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Health, communication, and religiosity: some thoughts about its relation with death and sexuality

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Fernando Lefèvre
Professor at Faculdade de Saúde Pública, Universidade de São Paulo (School of Public Health, University of São Paulo),São Paulo, Brazil.
flefevre@usp.br

Eliane Brígida Morais Falcão
Associate Professor at Núcleo de Tecnologia Educacional para a Saúde, Universidade Federal do Rio de Janeiro - Nesc/UFRJ (Center of Education Technology for Health, Federal University of Rio de Janeiro), Rio de Janeiro, Brazil.
elianebrigida@uol.com.br

Ana Maria Cavalcanti Lefèvre
PhD in Public Health from Faculdade de Saúde Pública, Universidade de São Paulo (School of Public Health, University of São Paulo), and Head-Professor at the Instituto de Pesquisa do Discurso do Sujeito Coletivo- IPDSC (Institute of Research in Collective Subject Discourse), São Paulo, Brazil.
ana@ipdsc.com.br

Sandra Dircinha Teixeira de Araújo Moraes
Researcher, PhD in Public Health from Faculdade de Saúde Pública, Universidade de São Paulo (School of Public Health, University of São Paulo), São Paulo, Brazil.
sandradi@usp.br

Antonio de Pádua Passos de Freitas
MSc in Educational Technology for Health at Núcleo de Tecnologia Educacional para a Saúde, Universidade Federal do Rio de Janeiro - Nesc/UFRJ (Center of Education Technology for Health, Federal University of Rio de Janeiro), Professor at Faculdade de Medicina de Campos (Medical College of Campos), Campos dos Goytacazes, RJ, Brazil.

Abstract

We hereby introduce two projects that have resulted from empiric researches to which we have applied the methodology of Collective Subject Discourse. The contents of these two projects concern the theme of religiosity and its relation with health, including topics about how death is dealt with in hospitals, and about the use of morning-after pills. Regarding the topic about death, some medical students and faculty members from a large university hospital in Rio de Janeiro were interviewed. Meanwhile, young men and women of age 13 to 20, as well as health professionals, were asked about the use of morning-after pills in the south region of São Paulo. Our findings must not be generalized, therefore the research data show current dynamic processes about how death and moral values are understood (or should be understood), which cannot be easily framed within a strict scientific-technological perspective.

Keywords

Religiosity; health; death; medicine; morning-after pills

This work refers to two projects: one of them regards religiosity and its relation with young Brazilians' sexuality, focusing on the issue of the use of morning-after pills; and the other one regards how health professionals in hospitals deal with death, and how religion or religiosity is included in this manner.

Both projects derive from empiric researches that have in common, besides focusing on the proposed theme for this issue of Reciis, something else, less evident, which is death. On one project death is described in hospitals which concern science and technology; on the other project death is within an orthodox religious context, where the use of morning-after

pills is seen as abortion itself and, "therefore", associated with death, or man's decision (instead of God's) to stopping a new born child from coming into the world.

How would you advise this young religious woman?

The following work is part of the research project: "Teenage Pregnancy and morning-after pills: unveiling its understandings among teenagers and health professionals", research project supported by CNPq and by the Health Ministry (process 550763/2007-4, period 2007 to 2010, approved by the Ethics Committee at Faculdade de Saúde Pública (College of Public Health) (OF COEP/262/07)

Emergency contraception - EC, sometimes simply referred to as the "morning-after pill", is a contraceptive method for situations of emergency that can be used up to five days after sex relation have occurred, and where there is a risk of pregnancy. The sooner the use after sex relation, the more efficient it will be.

It is recommended when there has been rape, inappropriate or inconsistent contraceptive methods (for instance, forgetting to take the pill or put the diaphragm, or even its displacement), failure of methods (such as the breaking of a condom, or IUD expulsion) and/or in case of unplanned or violent sex (BRASIL, 2005).

The emergency contraception consists of synthetic hormone concentrated doses, already used in common oral contraceptive pills of ethinyl estradiol and levonorgestrel. It acts mainly inhibiting or delaying ovulation and impairing the mobility of sperm in the uterus, so its effect is prior to fertilization (BRASIL, 2005). It is made of hormones that prevent ovulation and sperm motility in the uterus, preventing fertilization and thus pregnancy. It can be used as ready-dose (levonorgestrel) with efficacy of 99.9% or through combined doses (method Yuspe) from oral contraceptive pills, with efficacy of 96.8%. According to the specifications of the Ministry of Health (2005), such effectiveness may vary depending on the time between intercourse and administration of EC. According to World Health Organization, the Yuzpe regimen has failure rates of 2% between 0 and 24 hours, 4.1% from 25 to 48 hours and 4.7% between 49 and 72 hours. For the same periods of time, the failure rate of levonorgestrel is significantly smaller, 0.4, 1.2 and 2.7% respectively. On the first three days the mean rate is 3.2% for the Yuzpe regimen and 1.1% for levonorgestrel. Between the 4th and 5th days, the failure rate of EC is certainly higher.

