

## **Solidarity in family medicine in Brazil and in Italy: reflecting on ethical issues and contemporary challenges**

**A solidariedade na medicina de família no Brasil e na Itália: refletindo questões éticas e desafios contemporâneos**

**La solidaridad en la medicina de familia em Brasil y em Italia: reflejando cuestiones éticas y desafíos contemporâneos**

**Rita de Cássia Gabrielli Souza Lima<sup>I</sup>; Marta Inez Machado Verdi<sup>II</sup>**

<sup>I</sup>Doctor of Dental Surgery. Post Graduation Program in Public Health, Federal University of Santa Catarina (UFSC). Rua Francisco Vieira, 567. Morro das Pedras, Florianópolis, SC, Brasil. 88.066-010 <rcgslima@terra.com.br>

<sup>II</sup>Nurse. Post Graduation Program in Public Health, Federal University of Santa Catarina, UFSC.

### **ABSTRACT**

This study reflects on solidarity in the practice of family medicine in two realities. The objective is to search for solidarity as an ethical principle in the relationship between family doctor and subject. It is a descriptive exploratory research carried out in Florianópolis, state of Santa Catarina, Brazil, and in the Province of Rome, Lazio Region, Italy. It included fourteen Brazilian family doctors and fifteen Italian family doctors. The theoretical framework consisted of Pierre Bourdieu's theory of Symbolic Power. The results show the importance of the role of the family doctor in the materialization of this ethical principle, as a spokesman for scientific knowledge and as an agent of a State policy. Solidarity was understood within distinct domains and the discursive productions also demonstrated the negation of solidarity in such practice. Globalization proved to be a contemporary challenge for an ethical practice of family medicine that is marked by solidarity.

**Keywords:** Solidarity. Family medicine. Brazil. Italy. Ethics.

### **RESUMO**

Este estudo reflete sobre a solidariedade na prática da medicina de família no Brasil e na Itália, na perspectiva de buscá-la como um princípio ético na relação entre médico de família e sujeito. Trata-se de uma pesquisa exploratório-descritiva, realizada em Florianópolis, Brasil, e na Província de Roma, Itália, com 14 médicos de família brasileiros e 15 médicos de família italianos. Sob o referencial da

teoria de poder simbólico de Pierre Bourdieu, os resultados mostraram a importância do papel do médico de família na materialização deste princípio ético, enquanto porta-voz autorizado pelo saber científico e agente de uma política de Estado. A solidariedade foi apreendida, neste recorte, sob distintos domínios, e as produções discursivas também expressaram a negação da solidariedade nesta prática. Em nível macro, a globalização revelou-se um desafio contemporâneo para o exercício ético e solidário da medicina de família.

**Palavras-chave:** Solidariedade. Medicina de família. Brasil. Itália. Ética.

## RESUMEN

Este estudio reflexiona sobre la solidaridad en la práctica de la medicina de familia en Brasil y en Italia, en la perspectiva de buscarla como un principio ético en la relación entre médico de familia y sujeto. Se trata de una investigación exploratorio-descriptiva en Florianópolis, Brasil, y en la provincia de Roma, Italia, con 14 médicos de familia brasileños y 15 médicos de familia italianos. Bajo el referente de la teoría de poder simbólico de Pierre Bourdieu, los resultados mostraron la importancia del papel del médico de familia en la materialización de este principio ético como portavoz autorizado por el saber científico y agente de una política de Estado. La solidaridad se ha considerado bajo distintos dominios; y las producciones discursivas también expresan la negación de la solidaridad en esta práctica. A nivel macro, la globalización se revela un desafío contemporáneo para el ejercicio ético y solidario de la medicina de familia.

**Palabras clave:** Solidaridad. Medicina de familia. Brasil. Italia. Ética.

## INTRODUCTION

The contemporary debate on solidarity is directed towards a broad universe of conceptions and representations proceeding from distinct individual and collective subjects and from different discursive productions.

In the present paper, solidarity will be analyzed as an ethical principle guiding the relationship between family doctor and subject<sup>1</sup>, when that relationship is dealt with in the realm of freedom, and will be pondered over within a moral dimension for an ethical practice in the family medicine field.

