 7. Evaluation of satisfaction with the selection of a gynecological clinic, including marital status.

The statistical analysis showed no significant relationship between the professional activity of the surveyed women and the assessment of satisfaction with the selection of a gynecological clinic (p = 0.26). However, it was found that the respondents working more often were definitely satisfied with their choice (23.53%) than those surveyed who did not work (18.46%).

Statistical analysis showed that the respondents who had average economic conditions slightly more often were definitely satisfied with the choice of the clinic (22.58%) in comparison with the respondents who had very good or good conditions (15.35%). The differences found were not statistically significant (p = 0.08).

As a result of the conducted research, it was found that the respondents, which one child were significantly more often satisfied with the choice of gynecological clinic (31.25%) than those who had two children (25.00%) or three or more (9, 26%). The differences found were statistically significant (p = 0.02), (Table 8).

Number of births	Assessment of satisfaction with the selection of a gynecological clinic			Altogether
	Definitely yes	Rather, yes	Definitely not / rather not	
	n %	n %	n %	n %
One	15 31,25%	18 37,50%	15 31,25%	48 100,00%
Two	12 25,00%	20 41,67%	16 33,33%	48 100,00%
Three or more	5 9,26%	36 66,67%	13 24,07%5	54 100,00%
Totality	32 21,33%	74 49,33%	44 29.34%	150 100,00%
Statistical analysis: $Chi^2 = 12.26$; p = 0.02 *				

Table 8. Evaluation of satisfaction with the selection of a gynecological clinic taking into account the number of births

Statistical analysis showed that respondents who did not have gynecological surgery in the past were slightly more likely to judge that they were definitely satisfied with the choice of gynecological clinic (22.73%) than those who had surgery (11.12%). The differences found were not statistically significant (p = 0.26).

To assess the expectations of patients, PRF scales were used, consisting of 18 questions rated on a scale from 0 to 2. The maximum score in each range was 12 points. The more points there

are, the more expectations in the given scale range. It was found that the highest expectations of the respondents were in the field of information on research and treatment and explanation of the disease, and slightly lower in the scope of emotional support (Table 9).

Expectations	Average	Median	Standard deviation
Expectation of the explanation of the disease	7,31	8,00	4,10
Search for emotional support	5,91	6,00	3,54
Obtaining information on research and treatment	8,50	10,00	3,98

Table 9. Evaluation of expectations of respondents as patients of a gynaecological clinic.

The research shows that the respondents aged 31-40 had statistically significantly higher expectations regarding the explanation of the disease than those tested at the age of 30 and over 40 years ($p = 0.004$). Also in this age group, women were found to have significantly higher expectations on obtaining information on research and treatment, ($p = 0.006$), and no significant differences were found between age groups in assessing the search for emotional support ($p = 0.86$).

As a result of the conducted research, it was found that the respondents with secondary education were slightly more expecting an explanation of the disease in comparison with women with higher education or primary or vocational education. The differences found were not statistically significant ($p = 0.17$). It was also found that respondents with higher education had lower expectations in terms of emotional support than women with basic or vocational or higher education. The differences found were not statistically significant ($p = 0.07$). Statistical analysis did not show any significant differences between the education groups in the assessment of expectations for information about the disease and treatment ($p = 0.47$).

Statistical analysis did not show any significant differences between married women and unmarried women in the assessment of expectations regarding the explanation of the disease, information on the disease and treatment, and emotional support ($p < 0.05$).

As a result of the statistical analysis, there were no significant differences in the assessment of women's expectations between respondents from the city and from the village ($p > 0.05$).

The conducted research showed that the respondents who did not work to a slightly greater degree expected the explanation of the disease than the professional women. The differences found were not statistically significant ($p = 0.27$). Also, there were no significant differences between the groups in the assessment of the search for emotional support and expectations for information on research and treatment ($p > 0.05$).

Conclusion

Patient's satisfaction with medical services is a very important element that is used to assess the quality of these services. The patient plays the most important role in the basic care unit. Thanks to the understanding and meeting the client's requirements and expectations, a high quality of services is achieved. In every society there are certain norms and expectations regarding the provision of medical services. Patients value universal access to health care, choice, treatment, quality and quantity of messages delivered from medical staff, and time spent on each patient. Attending a gynecological clinic is one of the important elements of maintaining a woman's health. According to a study by Ulman-Włodarz et al. [15], one third of the surveyed women perform gynecological examinations once a year, every 6 months or more, and 13% of respondents once every 2-3 years. In the group of women surveyed, there were 11% of women who reported to the gynecologist only when they observed disturbing ailments. Only 2% of women surveyed studied gin ecologically every five years or less. According to Słopiecka's research [16], 58.1% of the respondents used the gynecological clinic less frequently than once a year or never, the remaining part of the surveyed women, or 41.9%, came to the gynecological clinic regularly, at least once a year. Gajewska [17], conducted a study, which shows that only 16.8% of women used the gynecologist's advice every six months or once a year. A relatively large group of 26.3% of the respondents were women who were never at the gynecologist. However, the largest number of respondents, ie 38.2% of people to the specialist, reported only when there were complaints.

