

Brazilian and Italian general practitioners' discourses on autonomy from the bioethical perspective

Discursos de médicos de família brasileiros e italianos sobre autonomia na perspectiva bioética

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Abstract

This article analyzes Brazilian and Italian general practitioners' discourses on the potential to boost autonomy among subjects-users who are cognitively competent with regard to their care decisions, through primary health care actions, from the bioethical perspective. Qualitative research with an exploratory approach, carried out in 2007, in Florianópolis, Santa Catarina, Brazil, and in the Province of Rome, Lazio Region, Italy, with 15 Brazilian general practitioners, 15 Italian general practitioners, and 1 health director of the Italian National Health Service (SSN). Semi-structured interviews and a field diary were used as data collection instruments. Processing and systematization of messages' content have generated two analytical categories: "biomedical rationality versus emancipatory rationality" and "from the historical condition of minority to the wish to be autonomous." In both countries, testimonies have revealed: a) poor materialization of autonomy in face of the contemporary risk-prevention biomedical imperative; and b) emancipatory movements that generate concrete and symbolic strategies in order to cope with deconstruction of the medical practice, historically produced through the path of obedience. Brazilian discourses pointed out productivist protocols, imposed by administrations, as an instrument for the preservation of the minorities. Italian general practitioners suggested greater recognition of subjects-citizens of rights when providing care. The research revealed there is a need the Brazilian Primary Health Care (APS) dialogue with humanities theories and invest in mechanisms to boost ethical

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behavior to review the sense that has been occupying the adoption of the risk prevention biopolicy in the contiguity of actual health at this time.

Keywords: Autonomy; Primary health care; Brazil; Italy; Risk prevention; Bioethics.

Resumo

Este artigo analisa discursos de médicos de família brasileiros e italianos sobre o potencial de impulsão à autonomia de sujeitos-usuários competentes cognitivamente nas decisões do cuidado, em ações de atenção primária à saúde, na perspectiva bioética. Pesquisa qualitativa de caráter exploratório, realizada em 2007, em Florianópolis, Santa Catarina, Brasil, e na província de Roma, região Lazio, Itália, com 15 médicos de família brasileiros, 15 médicos de família italianos e um diretor sanitário do Serviço Sanitário Nacional (SSN), Itália. Foram utilizados como instrumentos de coleta entrevistas semiestruturadas e diário de campo. O tratamento e a sistematização do conteúdo das mensagens geraram duas categorias analíticas: “racionalidade biomédica *versus* racionalidade emancipatória” e “da condição histórica de menoridade ao desejo de ser autônomo”. Em ambos os países, depoimentos revelaram: a) fragilidade na materialização da autonomia diante do imperativo biomédico contemporâneo de prevenir riscos probabilísticos; e b) movimentos emancipatórios geradores de estratégias concretas e simbólicas para o enfrentamento da desconstrução da prática médica, historicamente produzida através do lastro obediência. Discursos brasileiros apontaram os protocolos produtivistas, impostos por gestões, como limite para a preservação de menoridades. Médicos de família italianos sinalizaram um maior reconhecimento de sujeitos-cidadão de direitos na condução do cuidado. A pesquisa revelou a necessidade de a APS brasileira dialogar com teorias das ciências humanas e investir em mecanismos de impulsão ao exercício ético para rever o sentido que vem ocupando a adoção da bipolítica de prevenção ao risco na contiguidade da saúde concreta do tempo presente.

Palavras-chave: Autonomia; Atenção Primária à Saúde; Brasil; Itália; Prevenção ao Risco; Bioética.

Introduction

In 2013, we celebrated 25 years of the Brazilian Federal Constitution that devoted Chapter II for accommodating the collective dream for a democratic nation comprising in its structure the foundation of the right to health as a right to citizenship. This constitutional provision has resulted in the conquest of the Brazilian National Health System (SUS) (Lima, 2013). In the subsequent decade, the Brazilian Family Health Program (PSF)¹ was officially created by the Ministry of Health as a potential strategy to reorganize primary health care, named in Brazil primary care, which structures a new health care model (Heimann; Mendonça, 2005) ruled by comprehensiveness of care. In one of its senses, the principle of comprehensiveness expresses a push towards the autonomy of subjects-users with regard to decisions on their health and illness processes. The materialization of this face of comprehensiveness requires dialogue with humanities (Brasil, 2004).