It emerges from the understanding that this practice is an equality and differences social space, in which one of the subjects is a social agent authorized by the scientific knowledge to participate in the care process of those who look for him in vulnerable conditions. Besides, it infers that the materialization of this symbolic interactions social field as a space of solidarity depends on specificities of power relations and on biopolitics effects.

This Public Health strategy of bodies control - biopolitics – came forth in the European medical policy in the eighteenth century as the first subject medicalization form aiming at protecting the social body for the hygienist political functioning. Its device – biopower - has significant visibility in the risk prevention contemporary culture of pluralistic and democratic societies, continuously transforming the body into biopolitical reality (Foucault, 2007).

Pierre Bourdieu's study (1996) on linguistic changes, communication relations that are established especially under symbolic power relations, brought a significant contribution to social reality, actions and social practices analysis, therefore corroborating this reflection. It stems from the premise that there is a producer (or a speaker) with a linguistic capital, a consumer (or a market) able to generate

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<sup>1</sup> Subjectum, what results from the relationship [and] body to body between living beings and devices (Agamben, 2007).

profit in symbolic and material dimensions, and an acquired value in the producer-market relationship that depends on power relations established from the producer's linguistic competence.

According to that sociophilosophical logic, speeches convey symbolic attributes which formalize the recognition of a given class of agents and the authorization to make performative statements, that is to say, in order to be legitimized as an authorized market depends on: the formality degree granted by linguistic competence, the market offer (scientific knowledge), the discursive demand produced and the ability to perceive it (Bourdieu, 1996).

Bringing that to a context of family doctor and subject, it is possible to deduce that once the family doctors linguistic market is official, given the approval granted to it by the linguistic competence and by the collective recognition of its symbolic capital, those professionals hold the authority to utter and make public their speeches as authorized spokesmen. They are social agents whose linguistic practices possess resources that can afford, provided that they are available, generating symbolic and concrete strategies for a supportive medical practice.

The family doctor, in the use of his discursive dispositions, can generate positivenesses in awakening the subject symbolic capital, strengthening his values and respecting his rights to establish new norms to anchor the health he wishes to restore to himself (Canguilhem, 2006). Practice would be thereby outlined in the realm of freedom rather than in the need domain. An ethical and dialogical practice, a practice of solidarity.

Caponi (2000, p.44) coadunates that thought when conceiving solidarity, in its moral dimension, as "one of the most desirable ethical principles" based on respect for autonomy, admiration, symmetrical arrangement among moral subjects and materialized by means of words, language, dialogue, argumentation and of availability (Caponi, 2000). The representation that "the self and the other had the same experience" (Sennett, 2003, p.62).

When examining thoroughly the medical practice historical process (Cosmacini, 2005; Caponi, 2000) one perceives that, unlike that dialogic practice in the realm of freedom, the hegemonic practice is from a relational model constructed throughout history as unequal, probably maintained by the representation of a subject as a passive being as well as by the recognition of the doctor being an authority holder of a knowledge that is above the subject's knowledge.

This reflection will take place in two global, democratic and complex societies, distinct in their Human Development Index (HDI)<sup>42</sup>, Brazil and Italy, aiming at understanding if solidarity, as an ethical principle, is inserted into the outline of symbolic relations of that practice and the cultural capital influence.

Both countries are in the Primary Care reorganization process, temporally distant in their Public Health historical processes, despite being ideologically similar, in the twentieth century, regarding freedom both restriction movements (the Fascist State and the New State) and call for freedom movements (Health Reforms). They are also biopolitically united in the twenty-first century by means of the risk prevention culture.

Pondering those similarities, farawaynesses and different biopower effects in a developed globalized society (Italy) and in a developing globalized society (Brazil), the subject and family doctor social space analysis, from an ethical point of view, is held from those effects rather than individually.

### **A brief retrospective of Public Health in Italy and in Brazil**

The Italian State has a worldwide historical recognition regarding the first actions implemented in the Public Health field. The first sanitation facilities, aqueducts, sewage and baths systems builders were the Romans, in the period they conquered the Mediterranean world (Rosen, 2006).

