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Review Article

Doctor-Patient Relationship in the Case of Infertility: A Vision from General Medicine

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Abstract

The General Practitioner (GP) takes care of patients with infertility with some frequency, and probably this will be even greater because of ART. Infertility involves a family crisis. The doctor-patient relationship is especially important in these patients and has some typical nuances that include, at least, 1) Know the context and use it in the doctor-patient relationship; 2) Easy access to the GP; 3) Unique case; 4) Family and couple care; 5) The importance of information; 6) Recognize the psychological factors in the doctor-patient with sterility relationship; 7) Recognize the factors related to the quality of life; 8) The repercussions of the diagnosis; 9) Patient participation and shared decision making; 10) The importance of continuity of care; 11) Social support; And 12) The importance of the repercussions of the treatment. The infertility approach is biopsychosocial in nature, and so, it is essential that the GP establish an affective relationship with patients with infertility for creating a solid basis on psychological support. Some of the practical implications of the work of the GP, which are embedded in the doctor-patient relationship are: working on the acceptance of emotions and thoughts so that they do not overflow or paralyze patients, managing tension and anxiety, advise on sexual intercourse, preparing the couple for the chances of having multiple pregnancy, preparing the couple to face possible treatment failures, managing anxiety and uncertainty while waiting for the results of treatment, developing and training communication skills in the couple to use with family and friends, preparing couple, to make decisions that are often difficult, such as using donors, stopping the treatment or ending it, maintaining a continuity of care, and deciding when to refer for psychological intervention.

Keywords: Couple; Consultation; Doctor-patient communication; Family Crisis; General Practice; Infertility; Physician-Patient Relations; Patient-Centred Care; and Referral

Introduction

By doctor-patient relationship we understand the set of conditions and types of social behaviours that concurs in the action between the doctor and the patient, as well as the doctor's relationship with the object of his activity. From the medical point of view, the doctor-patient relationship has a determining importance, due to its therapeutic value [1].

Doctor-patient relationship has been and remains a keystone of care. But, there are many ways of understanding, classifying and practicing it. The doctor-patient relationship is a multidimensional phenomenon where several concepts can be differentiated, among which we can point out the doctor-patient communication, the participation of the patient in decision-making and patient satisfaction. The doctor-patient relationship is established in the consultation and has its central element around the clinical interview. This clinical interview is a technique or channel and place of doctor-patient communication, where the doctor-patient relationship is produced and developed. This communication and the doctor-patient relationship itself indicates to the General Practitioner (GP) (how to signal a path that shows us the direction to reach a place) the clinical environment for diagnosis and treatment [2-5].

Sociological point of view is more interested in understanding the behaviour not between a doctor and a patient, but between

"doctors" and "patients", and attempts are made to identify the social roles that influence and predict the behaviour in the consultation. The understanding of the doctor-patient relationship has been historically explained through different interpretative schemes linked to the historical moment and the social context. From the sociological point of view, the belief that doctor-patient relationship is fundamentally reciprocal is questioned. The worlds separated from the experience and reference (roles) of the ordinary person and the professional are always potential elements of conflicts between them [6].

Psychological point of view of doctor-patient relationship is more interested in thoughts and feelings related to the behaviours of human beings. Some of the positive consequences for health and health care that doctor-patient relationship and communication can produce arise from the fact that the relationships are linked to emotions, which also have a physiological correlation [7].

Thus, several models of doctor-patient relationship have been described: biomedical, biopsychosocial, patient-centered, relationship-centered, negotiating, consumer-centered and systemic. And different concepts can be differentiated in doctor-patient relationship and communication, such as: According to the degree of interpersonal relationship; According to the control exercised by the physician or the patient; According to the level of participation; According to the psychosocial aspects of diseases; According to age; etc. As expected in this mosaic complex, patients show a fairly high degree of inter and intra-individual variability with respect to the preference of communication styles (for example, patient participation) [2,8].

In any case, the importance of the doctor-patient relationship is given by the confirmed fact of the influence of some relationship models on the results of medical care [1,9]. In fact, the quality of doctor-patient interaction and communication is a powerful indicator of the quality of medical care and plays a fundamental role in the medical care process [10]. Some of these positive consequences for health care and health arise from the fact that relationships are linked to emotions and emotions have a physiological substrate [7].

