

## 45 years of Family and Community Medicine and 40 years of the Brazilian Society of Family and Community: role, challenges and perspectives in the process of strengthening and qualifying primary care and the Unified Health System in Brazil

45 anos de Medicina de Família e Comunidade e 40 anos da Sociedade Brasileira de Medicina de Família e Comunidade: papel, desafios e perspectivas no processo de fortalecimento e qualificação da Atenção Primária e do Sistema Único de Saúde no Brasil

*45 años de Medicina Familiar y Comunitaria y 40 años de la Sociedad Brasileña de Familia y Comunidad: rol, desafíos y perspectivas en el proceso de fortalecimiento y calificación de la Atención Primaria y del Sistema Único de Salud en Brasil*

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In the commemorative year of 40 years of the Brazilian Society of Family and Community Medicine (SBMFC) and 45 years of Family and Community Medicine (FCM) as a specialty in Brazil, this article, in the form of interviews, brings views and perceptions about residency programs in FCM and the participation of the specialty in undergraduate studies in health management research. Respondents here represent the past, present and future of FCM and SBMFC. They are professionals who relate to the history in these 40/45 years, considering some of their roles at FCM and SBMFC in this period. Their relations with FCM and SBMFC can be read in the Editorial of this commemorative issue. In this block, they answer questions that cover the challenges faced and the advances and perspectives of FCM and SBMFC in strengthening and qualifying primary care and the health system as a whole.

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**Source of financing:**

Not applicable.

**CEP report:**

Not applicable.

**Origin:**

Invited.

**Peer review:**

Not applicable.

Received on: October 1, 2021.

Approved on: October 17, 2021.

**Editors:**

Maria Inez Padula Anderson and Leonardo Cançado Monteiro Savassi

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**How to cite:** Anderson MIP, Savassi LCM. (orgs.). 45 years of Family and Community Medicine and 40 years of the Brazilian Society of Family and Community: role, challenges and perspectives in the process of strengthening and qualifying primary care and the Unified Health System in Brazil. Rev Bras Med Fam Comunidade. 2021;16(Suppl 1):7-17. [https://doi.org/10.5712/rbmfc16\(Suppl1\)3244](https://doi.org/10.5712/rbmfc16(Suppl1)3244)



**RBMFC: Looking at history, what factors would you identify as the ones that most hindered or posed obstacles to the introduction of FCM in Brazil?**

**Ricardo Donato Rodrigues:** The main obstacle is related to the hospital-centric care model centered on the biotechnological paradigm, which is still dominant in the country.

**João Werner Falk:** For decades, FCM, until 2001 called General Community Medicine (GCM), was valued little or nothing by medical entities and even opposed by them and by other medical specialties. The Brazilian population and the media were completely unaware of it, and the job market was practically non-existent. In the late 1980s, criticism of the GCM intensified, both from the “medical corporation” and the “right” (who considered the area as “Communist Medicine”, state-centralizing) and from the Brazilian Association of Collective Health (ABRASCO) and the health doctors to the “left” (seeing GCM as “American Family Medicine in disguise” of the time — model “poor health care for poor people”, etc.). In 1988, the National Institute of Medical Assistance of Personal Welfare (under the Presidency of a UERJ professor linked to ABRASCO) cut all medical residency grants for General Community Medicine in Brazil — and only cut grants for this specialty. Many programs closed, others changed their name to Preventive and Social Medicine so as not to close, and the very few that survived were those whose grants were not from the National Social Security Institute (INAMPS). GCM almost ended in Brazil, and it took 21 years of attempts to affiliate the Brazilian Society of Community General Medicine to the Brazilian Medical Association (AMB) until it was achieved, and with many difficulties, in 2002, already under the name of SBMFC.

**Airton Tetelbom Stein:** It was a pioneer in training a specialist with an interest in prevention and quality of life. Generally, the focal specialist’s interest is in a disease; this new paradigm for the physician has always been difficult.

**Maria Inez Padula Anderson:** I think that the biomedical paradigm, focused on the disease, embodied and strengthened within medical schools, especially since 1910, as a result of Flexner’s studies (Flexner Report), played an important role in this process of non-recognition or non-valuation of the specialty. This paradigm, still hegemonic, brought many benefits to people’s health, but it also brought important limitations since its logic is that hospital-centered health systems would be the most adequate to train doctors to meet the health needs of the population. Accordingly, Primary Health Care (PHC) - the central locus of FCM’s work - gains the label of “simplified medicine” because it deals with “simple diseases” for which specialists would not be needed and, consequently, FCM acquires a label of low valuation and “low status”.

