Contraception counseling: training group for physicians within the Family Health Program

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The potential for a group intervention with the purpose of training medical residents within the family health program for contraception counseling is analyzed. The intervention is based on the assumption that sexuality needs to be incorporated within this field. Strategies aimed at raising health professionals' awareness of the need to listen to the sexual issues that are implicit in contraception counseling are discussed. Qualitative methodology was used, and the corpus was constructed based on the technique of participant observation. It consisted of reports coming from transcription of the group coordinator's field diary notes. It was seen that the opportunity to share knowledge in a horizontal relationship facilitated revision of the beliefs and values that support medical practice. Thus, this helped health professionals to surmount the technical view of contraception guidance.

Key words: Contraception. Directive counseling. Family practice. Reproductive Behavior. Sexuality. Medical education.

Why counseling on contraception?

One of the major difficulties faced by professionals in medical practice is dealing with the emotional and behavioral aspects involved in their relationships with patients. The difficulty is even more striking when the task involves aspects of sexual behavior. In the case of counseling on contraception, due to it being an object of intense medicalization, there is a tendency toward prescriptive norms and toward a reduction to the biological body, leading to a naturalization of the issue and often a total ignorance about the issues of gender.

To medicalize the body and reduce it to mere biological aspects have been common strategies in medical practice, in order not to deal with the emotional and social aspects of quotidian working life, for which physicians feel unprepared. Furthermore, the recurrent use of these strategies reinforces the idea of the intense need for the specialist and for a medical solution to psychosocial issues where the answer may be beyond medical practice (Vieira, 2002).

In the case of the female body, there are several analyses that point to its "expropriation" by medical knowledge as a social control strategy, denying women autonomy and decision-making power over their own bodies (Enrenreich, English, 2003; Vieira, 2002; Illich, 1975). From another point of view, in the case of Brazil, there is a real need for female contraception which is unfulfilled within the health system. According to data from the 1996 National Demographic and Health Survey, about half of the women respondents did not want to have their last child or would have liked the pregnancy to have been at a different moment in their lives (BEMFAM / Macro, 1997).

Counseling on contraception is a fundamental procedure for allowing access to contraceptives and guidance in their correct use, increasing the efficacy of their action, especially for people with low income and limited access to scientific information. In this sense, the medical health professionals, nurses, social workers and psychologists play a crucial role, since they could provide appropriate orientation, legitimizing this requirement.

The Residency Program in Community Health and Family Medicine, Faculty of Medicine of Ribeirão Preto, University of Sao Paulo aims to train physicians for an integrated approach, making public health issues and those involving the establishment of a good physician-patient relationship the priority. This program is based on the assumptions that regulate the Family Health Program (PSF).

In the hospital context, the mechanistic approaches toward disease and healing are hegemonic and generate dissatisfaction both among patients and health professionals. The family health programs favor another view of care, integrated, humanized and cohesive care, which should restore the unity of the human being and deal with human problems in their multiple dimensions: biological, social, psychological and existential.

PSF is a public policy for primary health care created to operate the National Health Service (SUS) principles and guidelines, organizing the system in a network linked to other levels of health care (Brazil, 1997).

In this change of perspective operated by the family health strategy, the PSFs are configured as a fertile field for experimentation with different modalities of intervention in the area of health (Camargo-Borges, Cardoso, 2005). An aspect of this production of knowledge and innovative or transforming practice is the one that proposes to address and rethink the physician-patient relationship.

Physician-patient relationship in times of social and paradigmatic transition

Currently, medical education is considered a strategic component of the Brazilian National Health Reform (Aguiar, 2005). The improvement of the health care model towards a humanized and competent health practice, focused on the collective interests, regulated and efficiently controlled by society, depends, to a large extent, on medical education.

Authors such as Camargo (1992), Schraiber (1997, 1993), Minayo (1993a) and Machado (1997) bring medical training and quotidian medical work into discussion. One of the issues raised is the elimination of important dimensions of human experience with the advent of

scientific medicine. The multiple facets, social-community, emotional and spiritual, that compose human existence beyond the biological dimension, are separated, diluted or completely overlooked in the production of medical knowledge. In this, Clavreul (1983) recognizes a subtle strategy for the removal of the patient's subjectivity as it can not be integrated into medical practice. In order for this practice to be historically constituted, as we know it today, everything that was not encapsulated within the anatomopathological view and, therefore, could not be translated into exclusively rationalistic terms, had to be placed under suspicion.