> *The high security of the EC is explained by the very short* ***time of treatment and*** *the* ***low total dose which is administered****. As for the Yuzpe regimen, the dose is about 35% of the total dose of a box of any low-dose contraceptive available in the market. Furthermore, many clinical and epidemiological studies have found rare severe adverse effects, confirming the safety of EC* (BRASIL, 2005).

The advantage most often mentioned is that it is the only safe method of contraception, with few contraindications, which can be used by women after intercourse. According to the standards of the Ministry of Health,

> *many clinical and epidemiological studies have found rare severe adverse effects, confirming the safety of EC. Even for more serious events, such as thromboembolism and stroke, investigations have found very little risk associated with its use.*

Morning-after pill, adolescence, and consumer society

In the context of contemporary societies dominated by the principle of consumption (LEFEVRE *et al.*, 2007) which is the case of the Brazilian society, and it is indeed, health is in part understood as resulting from the consumption of products and services destined to counterbalance the effect of the so-called unhealthy behaviors that can cause diseases, and other (such as unwanted pregnancy, for example).

"If you eat or drink too much, take antacid so and so", "if you have quarreled with your boss and got a headache, take the painkiller so and so," "if you look aged and full of wrinkles, do plastic surgery at clinic so and so" and... "if you forgot to take your pill and slept with your boyfriend, take the morning-after pill".

The so-called "morning after pill" is therefore functional in the context of today's consumer societies because, in the context of such societies, the prevention of diseases and mistakes resulting from pleasurable behaviors can be repositioned to after the event, avoiding not the pleasurable behavior itself, but instead, on the "next day", the ***effects*** of this behavior.

In fact, in consumer societies today, thanks to technology, it is possible to reconcile pleasure and consumption, the elimination of the "disease effect" either through the removal of disease-producing elements (cholesterol, sodium, sugar etc.) that can be found in products/behaviors of pleasure, such as in the case of the morning-after pill, for the subsequent neutralization of the effects of unwanted behaviors and consumption of products that are said to be unhealthy.

In the case of events involving sexuality, classic preventive behavior (use of condoms, IUD, pill etc.) always interferes,

somehow, in the pleasure associated with sex, sometimes, the morning-after pill can "avoid such inconvenience" once it does not interfere in the pleasure of sex because it is designed for afterward prevention of possible undesired effects (pregnancy).

Thus, one can imagine, in the case of "morning-after pill," a tendency on the part of adolescents to make the use of a necessarily provisional in permanent method.

The morning-after pill and the health professional

It seems clear, moreover, that as a matter of public policy for prevention of teenage pregnancy, all aspects involved in the administration of the morning-after pill flow into health professionals who provide health services to male and female teenagers in demand and who come in search of morning-after pills as emergency contraception.

However, given the novelty and the issue of who takes the morning-after pill, one can imagine that the professional understanding of the various issues involved is crucial to the success of such policies.

In this sense, some technical issues and even moral, ideological, and ethical resistance, may show on health professionals. Such questions need to be raised, known, and described in order for these professionals to provide information in the most appropriate manner to all teens about the morning-after pill.

Thus, we could hypothetically raise the following questions concerning the morning-after pill:

- How does it work: does it abort or not?
- How bad is it to our health?
- Could it substitute other methods?
- When is it appropriate to use it?
- To what extent is it effective?
- How can we have access to the product?
- How should we use it?

With regard to possible resistance among the professionals, there is prejudice related to abortion, to "uncontrolled" and unplanned sexuality.

The aim of this survey, which we partly show here, was to, in the context of the problem of teenage pregnancy and as part of emergency contraception, understand patterns of use of morning-after pills, and its social meanings to adolescents, well as knowledge, doubts, and resistance among health professionals who work with adolescents on this matter.

In the screen project, in order to rescue the social representations of young people of both sexes, and health professionals responsible for giving orientation in health units about the use of emergency contraception, we interviewed 320 adolescents in the southern area of São Paulo, and 70 public health professionals from different specialties that work with adolescents.

This population was interviewed by answering six cases or brief stories that were related to the various situations that could involve the use of morning-after pills and also a formal question on the subject (LEFEVRE *et al.*, 2009)

The method used for data processing was the Collective Subject Discourse (LEFEVRE *et al.*, 2005) with the software QUALIQUANTISOFT (2004).