Primary care was deployed as a State policy (Temporão, 2009) in 2006, through the Brazilian National Primary Care Policy (PNAB), reviewed and updated in 2011. Primary care is characterized by a set of strategic actions, cross-sectional and comprehensive, aimed at health promotion and protection, illness prevention, diagnosis, treatment, rehabilitation, harm reduction, and health maintenance of individual and collective subjects, within a defined territory. Such actions must have a democratic and participatory nature, impact the autonomy of subjects-users with regard to their care process, considering the subject according to her/his uniqueness and socio-cultural integration (Brasil, 2011).

An international literature review conducted by means of two publishing houses available in the Capes Journals Web Page, Biomed Central and Sage, by using the keyword *primary care*, within the period from 1999 to 2009, aimed to specifically identify and analyze the professionals' everyday working process. The qualitative abstracts and articles selected and analyzed have suggested a gap between the PHC actions and the humanities. The authors

¹ Consolidating as a nationwide strategy, the Brazilian Family Health Program became recognized as the Brazilian Family Health Strategy (BRASIL, 2006).

show to be connected to the importance of recognizing “human” issues in the primary care domain, but this recognition does not turn into dialogue with human sciences’ theories, in the sense of promoting autonomy, subject competent to cope with their health and illness phenomena. The development of shared decision-making “is regarded as rare and difficult” (Souza; Meandro, 2011, p. 532). Most of the papers are focused on “[...] ‘the position of an expert’ who thinks, acts, and decides for the other” (Souza; Menandro, 2011, p. 533).

The Brazilian PHC challenges similar constraints. A “humanized” professional (Gomes; Ramos, 2014), who recognizes the right of a subject-user to narrate her/his wisdom, values, and perceptions about the suffering that affects her/him; who recognizes shared care as a space where knowledge and practice meet, revealing its own significance and the meaning of something else inherent to it, it is still a somber image-goal. According to Seppilli (2007), the meeting between a health care professional and a subject wishing care is not a space where individual subjectivities are produced, but they are dialectically connected to the real world experience. From this perspective, the non-recognition of the importance of listening on the way how the subject-user experiences her/his health-illness process lies on an ethical implication.

Part of this scenario is due to the fact that education in the health field is supported by a model that still “[...] has not promoted a political-pedagogical culture aimed at SUS” (Almeida-Filho, p. 1681). Most curricula still closed in Brazilian universities alienate different kinds of knowledge and avoid the badly needed humanistic education provided by rather general studies, resulting in workers who are unpre-

pared to deal with the complexity of the health-illness phenomenon (Almeida-Filho, 2013) in PHC. Thus, both education and practice are loci of bioethical discussion, because they are social spaces where values are (or not) estimated and put into practice (Finkler, 2009), micropowers and explanations about the health-illness process face each other, cultures are introduced, motivations are expressed, attitudes arise, and decision-making is consolidated.

This article aims to analyze ethical implications observed in Brazilian and Italian general practitioners’ discourses on the subject-user’s autonomy with regard to their care process. Autonomy is not thought of as a value *per se*, but it is produced in a relationship through dependency nets lacking subjection (Canguilhem, 2006), in the meeting with each cognitively and morally competent “another me” (Schramm, 2007). The Brazilian general practitioner is a social actor in the family health team in the Brazilian PHC and the Italian general practitioner represents the first listening point to the Italian citizen, concerning her/his health and illness process, although she/he is a self-employed private practitioner², affiliated with the Italian National Health Service (SSN)³. Professionals from both countries work according to a territory-based care model⁴ and, disregarding the specificities, they take multidisciplinary actions.

