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Which family and which community? Reconfigurations of Family and Community Medicine in supplementary health

Qual família e qual comunidade? Reconfigurações da Medicina de Família e Comunidade na saúde suplementar

¿Qué familia y qué comunidad? Reconfiguraciones de la Medicina Familiar y Comunitaria en salud complementaria

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Abstract

This is a cartographic study that sought to analyze the performance of family and community physicians in primary care of supplementary health, carried out through diaries and cartographic interviews between March 2021 and January 2022, which were weekly processed in research meetings. This study was based on the analyzers: 'territory', 'family' and 'community'. It was noticed that territorialization and family approach gain other contours in Family and Community Medicine practiced in supplementary health. In addition, it was found that some of the typical tools of basic care – such as home visits, health education, genogram, ecomap and health surveillance – were not used in supplementary care or had other dissonant applicabilities of the recommended model. It was concluded that Family and Community Medicine in supplementary health approaches a more clinical practice, with loss of power from the power lines that constitute such specialty, tending to a less familiar and community medicine.

Keywords family medicine and community; supplementary health; territorialization of primary care.

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Resumo

Trata-se de um estudo cartográfico que buscou analisar a atuação de médicos(as) de família e comunidade na Atenção Primária da saúde suplementar, realizado por meio de diários e entrevistas cartográficas entre março de 2021 e janeiro de 2022, processados semanalmente em reuniões de pesquisa. Tal estudo se deu com base nos analisadores: 'território', 'família' e 'comunidade'. Notou-se que a territorialização e a abordagem familiar ganham outros contornos na Medicina de Família e Comunidade praticada na saúde suplementar. Além disso, verificou-se que algumas das ferramentas típicas da Atenção Básica – como visita domiciliar, educação em saúde, genograma, ecomapa e vigilância em saúde – não eram utilizadas na atenção suplementar ou tiveram outras aplicabilidades dissonantes do modelo preconizado. Concluiu-se que a Medicina de Família e Comunidade na saúde suplementar se aproxima de uma atuação mais clínica, com perda da potência das linhas de força que constituem tal especialidade, tendendo a uma medicina menos familiar e comunitária.

Palavras-chave medicina de família e comunidade; saúde suplementar; territorialização da atenção primária.

Resumen

Se trata de un estudio cartográfico que buscó analizar el desempeño de los médicos de familia y comunidad en atención primaria de salud complementaria, realizado a través de diarios y entrevistas cartográficas entre marzo de 2021 y enero de 2022, que fueron procesados semanalmente en reuniones de investigación. Este estudio se basó en los analizadores: 'territorio', 'familia' y 'comunidad'. Se observó que la territorialización y el enfoque familiar adquieren otros contornos en la Medicina Familiar y Comunitaria practicada en salud complementaria. Además, se encontró que algunas de las herramientas típicas de la atención básica, como las visitas domiciliarias, la educación sanitaria, el genograma, el ecomap y la vigilancia sanitaria, no se utilizaron en la atención complementaria o tenían otra aplicabilidad disonante del modelo recomendado. Se concluyó que la Medicina Familiar y Comunitaria en salud complementaria se aproxima a una práctica más clínica, con pérdida de potencia de las líneas eléctricas que constituyen dicha especialidad, tendiendo a una medicina menos familiar y comunitaria.

Palabras clave medicina familiar y comunitaria; salud complementaria; territorialización de la atención primaria.

Introduction

Medical specialties are constituted through their approximations or disputes with different areas of knowledge. In the case of Brazilian Family and Community Medicine (FCM), we can mention relations with General and Community Medicine (GCM), Preventive and Social Medicine (PSM) and Collective Health (Andrade, 2017). In addition, there is a lot of proximity to the theoretical elaborations and practical experiences of Anglo-Saxon Primary Health Care (PHC), with Brazilian Basic Health Care (BHC) and other related levels of care in various health systems around the world (Segalla, 2021).

The concept of PHC was inherited by the Conference in Alma-Ata, carried out in 1978, and had three main characteristics in its intentions: universal access as the first point of contact for the healthcare system; inseparability between health and socio-economic development; and social participation. Starfield (2002) reinforces these characteristics by elaborating, for this level of care, the essential attributes of first contact access, comprehensiveness, coordination of care and longitudinality, in addition to attributes derived from family orientation, community orientation and cultural competence.

