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Research Article

Family approach in Primary Health Care with families experiencing violence: perceptions of preceptors in Family Practice Residency

Abordagem familiar na Atenção Primária à Saúde com famílias em situação de violência: percepção de preceptores de Residência em Medicina de Família e Comunidade

Enfoque familiar en la Atención Primaria de Salud con familias en situación de violencia: percepción de preceptores de Residencia en Medicina de Familia y Comunidad

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Abstract

Introduction: Violence is a severe and frequent public health issue. It has an impact on the health and lives of individuals, families, and communities, whether physically, psychologically, or socially. Among types of violence, domestic violence has a high prevalence; it has a systemic character, meaning all family members are somehow involved. In Primary Health Care (PHC), families experiencing violence are often attended to by professionals from the Family Health Strategy. However, there is an observed absence or little space in medical education addressing the issue. **Objective:** To understand the perspective of Family Practice Physicians (FPP), preceptors of Residency Programs in FPP, on the Family Approach in contexts of domestic violence in PHC. **Methods:** This is a qualitative study with a descriptive and exploratory character. A survey on the topic was applied to active preceptors in Rio de Janeiro at the time of the research, followed by interviews with 15 of these preceptors. **Results:** There were identified potentials and challenges for the daily practice of the Family Approach with families in violent situations in PHC. As advantages/potentials, the following stood out: strengthening of the bond between the professional and the family; expanding therapeutic resources and intervention effectiveness; promoting comprehensive care; networking across sectors; promoting reflection and self-care within families. Among the challenges reported were gaps in medical education and lack of practical experience in addressing the problem; silenced violence and fear of addressing domestic violence situations; lack of specific guidelines for PHC health professionals; poor working conditions, excessive designated population, care overload, difficulties in intersectoral networking, and management undervaluing the importance of the approach. **Conclusions:** The importance of the Family Approach by FPP was highlighted by the respondents as strategic in addressing domestic violence. However, there are many challenges to its practical application. Efforts and guidelines are needed for FPP and other professionals working in PHC to be valued, enabled, and trained to systematically and regularly address both family issues and domestic violence, considering its high prevalence and severity.

Keywords: Domestic violence; Family practice; Primary health care; Internship and residency; Professional-family relations.

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Resumo

Introdução: A violência é um grave e frequente problema de saúde pública que gera impacto na vida das pessoas, famílias e comunidades, seja no âmbito físico, psicológico ou social. Entre os tipos de violência, a intrafamiliar é de elevada prevalência; tem caráter sistêmico, ou seja, todos os membros da família estão envolvidos de alguma forma. Na Atenção Primária à Saúde (APS), famílias em situação de violência são frequentemente atendidas por profissionais da Estratégia Saúde da Família. Entretanto, observa-se ausência ou pouco espaço existente na formação médica para abordar o tema. **Objetivo:** Conhecer a perspectiva de Médicos de Família e Comunidade (MFC), preceptores de Programas de Residência em MFC, sobre a abordagem familiar em contextos de violência intrafamiliar na APS. **Métodos:** Estudo de abordagem qualitativa de caráter descritivo e exploratório. Foi aplicada enquete sobre o tema para os preceptores em atividade na cidade do Rio de Janeiro, à época da pesquisa, e a seguir foram realizadas entrevistas com 15 destes preceptores. **Resultados:** Foram identificados potencialidades e desafios para a prática cotidiana da abordagem familiar com famílias em situação de violência, na APS. Como vantagens/potencialidades, destacaram-se: o fortalecimento do vínculo do profissional com a família; a ampliação dos recursos terapêuticos e da efetividade das intervenções; o favorecimento do cuidado integral; a articulação da rede intersetorial; a promoção da reflexão e do autocuidado familiar. Entre os desafios, foram relatados: falhas na formação médica e falta de experiência prática na abordagem do problema; a violência silenciada e o medo de abordar as situações de violência intrafamiliar; falta de diretrizes específicas para profissionais de saúde da APS; além de más condições de trabalho, excesso de população adscrita, sobrecarga assistencial, dificuldades na articulação da rede intersetorial e não valorização da gestão sobre a importância da abordagem. **Conclusões:** A importância da abordagem familiar por MFC foi destacada pelos entrevistados como estratégica na abordagem de violência intrafamiliar. Entretanto há muitos desafios para sua aplicação na prática. São necessários esforços e diretrizes para que os MFC e demais profissionais que atuam na APS possam ser valorizados, possibilitados e capacitados para realizar a abordagem familiar e a abordagem da violência intrafamiliar de forma sistemática e cotidiana, considerando a alta prevalência e a gravidade deste fenômeno.