The Brazilian general practitioners’ conceptions were analyzed by means of a comparison to the Italian family medicine, because for three centuries (from early 17th century to early 20th century), this category preserved an anthropological-social nature to deal with health and illness processes within their society (Cosmacini, 2005). Although Italy has gone through deep ruptures and cultural rediscus-

2 Until 1992, Italian general practitioners were municipal civil servants. Since the De Lorenzo-Garavaglia Reform, which occurred that year, they chose private medicine, affiliating to SSN. The De Lorenzo-Garavaglia established the health management model *Aziendalizzazione* transferring the organization and functioning of SSN to general directors, at the health and administrative levels, within the regions. The reform was marked by the need to intervene in spending, accommodate health provision to the existing resources, and make available greater regional autonomy (Cavicchi, 2007).

3 Cicogna, V. A. *Entrevista* realizada em Albano Laziale, provincia de Roma, em 17 de abril. De 2008. Direttore Sanitario della USL Roma H, 2007 (unpublished material).

4 The territory medicine gained momentum in Italy in early 21st century. In 2006, the National Health Plan 2006-2008 took the reorganization of PHC. In 2008, the Italian State introduced to general practitioners a clinical-territorial government system, made up by themselves (accreditation of their offices), district physicians, outpatient experts, nurses, social workers, human resources in the field of rehabilitation, district technical-administrative staff, with community participation. One difference between the territorial model in Brazil and in Italy is that the Italian citizen is free to choose the professionals she/he wants in any municipality belonging to the district (Lima, 2008).

sions in this field throughout the 20th century, the contemporary discourse can express dimensions in this historical product and various modes on the way how to deduct from a paradigmatic rupture other changes, extending the field for a possibility of new meanings. In addition, through the voice of Italian general practitioners we may grasp “[...] the new subject, a political subject [...],” who emancipated from the original paradigm of a paternalistic tutelage model regarding her/his health, when she/he wished to stop being helped in a charitable way under a tutor-tutored hierarchy, capable-incapable, historically produced (Cavicchi, 2007, p. 12).

Methodology

Qualitative research with exploratory and descriptive approach, approved by the Research Ethics Committee of the Federal University of Santa Catarina (UFSC), under the Protocol 213/07, in 2007, complying with the provisions of Resolution CNS 196 (1996).

The sample consisted of 15 Brazilian general practitioners working in Florianópolis, Brazil; 15 Italian general practitioners working in the Province of Rome, Lazio region, Italy, and 1 health director in this province, chosen by random draw.

Data collection was processed through semi-structured interviews, recorded in audio, following a previously prepared script consisting of 2 clinical cases and 5 questions.

Clinical cases sought, respectively, the general practitioners’ behavior in face of a man who, due to job loss, did not attend a scheduled follow-up appointment to control diabetes and hypertension, and in face of the first appointment of a woman complaining of suffering by relying on her family members even for small everyday actions, due to severe generalized muscle pain.

The instrument questions explored consistencies and contradictions in the interface between discourses and practical examples on the way how a meeting is organized by the general practitioner, as well as the strengths and weaknesses of subjects’ participation in the clinical moment. The field diary

used stimulated thought and produced a “free flow of ideas” in data processing and analysis (Strauss; Corbin, 2008, p. 101). To the Italian field diary, copies of several notices, guidelines, and warnings by SSN were attached, observed in the offices visited, regarding the care protocol.

After organizing and transcribing the testimonies and translating the Italian interviews, the material was analyzed through a dialogic integration of three components: the epistemological, instrumental, and reflective (Minayo, 2010). This step resulted in two categories of analysis: “biomedical rationality versus emancipatory rationality” and “from the historical condition of minority to the wish to be autonomous.”

The anonymity of Brazilian subjects was ensured through codenames representing the founding members of the “Clube da Esquina⁵,” added with letter B (Brazil), and the anonymity of Italian subjects was preserved through codenames of filmmakers and followers of Italian neorealism, added with letter I (Italy).