**Gustavo Gusso:** The confusion of population strategies with individuals and the understanding that the focus of FCM should be populations and not the person.

**Nulvio Lermen:** 1. Lack of a clear professional training policy that focused on medical residency as a necessary standard for performance and that, in this way, acted in regulating the supply of specialists and their distribution in the country. 2. Lack of understanding and support from medical entities regarding the role and training of FCM. 3. Insufficient investment in PHC in both the public and private sectors.

**Thiago Trindade:** In the first decades of FCM’s history, the lack of support from educational bodies and civil society entities, representatives of health professionals, made it difficult to train these specialists, associated with a lack of opening in the labor market due to poor organization of the current system in structuring PHC. In the following decades, the little appreciation of FCM by managers from the three

spheres made it difficult for this specialist to be recognized as fundamental and essential for the structuring of PHC and the Unified Health System (SUS), often competing with outdated PHC models.

**Daniel Knupp:** Historically, low demand for FCM has been a major obstacle. In other words, the little appreciation of the specialty in the theoretical-scientific field and, mainly, in the field of valuing FCM in the work spaces makes relatively few people opt for the specialty. Accordingly, we have, for example, a great idleness in residence vacancies in FCM, which have barely responded to the stimuli that have been tried in the last ten years.

**Zeliete Zambon:** The main factor that I identify as hindering the insertion of FCM in Brazil for me is the failure to appreciate PHC as being important for the organization of the health system. Another issue is the medical graduation curriculum itself, which also does not rate the specialty highly. The absence of Family and Community Doctors (FCD) as professors. Finally, FCD being considered by public health scholars in the 1980s, when they thought that it would act against the strengthening of Public Health and the basis of a poor-to-poor health services format, or the strengthening of a basic health care basket that falls far short of what is needed.

**Ana Clara Arantes Gonçalves and Geferson Pelegrini for the Resident Directory:** The insertion of FCM in Brazil started to be more valued from the moment that graduation in medicine dedicated more hours to this specialty, as well as to practical activities in PHC. However, considering that since 1970, GCM was already a practice in the country; this insertion, as well as the reformulation of the curriculum, was done late. In addition, there was the challenge of creating well-structured residency programs that were present in all regions of the country. Without strong residency programs, it became more difficult to achieve specialty recognition. Today, in the labor market and in society in general, there is still the appreciation of the focal specialist to the detriment of the generalist, and I believe that FCM still needs to occupy more spaces so that it has more recognition and greater reach for its practice.

**Priscila Ferraz Bortolini for ALASF:** The lack of public policies that strengthen PHC and the medical prejudice in relation to the specialty are, in my view, the main factors that hampered the insertion of FCM in Brazil.

**RBMFC: What factors would you identify as the ones that most contributed to the insertion of FCM in Brazil?**

**Ricardo Donato Rodrigues:** The need to reorient the care model based on the development of a qualified model of primary care only achievable with the work of a doctor with generalist training, and not with focal specialists, to face the chronic crisis situation experienced by the health sector in Brazil. From this perspective, three pioneer medical residency programs were established in this area in 1976. The implementation of the Family Health Strategy (ESF) in 1994 reinforced this process of changing the teaching-care model.

**João Werner Falk:** The mobilization of a small group of tutors, residents and former residents of GCM from 1985 onwards, who held regional and national meetings, participated in the 8th National Health Conference in 1986 and, in the same year, reactivated the SBMGC, held the 1st Brazilian Congress of General Community Medicine in Sete Lagoas/MG and managed to get the Federal Council of Medicine (CFM) to recognize GCM as a medical specialty and the Brazilian Society of General Community Medicine as its representative. They also created the Revista Brasileira de Medicina General Comunitária, which unfortunately only had one issue and ended. In the following years, each of the Brazilian Congresses

of GCM was important — from the 2nd in 1987 to the 4th in 1991 and then as the Brazilian Congresses of FCM from 2001 onwards. Also the holding of the 1st Luso-Brazilian Meeting of General, Family and Community Medicine in Rio de Janeiro (RJ); the founding of each of the GCM State Societies, then FCM State Associations; and the reactivations of the SBMGC in 1986, 1990 and 2001, now as SBMFC. Also very important was the creation of the Family Health Program (PSF) in 1994, later changed to ESF, greatly increasing the job market for FCM. In 2002 the SBMFC joined the Ibero-American Confederation of Family Medicine (CIMF) and the World Organization of Family Doctors (WONCA). From 2004 onwards, the examination and curriculum competitions for the Tenure of Specialist in Family and Community Medicine (TEMFC) began in partnership between the SBMFC and the AMB, enabling a large contribution of new specialists in FCM.

