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Between flows and therapeutic projects: revisiting the notions of lines of care in health and therapeutic itineraries

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Abstract *This essay discusses the possibilities of conceptual and practical connections between the ideas of line of care and therapeutic itineraries, beginning with the theoretical contributions that lay the foundations for the Line of Integrated Healthcare and the hermeneutic approaches to Care. The implementation of lines of care tuned to individual and collective health needs can be glimpsed in the construction of therapeutic projects, inasmuch as they privilege the particularities of each situation in the agreement of flows of appointments, exams, and other procedures. The therapeutic project – taken as an arrangement, strategy, device, or basic dimension of Care in the work process in health - can be seen as an image that lays out a possibility of the future, which in turn is a projection conditioned by past experiences of health, illness, and life. From the criticism of explanatory models, preponderant in the studies of therapeutic itineraries, we defend the investment in approaches that privilege interpretation and understanding, capable of recuperating, contextualizing, and reconstructing trajectories, beginning with the subjects involved in the care process.*

Key words *Health, Line of care, Therapeutic itineraries, Therapeutic projects*

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Introduction

The goal of this article is to present and discuss possible conceptual and practical connections between the line of care and therapeutic itineraries, problematizing the emphasis of the explanatory approaches that are expressed in an instrumental relationship between the knowledge of therapeutic itineraries and their practical application.

The reflections expressed here are a supplement to a study in progress titled "Study on the access of men to diagnosis and treatment of sexually transmitted diseases," funded by CNPq Universal (the National Council for Scientific and Technological Development), and constitute an effort to deepen the knowledge of the theoretical constructs (line of care and therapeutic itineraries), exploring them under the rubric of integrality and care[1-4]. It is noted that both the concepts of line of care and therapeutic itinerary have been explored from different perspectives, mostly in a fragmented way and confined to a description of paths or flows, of the search and/or offer of healthcare, either through the formal system (the network of health services) or via the informal system (involving other standards, such as self-care, home remedies, and religious practices).

It begins with the assumption that, notwithstanding the existence of programmatic flows seeking to guide the path of citizens through the health system, these do not always correspond to those taken or pursued by people, resulting in unsuccessful journeys through the different health services. From the legal and normative point of view, there are means such as Decree 7.508/2011[5], which foresees the establishment of Healthcare Networks (RAS), and argues for the Clinical Protocol and Therapeutic Guidelines, whose objective is to establish criteria for the diagnosis, treatment, and other products and procedures to be followed by the managers of the Unified Health System (SUS).

Some regulatory documents come close to the provisions set forth in the aforementioned decree, beginning with the proposal of specific lines of care covering illness or cycles of life (breast cancer[6], high blood pressure and diabetes[7], pregnant or puerperal women[8]), generally designed by governmental agencies. In the case of Sexually Transmitted Diseases (STDs), the principal documents that suggest lines of care are the Manual for the Control of Sexually Transmitted Diseases[9] and the Guidelines for the Control of Congenital Syphilis[10]. The majority of these proposals for lines of care emphasize the flows aiming to organize the network of services and procedures (consultations, exams, hospital stays), mostly with an emphasis on the management of healthcare and/or the clinical protocols for the most common STDs.

The understanding of the line of care as merely a flow, which instrumentalizes the management and permits the establishment of clinical protocols, can be broadened and reconfigured via the proposition of the Line of Integrated Healthcare[11-13], which is an "image thought to express the flows of assistance assured and guaranteed to the user, to attend to their health needs"[11]. Aside from guiding the path of the users through the system and within the health services, the Line of Integrated Healthcare includes the relationships arising from this path.

Attuned to the work of Malta and Merhy[13], Merhy and Franco[14] and Merhy[15], such a formulation emphasizes the importance of the micro-political and relational dimension of health work, beginning with the construction of lines of care organized under the main theme of integrality in healthcare.