Results and discussion

Characterization of research subjects

The Brazilian sample consisted of 3 physicians from each of the 5 regions in Florianópolis, selected by draw. Out of the 15 subjects, 11 were women and 4 men, with a time since graduation ranging from 1 to 33 years. Out of the total subjects, 8 had completed a family and community medicine course, 2 had completed residency in other areas, and 5 had not attended any residency. Regarding the Italian research subjects, 8 were women and 8 man, with a time since graduation between 14 and 32 years; 7 worked with PHC since the end of graduation, among which 1 had completed residency in family medicine, 8 were specialists who chose to pursue family medicine, and 1 played the role of health director in a district in the Province of Rome. Some physicians had been graduated before SSN was deployed, it was conceived in the 1960s by the Health Reform Movement and the Italian society achieved it in 1978.

⁵ Minas Gerais, Brazil, cultural production generated through the combination of Brazilian regional rhythms and international rhythms such as jazz and Latin American songs (Souza, 2011).

The first category of analysis – biomedical rationality versus emancipatory rationality – refers to the unfolding of both rationales with regard to the right of the subject-user to express her/himself, if wanted, in decisions about her/his care process.

When asked about care management in face of a woman who claimed to be living differently by relying on her children to fulfill simple everyday tasks, since the onset of severe muscle aches, and a man who had started his report in a shy way, stating the fail to attend the follow-up appointment to control diabetes and hypertension was due to his job loss, the Brazilian and Italian general practitioners revealed a mismatch between the content perceived and the content-complaint, expressed in the speeches. The suffering expressed in “living differently” and in “job loss,” representing facts of the dialectical reality of the experiences of both subjects with regard to their life systems, was moved from the actual structure of realities (Kosik, 1986) and interpreted as resulting from muscle pain, diabetes, and hypertension:

[...] surely, I would start to investigate by asking blood tests, to assess general condition and muscle enzymes, and I would investigate whether she is using any medicine that could be leading to muscle problems (Germi/I).

[...] you are pre-diabetic and reached a crossroads: either you agree to change your lifestyle or you will become diabetic and stay here, in front of me [...]. (Beto/B).

[...] the disease is yours, you must manage it, and I will tell you how (Bertolucci/I).

[...] I would ask the routine tests that are required [...]. the correct way is referring this woman to a psychiatric clinic (Maricota/B).

Biomedical rationality seems to have the potential to turn social problems with an ethical nature into scientific technical problems. “Living differently” and the anguish due to “job loss” were not understood as moments of a whole set; as historical facts that, when produced, are products of a whole, expressed by a subject who is, since his/her

conception – and even before is –, a social subject⁶. The supremacy of a biologicistic practice focused on the technical procedure ended up just emptying the actual totality perspective that the expressed needs required, and listing the person who demands care as an object of duties, “*the disease is yours, you must manage it, and I will tell you how*” (Bertolucci/I).

Also, the central issue involved in suffering (intimidation for the late follow-up appointment due to job loss) was subsumed into the probabilistic risk – “*you are pre-diabetic and reached a crossroads*” (Beto/B). The guarantee of continence with regard to suffering at this time, a solid historical aspiration of existence, and a dimension of the right to health were melted in that context to emphasize a new solid, which has been leading the social order: a prediction about the future (Bauman, 2001), the core of risk prevention biopolicy. The behavior regarding care seems to focus on changing lifestyle.

In the lecture “The birth of social medicine,” published in 1989, Michel Foucault discusses the concept of biopolitics as a social control strategy that begins with the intervention “[...] on individuals [...], in the body, with the body” (Caponi, 2004, p. 447). In the construction of national States, the society was a strategic base, i.e. the “social” was an object of disciplinary intervention. By managing lives, the States were able to put the economy (then familiar) into a government rationale of political, into a political economy (Foucault, 2007).