**Airton Tetelbom Stein:** Strengthening SUS as a public health system that is responsive to the needs of the population. The encouragement of the SBMFC and also the state associations were very important for its insertion. Another factor was the fact that several colleagues have completed master's and doctoral degrees and started to work, not only in health services, but also in medical schools.

**Maria Inez Padula Anderson:** I think that the health reform movement, which took place in Brazil, even before 1978, after the World Health Conference in Alma Ata, was the first major milestone that contributed to the insertion of FCM and PHC into health systems. The conference highlighted the serious limitations of the hospital-centered model and placed PHC on the international agenda of health systems, although there were still problems of interpretation and conceptualization of what PHC would be and still simplifying its role and function. In Brazil, from the ESF onwards, FCM, despite having been in existence for 45 years and never having been properly valued either by the academy or by the management, started to have a window of opportunity for its visibility

**Gustavo Gusso:** The relationship with collaborators from other countries, especially Europeans, the personal initiative of some leaders and the epistemological dissociation of collective health and preventive medicine.

**Nulvio Lermen:** 1. Expansion of primary care in the public sector with the ESF. 2. Need for medical professionals with a generalist profile to work in sparsely populated areas. 3. Success from the clinical point of view and cost-effectiveness of primary care strategies initially in the public sector and later in the private sector.

**Thiago Trindade:** Initially, I would highlight the pioneering spirit of the first residency programs in the 1970s and 1980s, which were essential to introduce this specialist to society and to the Brazilian health system. Then, the creation of the PSF in 1994 brought a great opening of the job market for FCM. For the 2000s and 2010s, I would highlight the programs to support training in FCM, from graduation (with the National Curriculum Guidelines for undergraduate teaching in Medicine and for other areas of health in 2001 and 2014, PRO-SAUDE, PET-SAUDE) and then with incentives to promote residency, with federal policies inducing these two decades (PRORESIDENCIA, Programa Mais Médicos in its axis of fostering residency), which helped to expand the number of residencies in Brazil. The support of the municipalities, especially in the last decade, with complementation of residency grants and support for tutoring, has been essential to attract new residents and qualify training with qualified tutoring.

**Daniel Knupp:** The SBMFC had a decisive role in the growth of the specialty over the last decade, seeking to articulate itself with medical entities to defend the importance of the specialty and collaborating with the Ministries of Health and Education in a series of actions, particularly in the expansion of vacancies

residency in FCM and the insertion of FCM in undergraduate education. In addition to articulation and inter-institutional actions, the role of SBMFC in expanding the tenure test, in the growth of Brazilian FCM congresses, in the development of a competency-based curriculum, in the development of the tutors' workshop and Euract, in the translation and production of books of importance to the specialty and leading the way at WONCA and CIMF (including the holding of WONCA Rio in 2016) were also fundamental to the growth of the specialty.

**Zeliete Zambon:** Search for a more comprehensive and resolute Primary Care format, spending on Health increasing rapidly — I would identify them as the factors that most favored the insertion of FCM in Brazil.

**Ana Clara Arantes Gonçalves and Geferson Pelegrini for Resident Directory:** The reformulation of the curriculum of medical schools was essential to bring students closer to the reality of PHC. The strengthening of residency programs and their increase in number also made the specialty reach more regions of the country. Today, people's need for more comprehensive and individualized health care is still growing, especially when thinking about care coordination, both in the public network and in the supplementary system. In fact, I believe that the presence of FCM working in health plans and/or its own office has contributed in recent years to the visibility and appreciation of this professional.

**Priscila Ferraz Bortolini for ALASF:** The collective effort of the population, managers and health professionals would be the factors that I identify as favoring the insertion of FCM in our country.