Palavras-chave: Violência doméstica; Medicina de família e comunidade; Atenção primária à saúde; Internato e residência; Relações profissional-família.

Resumen

Introducción: La violencia es un grave y frecuente problema de salud pública que impacta la salud y la vida de las personas, familias y comunidades, en el ámbito físico, psicológico y social. Entre los tipos de violencia, la intrafamiliar tiene una alta prevalencia; tiene un carácter sistémico, es decir, todos los miembros de la familia están involucrados de alguna manera. En la Atención Primaria de Salud (APS), las familias en situación de violencia son atendidas frecuentemente por profesionales de la Estrategia de Salud Familiar. Sin embargo, se observa una ausencia o escaso espacio en la formación médica para tratar este tema. **Objetivo:** Conocer la perspectiva de los Médicos de Familia y Comunidad (MFC), preceptores de Programas de Residencia en MFC, sobre el Enfoque Familiar en contextos de violencia intrafamiliar en la APS. **Métodos:** Estudio de enfoque cualitativo de carácter descriptivo y exploratorio. Se aplicó una encuesta sobre el tema a los preceptores en actividad en la ciudad de Río de Janeiro, en el momento de la investigación, y luego se realizaron entrevistas con 15 de estos preceptores. **Resultados:** Se identificaron potencialidades y desafíos para la práctica diaria del Enfoque Familiar con familias en situación de violencia en la APS. Como ventajas/potencialidades se destacaron: el fortalecimiento del vínculo entre el profesional y la familia; la ampliación de los recursos terapéuticos y la efectividad de las intervenciones; el fomento de la atención integral; la articulación de la red intersectorial; la promoción de la reflexión y del autocuidado familiar. Entre los desafíos se informaron: deficiencias en la formación médica y falta de experiencia práctica en el abordaje del problema; la violencia silenciada y el miedo a tratar situaciones de violencia intrafamiliar; falta de directrices específicas para profesionales de salud de la APS; malas condiciones de trabajo, exceso de población asignada, sobrecarga asistencial, dificultades en la articulación de la red intersectorial y falta de valorización de la gestión sobre la importancia del enfoque. **Conclusiones:** La importancia del Enfoque Familiar por MFC fue destacada por los entrevistados como estratégica en el abordaje de la violencia intrafamiliar. Sin embargo, hay muchos desafíos para su aplicación práctica. Se requieren esfuerzos y directrices para que los MFC y otros profesionales que trabajan en APS puedan ser valorados, habilitados y capacitados para llevar a cabo el enfoque familiar y el abordaje de la violencia intrafamiliar de manera sistemática y cotidiana, considerando la alta prevalencia y gravedad de este fenómeno.

Palabras clave: Violencia doméstica; Medicina familiar y comunitaria; Atención primaria de salud; Internado y residencia; Relaciones profesional-familia.

INTRODUCTION

Violence, in all its forms, represents one of the most serious public health challenges today. Its impacts are evident across physical, psychological, and social dimensions, affecting individuals, families, and communities. Despite its far-reaching consequences, the recognition of violence as a public health issue is relatively recent. In 2002, the publication of the World Health Organization (WHO) report marked a turning point, bringing increased attention to the topic within public discourse and governmental agendas. This shift prompted greater reflection and action among health professionals and underscored the urgent need for public policies to address the problem.[1]

Domestic violence, also referred to as domestic violence, occurs within relationships among family members and takes place in the context of familial intimacy.[2] It is defined as any act or omission committed within the family that compromises the well-being, physical or psychological integrity, freedom, or right to the full development of another family member. Among vulnerable populations, violence by intimate partners, as well as violence against children and aged individuals, is particularly prominent. Domestic violence is considered a systemic phenomenon, as it is shaped by, and in turn shapes and affects, cultural and psychosocial behaviors.

Families experiencing violence are frequently attended to within the scope of Primary Health Care (PHC). Studies evaluating the handling of domestic violence in PHC settings have identified various weaknesses and limitations in the approach. One study conducted with health professionals in the city of São Paulo[3] revealed that some practitioners, particularly those working within the Family Health Strategy (FHS), are aware of violent situations in their communities. However, a significant gap remains between recognizing these situations and understanding them as integral to healthcare intervention. According to the authors, even when violence is identified, it is often not regarded as a legitimate target for health-related intervention. In instances where professionals choose to intervene, the response tends to be personal and informal, rather than guided by professional protocols, often resulting in displaced and ineffective actions.

