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MAIS MÉDICOS (MORE DOCTORS) PROGRAM: NARRATIVES, CHANGES AND LIMITS

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ABSTRACT

Objective: to analyze the narrative of users about the assistance received by the professionals of the *Mais Médicos* (More Doctors) Program.
Method: qualitative, exploratory, descriptive, comprehensive research carried out from August to December 2015. 16 interviews were carried out in four Basic Health Units that hired doctors who spoke the Spanish language. Systematic observation was performed with 30 hours of registration, and the respondents answered a socio-demographic questionnaire and a semi-structured interview. The analysis followed the triangulation of data from participant observation, interviews and the theoretical framework, using thematic analysis in the light of dialectical hermeneutics. Three operational categories have been developed: Quality and welcoming in consultation, Doctor-patient communication and foreign Doctor
Results: the interviewees stated that making an appointment for a medical appointment, unlike before, became possible and less time consuming with the arrival of new doctors. The interviewees were satisfied with the medical care received, highlighting the quality of care.
Conclusion: the medical reception received at the consultation, and the prescribed medications, seem to have a greater weight for the perception of the quality of the consultation, and to be more important for users than the understanding of the foreign language and the doctor's language. The low structural and operational competence of Primary Care remains the limit for the Mais Médicos Program.

DESCRIPTORS: Primary health care. Medical care. Unified health system. Public policy. Health consortium.

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PROGRAMA MAIS MÉDICOS: NARRATIVAS, MUDANÇAS E LIMITES

RESUMO

Objetivo: analisar a narrativa de usuários sobre a assistência recebida pelos profissionais do Programa Mais Médicos.
Método: pesquisa qualitativa, exploratória, descritiva, de natureza compreensiva, realizada no período de agosto a dezembro de 2015. Foram realizadas 16 entrevistas em quatro Unidades Básicas de Saúde que contrataram médicos que se expressavam no idioma espanhol. Foi realizada observação sistemática com 30 horas de registro, e os depoentes responderam a um questionário sócio demográfico e a uma entrevista semiestruturada. A análise obedeceu à triangulação dos dados da observação participante, das entrevistas e do referencial teórico, utilizando-se a análise temática à luz da hermenêutica dialética. Foram elaboradas três categorias operacionais: Qualidade e acolhimento na consulta, Comunicação médico-paciente e Médico estrangeiro.
Resultados: os entrevistados afirmaram que marcar uma consulta médica, diferente de antes, tornou-se possível e menos demorado com a chegada dos novos médicos. Os entrevistados mostraram-se satisfeitos com o atendimento médico recebido, realçando a qualidade na assistência.
Conclusão: o acolhimento médico recebido na consulta, e as medicações prescritas, parecem ter um peso maior para a percepção da qualidade da consulta, e serem mais importantes para os usuários do que a compreensão do idioma estrangeiro e da linguagem do médico. A baixa competência estrutural e operacional da Atenção Básica permanece como limite para o Programa Mais Médicos.

DESCRITORES: Atenção primária à saúde. Cuidados médicos. Sistema Único de Saúde. Políticas públicas. Consórcio de saúde.

PROGRAMA MAIS MÉDICOS: NARRATIVAS, CAMBIOS Y LÍMITES

RESUMEN

Objetivo: analizar la narrativa de los usuarios sobre la asistencia recibida por los profesionales del *Programa Mais Médicos*.
Método: investigación cualitativa, exploratoria, descriptiva, exhaustiva, realizada entre agosto y diciembre de 2015. Se realizaron 16 entrevistas en cuatro Unidades Básicas de Salud que contrataron médicos que hablaban español. La observación sistemática se realizó con 30 horas de registro, y los encuestados respondieron un cuestionario sociodemográfico y una entrevista semiestructurada. El análisis siguió la triangulación de datos de la observación participante, entrevistas y el marco teórico, utilizando análisis temáticos a la luz de la hermenéutica dialéctica. Se han desarrollado tres categorías operativas: calidad y bienvenida en la consulta, comunicación médico-paciente y médico extranjero.
Resultados: los entrevistados declararon que hacer una cita para una cita médica, a diferencia de antes, se hizo posible y llevó menos tiempo con la llegada de nuevos médicos. Los entrevistados quedaron satisfechos con la atención médica recibida, destacando la calidad de la atención.
Conclusion: la recepción médica recibida en la consulta, y los medicamentos recetados, parecen tener un mayor peso para la percepción de la calidad de la consulta, y son más importantes para los usuarios que la comprensión del idioma extranjero y el idioma del médico. La baja competencia estructural y operativa de Atención Primaria sigue siendo el límite para el Programa Mais Médicos.