According to the World Health Organization, there are approximately eighty million couples in the world with fertility or conception problems, that is, about fifteen out of every one hundred couples do not achieve fertility or cannot carry out a term pregnancy [11]. Infertility means the inability to have children and even with the possibility of pregnancy, which does not reach term. Therefore, an infertile woman can achieve a pregnancy, but it does not culminate her, she has no children, keeping the couple sex life for a year. Similarly, infertility in men is its inability to fertilize the egg. It must be taken into account that it can be associated or not, with impotence, as well as not being an irreversible condition as in the case of sterility [12].

Fertility was and is today, experienced as a "blessing" and infertility as a "curse", generally irremediable: a lack that is not reduced only to the biological level; it has repercussions on the individual life of the couple and in social life [13].

Infertility has been studied from different approaches. The biomedical approach has generated a large amount of pathophysiological, laboratory information and guidelines for diagnostic and therapeutic interventions; Psychology has been oriented to assess the important adverse impact of this disorder on mental well-being. In addition, it has been proposed that the disease should be evaluated from a biological, psychological and social globalizing perspective, and this perspective aims to improve the doctor-patient relationship. Great advances have been made in infertility treatment techniques and that the importance of paying attention to mental health in addressing these health problems is widely known, however, there is a certain lack of analysis of the doctor-patient relationship with sterility from general medicine [11,14]. In addition, the increase in health services involved with infertility and public disclosure of the phenomenon has led to an increase in the offer of care for infertile couples, which demands from the GP a greater knowledge of psycho sociocultural aspects that are in the middle of the phenomenon [11].

In this scenario, the doctor-patient with infertility relationship has its own characteristics, since in addition to the different pathologies that can cause infertility, this situation produces a profound alteration of the person and will manifest itself in all aspects of life. So, this article aims, based on a selected narrative review and the author's experience, to reflect, synthesize and conceptualize, about some of the basic elements of the doctor-patient with infertility relationship, from the point of view of general medicine and show its possible implications to clinical practice.

Discussion

Approximately 10% to 15% of couples of childbearing age experience infertility. Infertility has multiple aspects, including physical, emotional, financial, social and psychological effects. Although most GPs are more aware of problems related to the physical aspects of infertility, the difficulties and needs that arise from emotional aspects are often more important for couples. Therefore, it is crucial that GPs understand these needs [15,16].

According to studies, the most fruitful moment for women is around 25 years, from there it decreases slightly to 35 years, where the decrease becomes clearer. It is from the age of 35 when the quality of the ovules is lower and fibroids and endometriosis may appear in the uterus and fallopian tubes, which would make pregnancy difficult. The figures indicate that a woman will need between 3 and 4 months to become pregnant at 25 years and 12 to 13 months on average between 35 and 40 years of age. 80% of

couples, in which the woman is over 35 years, will have to wait a year to get pregnant. Of the other 20%, 10% will wait more than a year and the remaining 10% will go to doctor to meet His desire to conceive a son [17].

In the literature, the doctor-patient relationship has been given a fundamental role in the treatment of infertility due to the emotional implications of performing a treatment that makes it possible to have children [18].

If every link between peers requires an essential element for its consolidation such as empathy, in these medical contexts this factor must develop at its best, although without losing the distance or therapeutic reference. The GP is the doctor who usually receives these patients first, and must meet the needs of those women and men who come to his office. These patients, what they demand is a diagnosis and a positive result to the desire to be parents through the treatments that can best respond to the infertility picture they present in each case [19].

On the other hand, many infertility patients feel disappointed with infertility healthcare providers, especially after treatment failure, facing dilemmas among which is which doctor to choose. In the GP consultation many questions may arise about on how to decide and why or why not, consult more than one specialized doctor or change doctors to get a second opinion [20]. Therefore, if doctor-patient relationship is, by definition, a complex relationship in the context of doctor-patient with infertility relationship or in assisted reproduction treatment, nuances arise that require a specific approach. Table 1 shows some basic aspects to consider in the doctor-patient relationship with infertility in general medicine.