When sculpting the medical profession in this fashion, the medical discourse has direct effects on clinical practice. Discussing the quality of medical care, subject to constant questioning and discontent, Schraiber (1993) mentions the lack of commitment that arises when professionals believe themselves to be free from personal responsibility for their actions, delegating this to institutions, government or any other external body. This phenomenon, in which the person and the action are dissociated, is linked to what the author calls "depersonalization of care and dehumanization of assistance" (Schraiber, 1993, p.128). To combat this, it is necessary to incorporate, into the practice of Medicine, the lost human dimensions so that it effectively provides *care of the emotional health* (Sá, 2003).

It must be understood that the roots of this dissociation lie in the constitution of the object of the study of Medicine as a body-machine in the best tradition of Cartesian thought. Thus, "the object of medical knowledge is the disease and its occurrence in a body reduced to the biological needs" (Souza, 1998, p.91), trying to erase the dimension of the eroticized body or at least eroticizable in the area of the intersubjective relationship that is established in the act of care. For the erogenous body to not break through the biological body discourse, disrupting its intelligibility based on purely rational categories, to think (know) and to feel must remain unconnected. This implies inhibitions, anguish and the formation of symptoms, because there is always the risk of eroticization or of its negation. In this case the denial of the risk leads to the trivialization of the body, in order to support the presumption that it is an

exclusively biological body, which supposedly guarantees the neutrality of the "professional posture".

The social imagination credits the physician figure with a symbolic superlative power. People often transfer to the physician the respect and veneration they devote to their parents, in a manner analogous to what Freud (1996) found in the relationship of the student with the teacher, that resembles the child's relationship with its father. If it is true that the patient tends to see the professional as an incarnation of a wise and protective father figure, the physician could take advantage of this privileged position to try to shape himself in this image, reinforcing the patient's infantile dependency instead of feeding his legitimate desire to learn more about himself, to know what is still unknown to him using the discourse about his sexuality.

Alternatively, excessive expectations placed on the shoulders of the physician lead to an extraordinary idealization that is difficult to sustain in practice, for example, when treatment is unable to prevent the patient's death, which creates huge disappointment. Thus, the physician is always perceived with a certain ambivalence by the other who places him as someone who is expected to know safe and fundamental truths, but also as someone who can fail and succumb to feelings of powerlessness. Thus, power and powerlessness permeate the practice of Medicine and constitute the medical discourse (Clavreul, 1983).

Educated to embody one that holds all the answers, it is not easy for physicians to admit the limits of their knowledge and live with uncertainties and inaccuracies, especially when dealing with questions of the ideals and ambitions of healing. It turns out that this prescriptive knowledge, considered to be absolute, is inevitably confronted in a slippery field, such as that of sexuality which eludes crystallized categorization fixed as human attitudes and actions in descriptive categories. It is particularly uncomfortable for the physician to admit that neither he nor anyone else has all the knowledge, and that a single truth does not exist.

The disappearance of the certainty afforded by the possession of a positive knowledge, which is the feature that characterizes the transition to post-modernity, requires recognition of

the unpredictable and toleration of the paradoxes, ambiguities, incompleteness and the uniqueness of the psychic condition of each individual.

Within the physician-patient relationship, this means giving up the comfort that a full identification with the place of supposed knowledge ensures the professional. This implies allowing frequent navigation along an unknown route, exposed to danger from storms. Sometimes the unexpected will be a surprise, when the relationship with the patient reveals something that concerns the professional and puts into question his own subjectivity. This gives rise to the provocative question "who educates whom?", which inspires thoughts of Ramos, Cardoso de Mello e Souza Soares (1989) regarding the physician-patient relationship, suggesting that, when seen from the perspective of intersubjectivity, it is always a two-way street.

We live in a time of paradigmatic transition (Grandesso, 2000; Santos, 1989) which occurs in a peculiar way in the field of health. In recent years, under the assumptions of Health Promotion, the health-disease process has been understood as a social and cultural production, which can not be understood if it is isolated from the body of knowledge constructed and shared by the community, in the local context and historically located. We have witnessed the passage of the individual to the group in contemporaneity, that is, from the excessive emphasis on individualism to the consideration of the community dimension. Therefore, the professional in times of interdisciplinarity is increasingly required to have a peculiar ability to cope with the diversity of human potential and with heterogeneous social realities, locally and historically situated.

For these plural realities, a person circulates, who is, at all times, founded and refounded in intersubjectivity and in his historical transformation (Souza, 1998). This person lives with uncertainty and helplessness, which especially appear in the clinic.

Currently, clinical epidemiology recognizes the uncertainty in clinical practice (Sackett et al., 1994). As pointed out by Souza (1998, p.9), “the clinic brings to the physician the tension subjectivity/objectivity, singularity/objectivity, singularity/universality, diseased/disease, the

inevitable tensions within which the difficult medical act occurs considering the inclusive opposition between these antinomian pairs".