Permeated with the mission to protect public health against the other of order, chaos, biopolitics has been operating on a permanent state of exception, to which globalized societies are subject. This strategy breaks with boundaries when entering the individual private sphere with a utilitarian device, triggering the confinement of everyone in a single category, either vulnerable or violated, in an actual risk having a collective nature, in probabilistic risk arising from private individual choices, and sometimes blaming at an individual level (Schramm, 2006). Subjects who are authors of their histories are deprived of this right and reduced to bodies, to bare life (Agamben, 2007). In this sense, the risk prevention biopolicy has generated ethically unac-

6 Seppilli, T., 2012. *Entrevista*. Realizada na Fondazione Angelo Celli, Perugia, Italia, em 04 de dezembro de 2012 (material não publicado).

ceptable effects on the right of competent subjects regarding the moral and cognitive abilities, deciding on their lives, on the purposes of any person.

The robustness of this historic product is so significant that it generates a morally doubtful rationale of framing care for a woman who complained about “living differently,” due to a third-party dependency relationship to fulfill simple everyday tasks, within a psychiatric disorder: “*the correct way is referring this woman to a psychiatric clinic*” (Maricota/B). The operational choices of utilitarian rationality, which houses biomedical rationality, is mediated by some kind of subjective interest (Weber, 1987) and influenced by the social organization model. The capitalist production mode, by bringing a rational lens, which standardizes and organizes the future, has promoted silent operational events in knowledge construction and working ethics (Bauman, 2001). In this excluding social organization model it seems to be natural classifying a human being constrained with regard to her/his infrastructural conditions into a psychiatric disorder, generating reckless and intimidating effects, often capable to boost inner negative feelings in a context of suffering caused by lack of material conditions of existence.

Testimonies revealed that the subjects’ well-being will be achieved if the clinical moment is driven by confidence in the medical know-how. This model of practice corresponds to a historical product that was consolidated through an agreed obedience model (Schraiber, 2008):

[...] *My patients follow me, they comply with my guidelines* (Visconti/I).

Complying with the general practitioner’s guidelines may represent a sign of trust and recognition of a moral authority regarding medical know-how. It is true that such an element extends the range of possibilities for building healthy relationships between general practitioner and subject, since trust and recognition of medical know-how are positive attributes of care. However, care ruled by this historically determined trust will take moral value when the subject’s choice “to comply with the medical guidelines” emerges not from obedience, but from a negotiation

designed through the dialogical process, between subjects “[...] both cognitively and morally competent [...] in a society of authentic individuals, decisions about their lives should be personally taken?”

Although the Italian, in 1978, and the Brazilian health reforms have been configured through different axes, respectively, “[...] health tutelage in the workplace” (Berlinguer, 1983, p. 64) and health democratization (Lima et al., 2009) (such social movements were triggered by lens advocating for the work process in the health field that regards social reality as “[...] the culture broth of processes that are related to health” (Collicelli, 2011, p. 17); as a process that requires attention to phenomena as they are built in order to be grasped. From this perspective, SSN (1978) and SUS (1988) were achieved.

Although the historical process of the Italian family medicine is temporally distant from the Brazilian, both categories met in global historical conditions provided by the 20th century, upon which a call to the idea of risk spread, through “[...] media pressures often influenced by economic interests or dominant political positions” (Berlinguer, 2011, p. 39). In contrast to biomedical rationality, it was possible to recognize in Brazilian and Italian speeches a dialogic rationality experienced by cognitively competent subjects. A rationality that recognizes care as a complex social space where historical subjects meet and health dimensions are dialectically put:

Good! You failed to attend, but you are here now, tell me how life is, what losing your job was about [...] (Duca/B).

[...] *Dig your life, your family relationships, but above all listen, people have the right to speak, be heard* [...] *without feeling judged* (Tornatore/I).