DESCRIPTORES: Atención primaria de salud. Atención médica. Sistema de salud pública brasileño. Política pública. Consorcio de salud.

INTRODUCTION

The reality of access to health services in the country differs. Most doctors are concentrated in the South and Southeast regions, and when they migrate to other regions they prefer large urban centers, neglecting most remote cities, riverside communities and peripheral regions.[1]

To try to resolve the issue of poor distribution of doctors across the country, the Government implemented several initiatives in university extension, in offering incentives and benefits for professionals who wanted to work in the poorest areas of the country. Some of these interventions were the Rondon Project (1967) and the Program for the Interiorization of Health and Sanitation Actions (*Programa de Interiorização das Ações de Saúde e Saneamento*, PIASS), in 1976, prior to the creation of the Brazilian Public Health System (*Sistema* Único *de Saúde*, SUS). After the SUS was created, the Program for the Interiorization of the Brazilian Public Health System (*Programa de Interiorização do Sistema* Único *de Saúde*, PISUS), in 1993, the Program for the Interiorization of Health Work (*Programa de Interiorização do Trabalho em Saúde*, PITS), in 2001, and the Program for the Enhancement of Healthcare Professionals (*Programa de Valorização do Profissional da Atenção Básica*, PROVAB), in 2012. None of these measures managed to fully guarantee the equitable supply of doctors in the country.[2–4]

In 2011, the Institute for Applied Economic Research (*Instituto de Pesquisa Econômica Aplicada*, IPEA) conducted a survey, with 2,773 respondents, and the result revealed that 58.1% of the population pointed out the lack of doctors as the main problem of SUS.[4] In view of the continuing and problematic shortage of doctors, and again in an attempt to bring solutions, the Federal Government created the Mais Médicos Program through Provisional Measure No. 621[5] and Law No.12,871 of October 22, 2013,[6] with the goal of taking 15,000 doctors to regions where these professionals are lacking. In parallel, there was an increase in vacancies for medical courses and investments in materials, equipment and infrastructure, to improve health care conditions in the country, in addition to the strengthening of permanent education policies and the promotion of Public Policies.[7]

Only with the creation of the Mais Médicos Program, the country allocated, in just one year,14,462 doctors in 3,785 municipalities. The great novelty of this program was to allow the hiring of foreign doctors, mainly from Cuba, through international agreements. In order to meet the needs that motivated its creation, the Mais Médicos Program had three guidelines: a) Emergency Provision: immediate hiring of doctors; b) Education - restructuring in the country's medical training; c) Infrastructure - through the construction, expansion and refurbishment of basic health units (unidades básicas de saúde, UBS).[8]

Demonstrations against the program, protests and the promotion of strikes were carried out by various entities of the class, mainly disturbed by the failure to revalidate the diploma and hire Cuban professionals, on the grounds that their training would be precarious and unable to assist patients in the Brazilian reality.[9]

In view of the Law that created the Mais Médicos Program, considering the heated discussion produced by the collegiate bodies representing medical professionals, and in view of the conflicting opinions between those who support this program and those who criticize it, it was evaluated as important to better understand this reality from the perspective of the users, for whom the program was created. It is expected to obtain, through their narrative, an analysis of the value, acceptability and understanding in relation to the program. The present study aimed to analyze the narrative of users about the assistance received by the professionals of the Mais Médicos Program.

METHOD

It was a qualitative, exploratory, descriptive, comprehensive research, carried out from August to December 2015. We opted for a municipality with a larger number of foreign doctors linked to the

Mais Médicos Program. 16 interviews were carried out in four UBS that hired more doctors who spoke the Spanish language.