Contemporary studies have addressed the issue of medical education in the context of social needs, for training of human resources for the organization of the Unified Health System (Amoretti, 2005). The technical, biologicist model, directed toward hospital practice, which characterizes the strategy of hegemonic training, has not been able to satisfy the basic health needs of the population. Due to a growing sensitivity to these limitations, the process of training health professionals has been undergoing transformation, for example, the implementation of an integrated curriculum in their teaching methodology has emphasized the diversity of learning scenarios (Ferreira, Silva, Aguer, 2007).

The current scenario of social transition requires a professional who is able to identify the local health needs and to combine knowledge from different fields whose vectors converge in care. It is necessary to overcome the compartmentalization of knowledge and put it into dialogue so that we can move from fragmentation to integrated care. These assumptions have to be taken into account in the projects of improvement of medical education.

Pedagogic workshop as a medical teaching strategy

Among the constantly expanding applications of group work in education, we highlight reflection groups and continuing education programs (Osorio, 2003). *Reflection groups* emerged in the 1960s aiming to provide students the opportunity to participate in a group in which they could elaborate on the tensions raised by the course and their relationships with teachers and classmates. The *continuing education programs* promote the exchange of experiences of the participants as concerns their practice.

The employment of groups in medical education is not new. The Balint group has an established tradition of decades of applicability (Kelner, 1999; Balint, 1984), and is defined as a homogeneous group, consisting of physicians, that works as an instrument of research,

teaching and learning about the physician–patient relationship, with the coordinator acting as a catalyst for the group process.

Souza (1998) advocates the use of the group strategy as a privileged *locus* of learning to discuss the clinical training of physicians. She combined teachers and students in the initial phase of the clinical cycle in a reflection group. Analyzing the transcripts of the group reports, organized around the question of clinical practice, the author points out the constraints of the discourse in which these participants submitted to anatomoclinical rationality and disciplinary power, which according to several authors, such as Luz (1988), reveal and shape the discourse of knowledge in the institutional system of medicine.

These works that seek to explore the potential of group modality valorize interpersonal relationships in the context of medical education, trying to integrate knowledge and feeling into clinical practice. Despite differences in approaches, the authors converge in some beliefs, such as in that the student's professional preparation requires living with the uncertainties produced by the incompleteness of their domain and the increasingly vast medical knowledge. Another area of consensus in relation to the educational process is the need to address the denial of death and the anguish of helplessness experienced in a profession supported by an inherently flawed science, such as in Medicine.

Among the innovative tendencies, Souza (1998) highlights the work of Hunter (1996), in the United States, with the introduction of literature into the medical course, emphasizing the need to develop the *narrative competence* of future physicians. Narrative competence means the ability to adopt different perspectives and to follow the chain of complex stories, often chaotic, that the patient offers. It also assumes, according to Souza (1998), the ability to tolerate frustration and ambiguity, and to recognize the multiple and, sometimes, contradictory meanings of people's experiences. Furthermore, this work aims to increase the tolerance of the uncertainty of clinical practice and encourage the establishment of an empathetic relationship with patients.

The group dynamics allow a clearer understanding of the continuity that exists between the individual and the diverse groups in which he is inserted throughout his life cycle, in all

dimensions in which life occurs: family, social, cultural, professional and spiritual. Often, people who are willing to live the experience as members of a group are living evidence of the group potential for achieving greater integration of professional identity and a better quality of life.

In view of these considerations, this paper aims to describe a group intervention to train medical residents of the Family Health Program (PSF), in the approach to contraception counseling.

This study aims to discuss the group as a pedagogical strategy in the training of physicians, carrying out a theoretical review of some important concepts of the theme. To this end, we report a pilot experience of a one-off group as a reference of this dialogical discussion.

Method

The purpose of the study is to contribute towards rethinking the training and medical practices that dignify the profession of Medicine, placing them in line with the new paradigms that are emerging in the contemporaneity, in all fields of human knowledge.

Type of study

This is a descriptive and exploratory study, of a qualitative nature, considered an appropriate strategy for scientific research into human situations and phenomena that occur in natural conditions.

The qualitative approach is used here as the interest is in understanding the potentials of the intervention group, from the perspective of the participants in the situation under study (Goldemberg, 1997; Haguette, 1992; Triviños, 1987). Qualitative research seeks to deal with a level of reality that is not possible to quantify, or "the world of meanings, motives, aspirations, beliefs, values and attitudes, which corresponds to a more profound space in the relationships, processes and phenomena that can not be reduced to the operation of variables" (Minayo, 1993b, p.22).