It is noticed that the dialogical ethos of this rationality is at the meeting place and it has potential to turn it into a locus of social production of health. Mediating the human dimensions of “active life” (the working process of *homo faber* and action), and interpenetrating “[...] experience, materially and sensorially” (Arendt, 2008, p. 381; 562). The social production of care with an emancipatory basis facili-

7 Schramm, F. R. 2008. *Interview*. Performed through eletronic address on February 29th, 2008 (not published).

tates understanding health in reality by allowing the medical-institutional knowledge, socially recognized, to influence and be influenced by the knowledge of a subject in need of care, someone who is author of her/his life. In this traffic, the inevitably different social actors (Arendt, 2004), belonging to different social fields, recognize themselves as political subjects, free (Arendt, 1999), they produce each other.

In another approach, by conceiving the human being as “[...] a historically determined subject, i.e. who develops her/himself and lives under certain conditions, in a determined set of social relations” (Gramsci, 2007, p. 1765), emancipatory rationality allows deconstruction of the simplified model of skills, historically engendered in the education and practice within the health field. It constitutes a fertile ground for extending the concept of health, as the dimensions need and autonomy may organically interpenetrate.

The second category of analysis - from the historical condition of minority to the wish to be autonomous - revealed in the discourse of Brazilian and Italian general practitioners and subjects-users under the minority condition, i.e. under a subordinate condition in face of the medical know-how, and subjects who are respected with regard to their wish for autonomy concerning decisions that affect their lives. The minority referred herein takes the metaphorical sense in the option to attribute life tutelage to the general practitioner:

[...] they are ashamed, because sometimes they even do not know how to speak, they have to think about words (Wagner/B).

[...] sometimes I joke: “Do you see any crystal ball in front of me?” (Yé/B).

The subject is active in order to contribute to our therapeutic and diagnostic proposals [...] and do not get lost (Zavattini/I).

In Brazil, it is likely that the socio-historical process influence the choice of minority due to the strong trait of social exclusion fueled by feelings of smallness imprinted in a large portion of Brazilian society. Thus, the question may not be attributing her/his life tutelage to the general practitioner and

do not wish majority, but not feeling able to do so and do not see autonomy as a human value. However, since the general practitioner is a spokesperson authorized by his socially recognized linguistic competence, he can mobilize his nature as an actor (Bourdieu, 1996) and activate the symbolization system of the subjects he provides with care.

Commenting that he “does not have a crystal ball” in order to solve the problem of another person may have the intent of stimulating dialogue, through the use of the therapeutic playful resource “play with.” Resuming the conception that the entire human existence revolves around the children’s universe and bringing it closer to the view of culture as circulation of freedom, it might be thought that speech may encourage the subject to irradiate the childhood brightness and reconcile with her/his child, constitutive element of autonomy in an adult (D’Epinai, 1988). However, the metaphor may be internalized as an intimidation tool, narrowing the possibility that the subject manifest her/himself, it may demonstrate that the minority condition can be “[...] rather a prejudice than a hallmark of social imaginary in Brazil⁸.”

The Italian speech mentioning that “the active subject as a person who does not get lost” (Zavattini/I) lies on an ethical implication, since it paralyzes the potential of a subject to put participation into practice concerning her/his care, denies contingency, the historical nature of the human dimension, and pushes the process of social and political (non-)subjection. For bioethics, health and the exercise of freedoms are dimensions of quality of life (Schramm, 2007).

This process may be broken by the expansion of the ethical dimension in the production of health care (Finkler, 2009), which corresponds to reflection on a historical reality, exercised in the encounter between the estimation of values and reality (Cortina, 2005 quoted by Finkler, 2009), where we become “moral realities” (Gracia, 2000 quoted by Finkler, 2009). The encounter with reality enhances the estimation of values experienced on a daily basis in the living process (Cortina, 1995 quoted by Finkler, 2009), and it provides conditions to design shared actions and think of consequences. Thus, the ethical dimension comprises the possibility that a professional thinks

8 Schramm, F. R. 2008. *Interview*. Performed through electronic address on February 29th, 2008 (not published).

through her/himself, helped by the others, and recognizes the various types of action imposed by praxis that would be good for the self-production of work and for those involved who seek the professional to cope with some kind of suffering. The solidification of this dimension in the working process may legitimize know-how among historical subjects through the production of new relational spaces inducing autonomy.