Systematic observation was performed with 30 hours of recording. The systematic observation was done through the participation in the daily life of the group under study, to verify the daily situations that they normally face, and how they behave, before them, in this case, the daily life of a UBS. The researcher engaged in conversation with some, or all, involved in the situation, and discovered the interpretations they had about the events they observed. The empirical data obtained in this way required three stages of analysis: selection of problems, control over the frequency and distribution of phenomena and the incorporation of individual findings into the model of the organization under study (in this case, consultations within the Mais Médicos Program).[10] The interviewees were users of the health system and answered a socio-demographic questionnaire and a semi-structured interview. Data analysis observed the triangulation of data obtained by participant observation, interviews and the theoretical framework.

For analysis of the empirical material, content analysis was used, thematic modality, following the steps of pre-analysis, categorization and interpretation.[11]

The data were analyzed in the light of Hermeneutics-dialectics, based on the subjectification of the object and the objectification of the subject. Hermeneutics is based on the understanding of meaning, symbol, intentionality, while dialectic is based on the idea of criticism and change, process and contradiction. Hermeneutics deals with the art of understanding texts, in the extended sense (biographies, narratives, interviews, books, etc.) where, more than an unveiling of the truth of the object, what is sought is the revelation of what the other exposes as a truth, not an essentialist truth, but the semantics that the interviewee wanted to express. Three operational categories were elaborated: quality and welcome in the consultation, doctor-patient communication and foreign doctor. These categories served to approximate the object of research and proved to be appropriate for observation and fieldwork.[11]

This study followed the recommendations of Resolution 466/12 of the National Health Council and was approved by the Research Ethics Committee.

RESULTS

Quality and welcome in the consultation

The interviewed group consisted of women, aged between 33 and 68 years old, self-reported brown (included in this category the self-considered “brunette”).It should be noted that the group sought the consultation already showing symptoms of Systemic Arterial Hypertension (SAH) or with a clear clinical picture of *diabetes mellitus* installed, with classic, evident and self-perceived symptoms:

I came because I got sick, I was very thin, with weak legs. One day I tried my urine and saw that it was sweet... then when she went to the consultation, the doctor said that I was diabetic (E1).

The respondents stated that making a medical appointment, different from before, became possible and less time consuming, with the arrival of “new doctors”. The appointment was scheduled by the health agent, who, in turn, could be herself accessed by cell phone, changing the suffering routine of long lines at dawn to obtain a medical consultation password, which did not always happen due to the great patient demand;

Before the program it was more difficult to make an appointment, it was difficult to get it, because it was more people. I had to come here at the clinic to make an appointment. Not now, for some time now it is the Health Agent who scheduled appointments (E8).

It was found that, despite this new quantitative configuration of more medical professionals for care, self-education in health, constituting primary health care (APS), remains a deficit as a

concept. There are several examples of patients who neglect and/or underestimate their health status, missing scheduled appointments and returning months later, with significant injuries, resulting from hypertension or *diabetes mellitus*.

My appointment is from month to month; I leave here with it scheduled. Oh... but there are days when I fail, sometimes I spend two months without coming... then when I arrive the doctor says, why have I been feeling things complications due to hypertension and diabetes (E3).

The interviewed group recognizes the professionals as being foreigners, being different, but most of them, perhaps due to low education, are unable to specify the exact origin of the doctors. There is even the feeling that there is a certain privilege, due to the fact that they are being treated by an "outside doctor". Others, in addition to specifying Cuba as the country of origin, make comparisons between care with Brazilian and foreign doctors, and claim that there are differences:

And she is foreign, she is Cuban. Her difference is because Brazilian doctors seem to be there just to make money. As soon as he looks at you, he starts writing right away, he doesn't listen to what you have to say. It seems that they are disgusted of the people and she is not, she is different (E4).

Respondents say they were well received by medical professionals, say that there was dialogue between them, that they were given the opportunity and time to express their complaints and to be listened carefully and in addition, they point out these qualities, as being more difficult to be found among Brazilian doctors:

He welcomed me very well! He looks at us... he talks to the patient; he doesn't use of just keeping his head down writing... he listens to us nice... Because there is doctor that the person comes to see and he doesn't even pay attention, she doesn't, she does pay attention to us, she doesn't use to just taking notes, taking notes, like many I've already consulted (E3).