Although the stress may fall on integrality, it can be noted that such a formulation is consistent with the philosophical construction of care as developed by Ayres[3,4], which emphasizes the inter-subjective dimension of the process of health work. While even in the common usage the instrumental meaning of "care" in healthcare stands out, associated with "a group of technical procedures focused on the successful completion of a treatment"[3], the proposal of the author sheds light on its other dimensions. It brings the subjects involved in the process of care into the discussion, breaking with the well-known disparities between pre-established flows and the practical possibilities of their materialization.

Thus in addition to considering the importance of the role of flows of reference and counter-reference, this approach emphasizes the possibilities of the their agreement, in the sense of reorganizing the labor processes, recalling that such an agreement under the Lines of Integrated Healthcare requires the presence of providers and recipients of care. With this in mind, the most favorable assistance opportunity for the compatibility of different interests and realities is in the creation of therapeutic projects, as is discussed in the following section.

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Lines of Care and Therapeutic Projects

Referring to the work of Merhy[14,15] and considering the relations between health, society, and health needs, Oliveira[16] points to some approaches to therapeutic projects, synthesizing them as an arrangement, strategy, or device in the reorganization of the labor process of health teams. From a more general perspective and common understanding, that author notes that the therapeutic project can be taken as an "operational expression of the models of care in health practices […] considering the capacity to produce certain health practices within the world of health needs"[16], or rather, privileging technological actions in themselves.

In reflecting on the caregiving aspects of health practices, the therapeutic project is situated in the intersection between clinical and managerial action, this time configured as an Individual Therapeutic Project with the goal of "focused users."

In the realm of mental health, associating itself with the jargon of institutional analysis, the therapeutic project serves as a mechanism for integration and organization of professional health teams and end-users, facilitating and encouraging the citizenship of the latter, in addition to the reestablishment of affective and social relationships, expressed as psychosocial rehabilitation.

Also within the framework of institutional analysis, another emphasis on the therapeutic project would highlight the role of the professional reference agent that functions as a mechanism for accountability and the reinforcement of the link with the patient.

Finally, Oliveira[16] emphasizes the last branch of exploration of the therapeutic project, to be called the Singular Therapeutic Project, in which the implicit social dimension of this singularity is highlighted in valorizing the singularity of every case, whether in familiar, social, economic, or other terms, therefore having individuals and collectivities as recipients.

Adding to the frameworks anchored in institutional analyses, he emphasizes another approach based in the Marxian matrix of labor, which in the example of the Singular Therapeutic Project incorporates its dynamic and relational elements, having "care"[3,4] as a standard from which we can distinguish the acts of "to treat" from "to care" in the therapeutic project. The first term denotes a group of procedures and finalities defined *a priori,* generally aiming to correct, cure, or rehabilitate some morphofunctional abnormality taken as pathological. The principal characteristic of "care," for its part, is precisely the fact that healthcare cannot be cemented in *a priori* techniques, such as the desire "to treat," but in a succession of practices, or in other words, horizons that allow for the permeability of the technical by the non-technical, and the influx of different interests and projects, treated intersubjectively between the subjects.

In the approach to line of care that we intend to explore in the present text, the notion of the therapeutic project would not be reduced to care work in itself (although it can incorporate this), in as far as it is glimpsed as an image, an outcome agreed upon by the different actors and moments involved. Thus, from this perspective, the definition of a medical recommendation for the use of a specific medication or even a surgical procedure, for example, is not taken as solitary and sovereign: this evaluation is collated with that of other professionals of the health team, actively including the voice of the patient. For the health teams, this logic overcomes the recognized fragmentation of the labor processes, allowing an approximation of the notion of the "integrated team"[17,18].

The typology formulated by Peduzzi and Palma[17] and Peduzzi[18], based on studies of the work process in health[19] and the theory of communicative action[20], predicts two modalities of teamwork in health: cluster teams, expressed as a mere juxtaposition of the work processes, and integration teams, where there is an integration of actions beginning with the interaction of agents, aiming at a negotiated purpose between these agents and the patient. Based on this typology, it is hoped that the therapeutic project is not restricted to the framework of health services in which it originated, but involves and incorporates other forums and actors directly or indirectly linked to it.