	Specific Factors of the Doctor-Patient with Infertility Relationship
1	Know the context and use it in the doctor-patient relationship
2	Easy access to the GP
3	Unique case
4	Family and couple care
5	The importance of information
6	Recognize the psychological factors in the doctor-patient with sterility relationship
7	Recognize the factors related to the quality of life
8	The repercussions of the diagnosis
9	Patient participation and shared decision making
10	The importance of continuity of care
11	Social support
12	The importance of the repercussions of the treatment

Table 1: Specific factors of the doctor-patient with infertility relationship.

Know the context and use it in the doctor-patient relationship

Diagnosis is made by the GP in a similar way to the painter when he manages to highlight a figure in a background, recognizing the edges by contrast, and thus, only by observing the colour in its context, can he begin to understand its nature. For the GP, the same problem takes different forms depending on its context. There are different diagnoses of the same symptom according to the contexts. The way to reach objective decisions is to contextualize. The complexity of general medicine lies in the contextualization of medical care in each patient [21].

In the patient with infertility, their particular existential universe is very important, and the GP must make an effort to know the context surrounding those who want maternity / paternity and they find only difficulties to achieve it. Medical uncertainty is a well-recognized problem in medical care. Although the way in which doctors make decisions in the face of uncertainty has not yet been fully understood, there are two fundamental tools of GPs are contextualization and the doctor-patient relationship. The GP uses the doctor-patient relationship as a toolkit to deal with uncertainty [22].

Previously most of the academics treated infertility as a medical condition with psychological consequences rather than as a socially constructed reality. But, many studies now place infertility within broader social contexts and social scientific frameworks, and although clinical emphasis persists, currently, more attention is being given to the ways in which the infertility experience is determined by the social context. And this fact has significance for the medical management of infertility by the GP.

Easy accessibility to the GP

Infertility affects 10% of couples. Most couples who visit their GP do so because they are concerned about their fertility [23]. It has been seen that easy access to the doctor is an important factor influencing adherence to treatment [18].

Unique case

For patients it is very important to feel that they are taken seriously, and as a unique case. However, some patients report that they feel that their concerns were not taken seriously by their GP, or that they do not think GP are well informed about infertility [15]. It is important to avoid frivolity in dealing with the patient. That a doctor is familiar and accustomed to dealing with a large casuistry of infertility cases does not justify, that a new couple

be treated as another within the globality that we know from our experience. Each case is unique because each patient is individual and unrepeatable. Who comes to the consultation is a person who needs specialized and personalized attention, which must prioritize, above all, their well-being [19]. And, consequently, also the psychological intervention has to adjust to each case and the characteristics that make it unique and special [17].

Family and couple care

Generally, the couple can constitute the base subsystem of the family by fulfilling their procreation and paternity functions, but at the same time it maintains exclusively conjugal functions that vary throughout an evolutionary process, according to their own characteristics of functioning as roles, rules, communication patterns, negotiation, problem solving, etc. From the systemic posture, the couple is recognized as an interactional, open and autopoietic system that is organized under codes and is energized according to communication. Stressful situations, which appear in the life cycle of the couple since their formation, arise as acts in communication and social constructions that move human dilemmas.

From the perspective of the family life cycle, the couple starts early with the individual problems of future spouses by separating from their own families of origin, and in the formation and consolidation of the marital relationship. At the moment when the couple moves from this first stage to the next one, it is because they are ready to have children, it is assumed that the first stage has been resolved and that the next stage is providing new opportunities for the couple. For couples who have an infertility problem, the decision to start a family gives rise to a very difficult life experience. Usually, after attempts to achieve pregnancy without results, they will approach the GP and specialized medical consultation to confirm a diagnosis that is feared and thus, at the same time, obtain hope in their desire to be parents. The infertility crisis consists in the loss of a series of attachments of great emotional value for the individual and the infertile couple [11]. In general terms, infertility should not be understood as a problem of one of the members of the couple, but as a difficulty of both. In the treatment approach, the couple should be seen as a unit. And so, the couple care is one of the relevant factors in the increase of patient satisfaction with regard to the care received.

Infertility, considered as a non-transient crisis-generating event due to health problems, can have a very different impact on one family and another. A family can be being shaken by a serious crisis by a brief infertility, and another, on the other hand, remain immutable. The degree to which the crises are maintained or resolved depends largely on the ability and capacity of the family to act in favour of an adaptation to the new situation.