Despite this comprehensive proposition, international organizations such as the World Bank have proposed a selective and focused PHC model for developing countries. The Brazilian health movement was radically opposed to this and launched the name BHC to refer to an integral and territorial model of this level of care in the National Healthcare Systtem (SUS). In this article, just to facilitate the contrast between these proposals, it was decided to use BHC to refer to PHC in the Brazilian public sector and

PHC for the supplementary health experience or other international propositions. It is understood that, in practice, the two nomenclatures are interchangeable and their use depends on the political purposes to which each scientific communication is intended (Giovanella, 2018).

The first medical residency programs in PSM emerged in the 1960s in Brazil. They were heavily influenced by the "preventive movement" of the 1930s and 1940s in the United States (Massuda et al., 2009). In the Brazilian reality, this movement was deeply transformed with the interference of discussions in the field of Collective Health, the Sanitary Reform Movement and a certain rescue of Social Medicine. The MPS then became a space for articulating the areas of Epidemiology, Social and Political Sciences, Management and Planning and became an important device for the technical training of Health Reform activists (Massuda et al., 2009).

On the other hand, GCM had, as one of its main influences, the Community Medicine that emerged in the 1960s, also in the United States of America. One of its initial milestones was the proposal for specialized training for doctors via the "Project for a Community Health System" in Porto Alegre, in 1974, through the Health Department of the Rio Grande do Sul, along with other experiences in Pernambuco and Rio de Janeiro (Falk, 2004). With the Alma-Ata Declaration in 1978, other experiences emerged in the various federal states, leading the National Council of Medical Residency (CNRM) to recognize the specialty in 1981, formalizing the residency programs in MGC (Falk, 2004).

Massuda et al. (2009) problematize the existence of divergences between the GCM and the PSM. For them, while the first one had its main objective to train a clinical and generalist professional, with na enphasis on PHC in their traning, the second one focused on building a professional with a collective perspective on care who would be more conceraned with the social determinants of the health-disease process and than the individual clinical aspects. In these divergences, we can map what Giovanella (2018) points out as discursive tensions between the ideas of BHC, which would be closer to PSM, and PHC, which would be closer to the MGC. These tensions are still visible today in the disputes "promotion/prevention X care; collective health X clinic; programmatic actions X spontaneous demand; community orientation X health service" (Giovanella, 2018, p. 2).

Another tension is the idea of territory. While the Anglo-Saxon model of PHC does not organize its primary care teams based on the allocation of a territory as a delimited geographic space, the proposal of the Brazilian PHC, influenced by the work of Milton Santos (1996), in addition to having the allocation based on in a territory, understands it as a process that is dynamic and constantly permeated by changes. There is also, in this model, the understanding of it as endowed with a subjective dimension of a field of forces, which can be expressed by the people, families and/or communities that make up this web of relationships (Faria, 2020; Merhy et al. 2019).

In the 1990s, the Brazilian government prioritized the BHC model by creating the Family Health Program (FHP) in 2004, reformulated in 2006 into the Family Health Strategy (FHS), through the first National Policy of Primary Care (NPPC) (Giovanella, Franco and Almeida, 2020). An important milestone in the same decade, more specifically in 2001, was the change of name from GCM to FCM. Giovanella and collaborators (2020) argue that this change did not happen only in the context of the expansion of the field of practice with the FHS, but also in the construction of a distinct identity of the PSM, in an attempt to connect to the ideas of practices and knowledge of countries with more consolidated experiences of PHC such as Canada and England. An important point of this renaming is that it emphasizes the importance of the 'family' for the practice of the medical specialty. One of the attributions of this professional is to understand the entire person, taking into account their family and community context (Freeman, 2017).

At the same time as the renaming of FCM in Brazil, the provision of services by the private sector also underwent important changes. The National Supplementary Health Agency (ANS in Portuguese) was created, responsible for regulating health plans and operators in Brazil, which, for Menicucci (2007), marks state intervention in both the public and private sectors, even if in different ways.