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<sup>2</sup> Italy ranks 20th in the world HDI whereas Brazil ranks 70th (Brazil, 2008).

The first public disinfecting practices were adopted at the end of the thirteenth century to cope with the first black plague outbreak. Organically, the Public Health emerged in Italy in the fifteenth century, transition period from feudal to modern age, in a new episodes scenario of the ancient plague. The country dealt with urban epidemics in the sixteenth and seventeenth centuries, entering the eighteenth century immersed in poverty and progress diseases. After its unification, in the nineteenth century, the country went through its first health reform, through which it was able to improve the Italians' health, inasmuch it associated social medicine with scientific contribution to bacteriology (Cosmacini, 2005). At that first health reform emerged biopolitics, an strategy adopted for the social body order maintenance (Guzzanti, 1999).

In the rise of the twentieth century, Italy confronted both the First World War, entitled "the last epidemic," and fascism. In the fascist regime, it arose Mussolini's health hygienist policy, presenting to the country a centralized preventive policy focused on public disinfection. Epidemics were still present and Italy was devastated by urban endemic diseases due to the Second World War, "the mother of revolutions" (Cosmacini, 2005).

The country was rebuilt after the Second World War, conquering numberless health reforms, among them the Health Reform 78, from which was originated the National Health Service (NHS), whose main proposal was to consolidate the universal right to health from health management decentralization to Local Health Units. The National Health Service was guaranteed in law by the Law 833/78 and the commencement of that Italian public service arose under the veil of insurgency of a new biopolitics devide in democratic societies, which was utopic according to Berlinguer (1997): Health for all in the year 2000.

Italy started to adopt a new health management model with De Lorenzo-Garavaglia Health Reform, in 1992, having in view the regionalization, under administrative, health and general directors' command. Together with that proposal, the family medicine, representing their trade unions, opted for private medicine. The family doctor, who had previously been a municipal public server, became a liberal professional covenant with the National Health Service (Italy, 1992). The country entered the twenty-first century harbored by the risk prevention biopolitics, and the National Health Plan, prepared for the 2006-2008 biennium, engaged in the Primary Care reorganization.

In Brazil, on the other hand, that historical trajectory started in the twentieth century, during the First Republic, in which appeared the first Public Health polices, constituted within a huge economic and social transformations scenario directed towards an insertion and modernization policy of the capitalist mode of production. Three health polices stand out: Rio de Janeiro port reform, aiming at the necessary adequacy to establish strong business relations with countries interested in establishing trade relations with Brazil; the urban reform, for showing beauty, although for such conquest disrespected social differences; and the health hygienist reform, in order to beat epidemics and, consequently, change the Brazilian image and ensure the continuity of coffee exportation policy, which was the national economy flagship (Verdi, 2002).

In spite of emerging beneficial effects for the Brazilian health context, the instituted model engendered heavy social costs, including: lack of commitment regarding freedom of choice, health policy based on authoritarianism and disconnected from essencial values historically internalized by the Brazilian society and alienated from social inequalities (Verdi, 2002).

The Public Health state control model, the prevention, maintained its hegemony throughout the Brazilian Public Health historical process.

In the New state, the Brazilian Public Health has been institutionalized in order to give shape to a centralized system grounded in fascism (Arretche, 2005). After the Second World War, social conditions have grown worse and a great deal of diseases at population level have emerged.

In that postwar scenario, the United States decided to launch a foreign policy for Latin America that ushered the commencement of Preventive Medicine in Brazil, which endured for two decades

(Tambellini, 2003, cited in Arouca, 2003). In 1960, Brazil went through a social security system crisis, established after the Second World War, which prompted the individual medical care.

In the 1970s, Brazil experienced an "economic miracle", leading to a rural exodus and resulting marginalization in healthcare. Movements in the academy, faced with an unsustainable dictatorial scenario, impelled the medical practice, till then elaborated upon prevention control, to a social medical practice.

That movement was the embryo of the wide social mobilization for the Health Reform conquest, in the 1980s, a reform that was influenced by the 1978 Italian Health Reform. The end of dictatorship gave rise to the New Republic. The National Constituent Assembly called in the 8th National Health Conference, in 1986, in order to discuss a new health proposal which was approved in the 1988 Constitution.