The GP, within his family care work, will find that the situation of infertility originates experiences of responsibility for this diagnosis. Women often refer to anxious and depressive symptoms as an immediate response to the diagnosis, which is usually denied by men. Usually, men and women maintain supportive experiences of their families of origin. This unexpected situation of infertility leads to the joint search for a solution to the diagnosed problem, but unhealthy behaviours can appear among men. The GP's family care for the patient with infertility should start from the same diagnosis, because in this phase a "vital crisis" begins that is accompanied by feelings of guilt, impotence, lack of control, stress and a great emotional overload. At this time, it is common for the couple to experience emotions that can negatively affect their relationship.

So, the emotional life of the couple is restructured, to be accepted again, as an infertile couple, which represents a personal failure. They must face society as such, establish new self-worth and worth and find new goals or opt for other options such as staying without children, adoption or others. It also implies ending the conflict and ending a state of constant anguish and tension, restructuring marital life and seeking emotional tranquillity. Each couple has specific variants and each one will find an optimal solution if they discuss it openly [13]. Men can experience the infertility indirectly through the impact it has on their partners. It is convenient to involve the male partner throughout the entire treatment process, as well as for couples-based interventions when giving infertility advice [24].

On the other hand, the genogram is the clinical instrument that gathers the family reality, and therefore, a basic tool for the GP in the family care work methodology [25]. However, the new family models that emerge in the face of recent changes after couples go through Assisted Reproduction Techniques (ART) also imply limitations in their representation through the classic genogram. Thus, the new families pose a methodological challenge in the intelligible construction of genograms [26].

Information

Most infertility patients want to receive information about infertility, which also has implications as emotional support [18]. Information can make treatment less dramatic and improves adherence [27-29]. In addition, the provision of information is associated with better individual well-being [30]. Therefore, it is of special relevance to give the couple the necessary information to understand and know the medical aspects of the treatment, as well as to anticipate the emotional processes that may appear throughout the entire process. In this way the couple can adjust to expectations, uncertainties are eliminated and symptoms are normalized [17]. It may also be useful to consider the perceptions that patients have from the Internet as a source of information and support. Encouraging the use of the Internet can help women feel comfortable talking to the doctor and asking questions [20].

Psychological factors in the doctor-patient with infertility relationship

The infertility experience can be devastating for the couple who wants a child. For women, pregnancy and motherhood are developmental milestones that our culture emphasizes [31]. Infertility profoundly affects the psychosocial aspects of young couples, who often mistakenly take fertility for granted. The inevitable transformation of apparently healthy adults into patients can lead to loss of self-esteem, confidence, health, close relationships, security and hope [32].

Infertility is a health problem far beyond the difficulty of having children and also, you will generally it is lived in solitude, without the important support of family and friends, due to its special connotations. This generates tensions and problems that can be added that can even cause couple conflicts [33]. Moreover, infertility is invariably described as a crisis event. Couples who encounter infertility are further challenged with the feeling of profound losses that accompany: loss of health, sexuality, status and prestige, relationship, self-confidence, self-esteem, security and the fantasy of biological parenthood [34].

Not reaching maternity / paternity through natural means is a cause of psychological stress. Infertile couples experience a high level of stress [35]. When fertility treatment is used by couples, they go through various phases and uncertainties that make psychological support necessary. If there is a stressful situation that puts the couple to the test, this is the fruitless pursuit of being parents, living for years the frustration of their desire to conceive a child naturally and without medical help. It can lead to difficult-to-manage conflicts for the couple that can shake the happiness of their components and plunge them into a major crisis, both personal and relationship [17].

It is important that the GP make an identification of the values related to the couple and motherhood to face any discomfort in relation to which it makes sense to them; The GP should know the experience of the infertile couple from the psychological point of view. This implies understanding the emotional factors and providing timely psychological support to the patients, facilitating that they can use their psychological resources from the beginning of the treatment to understand what happens to them throughout the process and react in a timely manner to conflicting emotions [18,36].

In infertility, the couple faces a series of conflicts that, if not addressed, can cause lack of collaboration with the doctor's instructions or interruption of treatment. Patients who want maternity / paternity often find it difficult to achieve it. What for most people is something relatively simple, natural and free of difficulties - to achieve a pregnancy - for these people it has become little less than a challenge, which becomes more chimeric as results are not obtained to the treatment - that happens to condition its existence and its own circumstance (sometimes almost obsessively). Therefore, what a patient will never tolerate from her doctor is a treatment that minimizes the importance of her desire, which does not properly recognize the importance that maternity has for her according to her way of conceiving it. From here, therapeutic alternatives should be considered as options to consider, with due empathy and always listening to the patient [19].