Whether within the matrix of institutional analysis or that of communicative action, although they may stem from the act of care giving, therapeutic projects are not reduced to that act: the interactional logic of the therapeutic project considers all the moments and focal points of healthcare, apart from their different rationales, with the subjects, resources, and dynamics peculiar to each one of these, which can be fertile for the construction of lines of care committed to integrality and care. The enterprise based on the construction of therapeutic projects can sound relevant to some more than to others, or even be rejected by those that believe in the supremacy of "technical" criteria in relation to other rationalities in decisions regarding health.

Even when respecting all points of view, it must be agreed that the understanding of the concept of line of care as synonymous with a flowchart exclusively involving health services seems to neither correspond to nor meet the demands and expectations of people, in the face of their health needs and life contexts.

The incorporation of the construction of therapeutic projects into the labor processes in health work seems to be a fertile proposal that allows for incorporating and valorizing the particularities of the subjects in the way they deal with the different situations involving health and illness, rather than only acting from prescriptive protocols with little sensitivity to these particularities.

As much as flowcharts and protocols in healthcare have their function and importance, they become obstacles to care when they are not sufficiently clear or open to the different logics that are intertwined with the process of care in health. This is not to argue – as propositions of this nature are often wrongly interpreted as saying – for the establishment of a dictatorship of attention to singularities that would make institutional and collective work impossible. What we intend in emphasizing the importance of dynamics in the therapeutic project is to avoid making the flows and protocols into a shield against the possibilities of dialogue and the accountability of the different bodies and professionals in the health sector.

Whether conceived as light technology[14,15] or as practical knowledge[21], one of the great challenges of healthcare assistance is precisely this "non-standardizable" dimension of attention, that requires the presence and effective interaction of the subjects involved in the assistance act, creating propositions that move beyond the strictly technical objectives (standardized and reproducible) of health work.

Parallel to the route traced by the health system or in each of the points of attention, there exist mutually involved persons and contexts that conform to different expectations, resources, social and familial networks, values, and decisions that do not always correspond to the logic delineated by the health system. As an example, we take two concrete situations in two health services, drawn from observation and from interviews collected in the development of a theoretical-practical discipline of a graduate program in the area of health, coordinated by one of the authors.

In a public hospital – a national standard for its given specialty – in a large municipality, the waiting list for surgery holds hundreds of patients who can wait up to four years for the procedure. Before arriving on this waiting list, these persons trekked through other health services, often for an equal period of time spent between scheduling, appointments, and exams. Added to this context is the fact that, when admitted to this hospital, the patient reinitiates the entire diagnostic process, retaking exams and medical evaluations, discarding everything that was carried out "outside." Notwithstanding the delay, many people prefer to pass through this whole process and be operated on in this benchmark hospital than in any other, even ones in the same municipality and which can attend them within a shorter time span.

In another public hospital, in the same municipality, once a standard for a certain pathology, the current situation is of frank and visible shortage of human resources and materials, along with the degradation of its physical infrastructure. Combined with this scenario, the hospital is situated in an isolated location, difficult to access by public transit. Other hospitals in the municipality also offer the same services, possibly with better conditions in relation to physical infrastructure and available resources, including the number of professionals on staff. Notwithstanding such a panorama, the patients do not relinquish their link with this service, refusing to be attended in another locale.

Examples similar to these, to be addressed shortly, can be found at all levels of health care, suggesting the complexity of the process involving the supply and demand of health services. Even though it can be supposed at the outset that the main criteria used by people in the choice of a health service would be confidence in the technical staff of a hospital or the reputation of the institution, this is not always the key factor that mobilizes their decisions.

In the first case, we can infer the dissemination and consideration of success stories from this hospital, and/or of unsuccessful stories from others, and/or the "fame" of the institution in public opinion. In the other example, the network of solidarity and the affective links among their patients, and between those patients and the professionals, may justify the choice for that service, which in contrast with the previous case, has few technological resources or little service infrastructure. Nevertheless, to cling to only these hypotheses would be a very limited way to understand the complexity of relationships and contexts involved in the process of the search

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for care, within these examples inside the formal health system.