Machado et al.[4] observed that PHC professionals frequently feel unable to sustain support for families due to the multifactorial nature of violence. Additionally, it was identified that FHS teams face challenges in establishing effective coordination with agencies responsible for protecting and assisting individuals experiencing violence.

The *family approach* is defined by care that recognizes an individual's health-illness process within the context of their family.[5] The family is regarded as the primary and initial source of social support, with the potential to foster the development of autonomous and healthy individuals. However, depending on its mode of functioning, the family can also serve as a significant source of stress, contributing to the development of greater dependency and illness.[6]

The family approach often employs specific tools such as genograms, life cycle stages, and eco-maps to identify intrafamily relationships; generational patterns of illness; communication processes, family functioning, and the fulfillment of family roles, among other factors. Through these tools, the family approach provides strategic elements that help expand therapeutic resources and broaden the scope of care. The relationship with the family is closely connected to the health-disease process.

By recognizing domestic violence as a complex and multifactorial phenomenon from a systemic perspective, the family approach emerges as a form of qualified care that facilitates the understanding of its dynamics and guides interventions by the Family Practice Physician (FPP).

To explore the perspective of FPP, preceptors in Residency Programs in Family Practice, regarding the family approach in contexts of domestic violence within PHC.

METHODS

This study employed a qualitative approach with a descriptive and exploratory design, based on semi-structured interviews, preceded by a preliminary survey.

The study population comprised preceptors from the three Family Practice Residency Programs (*Programas de Residência em Medicina de Família e Comunidade* – PRMFCs) in the city of Rio de

Janeiro, namely: Universidade Federal do Rio de Janeiro/National School of Public Health (PRMFC UFRJ/*Escola Nacional de Saúde Pública* – ENSP), Universidade Estadual do Rio de Janeiro (PRMFC UERJ), and the Municipal Health Secretariat of Rio de Janeiro (PRMFC *Secretaria Municipal de Saúde do Rio de Janeiro* – SMS RJ).

Inclusion criteria were: holding a specialization in Family Practice, obtained either through a PRMFC or a Qualification Exam; having served as a preceptor in a PRMFC for at least two years; and being actively engaged in one of the three PRMFCs in the city of Rio de Janeiro at the time of the interview. Exclusion criteria included: serving as a preceptor in one of the three programs in Rio de Janeiro without holding a specialization in Family Practice; having less than two years of experience as a preceptor; not being affiliated with any of the three PRMFCs in Rio de Janeiro at the time of the study; or not having signed, or having refused to sign, the Informed Consent (IC).

The selection of PRMFC preceptors as interview participants was based on the understanding that they are FPP with skills developed within the field, and on their potential to contribute to the teaching-learning process in the specialty.

The research was conducted in 2020, during the COVID-19 pandemic, and was carried out in two stages. The first stage involved a sociodemographic survey administered via an online questionnaire (Google Forms), which was distributed by email to all preceptors from the three programs, following the consent of the respective PRMFC coordinators, who were contacted for this purpose. At the time, there were 125 preceptors.

The second stage consisted of individual interviews conducted by the researcher with a convenience sample, selected to reflect the greatest possible diversity based on the responses to the sociodemographic survey included in the online questionnaire. The selection considered variables such as gender, age group, length of service in a PRMFC, programmatic area (PA) of practice, and the specific PRMFC in which the participant was working.

In this context, due to the COVID-19 pandemic, the interviews were conducted in a virtual environment. All participants read and signed the IC, provided in electronic format, indicating their agreement with the research procedures. All interviews were recorded and subsequently transcribed.

Data analysis followed the principles of thematic content analysis as outlined by Bardin,[7] which aims to capture participants' narratives and classify the material into categories that facilitate the understanding of the underlying meanings.[8]

The content was initially organized into preliminary categories. Following an exhaustive reading of the material, these categories were consolidated into final categories for analysis. In the final phase, the results were processed, including the interpretation of the content presented.

This study was submitted to *Plataforma Brasil* and the Research Ethics Committee of Hospital Pedro Ernesto/Uerj, and was approved under protocol number CAAE 31784520.5.0000.5259.

RESULTS

In the first stage of the research, the sociodemographic survey conducted via the online questionnaire yielded responses from 84 of the 125 preceptors across the three programs, representing 67.2% of the total preceptor population at that time.