The initial reaction of the patients depends on the emotional aspects that arise, on the personality style, the personal situation of the man, the woman, the couple's relationship, the age of the patients, the diagnosis itself of the cause of infertility, the fear of not achieving maternity / paternity, the possibility of not achieving genetic-family continuity, loss of control over one's body. Infertility is recognized as an important clinical and social problem, due to the common occurrence and therapeutic difficulties. Some researchers suggest that psychopathological factors could play an important pathogenic role in their development, but others claim that psychopathology is rather secondary to infertility. Any case, infertility appears as a symptom regardless of the psychopathological structure [37]. In this sense, it has been reported that psychiatric morbidity was higher among female couples than male couples [38].

The emotional processes that the couple goes through are different depending on the time of the treatment they are in, so knowing them helps the GP empathize with them and welcome them in a clinical environment where they feel safe and understood [17]. Many times there are perceptions of defeat and entrapment in the psychological adjustment to infertility and assisted reproduction. These emotional processes must be taken into account and directed to the psychological interventions of couples undergoing ART. In fact, although paternity can be perceived as a central purpose for many couples who face difficulties in conceiving, it is when these difficulties are experienced as inevitable that couples can develop depressive symptoms [39].

Acceptance of the diagnosis is not always immediate; sometimes it is the result of a process that begins with a state of denial, followed by anger, feelings of injustice and misfortune, sadness and helplessness. Performing the process towards acceptance without being stuck at an earlier point is a matter of time in most cases and depends on the personal and couple context of each case, as well as the personality and coping skills of each person. But when something is not going well, when emotions do not flow, blockage and unnecessary suffering may appear. Then it may be appropriate to seek the psychological support of a specialized therapist either at the assisted reproduction clinic itself or outside it. Patients can go through some classic phases [11,40,41], as:

- **Surprise**

"How can this be happening to me?" "Why?"

- **Denial**

"It is not true what they tell me, they were wrong!" Here, more studies and second opinions may be requested by couple. Emotions generate contradiction, some relief can be experienced when knowing the origin of fertility problems and thus mark the beginning of the possible solution, but on the other hand there are two major losses, that of reproductive health and the realization of the couple's greatest desire, to be parents without major complications. There are many stress situations to go through, a simple blood or urine test takes on great significance and waiting for the results can be very distressing. It also goes through uncertainty in the face of new evidence and fear of the possibility of suffering pain in the course of them.

- **Anger with doctors and blame**

Some couples come to blame each other for their inability to conceive, experiencing resentment and expressing anger towards the other who is not able to give what is expected of him or her in the marriage.

- **Pact or negotiation**

Patient opens up to a series of promises to change, to improve, to do things in the future differently, which seem to be the viable alternative to his intense desire to improve.

- **Depression**

When the patient cannot continue to deny his infertility, his or her insensitivity or stoicism and anger will soon be replaced by a sense of loss.

- **Acceptance**

"This has to happen, there is no solution, I cannot fight against reality, I should prepare myself for this." After periods of intense hope and optimism that alternate with anguish, guilt and frustration, little by little couples who do not get pregnant are accepting their inability to conceive; the couple abandons the possibility of conception, accepting infertility as a personal reality. In this stage the emotional life of the couple is restructured, to be accepted again in other dimensions; Self-esteem and personal worth are restored by finding new personal goals and other possibilities are chosen, such as staying without children or adoption. It also implies ending a long road and ending with a state of constant anguish and tension, restructuring marital life and seeking emotional tranquillity.

Quality of life

Infertile women have a worse quality of life compared to infertile men and non-infertile controls. In addition, across different phases of ART, quality of life levels decreases progressively. In addition, a greater number of previous ART failures have a negative impact on the quality of life, regardless of gender and treatment phase, that is, that infertile women have a worse quality of life in all phases of ART in comparison with men, and this difference increases in infertile patients with more than one prior ART failure [42].