Furthermore, the study has the characteristic of participatory research (Tedlock, 2000), in which the researcher is inserted as part of the phenomenon investigated and, therefore, his presence is not neutral, and his actions contribute to modify what is observed.

Theoretical framework

The methodological strategy chosen was the pedagogical workshop. The perspective that underlies the analysis and discussion of the data uses psychoanalysis as the theoretical framework, centered on the postulation of a dynamic unconscious, considering that the individual with knowledge/ignorance is constituted in language. Thus, a view is adopted that links the framework of psychoanalysis to the group setting (Bezerra Junior, 1994).

Setting/context and justification of methodological choice

The intervention group occurred in an appropriate room for this type of activity, under comfortable conditions and with adequate privacy, at the premises of the Faculty of Medicine of Ribeirão Preto, University of Sao Paulo.

This study describes a strategy used in the approach to contraception counseling in order to raise awareness among professionals of the importance of listening to the issues of sexuality implicit in the counseling provided to users.

By focusing on group work, we aimed to complement what is commended by the literature in the area. This indicates the group strategy as the perfect tool for creating a learning environment conducive to the revision of beliefs, values and meanings, intended to obtain possible changes in the attitudes of individuals. It is understood also that the group approach is in agreement with the principles governing the family health strategy, with the perspective redirected towards the local, situated and relational contexts and the logic of integral care.

Participants

The participants were eight residents of the Medical Residency Program in Community Health and Family Medicine, Faculty of Medicine of Ribeirão Preto, consisting of five men and three women, all unmarried, aged between 24 and 28 years.

Material and procedure

Field work: the implementation of the group

The training was planned and coordinated by a medical specialist in reproductive health, the supervisor of the Residency Program. In order to incorporate sexuality into contraception, a strategy to facilitate group dynamics was used. This strategy was to present a set of "myths", "realities" and "challenges" as trigger questions for discussion, leading to the free flow of ideas within the group. The coordinator tried to foster discussion between the participants, helping to create a climate of trust and permissiveness, in order to facilitate the exposure of individual viewpoints.

The group session lasted around 1 hour and 15 minutes. We proposed a game where the participants had to categorize 15 written statements, drawn from a container. Each participant read aloud a statement that could be categorized as "myth", "reality" or "challenge". Upon giving an opinion, the physician then had to try to justify it, as completely as possible, explaining the arguments on which their classification of the statement was based, according to the three suggested categories.

The list of statements is presented in Box 1 in their "correct" categories. All statements are related to sexuality in the context of counseling on contraception. The statements categorized as **myths** are those that explore issues which act as barriers that hinder the approach toward sexuality in contraception care. The statements categorized as **reality** and **challenges** are based on the results of experiences from various family planning programs implemented in several countries (Population Reports, 1998).

Box 1: Myths, realities and challenges for incorporating the issue of sexuality into Family Planning Programs.

Myth	Reality	Challenge
1. Sexuality is a personal matter and people do not want to talk about it.	Precisely because sex is such a private subject, people feel the need to find constructive opportunities to talk about their sexual experiences, concerns and needs.	To find ways to make individuals more comfortable discussing their sex life with health professionals.
2. Sex is a voluntary activity between individuals of equal status.	The dynamics of power within a relationship strongly influence sexual activity; a significant number of women and girls, and sometimes boys, are coerced into having sex.	To identify and alleviate the inequalities of power between intimate partners.
3. Users prefer contraceptive methods that do not interfere with intercourse.	The tendency of women to choose methods not associated with intercourse is typically more influenced by factors such as: the bias of the provider of these methods and concern for the partner than on their individual needs and choices.	To help the user make an informed choice about contraceptive methods best suited to their relationship and needs.
4. A program for the provision of contraception must be prepared to respond to questions and needs of users in relation to sexuality.	Health providers can learn how to better explain the use of a contraceptive method, but few are trained in how to facilitate communication with clients on complex and intimate topics.	To help providers develop the necessary values, communication skills and technical information to respond to questions about sexuality of the user.
5. If we include the issue of sexuality in family planning programs it will create a huge	Increased client satisfaction and more effective use of contraceptives suggest that addressing issues of	To help family planning programs develop a range of services that address sexual and reproductive

demand.	sexuality is a worthwhile investment.	health.

As a pretext for seeking the right category, after the drawing and reading of each statement, the group was asked to express their opinion about which category would correspond to the statement read, and to give the reason for this classification.