It is worth mentioning that by revealing adult subjects-users who are aware of the right of expression, general practitioners also showed that they, the physicians, had been undergoing restriction of freedom through measures adopted by SSN⁹. This emphasizes the tendency that a human being, not infrequently, voices her/his distresses, when asked about human issues raised in her/his social relations.

Testimonies signaled that the Italian society has pointed out “[...] the requirement of citizenship [as] the primary meaning of being [...],” being demanding, knowing how to claim her/his right (Cavicchi, 2007, p. 75). This culturally stored knowledge (cultural capital) seems to boost majority concerning decisions about self-care, by acting as an instrument for fitness to be autonomous when dealing with health and illness phenomena:

[...] I am a co-participant [...] it is the patient who determines new solutions for himself (Puccini/I).

[...] freedom is a citizen's right and it should be a right for all [...] I bring the patient into making therapeutic choices (Castellani/I).

Brazilian discourses signaled “a blurring point” between the objective determination of PHC (contenance of suffering) and the subjective determinations of the subject's thought, which, “trapped within this reality,” account for the guarantee of objective actions in themselves. It is worth mentioning, quoting Marx, that such “blurring point” between the objective determination and the subjective determinations of social reality in PHC actions is not specific to this subsystem of SUS. From the Marxist perspective, the objective determinations of the entire social reality are also subjective determinations, since they are de-

termined by the subjects who are inevitably involved in the dialectic reality (Nhadan, 2012).

In this sense, the systemic “diagnosis” of the set of actions that determines a (central) goal of activities regarding PHC (contenance of suffering) is, in itself, subjective and also “a symptom of its own,” because it is the result of subjective reactions expressed by social actors who make up reality in response to the obstacles with which the social actors are faced in practice (Nhadan, 2012). An example of obstacle is the requirement to comply with productivist static protocols, as everyday standards, imposed by administrations:

[...] If I have to provide 20 [people] with care [...] it is not possible to ask: “How are you doing?” (Beto/B).

In the context above, the user society would be experiencing the suppression of the fundamental right to contenance of her/his suffering with quality, denial of health production as a means to achieve dignity (Diniz, 2009). The attitude stimulates the production of a society conditioned to bare life (Agamben, 2007). Because, in face of the institutional need for a minimum amount of productivity regarding patients provided with care/day, a subject who is suffering might be at the mercy of her/his fate, deprived of the possibility to act in managing her/his life, and it is possible to refer to Kant's dictum: “It is most convenient to be a minor!” (Kant, 1985, p. 100; emphasis by the author).

Conclusions

This study analyzed Brazilian and Italian general practitioners' conceptions on the potential to boost the autonomy of a subject regarding decisions about her/his care process, by general practitioners. The Brazilian National Primary Care Policy assigns to the PHC the main gateway and communication center in the health care network of SUS (Brasil, 2011). One objective of the actions taken by the teams, with a democratic and participatory nature, is to impact the autonomy of subjects-users (Brasil, 2011). The general practitioner is one of the social actors. The Italian PHC is the main structure of SSN, in a direct contact with people. The

⁹ As pharmaceutical expenditure in the Lazio region was out of control, the ‘Azienda Lazio’ issued a standard determining the obligation that general practitioners control their prescriptions, so as to not exceed the per capita ceiling of pharmaceutical care, within the region (€ 175 per capita) (Germi/I). Within the study period, notices and warnings were on the walls of medical offices to confirm such measures.

Italian general practitioner is regarded as the first reference of the nuclear family, an actual filter of clashes, since he represents the first listening point to the Italian citizen (Cicogna, 2007). PHC in both countries has a territorial basis, albeit with different specificities.

