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Research Article

Women's group: impact of collective care in the individual assistance to a high user of health services

Grupo de mulheres: impactos do cuidado em coletivo na assistência individual a uma usuária hiperutilizadora

Grupo de mujeres: impactos del cuidado en colectivo en la asistencia individual a una usuaria hiperutilizadora

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Abstract

Introduction: The term high user of health services has an extensive interpretation range. Still, in general terms, it refers to a person with a higher frequency of doctor's visits than expected for their age group or sex. For family health services and teams, considering the complexity of alternative contexts, it is essential to identify a rise in the frequency of a subject's office visits so that factors that should be reconsidered in care flow can be addressed. Among the responsibilities of primary health care professionals is organizing patient groups. These groups play a significant role in broadening the patient's understanding of care spaces, demonstrating that care is not confined to individual consultations. In this study, patient groups are viewed as vital tools in creating a safe space for sharing negative experiences and collectively developing coping strategies for common demands. Upon identifying a high user of health services in the Santa Cecília practice and other units of the Hospital de Clínicas de Porto Alegre complex, the team realized its limitations in providing the necessary care. As an alternative, it established a women's group with a specific objective: to provide comprehensive care and support. **Objective:** To describe the profile of a high user of health services and the motivation to include them in a group, as well as describe the development of the mentioned group and assess the patient's perceived effects in terms of health needs and distress manifestations after 6 months of participation. **Methods:** A case study was conducted on the basis of a single user and her participation in a women's group for 6 months. We used the participant's observations, analyzed observation contents, and reviewed her health records to assess her case follow-up and condition. **Results:** We observed a reduction in the frequency of doctor's visits, number of complimentary tests, and prescription use in all specialties. Observation records suggested that the group developed a strong support network, which seems to have contributed to the improvement of the user's clinical and emotional conditions. **Conclusions:** We could observe the benefits of a women's group practice on the user's health. This study contributes to primary health care by providing evidence on how to quantify and qualify this care tool to support the implementation of collective spaces of care for various stakeholders such as public administration, health care teams, and the public.

Keywords: Self-help groups; Group processes; Primary health care; Women's health.

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Resumo

Introdução: O termo hiperutilizador possui uma gama extensa de interpretações, mas, em termos gerais, é utilizado para designar a pessoa que consulta com frequência superior à expectativa para aquele grupo etário e de gênero. Para a equipe de saúde da família, problematizar o aumento na frequência de consultas de determinadas pessoas, considerando a complexidade dos diferentes contextos, é um passo necessário para identificar elementos a serem reconsiderados no cuidado. Entre as atribuições dos profissionais que atuam na Atenção Primária à Saúde (APS), encontra-se a realização de grupos, em uma lógica de superação das consultas individuais como o único espaço de cuidado. Neste estudo, o grupo é considerado como uma ferramenta assistencial em ambiente seguro de compartilhamento de sofrimentos e vivências, bem como a geração de estratégias de enfrentamento a demandas comuns. Com a identificação de uma paciente hiperutilizadora da unidade básica de saúde Santa Cecília e dos demais serviços do complexo Hospital de Clínicas de Porto Alegre, e a constatação dos limites da equipe em oferecer cuidado ao seu quadro, criou-se um espaço de grupo de mulheres como alternativa assistencial. **Objetivo:** Descrever o perfil da pessoa hiperutilizadora em questão e as motivações para incluí-la em um grupo, assim como descrever a criação desse grupo e analisar os efeitos percebidos nas demandas de saúde e nas manifestações de sofrimento da paciente após seis meses de participação. **Métodos:** Estudo de caso desenvolvido baseado em uma usuária singular e em sua participação no grupo de mulheres durante seis meses, utilizando-se observação participante, análise de conteúdo dos registros de observações e revisão de prontuários para avaliar a evolução do quadro de saúde e de sofrimento da usuária. **Resultados:** Constatou-se a redução do número de consultas em todas as especialidades, assim como do número de exames e uso de medicamentos. Os registros de observações sinalizaram que o grupo criou uma forte rede de apoio e suporte, que parecem ter contribuído para melhorar o quadro clínico e emocional da usuária. **Conclusões:** Foi possível identificar o benefício do grupo para a saúde da usuária. Este estudo traz contribuições aos profissionais da APS sobre como quantificar e qualificar essa ferramenta de cuidado, a fim de respaldar a potencialidade dos espaços grupais junto à gestão, à equipe e à população.

Palavras-chave: Grupos de apoio; Processos grupais; Atenção Primária à Saúde; Saúde das mulheres.