Although the expectations that lead people to look for care for their health and that which the health services offer are not necessarily convergent, an understanding of the trajectory and the meanings present in the outlined paths to deal with their demands can enrich the understanding and construction of therapeutic projects.

A reference that seems to contribute to this understanding is the notion of therapeutic itinerary: even with different focal points, it allows the incorporation and broadening of the meanings present in the trajectory of people when they search for a solution to some issue related to health. It is not restricted to a predetermined and rigid flow, involving only health institutions, diagnosis, and treatment of illness, nor only doctors and their prescriptions.

If the therapeutic project can be understood as an image that outlines a possibility for the future, and if this is to be understood as a projection marked or conditioned by past experiences – of health, illness, and life – it can be glimpsed that the knowledge about therapeutic itineraries can bring rich contributions to the planning and development of lines of care that come close to the proposal of Lines of Integrated Health Care.

Therapeutic Itineraries: Focal points and contributions

To situate the concept of therapeutic itinerary, we shall consult the respected well-known work of Alves and Souza[22], which is included as a reference in practically all Brazilian studies on the theme.

Associated with the literature on illness behavior, the early days of studies on therapeutic itineraries are attributed to works that postulated that the choices of individuals to resolve health issues were oriented by a rational process of evaluation based on a cost-benefit logic.

Contrasting biomedical rationality with the logical processes of lay knowledge, the studies on illness behavior generally sought to explain how cultural values determine the volume of utilization of professional medical services.

Even while considering the criticisms arising from the utilitarian and rationalist assumptions and the emphasis on medical care, the studies on illness behavior demonstrated the importance of extra-biological factors in the popular definition of illness and the ways of coping with it. From this perspective, beginning in 1970 there are investigations that privileged the cognitive and interactive aspects involved in the process of choice and medical treatment, such as the perception of illness and interpretations about normality, or concerning social networks, involving relatives and friends and their role in the search to resolve health problems. Relating the different interpretations of illness and the way one choses among different possible therapeutic alternatives, the model created by Kleinman in 1978[23] proposes to analyze the itineraries by using three social subsystems on the basis of which illness is experienced: professional (scientific medicine), folk ("non-official" specialists, such as faith healers), and popular (self-medication, social and familial networks). Drawing on this model, Kleinman developed a concept of an explanatory model that consists of:

"[…] an articulated group of explanations about illness and treatment, that determines what can be considered relevant *clinical evidence,* and how to organize and interpret this evidence with a base of rationalizations constructed from distinct therapeutic perspectives" (Kleinman cited in Cabral et al.[23], emphasis ours).

The concern with the search for elements that support medical work is the soil in which the notion of therapeutic itineraries has its roots. This notion developed primarily within Medical Anthropology, privileging the binary illness-treatment/cure and how the "sick" understand and respond to illness[23], or in other words having as its central aspect the point of view of the actors regarding their experience of illness and cure.

Oscillating between explanatory models and phenomenological models - or, more specifically, between understanding how social structures model the pathway of people in search of a solution to a health problem, or how the individuals subjectively perceive and react to illness – the notion of therapeutic itinerary is not unified regarding the theoretical frameworks that inform it: as a general rule, the references to the practical sense of the studies imply a certain claim of "application" of this knowledge.

Although we do not intend to question or raise objections to the expectation of the application of knowledge about therapeutic itineraries, we problematize the fragmented apprehensions that take knowledge and application as distinct acts within the process.

Therapeutic itineraries: between application and understanding. Back to therapeutic projects

In 2008, in a review of the scientific production[23] regarding "therapeutic itinerary," due to a lack of literal references with this designation, the search was enlarged to include related terms that alluded to this meaning. After the application of filters that excluded, for example, studies that exclusively approached the perception of patients about their illnesses, such a revision resulted in 11 references.