The diagnosis

Only some people who have the medically defined condition of 'infertility' adopt a self-definition of having a fertility problem, which has implications for social and behavioural responses, however, there is no clear consensus on why some people and others do not adopt a medical label [43].

Couples involved in the diagnoses that initiate the processes of assisted fertility begin to experience an anxious waiting period in which the main thing in the life of these couples is infertility and non-conception, and sometimes it is difficult for them to think about themselves, except in their roles as infertile people [11]. There may be some ambiguity in the perception of responsibility in the doctor-patient relationship in couples that receives medical treatment for infertility. The diagnosis reinforces people's sense of responsibility for their infertility; in this way, patients finally restore responsibility for their medical treatment [20].

On the other hand, women newly diagnosed with cancer appear to be especially vulnerable when they face the risk of infertility induced by treatment. The lack of shared decision-making about future fertility can cause distress and, therefore, it is necessary to improve fertility-related communication aimed at female cancer patients [44].

Patient participation and shared decision making

Active participation helps regain self-esteem that has been greatly damaged in the face of diagnosis and unrealistic expectations regarding therapy and the doctor are avoided [18,28]. It has been reported that involving patients in decision making, sharing information with them, being didactic in the explanations, exemplifying in an illustrative manner and, above all, listening to them, is the best way to deal with an infertility treatment in general medicine (which, obviously, will be based on medical technique at the specialized level). Confidence with the GP and a climate of well-being will improve prospects and possible outcomes. In infertility the couple faces a series of conflicts, related both to the desire of the individual and the couple to achieve a pregnancy with the help of science, which if not addressed can cause lack of collaboration to the doctor's instructions or interruption of treatment [45].

Continuity of care

Continuity of care is one of the basic elements of general medicine. It allows the doctor to see repeated patterns of events

and trends or regularities across generations, family functioning and their relationship to events, family structure, coalitions between members, family rules, myths, rituals, etc. It allows the GP to see patterns below the apparent diversity of reasons for the query; It facilitates the diagnosis and treatment, the monitoring of chronic patients, the implementation of preventive elements and improves patient satisfaction. Evolution in humans is not a linear or progressive process of accumulation, but a dialectical process in which the crises of life always impose a time for us to step back and another to move forward. Patients should be considered through long doctor-patient relationships [46,47].

GPs can find in their consultations cases of couples in crisis who need the help of therapy to recover from the difficult path to be parents and, in the worst case to face, without breaking the relationship the failure of their desire to be fathers. It is very important to understand the hard path that the couple is going through in their desire to have a child. Here the question of waiting times must be taken into account: when the couple goes to the assisted reproduction specialist, it has probably been a minimum of two years seeking pregnancy on their own, and in that period they have probably consulted several times with the GP. On the other hand, at this time, you have to add the waiting time from the first evaluation interviews until the start of the diagnostic tests, etc. In this time, the couple has gone from the illusion and hope of the first moments to the frustration, despair and fears that accompany each month of failure. This process is a stressful event that tests each of the members of the couple and the relationship itself [17].

Throughout this period, the most immediate contact is the GP, who can notice the suffering and lack of understanding in the couple that can make a dent in the relationship, and can decide when referral for specialized help is indicated. Infertility treatment is long and often both the patient and the doctor are afraid of disappointment and failure [28].

These couples after time in consultation get to have feelings of frustration and despair. Also one of the spouses can accuse the other of not participating equally in the treatment and evaluation and consequently one or the other may be more demanding of sex. On other occasions they refuse to have sex and dysfunctions of this type can occur that further complicate the situation [13]. The lack of this continuity of care alters the doctor-patient relationship and makes diagnosis and treatment difficult [48].

In any case, continuity in the GP and in specialized medical equipment is associated with the degree of satisfaction reported by patients [27]. In addition, it has been reported that continuity of care is associated with better individual well-being [30]. On the other hand, continuity of care promotes treatment compliance [49].

From the point of view of the GP, this continuity of care is extended after ART. Little is known about the long-term course taken in life by couples who had undergone to ART. In general, a good psychological adjustment has been reported both in couples without children and in post-ART parents (although with doubts regarding sexual satisfaction in couples without children). It can be said with certainty that the long-term quality of life is high, both in couples definitely without children and in post-ART parents. These data should be integrated into the information and advice for future parents before the infertility treatment that the GP can provide [50].