According to ANS, in 2022, about 49.6 million Brazilians were covered by private health plans and insurance, which represented 25.46% of the population (Agência Nacional de Saúde Suplementar, 2022). The private assistance model did not follow the changes in the assistance model that occurred in the public sector, still maintaining the organization of its health offers in the hegemonic model known for being hospital-centric, centered on procedures, of fragmented care and without focus on disease prevention actions and health promotion (Machado, Melo and Paula, 2019).

From the scenario of excessive expenses and centered on procedures in the private health, the FCM is invited to be part of health plan operators, promising the defense of a more longitudinal, integral and humanized care, but also, through Quaternary Prevention, making use of rational use in prescribing exams and therapeutic procedures (Machado, Melo and Paula, 2019). This insertion gained strength from 2013 onwards, when health plans such as the Banco do Brasil Employee Assistance Fund (CASSI), the National Confederation of Medical Cooperatives (UNIMED in Portuguese) and International Medical Assistance (AMIL in Portuguese) decided to structure their services around the PHC, betting on hiring FCM professionals to compose its health teams (Machado, Melo and Paula, 2019).

The ANS, recognizing the success of the BHC model, also started to encourage a change in the care model by adopting guidelines to encourage the adoption, implementation and qualification of health promotion and risk and disease prevention programs by health plan operators (Agência Nacional de Saúde Suplementar, 2019). Machado, Melo and Paula (2019) emphasize this by highlighting the lack of action aimed at the community and the impossibility of integrative practices in the PHC scenario.

Given this scenario, it is necessary to understand this recent phenomenon of FCM incorporation by Supplementary Care, with Brazilian scientific production still scarce. Thus, this article intends to analyze, in an exploratory way, how the family and community approaches of family and community doctors inserted in a specific context of a PHC clinic of a private health plan are configured.

Method

This qualitative article uses cartography (Kastrup, Escossia e Passos, 2017) as a methodological bet to develop research in a PHC clinic in the city of Natal, in the Northern region of Brazil. The clinic is made up of five PHC teams that serve beneficiaries of a health plan and these are made up of eleven Family and Community Doctors (FCD), four Family and Community Nurses and five nursing technicians who are appointed as Health Care Agents. Health. This health plan, attended by the clinic, is a group medicine company and has been experimenting with PHC since 2015, in a model that does not restructure the operator's entire health subsystem, does not work with a gatekeeper access model, but as a parallel and alternative care offer.

At the clinic, there are weekly meetings of these teams to discuss clinical cases, performance indicators and work process planning. In addition to the PHC teams, there are two nutritionists, a social worker, a psychologist, four receptionists and ten doctors from other specialties such as cardiology, gastroenterology, pediatrics, psychiatry, neurology and rheumatology. Between the PHC teams and these professionals, sometimes, there is a matrix relationship, but, generally, there is only a flow of referrals and counter-referrals through the electronic medical record.

The research was based on the production of several approximation strategies with the existential territories of the clinic's FCD, to produce different cartographic data. One of our researchers was a physician at that clinic and this facilitated his immersion in the daily routine of the service. This is because cartography values the 'in-world researcher', the one who 'gets dirty' himself within the analyzed field, producing and suffering interference at all times in the research process (Gomes and Merhy, 2014). His experiences in the field took place about four times a week, over eleven months, between March 2021 and January 2022, and were all recorded in cartographic diaries, which are a

research device that allows both the description of what is experienced, how much of the affections of the encounters between the collective-researcher and the researched-world (Slomp et al., 2020).

Another cartographic resource used were the interviews. These were of the semi-structured type, based on a script of guiding questions produced from the guiding question of the present study, namely: How is the work process of Family and Community Doctors (FCD) in Supplementary Care organized? Thus, they addressed topics such as the training and work journey of the professionals, their references in the field of FCM and how the FCM believed that the attributes of the family and community approach were realized in Supplementary Health.

The interviews were conducted with six FCDs who agreed to participate in the research and signed the Free and Informed Consent Form. The interviews were conducted in January 2022, remotely via Google Meet, at a previously scheduled time, with an average duration of one hour each. They were recorded with the consent of the participants and then transcribed.