**SBMFC: How do you assess the insertion and current situation of FCM in the health system in Brazil? What are the main advances? What are the main challenges?**

**Ricardo Donato Rodrigues:** The expansion of the ESF favored the expansion of training programs in FCM and the absorption of its graduates in the staff of the municipal health departments. The creation of incentives to complement these residents' scholarships has contributed to a more adequate filling of the vacancies offered. Government policies aimed at expanding and qualifying the ESF, which had been in place until 2016, provided indisputable gains with the results achieved in this field. However, this process was already interrupted with the 2016 National Primary Care Policy. The Health Minister of the Temer government stated that SUS did not fit into the nation's budget and the ESF dismantling policies continued since the first year of the Bolsonaro government, a framework that causes considerable pressure on FCMs and favors the private health market in the country. Resisting dismantling and continuing the process that was underway is the great challenge these days.

**João Werner Falk:** The job market for FCMs has been growing in SUS since the creation of the PSF in 2004 (now ESF) in PHC, as well as for professors at universities, residential tutors, in health management — mainly at the municipal level — and, more recently, in supplementary health. All of this with the growing recognition of the importance of FCM. The quality and updating of professionals has also been growing continuously, as have courses, competitions, congresses and other events, debates in working groups and on the SBMFC discussion list. Some of the challenges are to improve the quality of jobs, increase remuneration and establish more stable and less precarious links, with more longitudinality, less outsourcing, etc.

**Airton Tetelbom Stein:** I see the current insertion of FCM acting on several fronts - in the public service, in the private service, as a professional trained to meet the demand in a health center, as a manager, as an educator and mainly doing advocacy so that patients, especially the most vulnerable,

can receive comprehensive care, who is centered on the person and who values the effectiveness of interventions, so that we have an outcome for quality of life for patients who live in areas where FCM operates. Learning to work in a multidisciplinary team is also one of the essential characteristics.

**Maria Inez Padula Anderson:** I believe that FCM has gained space and visibility on the national scene, although there is still heterogeneously, considering that PHC has greater municipal responsibility, and that we have almost 6,000 municipalities, the vast majority of which are small and with few resources and technical knowledge to enable the development of a quality PHC, along the lines of the ESF. In this context, inducing policies and technical-financial support by the Ministry of Health are fundamental, such as those initiated in the first decade of the 2000s — from Pró-Saúde, which acted in the insertion of PHC in undergraduate courses in medicine; passing through Pró-Residência, which allowed the creation and/or expansion of FCM programs, the creation of ProfSaúde; the Master in Family Health; to ESF financing policies, including support for staff pay for building construction. A major concern is the discontinuity of these processes with the introduction and practice of a government with a strong capitalist/neoliberal base, as has been happening since 2016, with the coup d'état.

**Gustavo Gusso:** Advances have been greater clarity of definition, content and attributes, especially the difference between PHC, FCM and ESF, although there is still considerable confusion. The challenge is the confusion with party politics and the concepts of private system, private service, commodified service, public system and state system.

**Nulvio Lermen:** FCM is very well established in the public sector and increasingly embedded in the private health sector. There is still a need for advances in the regulation of medical training and recognition among peers. Added to this, there is also the need to establish the role of FCM as a competent and resolute clinician, and not a professional focused only on prevention and health promotion - a view that has changed over time, but which is connected directly with the lack of specific training requirement for working in PHC. As a major challenge for the maintenance of the specialty's growth, I think it is essential to maintain in the public sector the prioritization of primary care as a state policy, thus protecting it from government alternation, which can be a risk to its continuity. Despite the challenges and difficulties, I have a very optimistic view for FCM in the coming years. With the advancement of technology, bonding and access gain relevance and can be facilitated by the advent of strategies such as telemedicine, for example.

**Thiago Trindade:** Today, FCM is recognized in SUS and in supplementary health as the key specialty for the development of quality PHC. We had a substantial advance in the offer of residency vacancies in all regions of the country, bringing the offer of this professional to different populations. We still need to keep expanding the vacancies and filling them. I would emphasize the need to make FCM mandatory for PHC practice in Brazil, a fact that has become evident in the international experience as the key turning point for the orientation of health systems towards quality PHC. With these two measures, we would move to balance the supply and demand of this specialist in the system, reaching 30–40% of Brazilian physicians, and thus we would in fact have a PHC-oriented health system with this specialist occupying all the health teams of the family in the future.

**Daniel Knupp:** We made progress in valuing FCM in care and management in general. In the scope of SUS, it seems to me an advance that, although significant, is still quite restricted to municipalities and specific periods, and it is somewhat timid and not very linear if we think about the health system as a whole. In the context of supplementary health, considering that this is a space historically marked by a

fragmented system, with little or no role for PHC and FCM, it can be said that the insertion of the specialty has also advanced significantly.