In addition, the participants were asked whether they shared the same opinion or whether anyone held a different opinion, in order to explore the adoption of different perspectives that focus on the same issue and to understand that the multiplicity of voices and views of group members, on a certain topic, reflect different versions circulating within the community. These views, once put into circulation, are precious ingredients to enhance and enrich the discussion, creating possibilities for reconstruction of new meanings within the group.

Data collection and analysis

The *corpus* was constructed based on participant observation and consisted of reports coming from transcription of the group coordinator's field diary notes.

For the analysis of content, a transcription of the field diary was carried out and, later, a brief reading of the transcribed material was held, followed by a closer reading in which the main ideas linked to the theoretical foundation were located and underlined. The emerging themes were mapped, allowing the most important aspects for discussion to be highlighted. Qualitative analysis was based on the focus of psychoanalysis applied to groups, trying to extract the meanings that emerged in the conversation of the participants.

Members of the group formalized their agreement with the study by signing the consent form. The project was approved by the Ethics Committee in Research of the institution.

Results and discussion

After proposing the task, the immediate and enthusiastic participation of the professionals was noted, so the first statement was drawn.

Several situations in which the participants had passed were reported in free association with the statements. A young female physician reported the case of a 73 year old man, who came to her with a complaint of sexual disinterest and erectile dysfunction. The physician realized that this man was more worried about the loss of sexual potency than with decreased libido, although these complaints seemed related. She expressed concern, as she considered herself too young and inexperienced, and did not know what to say to the patient. Furthermore, she was fully aware that the medical school had not sufficiently prepared her for this type of consultation in which the patient, beyond seeking a solution to his problems, showed an interest in sharing his concerns about his relationship with his wife, shaken by the difficulty of consummating the sexual act, and its disturbing consequences in their married life.

Other participants took the opportunity to comment that they receive many sexual complaints in their quotidian working life, especially from women, and they do not know how to approach them. One of the physicians confided that in his experience, using sexual interdiction as a "prescription" had been a device that had yielded good results, since couples supported the restriction of sexual relations for the maximum of one month. Although intuitively, this professional made a prescriptive use of the paradox, in that he ordered compulsory sexual abstinence from the patient who complained of sexual problems. The physician explained that he hypothesized that sexual difficulties in this case had a psychogenic origin and should be treated with an instrument from the psychotherapeutic arsenal. Intuitively, he realized that what is of an essentially psychological nature calls for a psychological therapy that mobilizes the dimension of the symbolic efficacy of the human being.

This professional, unconsciously, understood the symbolic place that he occupies in the relationship with the patients and used the transference role to act in the paternal position, of authority responsible for the interdicted function (Freud, 1996). His insight is in the use of this function, to act in the relationship as one that sets an imperative that produces a paradoxical experience in a particular patient who complained of sexual dissatisfaction and could not have

a sexual relationship with her husband. The desire, in this case, was placed entirely on the other, not on her. It was up to her to just say *yes* or *no* to the advances of her husband who always initiated sexual relations. When advising her to remain abstinent for at least a month in the form of medical advice, the professional, in fact, led her to confront her own desire and, of course, helped her to contact what remained hidden in her unconscious. Thus, with the voice that “ordered” her to remain abstinent, the woman ended up “breaking” the rule before the deadline set by the physician, resuming her sex life with more involvement and pleasure. It was as if the paradoxical experience had contributed to unlock the inhibition mechanism that impeded her enjoyment of the pleasures of an intimate relationship with her partner.

The therapeutic bond in relationships is the focus of the family health strategy, which emphasizes the receptiveness as the modality of intervention which offers ongoing support to the user during the process of care, not limited to access to the service (Camargo-Borges, Cardoso, 2005). At the meeting in which this bond is produced, there is a process of identifying and negotiating the needs of those seeking help. Needs which, when verbalized, enable the transformation of the complaint into a demand. This was evidenced in the group, when a female physician said that contraception is a responsibility that society designates as exclusively that of the woman and that this *bad habit* is reproduced by physicians in their professional practice, since there is no rationale to include in the anamnesis, the question, directed towards men, on the type of contraception that they use.

There was consensus in the group regarding the need to listen attentively (which is more than just to listen) to the patient in his somatopsychic unit and to consider sexuality a component of contraception care, to learn more about communication and to incorporate a critical view of the gender inequalities. Therefore, the professional needs to let go of the stereotypes that lead to coercion of spontaneity and a limitation in the expression of emotions.

During the training activity, an increase in the readiness of the participants to go beyond the technological aspects of contraception counseling was noticed.

The strategy was appropriate for achieving the goal of raising awareness among professionals of the need to listen to the issues of sexuality that underlie contraception

counseling. The informal and ludic character of the activity found wide acceptance from the residents, who felt that their opinions were respected and valued.