A distinction on the production of autonomy in the Brazilian and Italian PHC is the cultural capital of societies. The Italian subject-patient emancipated from her/his original thinking style, a paternalistic model of health tutelage, to experience the patient's social figure turn into "[...] a new subject, a political subject [...]," who does not want to be helped in a charitable way, according to a tutor-tutored hierarchy, able-unable, by a universal public system (Cavicchi, 2007, p. 12). Brazil, in turn, has challenged fairness so that the right to health in the PHC can be a universal right and a means for dignity (Diniz, 2009), albeit under the term of the constitutional precept of health as a right for everyone and a duty of the State.

The survey revealed "biomedical rationality versus emancipatory rationality" when managing health and disease processes in both countries. On the one hand, testimonies revealed weakness in the materialization of the autonomy of subjects-users in face of the contemporary biomedical imperative to prevent probabilistic risk. The risk prevention device showed to be at the service of quality of life and it has proven to be prone to the prescriptive practice, inducing the emptying of dialogue potentials that can address the unique ways in which people relate to their life systems, as well as the way how they perceive, experience, feel, and think of health. In contrast, it also expressed emancipatory rationality, which generates concrete and symbolic strategies to cope with deconstruction of the historical practice produced through the path of obedience. Unlike Brazilian speeches, Italian testimonies showed the peculiarity that, even supported by biomedical rationality, appreciate listening aimed at risk prevention.

We grasped the need to expand the recognition of the ethical dimension in the production of care, in order to anchor shared paths, paving it in such a way that the cognitively competent user society can move on with freedom and confidence in their consolidation as historical subjects, authors of their histories. Data showed that the care process requires interaction in the light of the principle of singularity, the expression of each person, and ethi-

cal treatment in the way how this principle emerges in everyone, respecting the different inner times and contexts. It requires commitment to the ethical dimension of care and, quoting Gomes and Ramos (2014, p. 978), "[...] ethics as utopia of a new subject."

Another category explored was "from the historical condition of minority to the wish to be autonomous." The minority referred to herein took the metaphorical sense in the option to attribute life tutelage to the general practitioner. Brazilian general practitioners revealed the minority condition in subjects-users related to the feeling of shame to express, as the absence of concrete and symbolic resources to obtain the knowledge inherent to experiences of the health-illness process. Because of the strong trait of social exclusion fueled by feelings of smallness imprinted in a large portion of Brazilian society, it is likely that this is not an option for minority, but do not feel able to do so and do not understand autonomy as a universal human value.

Brazilian testimonies pointed out productivity protocols, imposed by administrations, as an instrument for the preservation of the minorities, revealing the need that the Brazilian PHC reviews its role in the construction of health care network in SUS, especially the way how it has built its programmatic actions. The right of subject-users to express their promoting, preventive, and curative knowledge constructed within their social groups has been subsumed by the productivity requirement, representing a setback in achieving the right to health as a right to citizenship.

Italian general practitioners also utter the minority of subjects-users. Using authoritarianism, a doctor pointed out that the subject-user shows up active in the decisions regarding her/his health-illness process when she/he chooses to "do not get lost" (Zavattini/I). However, more emphasis was observed in recognizing adult subjects, connoisseurs of the right for expression and the right to put their autonomy into practice with regard to their care as a right of citizenship.

The research revealed the need that the Brazilian PHC dialogues with humanities' theories and invest in mechanisms to boost ethical behavior to push the autonomy of competent subjects with regard to decisions about their health-illness processes, through the solidification of estimated values in

realities (Finkler, 2009) and promoting the debate about the role that the concept of risk has generated in contenance of suffering. Towards the age of enlightenment, concerning health and risk, fueled by a universal autonomous horizon.

The PNAB explains the importance that actions are guided by comprehensiveness of care, accountability, humanization, and social participation, as well as the importance of impact on the autonomy of subjects-users. However the adoption of risk criteria by the policy has represented a hegemony operation unifying thought and action aimed at the production of a health identity (Gramsci, 2007) as risk prevention: moving from contenance of actual health at this time to that of risk of probabilistic life.

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Authors' contribution

Lima participated in the conception, design, analysis, data interpretation, and writing of the article. Verdi participated in the conception, analysis, and data interpretation.

Received: 22/05/2014

Approved: 11/11/2014