Resumen

Introducción: El término hiperutilizador tiene una gama extensa de interpretaciones, pero en términos generales es utilizado para designar a una persona que consulta con más frecuencia de lo esperado para ese grupo de edad y de género. Para el equipo de la salud de la familia, problematizar el aumento de la frecuencia de consultas para determinadas personas, considerando la complejidad de los diferentes contextos, es un paso necesario para identificar elementos a reconsiderar en la atención. Entre las responsabilidades de los profesionales que actúan en la Atención Primaria de Salud, está la organización de grupos, en una lógica de superación de las consultas individuales como único espacio de atención. En este estudio, el grupo es considerado como una herramienta de cuidado en ambiente seguro para compartir sufrimientos y experiencias, así como generar estrategias para afrontar demandas comunes. A partir de la identificación de una paciente hiperutilizadora de la unidad básica de salud Santa Cecília y de otros servicios del complejo del Hospital de Clínicas de Porto Alegre y de la observación de las limitaciones del equipo para brindar atención a su cuadro, se creó un espacio grupal de mujeres como una opción alternativa de atención. **Objetivo:** Describir el perfil de la persona hiperutilizadora en cuestión y las motivaciones para incluirla en un grupo, tal como describir la creación de este grupo y analizar los efectos percibidos sobre las demandas de salud y en las manifestaciones de sufrimiento de la paciente después de 6 meses de participación. **Métodos:** Estudio de caso desarrollado a partir de una sola usuaria y su participación en el grupo de mujeres por 6 meses, utilizando la observación participante, análisis de contenido de registros de observaciones y revisión de historias clínicas para evaluar la evolución de la condición de salud y del sufrimiento de la usuaria. **Resultados:** Hubo reducción del número de consultas en todas las especialidades, tal como del número de análisis y uso de medicamentos. Los registros de observaciones señalaran que el grupo creó una fuerte red de apoyo y soporte, que parecen haber contribuido a mejorar el cuadro clínico y emocional de esta usuaria. **Conclusiones:** Fue posible identificar el beneficio del grupo para la salud de la usuaria. Este estudio trae aportes a los profesionales de la APS de como cuantificar y cualificar esa herramienta de atención para apoyar el potencial de los espacios grupales junto a la gestión, al equipo y a la población.

Palabras clave: Grupos de autoayuda; Procesos de grupo; Atención Primaria de Salud; Salud de las mujeres.

INTRODUCTION

The term high user has a wide range of interpretations, and there are even different nomenclatures for the concept, such as “people who have frequent doctor’s visits”.[1] In more general terms, it is used to designate a person who sees the doctor more frequently than expected for that age group or sex. This reference can vary from a subjective point of view of the professional (those people who cause discomfort by overloading the professional or causing a feeling of dissatisfaction due to the number of consultations) to a quantitative assessment based on the number of office visits.[1] In quantitative terms, ways of creating criteria for defining high user are suggested: frequency of consultation above the 97th percentile in relation to the population standard or people who visit the doctor between seven and twenty times.[1] Epidemiologically, frequent patients have chronic diseases and need medication management; furthermore, women tend to visit the doctor more. There is also the suggestion that consultation rates are higher for people who do not understand what causes their symptoms.[1]

For the physician and the entire family health team, questioning the increase in the frequency of doctor's visits for certain people generates a review of concepts and perceptions associated with these individuals, with the aim of identifying factors that should be reconsidered in their care. A key point is to assess whether the increase in the number of consultations is temporary or recurrent, and also whether these encounters generate an improvement in the health situation and reduce the patient's condition. Thus, it is the team's responsibility to question itself about other possibilities for managing and caring for this individual. To operationalize possible changes in care, the family and community physician needs to recover the skills present in their bag, which includes equipment that falls within the scope of hard technologies (stethoscope, sphygmomanometer); with tools that are in their head, consisting of soft-hard technologies (clinical and epidemiological); and with those that develop in the relational space between physician and user, foundations of the bond (soft technologies).[2,3]

The ability to use the doctor's bag, making the most of all the tools, demands a conscious effort from the physician to deal with the overusing individual. In a proposal for an integrated clinical model, proposed by Ramos and Carrapiço,[1] the self-reflective capacity of the professional is given importance, including the perception of their weaknesses and limitations. Furthermore, the need to understand the resources of the unit and the health system as a whole, the community resources and the social context is indicated. We can extend the issue of the overusing individual to another concept: that of "difficult patients". In general, patients considered difficult are those subjectively perceived by the professional as generators of negative emotions; high use individuals may be included in this category, although not exclusively. The interface where these two concepts meet is the domain of mental or psychosocial problems — people who have frequent doctor's visits often have an increased burden of distress, just as the "difficult" ones also reflect this characteristic.[1,4] The other connection between these concepts is that both highlight the weaknesses of the biomedical model that stigmatizes people, blocking reflection on practice.[4]