The group can be understood as an area of experimentation, in the sense that Oliveira (2003) proposes in his approach to groupality. The thing that ensures that the group works as a group is the possibility of *play*, the concept of which has a very different meaning from that which is usually employed. It is a serious activity that develops very early in the life of each individual, based on the type of relationship established with the mother, or a satisfactory experience of motherhood. Play is daring to externalize something uncertain. “It is possible to think of groups as a very special environment in which play can occur, perhaps more than anywhere else” (Oliveira, 2003, p.157). But to ensure that the groups are stimulating and facilitate the emergence of this intermediary area between subjective and objective reality which includes play, "it is necessary to build a *sufficiently reliable and trustworthy* environment" (Oliveira, 2003, p.158), actively adapting to the needs of expression of its members. In this sense, the ludic activity may be useful to place the physicians in contact with their own immediate area of experience, enhancing the production of knowledge that emanates from their own experiences, concerns and questions. With groups of professionals, this work proposal seems to have a vitalizing role, as it intends to enable them through the development of their resources.

This enlivening function of the group should be particularly emphasized in the context of the medical profession, as we are dealing with those who chose to make their work a continuous and constant contact with pain and death (Pitta, 1991). Thus, these professionals are faced with situations of suffering and pain, as a kind of *daily bread* that colors or tints their quotidian working life gray. Situations that continually test the limits of human endurance, and cross the core of our being with innumerable situations of loss of health, dreams, certainties, and the beliefs that give assurance to ideals, to reason to live and, ultimately, to life. It is in this context that a clinical view is established, based more on “knowing how to see” than on “knowing how to listen”. However, to develop the ability to listen to the other, it is necessary that professionals, in the course of their training process, have the experience of “being

listened to". In this sense, Bellodi (2007) shows the need to provide psychological support to the medical student. Therefore, the higher education institutions should make efforts to institutionalize specific services.

Souza (1998) believes that to better understand the formation of professional identity, it is necessary to valorize that which "is in language and through language the student structures the experience and constitutes, in addition to a clinical-anatomical view, a perspective with which to exercise the medical practice" (p.90). In this sense, we understand that giving voice to the physician is a way to diminish the gap between the experience narrated by the patient and that lived in the quotidian of the professional.

The possibility of sharing knowledge in a horizontal relationship can facilitate the re-evaluation of beliefs and the revision of values in which the attitudes and positions taken by each professional are grounded. This critical posture is essential to the practice of the profession, as it enables new concepts and re-describes the physician's role, adopting the ability to listen to relational aspects more attentively, leading to a clinical view devoid of prejudices and preconceptions. The group strategy can provide an important environment in which to respect and embrace human diversity, perceiving it as an element that amasses value and not as an adverse factor (Osorio, 2003b).

The Freudian approach allows sexuality to be related to language, that is, to the field of unconscious representations that are linked to experiences lived in the body. These psychic representations symbolically inscribe the body in the mind and determine sexuality. Thus, the sexual difference is not only determined by anatomy or physiology, but also by the symbolic inscription (Dal-Cól, Oliveira, 2005).

The separation between the biological and the symbolic is outlined in the area in which sexuality stands out from the body. Human beings are marked by desire, as a condition of their humanity (Dal-Cól, Oliveira, 2005). To consider that there is a story of desire, told in the discourse of users around contraception, opens space for an individual with desires to emerge. An individual with an unconscious will emerge, if we focus on the subjective dimension. An individual with rights will emerge, if we look through the social and political sphere. This

theoretical framework produces a repositioning of the professional concerning contraception counseling. The professionals no longer feel themselves the holders of knowledge that the others supposedly lack, but value listening in that this recognizes the knowledge of the others. They show sensitivity and respond to locally produced knowledge, and not just to what is considered correct, legitimate and true. Only then, armed with this new outlook, may the physician contribute to the necessary transformations, operating as an agent of change.

Final considerations

To share experiences enriched the group with reflection and criticism of social and individual aspects that emerge in medical practice. The professionals were able to identify and distinguish the myths, realities and challenges that permeate their performance in the field of contraception. To recognize as a **reality** that "people feel the need to have constructive opportunities to talk about their sexual experiences, concerns and needs" helps combat the **myth** that "sexuality is a purely personal matter and that people do not want to talk about it" (myth 1). Thus, in the deconstruction of this erroneous belief, the residents can be prepared to confront the **challenge** of "finding ways to make individuals more comfortable discussing their sexual life with health professionals" (Challenge 1).