Regarding physical examinations, they stated that doctors performed them whenever a complaint was referred. One interviewee said that the doctor was concerned about the patient's emotional state, and another reported that, despite complaining about the pain and showing the location, he did not undergo any physical examination.

She wants to know what's going on inside your house, because she knows that the emotional side reflects (E4). *No, about examining, she didn't examine me: she just asked where the pain was. She didn't arrive and examined where it was nothing* (E7).

Half of the interviewees reported on requests for imaging and/or laboratory tests, and some chose to pay private laboratories to perform the tests, alleging difficulties: long waiting time to perform the exam and also to receive the result. Others confirmed the above statements, with their experiences of having taken the exams at UBS or waiting for the schedule:

She asked me an X-ray, which was a struggle to schedule and almost three months to receive the result (E7).

Doctor-patient communication

Regarding the difficulty in understanding the "doctor's speech", the common response discourse is "a little", and it is accompanied by the justification that the professional speaks "with accent".

Sometimes we have a little difficulty, because she is not from here, then she has an accent, but now she is getting Portuguese really well (E6). *I have no difficulty; I understand it very well! But it is because I already worked at a hotel in Manaus, which had people from all over the world, Chilean, Argentine and etc... and that is why I had no difficulty with it* (E4).

There seems to be an appreciation here for welcoming, as an affectionate gift, and for medication prescription:

*She said some things I understood and others I did not understand. There are people who say: Ah I don't like this woman because she speaks wrong. Well, what I understand I support, and what I don't understand I say hum-hum (*interjection which means affirmation *and she keeps talking)* (E1).

More education, high school, and experience with people who speak other languages are realities found in the justifications of those who say they have no difficulty in understanding the medical discourse and their speeches.

Users do not adopt a passive stance in the face of difficulties in understanding the language. Most of them ask the doctor to repeat, others ask for help to someone who can translate what was said. This "someone" is here represented by a nurse, Nursing technician or Community Health Agent (CHA) who are present or close to the consultation room, that is, a certain "Brazilian way" of solving difficulties:

There are other lively strategies on the part of the users, who, without understanding the doctor's speech, ask her to write the explanations given, so that, at home, some of the children can help to understand.

I am also not stupid, I say: doctor, write down here, that at home my children explain to me, how do I take the medicine and how do I not take it (E1).

At other times, the initiative to clarify comes from the doctor, and the patient reveals that this attitude is rare among Brazilian doctors, that is: it is uncommon that in consultations held outside the Mais Médicos Program there is a concern that everything said by medical professional has been understood by the patient.

She is a foreigner; she knows that you may have difficulty understanding what she is saying. So, when she starts to attend us, she says: I will speak slowly, if you do not understand me, tell me, I repeat. So, she knows that we can have this difficulty. I wish there were more doctors like her here in Brazil (E4).

Then he asked the girl there, the Chief Nurse, to go there and translate for him, because he was not at all understanding what she was asking him (E7).

Foreign doctor

The assistance provided by the Program's physicians met the users' expectations in relation to the medical consultation. What authorizes to believe that they are satisfied with these professionals:

Her attendance takes a long time, when we come the first time, the delay is strange. But in compensation, we see that it takes time, it is because she attends us very well. Everyone who enters her office praises her, unlike Brazilians, that wherever we go the people are complaining (E4).

Although all interviewees were attended by a professional from the Mais Médicos Program, few are able to locate this professional as a participant in a Federal Program that makes up Public Policy in health. The others say they know nothing about the Mais Médicos Program, or have only heard of it, which suggests that the advertising and information initiatives used so far, although consuming a reasonable amount of resources, have not reached all sections of the population. Still on the Mais Médicos Program, a minority knew how to answer what it was about and did not recognize the doctor who attended it as a professional component of the Program. The others reported light and superficial information, or no knowledge.

What I see talking about is that the Mais Médicos came more doctors from outside, right. Like her case, right, that's not from here. That's it, to be able to help more (E8).