The entire content of the diaries and cartographic interviews was discussed in meetings with the research collective twice in month. These meetings served to elaborate devices, and survey analyzers and plan the next steps, since the cartographic research is modified and adapted throughout its execution (Kastrup, Escossia and Passos, 2017). Through discussions, based on the empirical material produced and on the theoretical references that support the present study, analyzers were raised that, according to René Lourau (2004), are "revealing events or phenomena and at the same time catalysts" (p.69) that serve to "making the institution speak" (p.69), enabling contradictory and hidden aspects in the process of institutional analysis (L'abbate, 2012). The analyzers analyzed in this article are 'family', 'community' and 'territory'.

To preserve the identity of the people who participated in the study, it was decided to refer to them with fictitious names. Açu (male, White, 35 years old), Apodi (female, White, 34 years old), Ceará-Mirim (female, White, 26 years old), Maxaranguape (male, White, 29 years old), Potengi (female, White, 32 years old) and Seridó (male, White, 44 years old).

Results and Discussion

About the professional practice of clinical FCDs, reinventions were observed as a way of adapting to the migration of work from the public health service, where they were trained in FCM, to the private health service where they work. These reinventions are present both in the dimension of service clients, as well as in the family and community. The nomenclature 'client' is used here to refer to the beneficiaries of the clinic, as this category reveals the process of commodification of their care relationship and problematizes the relational differences between the client of a service-commodity and the user of a social right.

Thinking about the territory, Seridó (male, White, 44 years old), right at the beginning of his interview, reflected on the reasons that led him to choose FCM as his specialty and, initially, to work in the public sector. He stated that:

> The different way of practicing medicine [from FCM], being closer to people and not just looking at the disease enchanted me. To be received in the houses is to see the reality, it is to know the mother, the father and the children. These are details that you don't notice just by looking at signs and symptoms and don't solve only clinical issues.

Seridó's perception of the importance of the family and the community in the production of care is similar to the propositions of the main theorists in the area who trace the emergence of FCM to a certain return of the historical medical figure of the 'general practitioner' who was predominant in the 19th century, who accompanied rich and influential families throughout their lives and visited their

homes (Freeman, 2017). This predominance of generalist practice was reduced throughout the 20th century, with technological advances and the strengthening of specializations in the field of health, and it only returned with the organizational reorientations of health systems at the end of the 1970s, after the Alma-Ata Conference (Freeman, 2017).

In Brazil, as already stated, the history of the specialty is also linked to GCM, which strengthened this aspect that Seridó highlights of "being closer to people and [...] being received in homes". This communitarianism, according to the works of Andrade (2017) and Segalla (2021), is permeated with tensions, since at the same time it was financed by organizations from central countries, such as the Kellogg Foundation and Ford, which propagated a focused and liberal model of medical practice, also developed in a Brazilian context of popular struggles against the civil-business-military dictatorship, marking out a political commitment to community health on the part of this generation of 'generalist' doctors.

Thus, 'community', in the history of Brazilian GCM, has a rich and polysemic meaning and is not just a limited geographic location with a natural and intimate association between its inhabitants, but a territory of action and political mobilization (Oberg, 2018). It retains some similarities, for example, with the historical processes, expanded in the 1970s, of professional categories such as psychology that sought to de-elite, becoming closer to the living conditions of the population and proposing clinical interventions contextualized by the local reality, of gender, race and social class (Scarparo and Guareschi, 2007). This will tension with the restricted collectivism of the community notion of the American GCM that is influenced by the Parsonian functionalism that understood 'community' only as a local microcosm, closed in its interests, distinct from society as a whole and object of an assistance action aimed at groups understood as 'vulnerable and at risk' (Andrade, 2017; Donnangelo and Pereira, 2011).

It is important to stress that this community politicization is linked to the political-ideological category of the territory which, in Brazil, is greatly influenced by the thinking of the geographer Milton Santos, who, as already mentioned, saw it as a living process of mediation between the world and society. society, far beyond its political-administrative dimension (Merhy et al., 2019). The SUS itself is structured around this expanded notion and is heir to a "decentralized, hierarchical and regionally integrated territorial project, through health care networks" (Faria, 2020, p. 4.522).