The intervention provided the physicians with the opportunity to talk and, at the same time, listen to each other and socialize their experiences, concerns and needs that arise during their consultations. This listening space is a potent mechanism to sensitize the professional to the importance of offering a genuine and empathic openness to the other, in the exercise of gentile receptiveness that valorizes the narrative and relational experience. For this reason, it is understood that the clinical practice is a privileged place for the exercise of living with diversity and for informal learning about the human condition. Thus, the group with the purpose of teaching and learning is a valuable space for building and sharing.

Medical education and professional training programs can not operate without spaces that attest to the transforming value of dialogue and listening to produce structural changes in

living together. Education should incorporate them into the traditional process of transmission of theoretical and technical knowledge that orients clinical practice. For these to be included in health practices, it is necessary to develop abilities and competencies in human relationships that go beyond the traditional requirements of technical competence normally demanded of the physician. There is a need to develop values, communication skills and the ability to capture the meaning of the technical information necessary to answer questions from users in the field of sexuality, resisting the temptation to medicalize psychosocial issues.

For this reason we must invest in relational spaces, such as sharing groups, in which professionals meet to talk about similar issues, forming networks of conversation in which the subjectivity of each professional can be valued as a possible instrument for the production of knowledge.

The professionals, at the end of the intervention, were more sensitive to the possibility of listening to and receiving the concerns and questions of patients, and constructing possibilities for conversation on the sexual theme without displaying moral judgment. They were aware of the enormous challenge of overcoming the technicist view, losing the fear of listening and leaving the place of the specialist, giving away imaginary power that, subtly or explicitly, wants to regulate the sexuality of the other, under the guise of “doing good”.

In this context, this work can be understood as a contribution to the production of references for the practice of the physician, in the context of a Public Health program, tending to view the development of the profession with a critical, transformative and interdisciplinary posture. In this way, it fulfills an important wish to amplify the possibilities for the creation of proposals to support the inclusion of practices that follow the logic of the work that guides the family health strategy. This offers resources for the incorporation of the issue of sexuality into Family Planning Programs, reinforcing the social commitment of medicine as a profession of health.

References

AGUIAR, A.C. Formação médica e trabalho em equipe de saúde. Editorial. **Rev. Bras. Educ. Méd.**, v.29, n.2, p.79, 2005.

AMORETTI, R. A educação médica diante das necessidades sociais em saúde. **Rev. Bras. Educ. Méd.**, v.29, n.2, p.136-46, 2005.

BALINT, M. **O médico, o paciente e a doença.** Rio de Janeiro: Atheneu, 1984.

BELLODI, P.L. Retaguarda emocional para o aluno de medicina da Santa Casa de São Paulo (REPAM): realizações e reflexões. **Rev. Bras. Educ. Méd.**, v.31, n.1, p.5-14, 2007.

BEMFAM/MACRO. Sociedade Civil Bem-Estar Familiar no Brasil/Programa de Pesquisas de Demografia e Saúde Macro International Inc. **Pesquisa Nacional sobre Demografia e Saúde** - Brasil, 1996. Rio de Janeiro: BEMFAM, 1997.

BEZERRA JUNIOR, B.C. Grupos: cultura psicológica e psicanálise. In: LANCETTI, A. (Org.). **Saúde e loucura**: grupos e coletivos. São Paulo: Hucitec, 1994. p.129-44.

BRASIL. Ministério da Saúde. Secretaria de Assistência à Saúde. **Saúde da Família**: uma estratégia para a reorganização do modelo assistencial. Brasília, 1997.

CAMARGO, K.R. (Ir)racionalidade médica: os paradoxos da clínica. **Physis**, v.2, n.1, p.203-28, 1992.

CAMARGO-BORGES, C.; CARDOSO, C.L. A psicologia e a estratégia saúde da família: compondo saberes e fazeres. **Psicol. Soc.**, v.17, n.2, p.26-32, 2005

CLAVREUL, J. **A ordem médica**: poder e impotência do discurso médico. Trad. Marco Antonio Coutinho Jorge. São Paulo: Brasiliense, 1983.

DAL-CÓL, D.M.L.; OLIVEIRA, M.L. O legado freudiano: a angústia na clínica psicanalítica e na cultura contemporânea. **Doxa (Araraquara)**, v.9, n.1, p.47-88, 2005.

EHRENREICH, B.; ENGLISH, D. **Para seu próprio bem.** Rio de Janeiro: Rosa dos Tempos, 2003.

FERREIRA, R.C.; SILVA, R.F.; AGUER, C.B. Formação do profissional médico: a aprendizagem na atenção básica de saúde. **Rev. Bras. Educ. Méd.**, v.31, n.1, p.52-9, 2007.