In the second stage, 15 FPP were selected from among those who responded in the first stage for the interview phase. The number of 15 professionals was initially determined as appropriate for qualitative research, considering the potential for response saturation. As previously described, the selection of these preceptors was based on a convenience sample aimed at maximizing diversity in terms of geographic area of work within the city, gender, age, length of time as a preceptor, and residency program affiliation. The sample included 8 women and 7 men, with ages ranging from 29 to 41 years. At the time of the interviews, participants worked in 5 of the 10 PAs in the city of Rio de Janeiro. Their tenure as PRMFC preceptors ranged from 2 to 8 years. Among them, 9 were affiliated with the PRMFC SMS RJ (the program with the largest number of preceptors and residents), 4 with the PRMFC UERJ, and 2 with the PRMFC UFRJ/ENSP (which has the smallest number of preceptors and residents).

The results of this study are presented according to the identified categories and subcategories derived from the responses. Excerpts from the interviewees' statements are used to illustrate each topic.

Violence, its impacts on health and the role of Family Practice

The relationship between violence and its impacts on health was extensively discussed and identified throughout the interviews. Structural violence was recognized as the broader context in which individuals are embedded and experience chronic exposure to violence. Similarly, these impacts were also observed within the closer context of the family.

> *"Institutionalized, structural violence, the state's repression, is something chronic; people gradually adapt to it and end up living with that really harsh reality" (E7).*

The recognition of violence as a health issue, along with its impacts and the need for appropriate care, was also evident in the interviewees' accounts, particularly when reflecting on experiences with violence encountered throughout their personal or professional trajectories:

> *"I think every situation of violence we witness or experience in our work affects us, it brings pain, but it also helps broaden our perspective. It makes us realize just how much people need to be heard and cared for. And in the same way, when we go through violence ourselves… even with all the privileges we have, we still wish for care; Now imagine someone living in extreme vulnerability, exposed to violence in every aspect of life since forever, how much more that person needs care" (E6).*

The high prevalence of domestic violence is well established; however, its non-identification or under-identification by society, particularly by health professionals, underscores the need to understand the factors contributing to the concealment of this phenomenon.

The difficulty healthcare professionals face in recognizing situations of violence within the family context, and among families experiencing such circumstances, often arises from the presence of moral taboos, which function as barriers to addressing violence. As a result, individuals seeking care frequently do not perceive the experience of violence as a health-related issue. Consequently, the presence of violence tends to be discernible only implicitly, embedded within their narratives as a hidden agenda, to be uncovered through the demands they themselves identify as pertaining to health.

"(...) it often shows up as some kind of hidden need in the care process; but as the bond develops, it starts to surface, sometimes more actively, other times in a more subtle, almost subliminal way" (E13).

The role of the Family Practice Physician in addressing domestic violence was emphasized by the interviewees at various points throughout the interviews. Identifying situations of domestic violence and ensuring access to care are considered fundamental responsibilities of FPP, given their position as the first point of contact for individuals experiencing violence and the family-centered nature of their practice.[9]

"I believe the first role [of the FPP] is to make a diagnosis; I see violence as a public health issue, and it needs to be identified. That means not just picking up on what's being said, but also paying attention to the silences... I think we have a real opportunity to catch certain problems early on" (E15).

Importance of territorialization in addressing situations of violence

The privileged position of professionals working in PHC in Brazil, stemming from their close ties and responsibilities within the assigned territory, the longitudinal care provided to families, and the bonds developed through these relationships, is viewed as a key asset in approaching families affected by violence.[10] This perspective was also emphasized by the interviewees, who highlighted the role of FPP within the community as fundamental in addressing situations of violence:

"I think the first step is to approach this in a broad, community-based way […] being present in the territory, developing activities around it, and also, from within the health unit, creating an environment that supports this work" (E11).

The ability to identify vulnerability and protection factors affecting families within a given territory contributes to addressing situations of violence by enabling the mobilization of local resources and the empowerment of individuals and communities.[11] From this perspective, the role of FPP in the prevention of violence can be meaningfully considered.

"[...] to prevent, to highlight situations that can get much worse and lead to violence; milder cases of violence that could escalate into more serious ones" (E5).

References to the relationship between violence in the territory and the underreporting of violent incidents frequently appeared in the statements, alongside the identification of health professionals' lack of preparation as a contributing factor:

"[...] domestic violence sometimes stays hidden because of the difficulty and fear that these issues might become known in the community" (E3).