The 1988 Constitution represented a great progress to the Brazilian society in the health field by assuring, at an institutional level, the right to health as a citizenship right.

The National Health System (SUS) was created. In 1990, SUS was regulated by means of the Health Organic Laws (8.080/90 and 8.142/90 respectively). In spite of the fact that SUS had shown good perspectives in early movements, it started to present limitations imposed by reality, triggering farawayness between the SUS that was planned and conceived by the Health Reform and the SUS that came into existence.

In that scenario it was established, in 1994, the Family Health Program (PSF). Anchored in the same logic of the Cuban, British and Canadian models, established in those countries in the 1980s, the Family Health Program elected the family and its social environment as the healthcare approach basic center (Brazil, 2007). It was based on the concept that offering health services in the community itself, supported by a multidisciplinary team through an interdisciplinary approach, could contribute to the social production of health.

In 2006, after twelve years of existence, it became a Primary Healthcare State policy and it started being named as Family Health Strategy (ESF), rather than being named as a program. The family doctor is one of the social agents that comprise the multidisciplinary staff that works for ESF. He differs from the Italian family doctor who opted for category privatization, though he is potentially committed to the social fabric of his area as well.

### **The methodological itinerary**

Empirical research of qualitative approach and of a descriptive exploratory character, evaluated and approved by the UFSC Ethics Committee under the number 213/07, accomplished in accordance with the Resolution CNS 196 (1996) determinations, in 2007, as part of the Master's Thesis.

The research subjects were 14 family doctors working in Florianópolis, Brazil, and 15 family doctors working in the Province of Rome, Italy. They were selected in view of the collaboration of Municipal Secretariat of Health, Florianópolis, Brazil, and of Health Directors of the National Health Service, Province of Rome, Italy.

Semi-structured interviews and observations recorded in a field diary were used for data collection. Data were analyzed through Bardin's Content Analysis (1977), resulting in two thematic categories: **the authorized spokesman and the authoritarian relationship - power relations specificities and solidarity in family medicine practice - between being supportive and not being supportive in different domains**. The Brazilian subjects' anonymity was guaranteed by the use of code names of members who comprise Clube da Esquina, a Brazilian cultural movement from Minas Gerais State that emerged in the 1960s, and the Italian subjects' anonymity was ensured by the use of filmmakers code names and by followers of the Italian Neo-Realism code names.

### **The authorized spokesman and the authoritarian relationship- specificities of power relations**

The Brazilian and Italian data analysis showed that the interaction between family doctor and subject is anchored by two practice models: a vertical practice, set up on an authoritarian relationship between family doctor and "patient", and another practice constructed based on a social relationship between two social agents in which the family doctor, as the authorized spokesman, acknowledges the subject as an agent of his care process.

In Italy, some of the interviewees expressed a care authoritarian practice, even though it was also perceived that this practice prioritizes the guided hearing and the bond, historically built in the Italian Public Health. Based on those statements, it could be seen that care design is delimited by family medicine concern in prioritizing risk prevention. The statements showed that "patients are empowered" to take care of themselves based on responsibility of preventing probabilistic risks:

[...] they do participate [...] they follow everything I say [...] they blindly trust everything I say  
(Visconti)

Based on Protection Bioethics - the applied ethics field, founded by Latin American researchers worried about Public Health ethical dilemmas and conflicts, committed to the alterity respect, to the materialization of dialogic ways between Public Health ethical and scientific knowledge, to the protection of vulnerable people (when applicants) and contrary to paternalistic State attitudes - the question posed requires visibility and discussion about the limits of this risk prevention mechanism in terms of its legitimacy and of citizen's privacy on his right to choose self-care (Schramm, 2006). In the delimitation of this study, it is noteworthy that preventing risk is being reflected upon a reality that does not involve third parties.

This vertical relationship would take a not morally questionable format when decided by both subjects in entire use of their cognitive and moral competencies as well as when the vulnerable subject explicitly place his confidence in the medical know-how, "although in a society of authentic subjects decisions upon their lives should be taken personally" (Schramm, 2008, p.3).