FREUD, S. Algumas reflexões sobre a psicologia do escolar. In: _______. **Obras psicológicas completas.** Rio de Janeiro: Imago, 1996. p.247-51. (Edição Standard Brasileira, v.13).

GOLDEMBERG, M. **A arte de pesquisar**: como fazer pesquisa qualitativa em ciências sociais. Rio de Janeiro: Record, 1997.

GRANDESSO, M. **Sobre a reconstrução do significado**: uma análise epistemológica e hermenêutica da prática clínica.São Paulo: Casa do Psicólogo, 2000.

HAGUETTE, T.M.F. **Metodologias qualitativas na sociologia.** Petrópolis: Vozes, 1992.

HUNTER, K.M. "Don't think zebras": uncertainty, interpretation, and the place of paradox in clinical education. **Theor. Med.**, v.17, n. 3, p.225-41, 1996.

ILLICH, I. **A expropriação da saúde.** Rio de Janeiro: Nova Fronteira, 1975.

KELNER, G. Grupos Balint. **Pulsional**, n.125, p.35-48, 1999.

LUZ, M.T. **Natural, racional, social**: razão médica e racionalidade científica moderna. Rio de Janeiro: Campus, 1988.

MACHADO, M.H. (Org.). **Os médicos no Brasil**: um retrato da realidade. Rio de Janeiro: Fiocruz, 1997.

MINAYO, M.C.S. A prática médica sob julgamento ou as potencialidades da crise. **Rev. Bras. Educ. Méd.**, v.17, n.3, p.21-4, 1993a.

______. **O desafio do conhecimento**: pesquisa qualitativa em saúde. São Paulo: Hucitec. Rio de Janeiro: Abrasco, 1993b.

OLIVEIRA, N.F.M. Espaço grupal: uma área de experimentação. In: FERNANDES, B.S.; SVARTMAN, B.; FERNANDES, W.J. (Orgs.). **Grupos e configurações vinculares.** Porto Alegre: ArtMed, 2003. p.157-9.

OSORIO, L.C. Práxis grupal. In: _______. **Psicologia grupal**: uma nova disciplina para o advento de uma era. Porto Alegre: ArtMed, 2003a. p.115-61.

______. Entendendo e atendendo sistemas humanos. In: FERNANDES, B.S.; SVARTMAN, B.; FERNANDES, W.J. (Orgs.). **Grupos e configurações vinculares.** Porto Alegre: ArtMed, 2003b. p.57-62.

PITTA, A.M.F. **Hospital**: dor e morte como ofício. 2.ed. São Paulo: Hucitec, 1991.

POPULATION REPORTS. **Guia REALCE de Orientação/Aconselhamento.** Baltimore: The Johns Hopkins University, 1998. v.26, n.4 (Série J).

RAMOS, C.L.; CARDOSO DE MELO, J.A.C.; SOUZA SOARES, J.C.R. Quem educa quem? Repensando a relação médico-paciente. In: COSTA, N.R. et al. (Orgs.). **Demandas populares, políticas públicas e saúde.** Petrópolis: Vozes. Rio de Janeiro: Abrasco, 1989. v.2. p.146-64.

SÁ, A.C. **O cuidado do emocional em saúde.** 2.ed. Rio de Janeiro: Jorge Zahar, 2003.

SACKETT, D.L. et al. **Epidemiología clínica**: ciencia básica para la medicina clínica. 2.ed. Madrid: Médica Panamericana, 1994.

SANTOS, B.S. **Introdução a uma ciência pós-moderna.** Rio de Janeiro: Graal, 1989.

SCHRAIBER, L.B. No encontro da técnica com a Ética: o exercício de julgar e decidir no cotidiano do trabalho em Medicina. **Interface - Comunic., Saúde, Educ.**, v.1, n.1, p.123-40, 1997.

______. **O médico e seu trabalho**: limites da liberdade. São Paulo: Hucitec, 1993.

SOUZA, A.R.N. **Formação médica, racionalidade e experiência**: o discurso médico e o ensino da clínica. 1998. Tese (Doutorado) - Instituto de Psiquiatria, Universidade Federal do Rio de Janeiro, Rio de Janeiro. 1998.

TEDLOCK, B. Ethnography and ethnographic representation. In: DENZIN, N.K.; LINCOLN, Y.S. (Eds.). **Handbook of qualitative research.** 2.ed. London: Sage Publications, 2000. p.455-86.

TRIVIÑOS, A.N.S. **Introdução à pesquisa em ciências sociais**: a pesquisa qualitativa em educação. São Paulo: Atlas, 1987.

VIEIRA, E.M. **A medicalização do corpo feminino.** Rio de Janeiro: Fiocruz, 2002.

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