**Zeliete Zambon:** At this moment, we are the specialty that stands out the most, with a growing presence in Brazil. We are recognized as the specialty that will make things different; who will be responsible for managing people's health to obtain better results and more satisfaction. The biggest challenge we face is that this vision is not only linked to the expectation of increased profits for healthcare companies. Another great challenge is to bring this vision to Family and Community Doctors: that we have a lot to show in caring for people, communities and the environment, doing science, management and assistance and being able to change time and quality for all, which would even affect the country's economic sustainability.

**Ana Clara Arantes Gonçalves and Geferson Pelegrini for Resident Directory:** There is a visible advance with regard to people's access to a FCM, as well as knowledge about what this professional does. The dissemination of the work of several of these physicians in Brazil through social networks greatly increased the search of medical students to know more about the specialty and to be interested in residency in FCM. In addition, the understanding that there was a social aspect, in which the family doctor only attended to the most vulnerable part of the population, has been gradually undone, since everyone can count on a family doctor, whether in the public health system, or in the supplementary. The challenge is to reconcile the practice based on the best scientific evidence of family doctors, based on the interests and needs of their community, with the logic of the health market, when applicable. It is also a challenge to act in contexts where there is no well-defined territory or where there is a lack of resources.

**Priscila Ferraz Bortolini for ALASF:** FCM is still taking short steps, but I see a greater interest from medical students in knowing the specialty. This is due to the dissemination made by Academic Leagues associated with student movements, which no longer accept this hospital-centric medicine of past decades. The biggest challenges are to link these students and keep them engaged in the cause, as we still have a shortage of FCM in teaching. And without them, it's hard to bring good examples to students.

**RBMFC: How do you assess the current situation and role of SBMFC in relation to FCM and PHC? What are the main advances? What are the main challenges?**

**Ricardo Donato Rodrigues:** As mentioned in the previous answer, the current situation is critical due to the instability created by the policies of the Ministry of Health, instituted in the absence of the National Health Council (CNS) in the last five years. It is up to the SBMFC to articulate itself with the movement in defense of SUS and the ESF, led by the CNS itself, and to develop efforts aimed at the implementation of a State career plan, especially for the health professionals of PHC/ESF, particularly FCM. In the same sense, make efforts aiming at the universalization of medical residency places, with 40% destined to FCM; to the implementation of programs for the formation and retention of preceptors, the expansion and qualification of the ESF, the continuity of actions in the field of continuing education and permanent education, and also the reduction in the number of people/families registered per team, as required. that there is expansion of training and insertion of new professionals in the units, with a consequent increase in the number of teams. Finally, contribute to the formation and training of managers within the ESF and to the incorporation of new knowledge and technologies in this area.

**João Werner Falk:** The SBMFC has already been working hard, but should continue to support scientific, political and inter-institutional activities in favor of Family and Community Doctors and other PHC professionals. It should continue to seek the qualification of PHC in different ways to improve health

care for people, families, communities and the population as a whole. The different working groups of the SBMFC are being instrumental in this.

**Airton Tetelbom Stein:** The job market for FCM has greatly improved, there has been greater interest from medical school graduates in FCM and, particularly, the best students often choose to pursue a specialization in FCM. There was greater diversification of positions for FCMs. One of the main challenges is to improve the quality of research in PHC and there is a need to invest in training researchers in PHC. Another essential area to be developed is that of clinical governance, and one of the strategies is the formation of clinical guidelines. Global health action is one of the areas that also deserves emphasis, particularly in planetary health actions.