The BHC, a model of care that circumscribes the propositions and formation of the FCM, according to Merhy and collaborators (2019, p. 74), was thought of as a possibility of territorialized care and that, in addition to addressing its "demographic, geographic, economic, social, cultural and epidemiological", through health surveillance, still comprises the multiplicity of ways of living of the collectives that inhabit these spaces. Thus, it is highlighted that the territory has both political dimensions, as well as clinical-epidemiological and affective-existential dimensions. These characteristics of the BHC are praised by other interviewed FCDs and are also seen as a result of the territorialization that is one of its foundations. As Apodi (female, White, 34 years old) highlighted: "In the SUS there is more freedom, the health agent circulates in the community. The scope of a specific area favors the approach."

Patient List: A Depotentialization of the Territory in Supplementary Health

In the PHC of Supplementary Health, the size of the territory takes on another meaning and territorialization loses potency as a strength-value of professional performance. As Ceará-Mirim (female, White, 26 years old) pointed out: "In the supplementary, it is by the subscribed population. People are registered in a patient portfolio and it has people from different cities."

Potengi (female, White, 32 years old) is even more radical when denouncing that:

> The community that explodes, there is no community. It's a list of patients, not a territory. It was not possible. It was the first thing deleted in our practice within the supplementary. There were population studies of patient lists, but nothing more.

This 'patient list' model, cited by the FCD, is inspired by the American managed care models and the pay-per-capture system of the British health system (Norman, 2021). In American Managed Care, an organizational system assumes the financial budget and is responsible for a set of clinical services, the Health Maintenance Organizations (HMOs). Each of them assists certain population strata and controls the access of beneficiaries through primary care physicians and coverage restrictions (Freeman, 2017). Private health plans in Brazil use this same logic and the 'patient list' is a mechanism for both payment and customer loyalty to a given service provider (Norman, 2021).

The British National Health Service (NHS), despite inaugurating the universal health model in 1948, had to gain the support of general practitioners (GPs) and maintained their remuneration through the payment-by-capture model that had existed since 1911. This way, payment is made based on the number of patients registered with a specific provider, anchored in a unit of time, for example, the number of consultations in a given period of service operation.

It is interesting to note that this English health professional equivalent to the FCM, the 'general practitioner', would have an approximate translation of his name of 'general practitioner'. There is no mention of 'community' in the British name of the specialty, unlike the Brazilian name. This perhaps indicates that with the absence of territorial ascription, as in England, the community approach is weakened. Also, in the United States, the name carries no reference to the community. There, the specialist is the 'family physician' seeming to indicate a certain historical distance even from Community Medicine.

In this sense, Potengi (female, White, 32 years old) points out that:

> The attributes of primary care and community involvement are not possible in a health plan and the work is closer to that of a clinician. It's a four-wall job.

It is interesting to note that one of the clinical tools used by FCM is the Person-Centered Clinical Approach (MCCP), as an attempt to overcome a disease-centered clinical model (Stewart et al., 2017). Despite this tool valuing the family and community context, Andrade (2021) points out that the MCCP, in a historical moment marked by neoliberalism, it can fall into an individualist logic and focus its actions on the individual person who, even if contextualized, in this logic seems to be na abstraction detachedfrom society. The family and the community cease to be an active territory permeated by conflicts, disputes and power lines and become a context for the patient to be considered in the therapeutic process.

Thus, the 'Medicine of the Person', despite surpassing the 'Medicine of the Disease', may end up producing a weakening of the territorial dimension of the clinic, therefore, a weakening of the community and family approach. If the community and the family are seen as living territories and a web of relationships where individuals build their subjectivities and have their encounters, this de-potentialization is quite important for the professional approach (Merhy et al., 2019). In a way, there is a reduction in the potential for expansion of the clinic that sees beyond the disease but does not go beyond what would be the isolated person. Seridó (male, White, 44 years old) even commented that at suplementar "there is no community intervention to change the reality of the community. Our approach may even be communitarian, but the focus of the action is the individual."