On the basis of this idea, it is understood that people who have frequent doctor's visits have a combination of physical, emotional and social symptoms, often presenting with vague and non-specific symptoms. Freitas, Dal Magro and Felipi[5] point out the relationship between somatization and overuse of health services, which translates into unexplained symptoms and non-specific reasons for consultation. Physical complaints are representations of the user's psychological distress which, if not understood by the professional who treats them, lead to behaviors that are not very effective and even iatrogenic.

There is little certainty about effective interventions to modify the tendency of users to have frequent office visits; however, there is a consensus that it is necessary to use self-awareness of limitations and to recover the versatility of the physician to try to change this pattern.[1] Depending on the preparation, competence, workload, approach style, and relational and communication skills, the professional becomes the protagonist of the high user's drama, and can significantly improve or worsen the situation. Therefore, it is important to discuss possible instruments to provide more care for these people.

During the residency in Family and Community Medicine (FCM) at the Santa Cecília Basic Health Unit (UBS) in Porto Alegre, the main authors came across the experience of frequent consultations of some people. The case of one of them, specifically, motivated reflection on the practice of care offered, leading to the realization that individual consultations were not sufficient to resolve the demands and problems of this patient. She had a chronic condition related to multiple factors, and used not only the UBS, but also many specialized services in the relentless search for improvement of her illnesses, but without success. Verifying that this was a complex case of a hyperusing person, but not the only one, we sought to identify other people in this same category of frequent users. This movement made it possible to perceive a certain profile, characterized by women in prolonged psychological distress, who saw the doctor frequently and who had a fragile support network. Based on considerations about possible assistance instruments aimed at this identified profile, we thought about creating a group in the form of a space for coexistence, sharing and listening, which would welcome these women, and which could also be a way of reducing the frequency of consultations.

Groups are a type of intervention that can occur in primary health care (PHC) and enable the development of actions that break the logic of individual consultations as the only space for care. In the collective environment, health education, integration, exchange of experiences and expansion of the support network are offered.[6] The group approach qualifies health care, considering that expanding the capacity of health professionals to care requires breaking the traditional biomedical hierarchy and investing in processes in which care values the knowledge of individuals and teams.[7] People talking in a group share problems and generate solutions to the problems they have, on the basis of popular knowledge, originating from their own experiences.

According to Zimerman and Osório,[8] the characterization of a group is based on many intrinsic elements, being more than just the sum of people, but an entity in itself. In addition, the people in the group come together with a common objective that is clear to everyone, with prior agreements and rules to be observed, behaving as a whole. When operating a group, some recommendations must be followed for its potential success: appropriate selection of individuals for that objective, framework (such as rules and combinations), management of resistance that may arise in the group field (which is resolved by having clarity about the roles of each person), management of transferential aspects and clear communication, are among them. Groups, as described above, differ from broader collective practices or activities that may occur within the scope of PHC. Such as meetings between health professionals or with the public, local council activities, health education groups, workshops, physical activity groups, group care for health conditions, collective procedures such as anthropometric assessment, as well as moments of social mobilization.[9]

In short, this article presents an analysis of how the experience of caring for a high-utilization patient generated reflection on differentiated care tools. This occurred in the face of a chronic multifactorial condition, with little improvement or relief of problems, despite a large number of individual consultations, leading to the creation of a new care space outside the office. The objective of this study was to describe the profile of the hyperusing person in question and the motivations for including them in a group, as well as to describe the creation of this group and analyze the effects perceived in the health demands and manifestations of the patient's condition after six months of participation. As secondary objectives, we intended to discuss the potential of the PHC as a care coordinator and as a space that enables various care technologies, with emphasis on groups.

METHODS

We conducted a case study that analyzed the process of the participation of a person who overuses the service in a women's group at a UBS, and the perceived effects on her health.