According to our own research, 34.21% of women went to the doctor at least once a year, and these were women aged 31-40. In comparison with the respondents aged up to 30, the percentage was 21.15%, while over the age of 40, 20% were found. Taking into account the type of education, 35.29% of the surveyed women used visits to the gynecologist at least once a year, of which 25.88% of the respondents had secondary, basic or vocational education 6.45%. The research showed that respondents living in the countryside were slightly more likely to visit the gynecologist at least once a year, 31.43% than those from the city (17.50%). The differences found were not statistically significant. Ulman-Włodarz et al. [18] in their research they showed that 56% of the respondents reported to the gynecologist for control tests, 31% of the respondents reported problems, while 13% reported visits for the use of contraception. Słopiecka [16] in her research reported that 21% of the respondents reported to the gynecologist for advice, and 9% of the respondents managed to visit the clinic because of the complaints. 69.5% of women reported to the clinic during pregnancy. In turn, from the research carried out by Łepecka-Klusek et al. [19], it appears that the largest group of women (46.8%) came to the

first visit because of disturbing symptoms. The second, also a large group (41.7%) were people who felt a personal need to check the condition of the reproductive organs. Relatively few respondents (11.5%) managed to gynecological counseling in matters related to procreation, that is, after becoming pregnant or choosing a contraceptive.

According to our own research, the most frequently interviewed, as the reason for the visit to the gynecologist, were: control examination - 32.67%, cytological examination - 25.33%, and 48% of the surveyed women reported to the gynecological clinic due to disturbing ailments. One of the frequent reasons for women to visit a gynecological clinic is worrying symptoms that may indicate a cancerous condition. Women often report problems with abnormal bleeding, various types of pain and disturbing vagaries. Słopiecka's research [16] indicates that 42.1% of women reported with menstrual bleeding disorders. Subsequently, the examined women mentioned abdominal pain - 31.6%; Vaginal discharge, itching and burning - 15.8%, with infertility problems reported by 10.5% of respondents. Our own research shows that women reported most frequently because of disturbing ailments among others: pain (16.67%) and bleeding from genital tract (13.33%), and rarely pruritus (9.33%), malaise (3 , 33%), insertion of an intrauterine device (2.67%) or other reasons (2.67%). Cytology is a diagnostic method for the prevention and detection of precancerous (pre-cancerous) and invasive cervical cancer. From research carried out by Bojar et al. [20] it follows that only 35.8% of women report to a gynecologist for cytological examination and 64.2% do not have cytology. According to our own research, 25.33% of women reported for a cytological examination, 74.67% of the respondents did not have a cytological examination. The studies show that 83.33% of the women surveyed expect a cytological examination. For women, gynecological examination remains one of the most intimate medical procedures. Therefore, it should be carried out professionally, respecting the privacy and preferences of the patient. Szymoniak and colleagues [21] in their research reported that as many as 66% of women surveyed prefer to be examined by a man, and 28% by a woman. Different results are presented by Widzowska-Mączyńska et al. [22], where only 14.9% of women chose a male doctor. Our own research shows that 69.33% of the surveyed women preferred to be examined by a woman, 10% of women surveyed prefer a gynecological examination by a man.

In the conducted study, for 74.67% of women, the gender of the gynecologist was significant, and for 25.33% of the women surveyed, the doctor's gender was irrelevant. The society has specific norms and expectations regarding medical services in a gynecological clinic. Women appreciate universal access to health care, the ability to choose a variety of medical services

performed at a high level of quality. Each gynecological and obstetrician office strives to ensure that women who use medical services are satisfied with the actions taken in the clinic.

Expectations of women during a visit to the gynecological clinic concern primarily information about research and treatment, explanation of the disease and emotional support. Women during a visit to a gynecological clinic expect first of all a gynecological, cytological examination and a breast examination as well as an ultrasound examination. In the slightest degree, receiving a doctor's leave and measuring blood pressure.

Women using the gynecological clinic are satisfied with the offered medical services and the way the clinic operates. Women aged 30-41 with higher education are significantly more satisfied with the gynecological clinic than women under 30 and over 40 years of age and with basic or vocational and married education.