Despite Potengi and Seridó recognizing the harm caused by this reduction in scope, Ceará-Mirim (female, White, 26 years old) goes so far as to comment that: "In supplementary health, people are from a territory that is not so vulnerable. The environment is not so risky. The neighborhood and the community don't matter much." This idea that the community approach is relevant only for poor populations, in situations of vulnerability and at risk, is very close to the welfare ideals of a restricted and selective PHC of organizations such as the World Bank (Rizotto, 2021).

This conception of territory, in light of the analytical perspective of raciality, the territories of people served by private health plans, who are mostly White and middle class (Souza Júnior et al.,

2021), are universal and do not need to be brought to the clinical scene. This is different from the territories inhabited by economically expropriated Black and Brown populations that are seen as 'at risk' and need to be named and brought to the scene of clinical practice (Silva, 2014). This dominance of the 'pathological' in these territories is also what serves as a justification for the brutal violence of the State personified by the police forces.

Reconfigurations of Family and Community Approaches

About the family, Açu (male, White, 35 years old) stated: "The family approach may be necessary or it may not be. The family unit is not always fully addressed. In the health plan, different people from the same family can be accompanied by different doctors." Some MeFCs from the clinic, when asked about the Family and Community Approach in supplementary PHC, even mention some tools that are directly related to this territorial dimension. Some of these tools were considered more present in the supplementary work and others less so. They are: the home visit; health education activities; some specific tools of FCM practice such as genogram and ecomap and health surveillance.

Açu (male, White, 35 years old) stated, regarding his work in supplementary health, that "there are no home visits by family doctors in supplementary health." Despite this, Maxaranguape (male, White, 29 years old) sees telemedicine as a possibility to replace this: "We serve, now with telemedicine, even people from other countries. It's like a home visit. You see a misplaced rug in an elderly person's home and you can guide." Thus, it is observed that this understanding of home care reiterates only its aspects of surveillance in its more supervisory attributions and favors the exercise of biopower in prescribing a healthier habit of life (Santana et al., 2019). Thus, the dimension of a more horizontal, dialogic and emancipatory home practice through the intimacy of the 'house' is lost.

Regarding health education, the same doctor pointed out that: "There is no territorialization in private health services, but we manage to do some groups and courses such as pregnant women and smokers." In the same sense, Seridó (male, White, 44 years old) commented that:

> What we can do is in terms of health education. We made several videos for Instagram and Youtube. 'Lives' might be a good idea. The physiotherapist at the clinic is thinking about doing activities in a square or on a beach.

Thus, as in the home visit, the health model that guides the health education practices carried out is the traditional, hierarchical and banking model. There is a focus on the technical knowledge of health professionals and a distancing from the dialogic possibilities of the clients' knowledge, from approaches to community life and the contexts of the social determination of the health-disease process.

With respect to some other tools, Maxaranguape (male, White, 29 years old) stated that he uses "the genogram a lot, but time is very busy." Açu also pointed out that: "Occasionally, genograms and ecomaps are used." It is interesting to think that these tools are losing more and more space in the reality of supplementary health due to the short consultation time and the loss of the territorial dimension of PHC in supplementary health. In the cartographic diaries, this reflection is present:

> In our suitcases, we have the tool of the Person-Centered Clinical Method. I think this is a very beautiful tool, but how to implement it in the context of 15-minute consultations with many people that we are even seeing for the first time? I feel a lot like Chaplin tightening the screws in 'Modern Times'. (Cartographic Diary)

Still, about family and time, Potengi declared that:

> I even called relatives of the same family for a consultation to approach the family, but the health plan was not interested in providing the necessary consultation time for this. I tried to talk to the social worker, but there was no time set aside for that.

Potengi also comments that the schedule was very inflexible and that she tried to get out of the role of 'just a clinic', but could not because of that. "I was not part of the family, I attended to the individual. I was not a family doctor, I was a clinician, an individual clinician." This view of a reduction to the role of a 'clinic' stems from the view that the FCM has a broader view of a person's care than that of a specialist in internal medicine, as it includes people-centered medicine and territorial aproaches.