The authors of the aforementioned study indicated that the central interest of the works about therapeutic itineraries in Brazil has been the behavior/perception of patients or their relatives about their illness or treatment, looking to consider the multiplicity of practices involved in this process. They also retrieved the possibilities of articulation between the knowledge concerning therapeutic itineraries and the management of health care, either in the organization of services, in the interactions between professionals and patients, or in access to healthcare itself.

In a recent search, from May of 2014, directly using the descriptors "itineraries" *and* "therapeutic" *and* "health," in the database of the Virtual Health Library, 60 titles were encountered, indicating a significant increase in the utilization of this term as a reference for the studies about the pathway of users in the search for a solution to their health problems, whether in the formal system or not. Beginning with this emphasis on the perception of the sick on their illnesses and which mechanisms were employed in their confrontation, the studies on therapeutic itineraries have sought to provide a broader understanding of the cultural conditioners of health practices. It should be emphasized that this understanding follows an expectation that this knowledge can instrumentalize the action of professionals, as can be seen in the following citation from the authors:

"[the studies on therapeutic itineraries] have as their goals, among other things, to know the mechanisms of care actuated by the patient and by the family in confronting the illness and to suggest a broader vision on the part of health professionals about the cultural universe of the users *in such a manner as to accommodate practices and accomplish more effective therapeutic results*"[23]. (our emphasis)

If, on one hand, the broadening of a strictly biomedical logic of health practices opens up other perspectives of a sociocultural nature, on the other hand the instrumental relationship established between knowledge and its practical application is noteworthy. In other words, this understanding that different conceptions about the illness and/or the different social contexts that bring people to construct different pathways in the search for care, and that this information can supplement the action of professionals, leads to two distinct and not necessarily interchangeable actions: 1) to know the itineraries, and 2) to support and outline actions based on this knowledge.

When postulating possibilities of articulation between lines of care and therapeutic itineraries, we can infer a mere sequence of events, interconnected by causal relation, or rather, an explanation of the itineraries would have the capacity to cause the health professionals to react, whether accommodating the needs of patients, or identifying the need to encourage the correct or desirable use of the service network and of healthcare.

It can be argued that it is possible to explore the fecundity of knowledge about therapeutic itineraries, qualifying the creation of lines of care, without necessarily establishing this relationship of causality. For this purpose, it is necessary to initially scrutinize how one constructs the knowledge about therapeutic itineraries to then ask about its pragmatic meaning.

Revisiting the work of Alves and Souza[22] still situates us in relation to this task of deepening the knowledge about therapeutic itineraries, drawing on the socio-anthropological literature, touching on systematic and phenomenological approaches. These same authors broach the interpretive process that permeates the studies on therapeutic itineraries, markedly of an explanatory nature whose paradigm belongs to the natural sciences and mathematics:

"The explanatory logic is based in the search for regularity, of a presumed order. It is through enunciations, taken as universal, that the investigator structures their logical argument to understand the multiplicity of social actions"[22]. In emphasizing the logic present in the process of explanation, the authors call attention to the epistemological inconsistency of reducing an interpretation to an explanatory act: "the explanatory attitude does not sufficiently take into account the intentional, circumstantial, and dialogical context in which individuals develop their actions"[22].

Both the knowledge of the itineraries as well as their practical understanding pass through this process of interpretation that emphasizes the

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dialogical and intersubjective dimension of the construction of the itineraries and, equally, of the lines of care and therapeutic projects. The intersubjective character, that for each meeting delineates contexts and decisions, and which involves other agents besides patients and doctors, defines the dynamic nature of the process and challenges us in our professional activity.

In the face of the imponderable in these meetings, how are we to understand the examples mentioned above, and how should one act in these situations? In the examples cited above, what leads the hospital to ignore the whole pathway of the patient through the formal health system, including exams and diagnosis? Why does the patient prefer to wait for years on a waiting list, rather than be attended at another hospital? Or why would they persist in being hospitalized in such precarious conditions?