We will present some results of the survey, selecting those strata of the Collective Subject Discourse (CSD) that had explicit references to religion.

We will focus here only on the qualitative aspects of responses, to the extent that the subject being discussed here regards the entries to religion more than its relevance in the total of CSDs.

Discussion

Religion represented in the screen project, both by professionals and by young people, is related in many different ways with the morning-after pill, and consequently, to sexuality.

It may, for professionals, represent both a barrier ...

> *.. If she has a religion that she wants to follow, so we cannot go against her religion ..*

> *And try not to interfere, because when it's about religion, we do not interfere much, right? People go with what they believe. If the her concept says she should not use it, then she should not use it.*

... As a conviction or belief that runs (or should run) parallel to the problems of practice and sexuality and the prevention of unwanted effects

> *We know that the morning-after pill is not abortive, so it's actually prejudice of the church, and not the actual pill. The pill itself is not abortive. Even being religious, she should take the pill because the pill was not going to kill the child, she would just keep her from being pregnant.*

The same applies to young people for whom religion can represent a barrier or ...

> *I would tell her not to take it? If she was a religious person she knew what she was doing at the moment, she knew what could happen to her, she knows right from wrong, she should be aware of what she did.*

She knows she was wrong. Now she should face the consequences. If she were pregnant, did it happen? Abortion is not the solution.

... or something that runs parallel to the "laic" life

I would tell her not to care about religion and take the pill, because that is not only about religion, but also about her health, welfare, and her family, and religion does not forbid it, because it would not be abortion.

Religion is one thing and pregnancy is something entirely different, that's why you have to take the pill. You have to prevent it. This religion business is a complicated thing, right? But we are in the 21st century, it is hard for us to take religious concepts into account, it's hard. I would tell her: you have to update, being religious and, say, using science, using reason, all at the same time, because you know about the risks of not using contraception, something like that, right? I would tell her that.

Survey data suggest that the practice of sexuality and its prevention, today, at least among young people and professionals who have a similar profile to the respondents, is not necessarily tied to a religious perspective, and it can, however, for a portion of the population, be (maybe still) tied to it.

Not only the importance of it, but also this specific armor of religion in its relation to human sexuality, is so remarkable about the Brazilian culture today and always, it is nevertheless a matter to be widely discussed.

It might be asked, for example, if other religions or religious variants relate to sexuality in the same way that Catholicism does, yet (at least in its most conservative, which is dominant) linked to the idea of chastity and sexuality tied to marriage (indissoluble) and the destination is in the "hands of God."

I would tell her not to take it; the Catholic Church does not allow it, right? If God wants her to have a kid, she will have one, otherwise she won't. I would tell her to wait, whatever was supposed to happen would happen. And if she got pregnant she would have to accept it, because she was religious. I would not tell some religious person to take the pill.

On the other hand, religion in the context of this research is often associated with decisions and values on what is ethic and moral.

I would tell her not to take it? If she was a religious person she knew what she was doing at the moment, she knew what could happen to her, she knows right from wrong, she should be aware of what she did. She knows she was wrong. Now she should face the consequences. If she were pregnant, did it happen? Abortion is not the solution.

The religious aspects associated with morning-after pills vary, but in this present article we can hypothetically say that the pill is perceived as a technology of prevention and therefore as something laic and pragmatic, that is increasingly governing all aspects of human life in general process of secularization. Thus religion and religious institutions may end up having less influence than imagined about how we see and use this new contraceptive method,

New research on the topic, with different populations may add to or disprove this hypothesis.

Medical professors and religious volunteers coping with death, suffering, and life science technologies: some reflections

Some researches that were conducted in a large university hospital in Rio de Janeiro allow some reflections on the social representations of medical faculty and medical students regarding the care provided to patients that are dying in the institution.

[1]In these investigations, it was found suffering experienced in day to day professional practice around the death of a patient, as shown by testimony of faculty physicians (FALCÃO *et al.*, 2009) and medical students (FREITAS, 2007). Perplexities, doubts and anxieties pervade the work of those who are faced with patients who, exhausted the resources of biomedicine, are close to death, which is accentuated by a perception of power attributed to the doctor. Such a situation appears clearly in the speeches of the people involved in the investigation: medical students at the beginning of the course and on the ninth period:

Dealing with human suffering is always distressing, very difficult, very frustrating, very stressful, a very painful experience. (...) It is always a great nuisance to inform the patient that he has an incurable disease that will progress to death(...) Death is horrible, if we could skip that part of medicine it would be better. Death tends to bring heavy emotional burdens, and in order to protect himself, the doctor keeps an emotional distance from his dying patient . It is hard to maintain an ideal state of equilibrium and make proper decisions. When we graduated, we are dazzled (...) and when we face the inevitability of death in our patients, we realize that we are not so powerful. And the wonder fades. This can