References:

1. Barawski J., Windak A., Optymalizacja polskiego systemu finansowania podstawowej opieki zdrowotnej, Wydawnictwo Sprawne Państwo, Warszawa 2012; 10-13.
2. Brodzińska M., Modzelewska K., Stachowska M., Talarska D.: Stratyfikacja czynników determinujących opinię o jakości świadczeń w zakresie kompetencji pielęgniarki i położnej opieki zdrowotnej. Doniesienia wstępne. Problemy Higieny i Epidemiologii 2010, 91, 2, 303-307.
3. Fiedorczuk I, Marcinowicz L, Chlabicz S.: Rola położnej rodzinnej w środowiskowej opiece zdrowotnej nad noworodkiem – dokumentacja procesu pielęgnowania. Pielęgniarstwo XXI w 2011, 3, 36, 27–34.
4. Kosiek K., Godycki-Ćwirko M.: Poprawa bezpieczeństwa pacjenta w podstawoej opiece zdrowotnej. Zdrowie Publiczne i Zarządzanie 2014, 12, 4, 327-330.
5. Ustawa z dnia 6 listopada 2008 r. o prawach pacjenta i Rzeczniku Praw Pacjenta (Dz.U. 2009 nr 52 poz. 417). Warszawa, Sejm RP 2008.
6. Galicki J. Współczesne zarządzanie w zakładzie opieki zdrowotnej [w:] Głowacka M. D. (red.), Zarządzanie Zakładem Opieki Zdrowotnej Konteksty i Determinanty. Wydawnictwo Polskie Towarzystwo Nauk o Zdrowiu, Poznań 2011; 9-24.
7. Godycki-Ćwirko M., Nowak P, Windak A, Kosiek K. (2004), Zarys historii medycyny rodzinnej w Polsce. [w:] Lukas W, Latkowski J.B. (red.) Medycyna rodzinna. Wydawnictwo Lekarskie PZWL, Warszawa 5–13.
8. Marcinowicz L.: Rola pielęgniarki i położnej w sprawowaniu podstawowej opieki zdrowotnej. Zdrowie Publiczne i Zarządzanie 2014, 12, 4, 352-357.
9. Bojar I., Wdowiak L., Miotła P., Strzemecka J.: Satysfakcja pacjentek z usług publicznych i niepublicznych poradni ginekologiczno-położniczej na terenie miasta Lublina. Zdrowie Publiczne 2006, 116, 1, 189-191.
10. Bojar I., Wdowiak L., Ostrowski T. I wsp.: Dostępność Poradni POZ w Opinii Pacjentów. Zdrowie Publiczne 2004 , 189-193.
11. Doroszkiewicz H., Bień B.:pielęgniarka Środowiskowa szansą naprawy systemu podstawowej opieki pediatrycznej. Medycyna Rodzinna 2001, 14, 3-4, 155.
12. Szymoniak K., Malinowski W., Ćwiek D.: Oczekiwania kobiet wobec badań ginekologicznych w gabinetach prywatnych. Family Medicine & Primary Care Review 2013; 15, 3, 397–399.
13. Golinowska S., Tambor M.: Źródła finansowania opieki zdrowotnej. Zdrowie Publiczne i Zarządzanie 2014, 12, 3, 205-217.

14. Paszkowska M. (2009), Public relations gabinetu POZ-cz. II., ,,Lekarz", 5, 18–21.
15. Ulman-Włodarz I., Nowosielski K., Romanik M., Pozowski J., Jurek M.:Świadomość profilaktyki raka szyjki macicy wśród kobiet zgłaszających się do poradni K. Ginekol Pol. 2011, 82, 22-25.
16. Słopicka A.: Korzystanie przez kobiety z porad lekarza ginekologa. Problemy pielęgniarstwa 2013, 21,1, 47-54.
17. Gajewska M.: Ocena świadomości kobiet regionu środkowowschodniego o czynnikach ryzyka chorób nowotworowych narządu rodnego i raka piersi. Praca doktorska. Instytut Medycyny Wsi, Lublin 1996
18. Ulman-Włodarz I., Nowosielski K., Romanik M., Pozowski J., Jurek M.:Świadomość profilaktyki raka szyjki macicy wśród kobiet zgłaszających się do poradni K. Ginekol Pol. 2011, 82, 22-25.
19. Łepecka-Klusek C., Bucholc M., Pilewska A., Kanadys K.: Kobiety w wieku rozrodczym wobec profilaktycznych badań ginekologicznych. Ginek. Pol. 2001; 72: 1473–1477.
20. Bojar I., Woźnica I., Holecki T., Diatczyk J.: Dostępność, Jakość i Sprawność Funkcjonowania Opieki Zdrowotnej w Polsce w Opinii Pacjentek Korzystających i Niekorzystających z Prywatnej Opieki Ginekologicznej. Medycyna Ogólna 2010, XLV, 2
21. Szymoniak K., Malinowski W., Ćwiek D.: Oczekiwania kobiet wobec badań ginekologicznych w gabinetach prywatnych. Family Medicine & Primary Care Review 2013; 15, 3, 397–399.
22. Wdowiak A., Guz A., Lewicka M., Sulima M., Krakowski J. (2013),Funkcjonowanie poradni ginekologiczno-położniczej w systemie ochrony zdrowia, [w:] Krakowski J. , Ciechońska D. (red.) Przedsiębiorczość i Zarządzanie, Wydawnictwo Społecznej Akademi Nauk, Łódź, XVI, 10, 123-132.