The simple formulation of these questions can lead to the expectation of a particular type of response. In asking the "why" of something, it is possible to deduce the expectation of a peremptory explanation, of the type: "the confidence level of the doctors in the hospital of reference is 90%, while for other hospitals this proportion oscillates between 20% and 40%." To ask about the "how" or "what would lead," is to hope for a contextualized response, involving temporalities, places and/or persons, such as: the hospital that today has precarious conditions was the pioneer in caring for patients with this pathology; the patients know all the professionals, establishing reciprocal affective links; the experiences of the patients in other services were not evaluated as successful, etc.

Note the distinction between one route that operates from a simplified analysis, with universalizing assumptions, and the other that enquires about the fabric of the construction of these choices and the disputed elements in the (re)construction of these tapestries that involve a myriad of actors – researchers, "research subjects," health professionals, and patients.

We question, here, the scope of the proposals of studies about itineraries that subsume into mere description of the route of users through the formal or informal health systems or the attempts to investigate "causes" for these pathways. On another level, the criticism lands on the instrumental relations between explanations about therapeutic itineraries and the construction of lines of care, as if the knowledge about itineraries can be applied merely in the formulation of lines of care.

Itineraries, projects, therapeutic encounters

From the criticism of the understanding of application as the mere identification of a method that would permit the unidirectional "transposition" of knowledge, whether biomedical or socio-anthropological, in setting out lines of care, we can envision work that retrieves the hermeneutic potential of health studies. In its broad sense, hermeneutics refers to interpretation and understanding[24,25], emphasizing the involvement of subjects, temporalities, and an opening to the construction of new meanings in this process, expressed as a fusion of horizons[26].

There is no space here to recuperate the density of discussion about hermeneutics and Gadamerian philosophy, as the above-mentioned authors have exemplarily done, but it is worth retaining the centrality of the intimate relationship involving broader social structures as well as the singular experiences of individuals.

In order for lines of care not to be reduced to mere technical and assistance-based flows, founded on clinical protocols, and in order for the itineraries to not be mere thermometers to preemptively guide the lines of care in attention to pathologies, knowledge about therapeutic itineraries presupposes a sensibility to capture this relationship, intimately related to conceptions of health, illness, and well-being. If this sensibility also permeates health practices and the construction of therapeutic projects, we can therefore speak of the possibilities of articulation between knowledge about therapeutic itineraries and the construction of the Lines of Integral Healthcare. So valuable to the Lines of Integral Healthcare, the therapeutic projects are fertile enough that it would be possible to learn the itineraries of the users, beyond the strict and immediate sense of the technical goals that mobilize their trajectories. Even though the correction of a morphofunctional disturbance is part of the therapeutic project, its principal characteristic resides in the opening to a development and the sharing of ethical, moral, and political values in the process of their construction, expressed as a practical success[3,21].

In the examples cited above, the emphasis on technical or practical success can be identified in each of the positions of the users of hospitals, and from this theme it is possible to contextualize and understand the motivations and aspirations not only of the users, but of the subjects and institutions involved in interaction. The articulation between therapeutic itineraries and lines of care will

not come about imminently through technical or instrumental means, but to the degree in which the discursive and ethical-political dimensions are actively incorporated as much into the interpretation of the itineraries as in the way they are understood in the construction of therapeutic projects, encouraging encounters between individuals – users of services, health professionals, and managers.

Certainly, this is not the easiest way to know the flows of the users in the search for healthcare and to construct proposals for the care of the population. It is an ongoing challenge for Collective Health, a task that must not be shaped only according to the generic and verticalized standards and protocols, nor arbitrarily submit to "emotional" appeals for each case. In other words, it is an invitation to all of us – users, health professionals, and managers – for innovation and the valorization of the experiences that have Care as their goal, and as a point of departure.

Collaborations

NEK Silva worked on the conceptualization and construction of the article. WS Figueiredo worked on the critical revision of the article. LG Sancho worked on the revision of the bibliography.

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