> *tinker much with us, it can be difficult to overcome, and cause profound impacts on our lives. I had great difficulty in accepting death and continuing the practice of medicine* (*apud* FALCÃO *et al.*, 2009).
>
> *The doctor has to show trust, peace, love, and help, as much as possible, so the patient can go through it easier. The doctor must be reliable and calm. The physician should monitor the patient trying to comfort him as best as possible, considering their emotions and not treating them like a walking disease. The doctor's role is to monitor the psychological evolution of his patient, providing comfort in every possible aspect* (*apud* FREITAS, 2005).
>
> (...) *It is complicated to go through the process of death.* (...) *It is the type of work that must be improved with time, through the practice of medicine.* (...) *Theoretically, through what was discussed in class, maybe I know how to deal with a terminally ill patient. But I think that patients should not be treated as a whole, but individually. I think it is necessary to practice in the profession to know whether, in fact, and I'm able to handle it.*(...) *I do not know, I will only know for sure when it happens.*(...) *but I'm sure that whatever I can do about it was not taught to me in Medical School* (*apud* FREITAS, 2005).

In these statements, we notice the perception of the groups investigated regarding the variety of personal and professional resources that dying patient care demands: psychological balance, familiarity gained by the exercise of professional practice, affective motivation to serve him who is approaching death. It is not without a reason that professors recognize that the contemplation of the dying man *tend to bring heavy emotional burdens* even when some refer to death as something 'natural'.

Note that the testimony presented, although originated in three different levels of medical experience, express similar perception: the monitoring of a dying patient requires specific efforts and therefore also good preparation that must be specific or specialized. The speeches, however, revealed no recognition of such preparation and also did not mention institutional situations that regularly occur in conversations or exchanges among colleagues about their experiences, concerns or anxieties about the topic of death or death of a human patient. Although some students have reported moments of reflection on the subject during the course of medicine, in the testimonies of students in ninth period, the lack of awareness about such reflection prevails:

> *It would be indeed useful to have a bigger approach to this manner, th problem is lack of time It would be interesting to have psychological counseling for students during periods of cohabitation with the University Hospital wards* (...). *As you can see from the above curriculum guidelines, the responsibility of the physician is huge, and sometimes scares an academic or a medical graduate. It's nice to work in units where the responsibility of the death process is shared with other professionals (*apud FREITAS, 2005).

Although the focus on both surveys allows showing the relationship between the activity of the medical faculty and the lack of personal resources for students and professionals regarding the death of their patients, this perception is not evident in the speech of professors:

> *(...) They* [the students] *do not know how to deal with a sick human being, and have no idea how to deal with death. Death is frightening. (...) They (...) are afraid, have prejudice (...). They make awkward comments about ill people. I observe that (...) They do know how to communicate with the patients. (...) It is a personal problem and a cultural matter. In Semiology we try to teach students how to build and sustain an ideal patient-physician relationship (...). But it requires students to have some control of communication skills, and they usually don't. (...) (...) That is why it is difficult for them to deal with patients, especially if the patient is very sick, with limitations, and dying. (...) They have no idea about what is happening. (...) When they realize what it takes to be a true doctor, they feel astonished (...)* (*apud* FALCÃO *et al.*, 2009)

It is not difficult to associate this discourse to the absence of exchanges in areas of the investigated university hospital, as well as to the perception that coping with patients' death is not learned in the context of medical training. Involved , in a non-shared way, with the suffering triggered by proximity to death, medical professors do not see themselves as clearly influential to the their students' conduct. The general perception among them approaches the conviction that representations about the death topic are formed prior to medical school and cannot be influenced by medical education.

In this scenario, where communication difficulties between medical professors and medical students are detectable, it may be thought that the reports collected by the contact with patients at serious risk of life or death, is restricted to health professionals. Although the respondents have mentioned about the relatives of patients, as well as those involved in this

matter, they did not mention about other doctors. However, we observed the presence of another agent at the studied hospital: the assistance of priests.