The confidence in medical know-how, in spite of being historically built based on an obedience agreed model, is the doctor-subject interaction axis. Its unfolding, the medical practice private nature and the the act uniqueness, added to professional performance, give to that practice the "dependent morality" character and the level of that dependence establishes the relationship route (Schraiber, 1993a, cited in Schraiber, 2008).

Referring to power, which is one of Foucault's genealogy domain, it can be noticed that the social relations as power spaces in which citizens act on others are endowed with potentialities and negativities (Machado, cited in Foucault, 2007). The authority relationship agreed on confidence or harbored by linguistic competence and by collective recognition is translated into power positiveness. The not agreed authoritarian relationship between family doctor and "patient" is the power negative conception expression, since the family doctor does not intervene "in the subject's" care, but rather "for the patient's" care. Hence, a morally questionable relationship.

In Brazil, the data analysis also showed an authoritarian care practice based on risk prevention prioritization, expressing responsibility towards changing habits and lifestyle as an outstanding axis to achieve "the overall quality of life" (Schramm, 2007), according to the statement below:

[...] we have to engage the whole family in a health lifestyle [...] I always say that we can try to find a way out together [...] he is as responsible for the treatment as I am. (Fernando)

That policy takes another direction in the Brazilian reality, inasmuch the Brazilian corporate demand differs greatly from the Italian. The significant gap between Brazilian and Italian Human Development Index (HDI) translates the space and time meaning in each of those realities. In third world countries

(as Brazil) global life takes place in a time compressed space, whereas in first world countries (as Italy) global life does focus on time, rather than on space, as long as this world is increasingly free of borders (Bauman, 1999).

This process of living configuration in different global societies shows that mobility conditions given to The National Health System (SUS) users and to the National Health Service (SSN) users are not symmetrical because whereas the Italian society owns its time the Brazilian society seems to possess a space chained to a time that does not have any owner. A time which restrains its movements. A time that obstructs its understanding ability in terms of care as a citizenship's right. A time producer of so many blemishes, able of probably inducing the perception that it is easier to choose the vertical relationship and, therefore, the minority:

[...] I try to give autonomy to the patient for him to look for his treatment by himself, but that is not always possible [...]. (Bituca)

On the other hand, both countries also showed an emancipatable practice model, rather than a non-paternalistic one. As authorized spokesmen to the application of performative utterances, Italian reports express the authority exercise in the construction of care for the Other from what that Other wishes for himself, as shown in the following statement:

[...] the sense I give to my job is a sense of global approach to individual integrity [...] I would never love being a tutor. (Puccini)

Brazilian family doctors also showed openness to turn power relations into a transformation tool in order to reach a liberating practice. It was possible to apprehend that the Brazilian family medicine practice is gradually building a dialogic practice, opening up possibilities for an integrated practice committed to the welcoming and to the qualified hearing, albeit based on the "patient's" responsibility and on risk prevention.

The main axis of this new model appear to emerge from the proposals established by the Brazilian State from the Family Health Program in 1994, in spite of some reports having expressed intrinsic values and life stories as determinants in designating a care model lived between two moral subjects, as shown in the report below:

[...] when I got into college, I was enchanted by family medicine, it looked like more beautiful to me [...] as that one who thought when I used to take my grandmother to the doctor [...](Marilton)

### **Solidarity in the family medicine practice: between being supportive in different domains and not being supportive**

In this category are discussed the need and freedom domains based on research subjects' conceptions on solidarity and the concept of practice with solidarity as well as the solidarity denial in the family medicine practice.

Endeavoring to classify these visions of solidarity in two different domains, it is important to bring to this discussion the compassion concept.

Compassion is structured based on a unique power device, built on servitude and on obedience, ushering vertical relationships, "between those who attend and those who are attended by someone else" (Caponi, 2000, p.16), thus being in the need domain.

Solidarity, in turn, if experienced in the freedom domain, is an ethical principle that translates willingness into respect towards human dignity.

When the Italian family doctors were asked about the sense of solidarity in family medicine practice, perceptions emerged within the need domain based on compassionate power technology, in the freedom domain, and also as a denial of the family doctor and subject relationship.