The women's group was created in a format in which all participants could talk to each other, in a different way from the common group practices provided in health services — focused predominantly on guidance and lectures, centered on the figure of the professional.[10] It had the following basic guidelines: to be a group for women, with a maximum of 10 participating users, with a profile of prolonged mental distress and little social network and family support. In the group, facilitation procedures were carried out, and a protected place and an environment of psychological safety were provided so that users could exercise their autonomy and co-responsibility in sharing problems. Agreements on how the group would operate were defined jointly by facilitators and participants. Some of the arrangements made were: introducing themselves so that everyone could get to know each other, defining rules and combinations, and group objectives, among others. This made it possible to provide an environment of psychological safety that guaranteed the free expression of thoughts and feelings regarding the unique issues in the participants' lives, while also enabling conversation among all: in the same place where they shared difficulties, they also shared and created solutions.

The group meetings took place weekly, lasting 1 hour and 15 minutes, always on the same day of the week and time. For this study, a six-month period was analyzed, from September 2022 to February 2023. This group was characterized as open, with no pre-defined themes, with the subjects arising spontaneously by the participants, based on open-ended trigger questions raised by the facilitators at the beginning of each meeting. The facilitators were the FCM residents, with observation by a responsible advisor (all authors of this work) every two weeks. In each meeting, the residents alternated the roles of facilitator and observer. The one who was in the role of observer was also responsible for the observation records, which were stored in the cloud using Google Drive software. The records were reviewed and discussed biweekly with a supervisor, a specialist in groups at the PHC, who was also the author of this work. Furthermore, a WhatsApp group was created by the participants, in which the messages circulated freely, and the analysis of these was done retrospectively after the final six-month period.

The case study, as a research method, is characterized by detailing a research unit, deepening the analysis and discussion to create change based on a real experience.[11] To this end, both quantitative and qualitative data are used to clarify certain aspects. The participant observation technique was used, in which written records of the group meetings were made. These observation records, as well as those of the collective conversations that circulated on the WhatsApp application, were analyzed through content analysis. The analysis carried out was based on a set of techniques that seek to make inferences about a given process replicable and valid. According to Minayo,[12] content analysis seeks to analyze the reading of the statements to achieve greater depth, going beyond the meanings manifested in the material. In addition, a review of medical records was performed in the computerized system of the Hospital de Clínicas as a source of information used to assess changes in the patient's health pattern (number of consultations, reasons for consultations, use of psychotropic drugs, change in symptom pattern) from the beginning of participation in the group until the end of this study (six-month period).

All participants signed an informed consent form, including the patient who was the focus of this study. This research project complied with CONEP standards, according to Resolution No. 466/12 of the National Health Council, and was approved by the Research Ethics Committee of the institution involved (CAEE: 65253522.1.0000.5327).

RESULTS

The patient we dealt with was a 68-year-old white woman, married, with two children, retired (previously working as a caregiver for older people, in addition to having a degree as a nursing technician), Catholic, with a high school education. She had been followed at the UBS since 2014, having started the follow-up with the main author of this article in January 2022. During this period (eight years), it was possible to extract from her medical records (accessible through the AGHuse program of the Hospital de Clínicas) consultations with 14 medical specialties, in addition to consultations with nursing, psychology and social service professionals, totaling 356 consultation records (an average of 44 consultations per year) only in the services of the aforementioned hospital. During this same period and hospital, she underwent 12 surgeries; of these, 10 were orthopedic. Approximately 465 examinations (laboratory and imaging) had been requested since 2013 — an average of 51 examinations/year. In the municipal network, 16 consultations were carried out in seven years, including two more medical specialties, different from the 14 already consulted. In addition, a private psychiatrist was seen for many years.

At the first contact, she presented with the following list of problems: personality disorder, recurrent depression, chronic musculoskeletal pain, fibromyalgia, gonarthrosis, carpal tunnel syndrome, trochanteric bursitis, tuberculosis, gastroesophageal reflux disease, investigation of systemic disease and dyspnea. The list of medications already used and without success included eight substances, and at that time she was using nine drugs, including vitamins, antidepressants and pain modulators. Despite evaluations and monitoring for a certain period of time, the patient did not show any response to her demands and/or symptoms, which ended up resulting in her being discharged from 12 of the 14 specialties consulted. It is important to clarify that, even though there was a record of "discharge" for the patient, this did not mean, in practice, that she was unable to continue being seen by these services, since the person is not prohibited from being referred again or from attending the location (such as the pain service, for example, which has open doors on certain days). The "discharge" records examined in the medical records contained observations by professionals regarding the low response or the need to be referred to another specialty.

During the first follow-up appointments with the resident/author, who became the attending physician, the diagnoses and complementary examinations were reviewed, which led to the list of problems being reduced to three basic issues: cluster B personality disorder (diagnosis corroborated by the psychiatrist who was treating her), chronic fatigue syndrome, and chronic pain syndrome. These last two syndromes led her to more frequent appointments at the PHC, always without improvement.