**Maria Inez Padula Anderson:** I understand that SBMFC has always been a space of resistance and resilience in favor of FCM; a technical and political reference for Family and Community Doctors and also for other doctors and health professionals working in PHC. Over the last 20 years, we have gone through some cycles and have gained visibility beyond FCM — to other specialties and outside Brazil as well. I had the opportunity to be elected, in two consecutive terms, by the Family Medicine Associations of 20 countries in Ibero-America and then, for five years, I was president of the Ibero-American Confederation of Family Medicine. I understand this as recognition, for besides personal, more of the role I played in front of SBMFC and, mainly, the institutional recognition given to it. I also assess that, from the ESF, the SBMFC had and took advantage of a large window of opportunities and grew, always seeking to influence and act to enhance the specialty, in the field of teaching, assistance, management and research. I think that, today, SBMFC is established as a reference in the area of PHC and, naturally, of FCM itself. The main challenge I see is to maintain consistency with the principles of FCM, a specialty that was born to build more equitable health systems, more suited to the needs of the population. In that sense, I remind McWhinney: we have to know about the “importance of being different”. When we do “more of the same”, we are unable to show our skills and we are diluted, without distinction. In other words, we need to strengthen and develop FCM, with all its lyrics, as we have been doing in the management of the current board — of which I have the honor of being part of scientific director — which has been recognized and valued by the number of new and new associates and associates, which in fact grew by more than 50% in these 14 months of operation. Moving in this direction, of valuing FCM in all its letters, requires technical-political action, which some, unfortunately, erroneously assess as “party politics”.

**Gustavo Gusso:** I believe that there was an excessive politicization (in the partisan sense). It is essential to return to the specific content of FCM, which has a chance to bring professionals together again.

**Nulvio Lermen:** The SBMFC can and should play a role through the State and medical and health entities to strengthen PHC and, consequently, the specialty itself. I sometimes see it as a risk to focus only on entities that have similar ideological and healthcare understandings to ours. We certainly have to strengthen these links, but it is of paramount importance to seek points in common with other entities and the government that can guarantee greater support for PHC valorization policies. Even though we understand that we all have a political role that we must play, and that most of our experts have a similar ideology, I fear that, with the political polarization we are experiencing, radicalization will harm the specialty as a whole. Therefore, I defend a firm role by the SBMFC in defending PHC and the specialty, but moderate with regard to policies that do not reach our area of daily activity.



**Thiago Trindade:** SBMFC had and is playing a leading role in the recognition and development of Brazilian family medicine and in the qualification of PHC. In its 40 years of history, it has always been fighting to qualify public policies of interest and our health system. More than 7,000 Brazilian FCMs recognize the entity as their scientific representation, which, through its various boards and working groups, has collaborated in training at all levels of the Brazilian FCM, also seeking to support other professions in PHC. The Brazilian scientific production, in relation to PHC and FCM, has grown consistently in the last decades, with a strong role also played by the SBMFC in book publications and in the qualification of the journal. International partnerships have also been fundamental for the qualification of all these processes. The challenges of the moment are to continue defending our PHC and SUS so that they are not further weakened by governments that, with their neoliberal and fiscal austerity policies, lead to a scrapping of the system by worsening funding, which ultimately it directly affects the Brazilian PHC in its expansion and qualification. The SBMFC must follow its role of scientific qualification of the specialty, supporting and offering all educational formats to ensure the continuous professional development of primary care physicians in Brazil.

**Daniel Knupp:** Until then, SBMFC has been the strength of the specialty in Brazil, both institutionally and scientifically. And also, for many years, it has been taking a leading role with regard to PHC. Certainly, over the past few years, SBMFC has gained great institutional recognition as a reference in the specialty and field of PHC. The challenge is to think, given the growth in the number of FCM and the changes that have been taking place in the health scenario, both in SUS and in private/private health, how the representativeness of the SBMFC will be and how the institution will position itself.

**Zeliete Zambon:** Today, SBMFC, given all the historical action of its construction over time, represents family and community doctors on an equal basis with other specialties. SBMFC is recognized by them as one that brings their own knowledge, which is necessary to better monitor people's health. In relation to PHC, FCM is a recognized medical specialty, which supports it as an area of activity for FCM itself. The main challenge is to make this historic moment — which makes PHC and FCM considered important for sustaining the health system — not just a ripple that will soon die out. In this sense, expanding the importance of PHC and FCM as de facto coordinators of the system, in addition to reducing health expenses, is the only way to survive for a new health, in a new world, with other values.

**Ana Clara Arantes Gonçalves and Geferson Pelegrini for Resident Directory:** Over time, SBMFC has guaranteed the interests of Family and Community Doctors, contributing with their positions and also committing to defend the needs of professionals, so that their principles are not lost. In addition, it has been very close to resident physicians and undergraduates mainly through social networks, facilitating their access to decision-making and participation processes. Offering promotional values at conferences and access to databases most used in our practice has also greatly increased the interest of professionals in joining. Despite this, the association and congress values, which are often prohibitive for most young physicians or resident physicians, are still an obstacle to having more associated values.