Reflecting the solidarity denial in the medicine practice of the Italian family, it was understood that this principle is denied for being understood as friendship.

When these professionals bring friendship to the medical practice universe, in other words, to a wider dimension, they show themselves apprehensive about making mistakes when giving a diagnosis and about conducting the meeting based on dangerous elaborations, as a result of primary emotions, as for example:

stay calm, it is nothing serious; [...] solidarity is a very dangerous element [...] you lose your clinical lucidity [...] you endanger the ideal practice [...] it makes you estimate badly [...] (Bertolucci)

When those doctors reported clinical trials to justify solidarity denial in their practice, they placed denial as a resource to preserve respect for the Other and for the own freedom of the Other. In other words, solidarity becomes compassionate and restrainer when understood as friendship:

[...] um grande amigo meu, bem mais velho que eu, meu professor de tênis, com câncer de próstata [...] não queria se curar e eu o controlava em tudo. (Bertolucci)

[...] a great friend of mine, much older than me, my tennis teacher, who had prostate cancer [...] did not want to be cured, so I controlled him in everything. (Bertolucci)

In regard to the senses bestowed upon solidarity in the freedom and need domains (as compassion), some Foucault's concepts (Caponi, 2000) about the relationship between power and freedom will be recapitulated in this study in a new approach to Cosmacini (2005), in an attempt to understand the solidarity historicity in the need domain and the power relations which are intertwined in that domain.

In Cosmacini (2005) were indicated some elements that signalize the way the care medical practice was built in emergency of Italian hospitals in the fourteenth century. The monarchists doctors were Christian doctors who saw Christ incarnated in the patients, and the relations were established based on charity. Hospitals were free charitable spaces and they functioned in a logic of promoting contention to the afflicted humanity that suffered with the incarnation of their Redeemer. In other words, the humanity was considered for what it represented.

In Foucault (cited in Caponi, 2000, p.16), that charitable dimension demonstrated in reports is the emergence result of "a new power exercise mode" provided by the way it was set up the care medical practice, generating questionable effects from the bioethical point of view, among them the ordinarily crystallization of the relationship between family doctor and patient in the need domain:

[...] my wife tells me that I'm more a priest than a doctor [...] who knows in ten years from now I can be a bit tougher and say it's not my problem [...]. (Ingrao)

The asymmetric representation, compassion towards the other, seems to have historically remained in the medical imaginary as a legitimate moral action due to the fact that it presents itself on a colorful humanitarian. That strategy erupted under the veil of a power action available to the Other (merciful), named by Foucault as pastoral technology<sup>3</sup> (Caponi, 2000).

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<sup>3</sup> Power relationship over which the shepherd is responsible for the material existence of his whole herd as for each one of the sheep (Caponi, 2000).

Corroborating that opinion, Nietzsche (1981, p.133) states that, in the charitable action, "we think much more in ourselves than in others." The action axis is placed in a projection mechanism to alleviate the own discomfort. By acting on the other's behalf in order to relieve the suffering of another human being, man stops his own pain.

Given the aforementioned matter, it was perceived that solidarity presented in some reports, within the need domain, does not actually correspond to solidarity, but to merciful charity, to compassion, an entity that limits freedom and which is structured along a vertical dimension, resulting in non-symmetrical relations.

The solidarity concept in the freedom domain and as key element in the relationship between family doctor and subject was present in the reports as well. This fundamental human right, freedom, is deemed crucial in the Italian Public Health historical process and it is one of the inspiring principles of the National Health Service consolidation. Perhaps, for that reason, for its historicity, solidarity has been conceptually presented in an expressive form in the freedom domain:

[...] it is crucial in our practice [...] make them talk [...] share. (Tornatore)

[...] solidarity is being ready, it's not care attendance. (Pasolini)

These statements meet significant resonance in the expressive hegemony noted in the Italian statements that family medicine establishes its practice with human beings rather than with patients. Notwithstanding, the speeches reveal an incongruous synchronism: the supportive relationship recognition in freedom domain was shown by interviewees on a relational model that shows itself authoritarian by giving priority to risk prevention and to the "patient's" responsibility over his care process.