This service, which is daily and given by members of denominations Catholic, Evangelical, and spiritualist, is heralded at a small room with an agenda on the door. The room is about three square meters and contains a small table, seven benches, and six Bibles, is shared by the three different religious denominations. Once a week they celebrate a Catholic mass. The room is in a very precarious condition and, according to some information, being repaired at its supporters' expenses, since the hospital board does not consider such costs as part of the scope of institutional commitments. It was also reported that doctors do not decide about such treatment, since it is a patients' right guaranteed by law.[2] One of the religious people that provide care to patients presented the outlining of the service they provide:

> *Priority is always of medical care (or other health professionals), even though we are at our office during working hours. We try not to bring problems, but only serve the suffering of a patient receiving, for example, news that has cancer and finds himself alone and distressed. Most professionals seem to understand our job, but some look at us in a criticizing manner.*

Although about 75% of the investigated medical faculty has indicated that they believe in God (in the context or not, of any religion), religious discourse has not been identified (or terms related to religious beliefs) among the professionals themselves nor they mentioned about the religious service formally provided in the hospital. Is this another sign of conflict and the difficulties of communication among those involved in the care of patients admitted there?

The investigated hospital is an important center of scientific research dedicated to think about the maintenance of life or the restoration of health-assurance processes. Would talking about death and religious beliefs, in that environment, be a conduct close to betraying the scientific commitment in a life sustaining context? Would it be an undesirable behavior in an academic setting?

In the surveys that were conducted, there was another important issue regarding the care of terminal patients: the technologies of biomedicine. The commitment to sustain life through their use proved to be one element that, although serving as an evidence of the hospital service's quality, could also be interpreted as an obstacle to facing death, as listed in the following report: (...) *It is important to rethink (...) the medical education (...). This school focuses excessively scientific and technological issues* (*apud* FALCÃO *et al.*, 2009).

From the collected statements and the reflections they have provided, it is possible to apprehend an institutional space where the communication processes that cross it, involving patients, doctors, professors, medical students, and religious leaders appear to include a tacit agreement to recognize neither the dying situation's reality itself, nor the suitable professional behaviors/procedures regarding a patient that dies. Bioscience, with its technologies, there emerges as an "autonomous" actor: yet perceived as 'excessively used' by the medical school, they does not seem to be recognized as an instrument of deliberate use by the professionals themselves.

The apparent silence surrounding death in the context of this hospital shows visible limitations and distortions in communication processes already installed: different aspects of care to patients are not perceived and there is little talk about the issue. There seems to dominate the perception that both the topic and the experience related to it are an intimate and individual matter. Nevertheless, the human demand for communication, the use of religious assistance and the criticism expressed throughout the collected testimonials, seem to open shortcuts to the route to be traveled, indicating there is a need, which they haven't objectively spoken about, to communicate, or to access the Other. What Other could this be, if not the suffering involved in such an environment? This suffering that, according to the testimony, involves all people in the hospital who face the issue of the proximity to death: the patients, the doctors, professors and their pupils, the medical students.

Death is part of the human experience. The statements of the medical faculty and students, presented here, although they express this understanding, show that its explicitation in the medical environment is quite deficient. Reflections built around the testimonies gathered in the two groups surveyed in the investigated hospital indicate that two 'agents' - biomedicine technologies and human suffering - must be integrated in communication processes involving care to the terminal or high risk patient, so that this care is developed with greater integrity. This integrity involves establishing communication processes in which experiences, feelings, emotions, values, beliefs and religious convictions can be included. If established as a dialogue topic, the integrity of the human experience of faculty physicians and medical students, as well as the patients', will be favored because their roles as both subjects and authors for the actions and everyday experiences would be evidenced.

Final thoughts

According to the results of this research project, the secular world within pragmatic decisions are taken based in science and technology can be understood among us Brazilians, nowadays, in the frame of a generalized process of secularization that tends to occupy every single aspect of human life, leaving to religion those (or as shown on this survey, "non-invested" aspects in the hospital) concerning human condition, as death, for instance. And thus, death ends up being the incomprehensible and failure aspect of technology (in case of medicine).

On the other hand, if the social representation of religion regarding the aspect of sexuality is, among other things, believing that human beings' coming into the world, or not, is a decision that is up to divinity, such representation is contrary to that of the prevention of diseases, or, in the case of the morning-after pill, of unplanned pregnancy.

Finnally, should we ask ourselves if there is legitimate space for institutionalized influences of religion in the modern world, and, more specifically, in the health/disease field?

Or in order to fit this modern world, namely the health field within it, should religion be resignified?

Notes

1. We used the Social Representation Theory (MOSCOVICI, 2003). Professors were interviewed and students answered a questionnaire. Some observations made at the hospital analyzed were added to the data collected which were studied from the methodological proposition by LEFÈVRE & LEFÈVRE (2003), the Collective Subject Discourse (CSD).

2. Law n. 9.982, July 14th 2000, regards the religious assistance in hospital environments that may be public or private, as well as military and civil prison facilities.

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