**Priscila Ferraz Bortolini (ALASF):** I perceive an approximation of the SBMFC both for students and professionals from PHC and other associations that focus on the study of collective health. In recent years, dissemination via social media has been crucial to popularize and bring the SBMFC closer to professionals. The challenge continues to be the permanence of the interest of these professionals, as there is a devaluation of the class and a scrapping of public health.

**SBMFC - Currently, we have thousands of doctors who work in the ESF/PHC and do not have residency or tenure. How to attract them and incorporate them into the specialty?**

**Ricardo Donato Rodrigues:** First of all, it is necessary to implement: a process of permanent education in all units, stressing the importance of the Family Health Support Centers in this regard; reflection sessions on the practical activities carried out; and facilities for participation in scientific events and other activities related to continuing education. Finally, it is necessary to provide specialization courses approved by the SBMFC.

**João Werner Falk:** Conduct frequent contests for TEMFC, provide free and quality refresher courses, publicize SBMFC activities, its website, its mailing list, and invite them to join the SBMFC.

**Airton Tetelbom Stein:** One way is to show, through research, that FCMs with residency perform better. In this sense, having a better salary for those who have residency; have a career plan in which the benefit of having a residency is clear; encourage training in specialization courses such as the Open University of SUS (Unasus) to carry out this type of formal training.

**Maria Inez Padula Anderson:** There are international examples that we can look at. But we are still a little on this path — basically, we have done the degree through the AMB/SBMFC exams. I think we can take as an example what happened in some countries, which considered physicians who had worked in PHC for a certain number of years as specialists and, at the same time, offered specialization courses and continuous professional development to them. From a certain point in time, and to work in PHC, everyone should be trained by residency and/or show proof of tenure. Today, we have about 45 thousand doctors working in the ESF. If we do not have a courageous, albeit imperfect, policy to incorporate them, we will not get out of the vicious circle: 1) we do not have a number of FCMs, 2) therefore, we cannot demand training in the area, at the risk of further weakening PHC, and 3) we are not appreciated because a degree is not required to work in the area; and so we go on *ad aeternum*...

**Gustavo Gusso:** A national project with several actions would be important. An isolated action as differentiated remuneration would not be effective.

**Nulvio Lermen:** This has already been done in several countries and has already been described in documents from the SBMFC itself, which provides for the absorption of these professionals and their qualification to become FCM and the establishment of a cutoff point from which every trained physician, after this milestone, must have specialized training to work in SUS. A public policy in these terms is likely to be implemented in less than a decade and will result in a better quality of care provided to the population and certainly in better cost-effectiveness for the health system as a whole.

**Thiago Trindade:** These doctors need to be supported in their training process, offering continuing education programs. It is necessary to form partnerships between the three management spheres of SUS, seeking tenure for all professionals who work in PHC and did not undergo residency training, thus putting an end to this wall that divides PHC specialists and non-specialists. Thus, these physicians would tend to feel much more belonging to the FCM specialty and would certainly exercise an even more qualified practice, with training support and qualifications as a form of validation among peers. Municipal employers could define financial incentives for the FCM specialist in their career plans. This would help as an incentive policy to search for the specialty.

**Daniel Knupp:** The most powerful mechanism of attraction involves the stimulus in the field of work, both in the differentiation of tenure and residency in the career and in professional remuneration, as well as in pointing out the need for a residency/tenure for professional practice in the ESF/PHC.

**Zeliete Zambon:** To face this challenge, we need quality training built by the SBMFC, with effective partnerships with public agencies, preferably with municipal representation, to reach out in a disseminated way to those who can benefit from the training. Train for later tenure.

**Ana Clara Arantes Gonçalves and Geferson Pelegrini for Resident Directory:** For those who already work in the network but do not yet have the specialty, the only incentive that, in practice, will bring these professionals to specialization in residency is to show that the professional qualified by a Residency Program in Family and Community Medicine is more valued than one who did not do a residency. In view of the functioning of our health system, we believe that the best way to do this is with financial incentives; that is, those who have tenure by residence earn a higher salary than those who do not and, in the future, to be mandatory residency or qualification in FCM to work in PHC.

**Priscila Ferraz Bortolini (ALASF):** To attract these professionals to the specialty, we have to approach them through strong campaigns, showing the importance of FCM, showing how light technologies are important, effective and efficient in the vast majority of PHC cases.