The diagnosis and approach to domestic violence must recognize that violence is embedded within family dynamics and communication patterns. Therefore, it should not be analyzed simplistically by solely blaming the aggressor, criminalizing poverty, or reducing the issue to one of public safety. Interventions must aim to break the cycle of violence and prevent its transmission across generations.[12] Within this framework, attention to the care of the aggressor is also reflected in the interviewees' statements:

"[...] providing care to the aggressor is also part of our role. So, when we think about domestic violence, I believe I have a responsibility to look after everyone involved. That family, that aggressor is suffering too. Maybe my role is to help… to remove that stigma and also offer some kind of care to that person" (E2).

The family approach to care for situations of domestic violence

The use of the family approach and its associated tools (genograms, life cycle stages, and eco-maps) is presented as a powerful method for engaging with families experiencing violence. Through this approach, FPP play a role in fostering reflection and problematizing the situation. These reflections should encompass issues related to parental roles, gender role differentiation, and the care of aged family members.

"We have a role in encouraging users to reflect on the fact that these issues need to be talked about and that there should be a safe space for that. I feel responsible for staying alert, raising these concerns, and checking whether the person feels safe or not" (E2).

"Witnessing these situations, learning the tools, learning how to approach violence using family-centered methods... it's going to help these residents handle such cases better in the future. First, because using a family approach allows for a more effective way of addressing the issue. And second, because it helps us understand the problem in a deeper and more comprehensive way, which in turn helps residents realize that these situations are often more complex than they might seem at first" (E14).

By identifying and strengthening the protective factors in that family, exploring its resilience potential and seeking to discover new meanings and new dynamics in relationships, it was possible to observe in the interviewees' statements the search for resignification and reflection on the situation experienced, using their own resources and relying on attitudes.

"Overall, it's about taking action to try and empower the victim, so they can take charge and decide for themselves how to handle their own situation" (E8).

The sharing of situations involving violence with the health team was mentioned by interviewees in several statements. In certain contexts, particularly those requiring confidentiality, such as territories affected by violence and drug trafficking, this sharing is limited to select team members.

"But most of the time, the professional who receives the case welcomes the person and then we discuss it in the team meeting. However, when it's something too sensitive […] and considering we work in an area controlled by militias, in cases that were very delicate and needed to be kept between as few people as possible, we wouldn't bring them up in the team meeting" (E6).

Weaknesses and challenges in dealing with situations of domestic violence

The weaknesses and challenges faced by Family Practice Physicians in addressing situations of domestic violence were highlighted in the interviews. Inadequate working conditions, teams responsible for

large assigned populations, intense care demands, high professional turnover, and a lack of understanding and appreciation for the importance of this approach by local management and team members all negatively affect the opportunities and capacity to address such situations effectively.

"[...] a dismantled team, layoffs, the instability within the team" (E1).

"Sometimes, maybe because we get caught up in the rush of day-to-day work, with so many things that need to get done, and also having to juggle the roles of doctor and preceptor, we end up setting certain situations aside" (E10).

Insufficient technical capacity and lack of support for FPP in addressing situations of violence were also recurring themes in the interviews.

"[...] there's a lack of the necessary skills, experience, and support. Training, without a doubt. Overall, I think we tend to avoid what we don't know how to handle. It's very common for family doctors or primary care providers to focus only on hypertension, diabetes, prenatal care, and child health because they're not comfortable identifying these kinds of cases" (E9).

"But the bigger challenge is that it's not something we feel confident doing, it's not something we do routinely" (E7).

Intersectoral coordination involving components of the PHC network is essential for addressing situations of domestic violence.[13] The challenges associated with achieving effective coordination are recognized as a significant factor contributing to the difficulties in managing these cases.

"[...] support from other levels of care and from institutions beyond just healthcare" (E9).

Violence in the territory as a challenge in addressing domestic violence

The presence of violence within the territory is identified as a significant challenge in addressing domestic violence.

"[...] issues around confidentiality and the risks linked to drug trafficking, I think those are challenges too" (E6).

"The challenge often lies in the fear of who we're dealing with, wondering if it's safe to get involved, and how far we can actually go in confronting the situation" (E12).