Moreover, by expressing the idea of practice of solidarity based on practical experiences with the subjects, the interviewees have shifted away from the freedom domain and showed it in the need domain, a practice "for the patient."

The understanding of that displacement seems to lay in the fact that human beings not always act in the same manner they defend their own standard. In other words, man creates his normative guide of values that must be disclosed in his process of living. However, that does not mean that those values will always be expressed in actions. "Values are manifested in actions when they function as a fact substantiated to explain commitments, objectives and actions" (Fernandez, 2004, p.219).

Values coexist in a social field of tensions and when desires and aspirations overcome the area for what is possible, due to the lack of self-understanding or because of the tendency for social conformity, gaps are formed between the values expressed in consciousness, articulated in words and manifested in actions (Fernandez, 2004). That perception seems to facilitate the understanding of the gap between conceiving solidarity in the freedom domain and acting in the need domain.

In the Brazilian context, solidarity was signaled as uncertainty over its existence in family medicine practice and, when displayed as crucial, it was present on different ways: listening, bond, availability, generosity, dealing with one another as equals, putting yourself in the other's place, and flexibility were the most expressive forms. One of these looks is shown below:

[...] it is to be flexible [...] to find a way out of your straight assignments [...] to get involved to develop new forms of care. (Sérvulo)

These reports demonstrated the emergence of a practice committed to qualified hearing and to bond. Nevertheless, not all interviewee showed availability for practice of solidarity set up on the freedom

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domain. Several contradictions were observed by approaching those concepts of solidarity to required clinical examples, as shown in the following statement:

[...] solidarity is to understand the person's reality [...] one day a woman came asking me if I knew where she could find a plumber [...] I said, so it's not possible, is it? [...] there are days that we are tired. (Salomão)

The interviewee expressed commitment towards a health broadened concept by indicating willingness to "understand the person's reality", but showed himself contradictory when expressed the practice in discourse. That inconsistency between discourse and practice was justified by the need for the user society understand the existence of limits that should be considered in the family medicine practice. Going back to Fernandez's (2004) thoughts - stating that the values normatively elected by the man not always are present in his actions - and considering the medical discourse a legitimated performative utterance endowed with symbolic capital, that is to say, endowed with values that, in the family medicine exercise, should be at the subject's care process service and should be committed to the Family Health Strategy doctrinal principles, this unsuitable use of performative utterance requires reflection from an ethical point of view, since it is beyond contradiction itself.

### **Final remarks**

The findings of this study showed two axis on which rests the solidarity question in the family medicine exercise in Italy and in Brazil.

The first discussion axis was led towards the social interaction space between family doctor and subject aiming to understand how solidarity is expressed in that meeting. Both in Italy and in Brazil, solidarity was shown in different patterns. To some doctors, the supportive relationship in family medicine presents negativeness, while for others it presents positiveness.

For those who see solidarity as a fundamental device for that practice, there are those who conceive it in the discursive articulation and in practice examples on the freedom domain, in which the "patient" is the "subject," being respected, in that conduct, the subject autonomy as well as the consistency between knowledge and action.

There also are those who expressed a solidarity conception based on freedom. However, when they were asked to report the idea of practice in their speech, they showed it in the need domain, that is, as compassion.

Some interviewees pointed to solidarity in the need domain, in the speech and in the practice idea, demonstrating that they considered the "patient" as a "patient." And, lastly, doubts as for the solidarity existence were also revealed in the family medicine practice.

In freedom and need domains underlies the relational model established between family doctor and subject.

Solidarity on the freedom domain was presented by family doctors, social agents, who, as authorized spokesmen, authorized by the linguistic competence and being socially legitimated, recognize, respect and foster the subject's autonomy and his preferences, while allocating cultural capital.

As mentioned in the Human Development Index (HDI) of both societies, the Italian cultural capital is different from the Brazilian cultural capital. Both countries are also distinct with regard to space-time configuration in the process of living of their respective societies.

It is probable that due to the low cultural capital in most of Brazilian society, constructed along a historical process marked by social exclusion, it is acceptable the possibility of the "patient" recognizing himself as the holder subject of the right to choose self-care.