Initially, the offer of the group as a therapeutic option and care tool was not well received by the patient. She thought that she would not feel comfortable in this collective space; in the same way, she saw this alternative as too simplistic, considering that she had already undergone the most advanced treatments (medication and even electroconvulsive therapy). For the attending physician, this resource emerged as a new therapeutic option (even though the user did not have the best profile to participate in a group, as she did not initially want to), because, in a four-month period of care, the medications had been corrected and optimized; offered were dry needling, auriculotherapy, psychoeducation on chronic pain, considerations on cannabis, massages, guidance on exercises and stretching, all with very little success.

Initially, after agreeing to participate in the group, the user only attended every two weeks in the first month, contravening one of the group rules (a contract made between participants and facilitators at the first meeting and revised as necessary). Following the second month, there was a change in her personal perception of events, where she writes on WhatsApp "*I am beginning to understand what a therapeutic group is (...) Who knows, maybe I will start to change my opinion about 'group'*" or "(...) *reflecting on the mysteries of the impact of how it is born, emerging a group of people who have never met before but who seem to have known each other for a long time and who will meet again one day*[1]".

During a consultation, after three months of participating in the group, the user complained of a symptom that had not appeared previously — intense stomach pain and burning sensation in the chest. During the conversation, we remembered that another participant in the group commented that it seemed as if the patient "*had a lot of things stored up*", after she commented that "*she swallowed a lot of things*". In the next group meeting, the patient brought up a traumatic experience that occurred in her childhood, which she had rarely shared in her life. Despite the content with a high emotional impact, there was containment and immediate support from the group. On the same day, she wrote: "*Girls, I was very confused. Everything comes to mind. SORRY (...) Gosh, there are only 6 people who know about this. 3 cousins... who didn't believe it, doctors (...) and now you (...) It seems like I'm 12 or 13 years old and I feel lost"*. Here, we observe the presumed relationship between the increase in office visits (description below) and mental anguish. It is worth mentioning that the patient never mentioned the reflux complaint again.

This episode helps in understanding the association between traumas and emotional pain and physiological symptoms: quantitatively, it is possible to analyze the patient's consultations in relation to what was happening in the group. As soon as she started, consultations varied from zero to one per month; at the end of the third month, after the above-mentioned event, the patient went to the service five times due to acute pain. In the two weeks following the traumatic report, she missed the group and, on the other hand, went to the UBS complaining of unbearable pain. Therapeutically, she showed improvement in consultation after empathic listening.

When she manages to return to the group meetings, the consultations gradually decrease. *I came to the group because I was forced by Dr. (...); her dedication, focus, wisdom, determination, persistence and a lot of stubbornness managed to bring people (us) together to help and try to make us have a better quality of life. Helping us overcome our fears, traumas, anxieties, bringing back to us the confidence, the faith that YES, it is possible to believe in the possibility that tomorrow will be better*."

Through the evaluation of medical records, it was possible to determine visible results in the number of consultations in all specialties, as well as in the number of exams and medication use of the patient described here. In previous years, it was found that there were an average of 44 consultations/year, including PHC and secondary care (focal specialties); more specifically, in the six months prior to the beginning of the group, the patient consulted 20 times. In the six months of participation in the group, even though the patient did not attend all the meetings, the consultations fell to eight (five consultations with an ophthalmologist were excluded from the analysis, since the user underwent cataract surgery already scheduled prior to the beginning of the group), totaling a decrease of 60% in visits compared to the previous semester, and 81% compared to previous years. In terms of exams, even with the surgery, six were requested (in the general context of all consultations, both in the specialties and in PHC), observing a decrease of 79% in relation to the previous semester (29 exams requested). In the last month of the group, there were no consultations at the UBS, only one intra-articular application for trigger finger, previously scheduled. The user had been doing the guided exercises at home, spontaneously requesting a reduction in the dosage of pain-modulating medications by 25%.

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[1] Spelling errors have not been corrected to maintain the authenticity of the original messages.