The absence or insufficient coverage of the topic of violence in training settings was reported and aligns with studies highlighting the lack of focus on violence in medical undergraduate curricula.[14,15] Similarly, Anderson et al.[16] found that 80% of the professionals evaluated believed that the topic was either not addressed or was inadequately covered during their medical education. This training gap was also emphasized in the interviewees' statements:

"Even though it's very common, there's a gap in medical school training when it comes to this issue" (E15).

"[...] because in my undergraduate studies, at least where I came from, that didn't exist; it was something I had no idea could even exist" (E12).

Chart 1 summarizes the main dimensions explored in the interviews concerning the opportunities, potential, obstacles, and challenges related to the family approach and the management of violence by FPP in PHC.

Chart 1. Summary of the dimensions of the family approach and the approach to violence: strengths and challenges according to the interviewed preceptors.

Opportunities and strengths of the family/violence approach in Primary Health Care by Family Practice Physicians	Obstacles and challenges of the family/violence approach in Primary Health Care by Family Practice Physicians
Strengthening the bond between professionals, the healthcare team, and the family.	Gaps in medical training and lack of experience.
Expansion of therapeutic resources.	Silence around violence and fear of addressing domestic violence.
Increased effectiveness of interventions.	Lack of specific guidelines on addressing domestic violence for Primary Health Care professionals.
Promotion of comprehensive, community-based care.	Working conditions: teams assigned to large populations, high care pressure.
Coordination with intersectoral networks and support systems.	Difficulties in coordinating with the intersectoral network.
Encouraging family reflection and self-care.	Lack of recognition by management of the importance of the family approach in the team's work process.

DISCUSSION

The impacts of violence on health and the approach to domestic violence within Primary Health Care were topics addressed and discussed by preceptors of PRMFCs in the city of Rio de Janeiro.

The understanding of the relationship between violence and health, widely discussed in the literature, was also identified among the PRMFC preceptors participating in the study. Notably, several aspects stood out: the various forms in which violence manifests, often subtle and "hidden" within health care interactions; the difficulty of individuals involved in violent situations to recognize the presence of violence; and broader forms of violence, such as structural violence. These factors were identified as contributing to the invisibility of violence.

The role of FPP in addressing domestic violence was regarded as fundamental by the interviewees, contrasting with findings from several studies that indicate PHC professionals in Brazil, particularly physicians, are often not engaged in the care of such cases or do not fully recognize the sector's role in responding to these situations[4,9,17].

The family approach and its associated tools have been identified as strategic in caring for families experiencing violence. By engaging with families, Family Practice Physicians can gather information about the relationships among members, identify patterns of illness across generations and life cycle

transitions, and better understand their context.[5] From a systemic perspective, the family approach enables the understanding of violence as a form of communication and as a dynamic established within family relationships.[12]

The privileged position of PHC in Brazil is particularly notable through the Family Health Strategy, which serves as the entry point to the health system. Its established connections, territorial integration, and proximity to the community — along with its focus on family and community orientation — are fundamental elements structuring health interventions.

Challenges in approaching families experiencing violence were identified and examined. Examples cited include gaps in medical training, work overload, and difficulties with intersectoral coordination. Additionally, the absence of specific guidelines for professionals working in PHC and obstacles in intersectoral collaboration were highlighted in the interviews.

The context of the teaching-learning process within Family Practice residency programs was explored, with both potentialities and challenges discussed. One of the most evident obstacles in providing care in situations involving domestic violence is the lack of dedicated space for this topic in medical training, particularly regarding the family approach and its associated tools.

Violence is a frequent, complex, and multifaceted health issue, rooted in social, cultural, and economic factors, and must be addressed accordingly, without simplification or concealment. This underscores the need to expand the discussion on the systematic inclusion of both theoretical and practical content related to the family approach in the routine practice of FPP, particularly in the context of domestic violence. In this regard, the potential of the teaching-learning process within PRMFCs to train physicians to act from a systemic perspective should be recognized and valued. Furthermore, the development of clear guidelines to support PHC professionals in managing and caring for families in situations of violence is of critical importance.

The perceptions of PRMFC preceptors presented in this study may contribute to the development of such guidelines and support the creation of pedagogical strategies, designed by the preceptors themselves, for incorporating the practice of addressing domestic violence into the training of Family Practice Physicians.

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CONFLICT OF INTERESTS

Nothing to declare.

AUTHORS' CONTRIBUTIONS

RC: Conceptualization, Project administration, Investigation, Methodology, Writing – Original Draft, Writing – Review & Editing. MIPA: Conceptualization, Writing – Original Draft, Writing – Review & Editing, Methodology, Supervision.

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