As for health surveillance, according to the FCD reports, nursing was exclusively responsible for epidemiological surveillance and collective and group activities. In the nursing routine, there are workload spaces for carrying out groups of pregnant women, smoking cessation, weight reduction and contraception. There is also room for compiling and analyzing health indicators such as the number of pregnant, hypertensive, diabetic and asthmatic people generated by the electronic medical record system. These activities are seen by the health plan insurer as secondary and non-essential for daily medical practice, according to Açu, reproducing this view, "they can very well be performed by nursing" (male, White, 35 years old). With that, there is a decrease in the power not only of the political and affective-existential dimension of the territory but also of its clinical-epidemiological dimension.

Regarding the family approach, Seridó (male, White, 44 years old) states that "I offer the best possible care for the next family member." And in other speeches, it appears that this individual approach of a family member could already be considered a family approach. This conception comes from the systemic approach that is the dominant FCM conception of the family (Dias, 2018). For this approach, the family is a set of individuals who share ties of kinship or friendship and who live under the same roof. However, even though family arrangements can be multiple, they follow a life cycle that has decisive and predictable moments such as: leaving the parental home and becoming an independent adult, forming a couple, having children, seeing the children grow up, launching children into the world and have a final stage with an 'empty nest' (Dias, 2018).

This model, even if it foresees the possibility of different arrangements, is organized around the ideals, concepts and development marked by the normativity of a family Eurocenter model (Tokuda, Peres and Andrêo, 2016). This perspective is quite limited, as the family experiences that this approach predicts for each cycle naturalize the biases of a patriarchal society in which childhood and the upbringing of all progeny is not an attribute of the community as a whole, but of a hetero-affective couple of individuals from the family niche, mainly women. There is also the problematic notion of a functional and dysfunctional family that carries in itself a biological and normative view of what would be normal or pathological and that does not make sense in the Brazilian reality, where 14,7% of families, according to Instituto Brasileiro de Geografia e Estatística (2022) data, are single parents, headed by women.

Final Considerations

In face of this panorama, one sees the devaluation of the fundamental principles that permeate the name of the specialty itself and the weakening of the community and family dimension in supplementary health. Thus, FCM, within supplementary health, loses part of its potential and scope of action. It drops the letters "F" and "C" and focuses her work on a clinic centered on individuality, without being able to act directly on the 'family', the 'community' and the 'territory'. This is due to specific arrangements of the PHC model within the supplementary health that was studied: with enrollment through a

patient list, without the possibility of home visits by primary care teams and with family care limited to members who were beneficiaries of the plan private healthcare. Actions such as health education are only carried out in their most prescriptive and less emancipatory form. Home visits, which are important in the comprehensive ABS model, are not included in the list of activities performed in family medicine practiced within the private healthcare sector.

Although this work has the limitation of having centered its analysis on the performance of the CFD of a single clinic of a health plan operator, it already points out the general challenges of the performance of this specialty at this level of care. Despite FCM being an alternative to the hospital-centered model centered on high-cost procedures; in this private environment, it goes through metamorphoses in its scope of action and distances itself, as demonstrated, from its territorial vocation.

It is important to point out that this deterritorialization does not occur exclusively in the private context. Private rationality has been incorporated into public policies, undermining the principles and practices of ABS, with a particular negative impact on territorialization. The 2017 National Policy of Primary Care makes the presence of CHAs more flexible through the creation of teams of Primary Care (eAB) and the complementary normative that establishes Primary Care Teams without CHAs has led to a detachment from the local territory. In this scenario, there is an advocacy for a SUS-centered on the BHC, capable of instrumentalizing the struggles in defense of a level of care that is territorial, community and integral. When we analyze the situation of Family and Community Medicine in the supplementary sector and its implications for different healthcare approaches, we continue to doubt whether there is a genuine possibility of reconciling it with the comprehensive logic, where health in the broader sense is understood as a right, while also addressing the tensions of the private sector, where health is often treated as a commodity.

Article information

Author Contributions

All authors equally contributed to the conception of the study, data curation, collection, and analysis, the writing of the original manuscript, as well as the revision and final editing.

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Conflicts of Interest

We declare that there are no conflicts of interest.

Ethical Considerations

This research followed all ethical recommendations outlined in Resolution No. 466/12 of the National Health Council (CNS) and was approved by the Research Ethics Committee of the Center for Medical Sciences (CCM) at the Federal University of Paraíba, CAAE: 42482721.7.0000.8069, on February 26, 2021.

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