DISCUSSION

This is not a simple case, and therefore we find it relevant to present it as an example of people who need expanded care that can and should be offered in the PHC, valuing the inclusion in the community that characterizes FCM. During the meetings, we were able to objectively and subjectively evaluate the change in the health profile and problems of the user who was the focus of this case study, as well as to demonstrate how group work promotes interaction between diverse people, with different life stories and unique knowledge. The results obtained, which show a decrease in the number of office visits, examinations and medications, can be attributed to a set of factors; among them, the strengthening of the bond with the PHC, the expansion of care strategies, listening and support network provided through participation in the group, and also as a result of the centralization of care in the UBS with defined professionals. Regarding the periods in which there was an increase in the frequency of consultations, there seems to have been a relationship with triggers activated in the group. Ramos and Carrapiço1 warn about trigger factors related to the emotional and health needs of high users, which lead to an increase in visits. There is growing evidence of the association of emotional trauma with persistent pain, and it is even a predisposing factor for chronic pain.[13]

We found that the group space enabled the exchange of experiences that led to subjective transformations that are difficult to achieve with individual care. As long as it is well structured in terms of purpose and management, this type of care provision in PHC enhances it and translates it into visible results, enabling, above all, a support network. Thus, the group becomes a place for strengthening health and preventing diseases.[6] The therapeutic possibility of group care is evident in the patient's statement, "(...) *I'm starting to feel that sharing the weight and problems with you makes me feel lighter. Thank you very much*."

Group activities also aim to provide social support and create a network. There is cumulative evidence demonstrating that social ties and the feeling of belonging to a group, and of feeling cared for as a consequence of this interaction, are positively associated with mental and physical health and life expectancy.[13] Although some authors indicate that people's social and emotional needs worsen pain and fatigue,[13] there are few reports of the power of collective care. It is expected that this work will show that PHC should be strengthened by the joint work of professionals, to truly establish itself as an organizer of care. The group, as a strategy, is configured in itself as an extraordinary power; however, it is necessary to dedicate oneself, to facilitate conversations between participants, following recommended procedures.[14] In the literature on group psychology,[8,15] there is consensus on the need to establish rules and arrangements for coexistence between group participants (a setting) that guarantee a climate of psychological safety. In addition, they agree on a set of technical procedures that enable and encourage circular conversation among everyone and the possibility of reflection, learning and insight.

In this case, it is important to highlight the issue of sex. Although some organic aspects are essential for addressing women's health, women are known to be the main population seeking care in PHC, as corroborated by the 2019 National Health Survey.[16] Many women with mental health problems encounter problems and barriers in addressing issues inherent to being a woman. As seen, group approaches, when facilitated according to the recommended procedures,[14] offer a safe environment for sharing distress and experiences, such as abusive romantic relationships, emotional breakups, situations of violence, abortion, as well as other issues that affect women's lives and produce vulnerability. Furthermore, these are spaces that provide opportunities for the generation of strategies to address common demands.[7]

One of the greatest difficulties encountered in the creation of groups in PHC, described in the literature — and which we also found in a pronounced way in our experience — is the understanding that individual care should be prioritized.[7] There is a certain trivialization around groups, making them more subject to unfavorable situations — making it difficult to find physical space and schedule, devaluing the professional who proposes them, not having any type of specific financing, not providing protected space in the routine of professionals for this activity. In fact, any union of people cannot be considered as a cohesive “group” with specific objectives for care. There needs to be a certain horizontality, alignment of ideas and thoughts on the part of the team.[7] In addition, the PHC scenario in each location must be considered. Often, what happens is that the potential of a collective activity is reversed in favor of classic forms of care and their stagnant and doctor-centered concepts, not only due to a lack of political interest but also due to ignorance on the part of the team, which does not seek to update technologies. Furthermore, it is worth highlighting that there is a lack of knowledge among doctors about how to facilitate groups, since this has no place in their training.[7,14] With this study, we seek to bring contributions to PHC professionals on how to quantify and qualify this care tool, to support the potential of group spaces with management, the team and the public.

CONCLUSION

The case studied, through its particularities (a person who overuses health services, with various health problems and does not respond well to management, who initially did not express a desire to participate in a therapeutic group, and whose participation resulted in visible positive impacts), brings new evidence that soft technologies can produce health, associated with hard and soft-hard technologies, used by the doctor. In addition, this work offers the doctor, if they wish, guidance on how to form a user group, so that the group environment offers conditions for the people who participate to help each other in solving the problems.

CONFLICT OF INTERESTS

Nothing to declare.

AUTHORS’ CONTRIBUTIONS

EPS: Conceptualization, Data Curation, Formal analysis, Writing – original draft, Writing – review & editing. MOT: Conceptualization, Data curation, Writing – review & editing. CG: Methodology, Supervision, Writing – review & editing. NS: Methodology, Supervision, Writing – review & editing.

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