Social support

The importance of the support of the couple to alleviate the burden of infertility has been emphasized [24]. Personal resources of each member of the couple and those of the couple as a whole must be taken into account, the strength and stability of the couple's relationships, the level of understanding between the two, the security and support provided, the psychological well-being, intelligence, personality characteristics of each member. All these aspects influence the coping with the crisis.

It is essential to work on the maintenance or creation of social networks of support and collaboration, to favour the necessary distraction and relief in the hard moment that the patients are going through. The goal may be that their lives do not paralyze and do not stop caring for themselves and the other. This difficult situation affects both women and men. In a significant subgroup of men, male factor infertility negatively affects their intimate relationship. Infertile men do not use broader sources of social support, since they depend primarily on the information and support provided by the doctor. This may indicate that psychological supportive care is particularly important, at least in a subgroup, of men diagnosed as infertile [51].

The treatment

To request a fertility study, in many places within the public assistance, it is necessary to take at least one year trying to get the pregnancy unsuccessful. Depending on the age, the family situation and the socio-economic context of the couple usually turn to public or private health. It is also common to go to both at the same time, in an attempt to save time and exhaust all possibilities [17]. Treatment occurs in secondary care, but GPs can play an invaluable role in the initiation of investigations, referrals and support throughout the treatment and beyond [24]. Treatment in the assisted reproduction unit is a disturbing moment of illusion and uncertainty. A door opens to hope after months of frustration. Couples put their faith in that reproduction techniques work and can finally have a child. Frequently, when emotional and psychological resources decrease after prolonged infertility, the couple can express their desperate desire to have a family, accepting without reserve the risks of multiple pregnancies, ignoring the undeniable increase in morbidity and mortality associated with these gestations. It is not clear why a couple embarking on the infertility treatment trip

may prefer a pregnancy that is ten times more likely to have a serious adverse outcome. Of the three possible explanations for such an attitude (despair, denial and ignorance), only the last can be resolved with patient education and appropriate advice [32].

ART create hope and cure for the problem, on the one hand, but place a tremendous burden on the couple's resources on the other. ART technologies carry potential risks for the baby and the mother, as well as various negative psychosocial consequences for the couple. However, it seems that couples ignore these risks or do not know them and, therefore, wish to achieve "instant family" (more than one child) through a shortcut (a pregnancy). Although it is impossible to ignore the many children born with the help of ART, it is crucial that GPs inform the couple about the medical and psychological consequences that accompany fertility treatments, so that couples can make more realistic decisions [34].

Conclusion

The GP takes care of patients with infertility with some frequency, and probably this will be even greater when ART is generalized. Always the Infertility means a family crisis. Doctor-patient relationship is especially important in these patients. The doctor-patient relationship with infertility has some typical nuances that include, at least, 1) Know the context and use it in the doctor-patient relationship; 2) Easy access to the GP; 3) Unique case; 4) Family and couple care; 5) The importance of information; 6) Recognize the psychological factors in the doctor-patient relationship with sterility; 7) Recognize the factors related to the quality of life; 8) The repercussions of the diagnosis; 9) Patient participation and shared decision making; 10) The importance of continuity of care; 11) Social support; And 12) The importance of the repercussions of the treatment. The infertility approach is psychosocial in nature. Some practical aspects to be applied by the GP, which are embedded in the doctor-patient relationship, are presented in Table 2.

Practical aspects of doctor-patient with infertility relationship	
1	Work on the acceptance of emotions and thoughts so that they do not overflow or paralyze patients
2	Manage tension and anxiety about infertility
3	Advise on sexual relations
4	Prepare couple before the chances of being pregnant multiple
5	Prepare the couple to face possible treatment failures
6	Manage anxiety and uncertainty while waiting for the results of the treatment
7	Develop and train in the couple communication skills to use with family and friends to report the results and maintain or set limits to protect against possible pressures or invasions in their privacy
8	Prepare the couple to, when the time comes, make decisions that are often difficult, such as using donors, stopping treatment or ending it
9	Maintaining a continuity of care
10	Deciding when to refer for psychological intervention

Table 2: Some pratical aspects to be applied to be gp that are imbrined in the medical-patient with infertility relationship.

It is essential that the GP establish an affective relationship with patients with infertility for creating a solid basis on psychological support.

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