That society confronts daily ongoing emerging needs in a crystallized scenario of persistent needs (Garrafa and Porto, 2003) and of temporary absence of belonging, unlike the Italian society which has historically recognized its right to choose.

In spite of the fact that this recognition does not confer homogeneity to the cultural capital of the Italian society, symmetrical social relations and absence of social blemishes, the family medicine practice in Brazil requires a stronger personal investment by the family doctors in "freeing the patient," historically oppressed in his living space.

In relation to the statements exposed based on compassion, Brazilian and Italian family doctors showed they controlled the "patient" care process in a relationship authoritarian model, solidifying, thereby, the historically constructed inequality of subject denial. It is noteworthy that it was not mentioned in the statements any agreement between the parties in order to legitimize the family doctor to manage that care.

The relationship of solidarity as an ethical principle inscribed in the field of real was also present in the delimitation of this study, signaling, in this way, that a part of this practice is substantiated on horizontality and on symmetrical, dialogic and argumentative relations.

The second axis encompasses a core and contemporary issue, not anymore in a micro level of interaction between family doctor and subject, but rather in the global societies social universe in general, whose role shown in this research has an impact on the freedom of choice, on respect to autonomy and on the ethical practice construction; consequently, on a practice of solidarity: the effects of biopolitics.

The risk prevention hegemonic political culture, established in democratic and pluralistic societies in global times, carries, underlying a previous view of the need to adopt healthy behaviors and lifestyles, a control device (biopower) that sets off poor visibility: the citizen's right limitation to decide upon his care, his new norms, the disease representation in his life, and upon his ability to bear discomfort inherent to human condition.

That biopower strategy entered the subjects' body and lives and it seems to be shifting away from its protective role to vulnerable people towards the intervening role in issues guaranteed by law and of the subject's competence (Schramm, 2007). Dressed in the protection and order control apparel, it touches issues related to private domain, as if they were the chaos.

That state control strategy, from a bioethical standpoint, anchored in its own scientific assumptions and seized in a single logic, that one of the "New Global National States" which determines to the social body the route to be tracked in order to reach health, controlling it and dictating to it how to live, is not morally acceptable in situations where third parties are not involved. Its effects dramatically achieves the Primary Care, since they derive from a perverse policy sufficiently able to re-signify, according to its vision, attempts of practice horizontality.

In this way, it is a great challenge for bioethics to think of the social space between family doctor and subject as a space of solidarity, compounded by symmetrical relations between two moral subjects "of age" in globalized societies.

In the Brazilian outline studied, minority can be a conformity and resignation option resulting from restrictive social specificities. According to Bauman (1999a), globalization is a process that fragments under the guise of uniting, conditioning the process of living to immobilization of the vast majority of citizens. The moving possibility in global societies is stratified. The big ones are free to have their own motion, while the small ones are left imprisoned in their spaces. In other words, human condition was stratified as "if we were not all the same, that is, humans" (Arendt, 2008, p.16).

It is worth highlighting that in Brazil, while coping with potentially asymmetrical social relations, that minority tempts the user society with stronger persuasion, albeit Italy classification, as a privileged Human Development Index holder, does not confer it social immunity, given the historical inequality between north and south regions.

The contemporary bioethical challenge, regarding labor relations in Primary Health Care, gateway to unlimited human suffering, lies on fostering the responsibility perception of health professionals, whether they are institutionalized in the public domain (family doctor in Brazil) or in the private domain covenant with the State (family doctor in Italy), and of States not careful enough, leading them to a constant critical analysis of authoritarian practices effects in the subject's living process. Those effects, despite being interpreted by many as inaccurate and unattainable by theoretical reason, are potentially destructive to a symbolic level and may breach the subject's right to privately establish his own norm, as reported to a Brazilian family doctor:

[...] I starved and I was in need all life long; now that I have money to buy my sausage, I cannot have the things I like. (Bituca)

## **COLLABORATORS**

The author, Rita de Cássia Gabrielli Souza Lima, was responsible for the research, analysis and for writing this paper. Marta Inez Machado Verdi supervised the research and reviewed the text.

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<sup>i</sup> Address: Rua Francisco Vieira, 567. Morro das Pedras, Florianópolis, SC, Brasil. 88.066-010.