DISCUSSION

A greater number of children was perceived in the age group between 40 and 60 years, which means that they were born in the 50s and 60s, where the discussion about contraceptives, and access to them, was not expanded and facilitated. In the younger age groups the average was 2 to 3 children, however, even higher than the national average of 1.77 children per mother.[12]

This research registered precarious health promotion and disease prevention actions, which are part of the basic health action policy and, in fact, are the actions that most qualify and differentiate this level of care. The precariousness of health equipment is dramatized when there is a need to ingest urine to confirm the presence of glucose. However, the report of having been well received by medical professionals appeared frequently, too, in another study.[13] The willingness of the doctor to know how people are creating bonds with the community, as the community internalizes that they will be cared for by an equal.[14] Authors found that the Mais Médicos Program significantly increased the number of home visits, with greater monitoring of users, greater knowledge of the area and higher quality of care provided.[15]

Patients with Chronic Noncommunicable Diseases (CNCD), in general, have low knowledge about diabetes and difficulty coping with disease, which may lead to a worsening of self-care and, consequently, of metabolic control with increased rates of associated complications.[16] The general population seems to be more sensitive to the exuberance of symptoms, not having enough knowledge to pay attention to the silent phases of both SAH and diabetes. The limits of the Mais Médicos Program are faced with the fact that the Program has failed to change the isolation of primary care and, therefore, the low capacity of the exercise of regulation, where, despite the expansion of investment in infrastructure, it is still insufficient, and very dependent on the municipalities' management capacity.[17]

This devaluation of the silence of symptoms continues to challenge Primary Health Care and has an impact on the quality of life of affected individuals, with physical disability, absenteeism at work, premature death, and adverse economic effects for families and communities. This new reality of making it easier for medical consultations underscores, even contradictorily, the fact that, for quality PHC, the number of doctors is important, but does not resolve the issue of health care: it is necessary that medical consultations and other professionals also produce the development of health awareness, and the autonomy of patients for self-care with health. This reality reiterates the findings of other authors who found a high degree of satisfaction in the dimensions "waiting time" to schedule the consultation.[13,15]

Here the reflections are confirmed,[17] pointing out the structural obstacles of the Mais Médicos Program, in the challenge that remains of expanding the look beyond medical assistance, seeking interprofessionality, bringing a greater view of the expanded clinic and health promotion. Other authors point out the contradiction in the reality of the doctor who lives in small municipalities, in which life "hurries slowly" and where the doctor is part of the social context and the most everyday encounters in life strengthen relationships, generating sociability risk tolerance. In these situations, some residents may feel healthy, even with hypertension and diabetes.[14]

The Cuban doctor's stance is not like that of a professional who goes to the municipality in search of professional interests and income, to assist patients, order tests and prescribe medications. The attitude is closer to that of a health promoter, also responsible for the health situation of the territory and where the local way of life gains medical salience. In the context of medical training, Cuban culture is social, based on humanism and solidarity.[14] It is necessary to overcome traditional practice, centered on the exclusivity of the biological dimension, in order to expand listening and reconsider the human perspective in the interaction between professionals health and users.[18]

SUS, conquered in 1986 from socialist principles, has several limits of its current unsustainability linked to the inability of the capitalist mode of production to understand and accept health as the right of all and the duty of the State. Regarding academic education, health courses, medical courses, above all, have not been able to train professionals capable of understanding and acting in SUS.[13] The socio-cultural reality seems to make them indifferent.

The three axes that comprised the Mais Médicos Program (emergency provision, infrastructure qualification and change in medical training) emphasize that the qualification of primary care infrastructure suffers direct restrictions from the difficulties of municipal management, both in terms of resources and the valorization of Primary Care. The interior reality, where almost everything is lacking in small municipalities, and the lack of regularity in the payment of the contracted professionals are also responsible for the failure of medical and hospital assistance.

It should be noted that the addition of 14,462 doctors to the SUS in just over a year, through interference by the Ministry of Health, portrays the Mais Médicos Program as clear evidence of the impossibility of municipalities to implement and manage care networks quality, sustainability and coverage for 80% of the Brazilian population.[19]

According to one of the users, understanding the language, and the doctor's language, is less important than being able to enjoy the gift of medical consultation. Having access to a doctor is experienced as hope for treatment and cure, therefore, with considerable symbolic value.

Clearly understanding what he says, or not understanding his speech, is not as important as having access to the consultation. These statements lead us to question what it means, objectively, for the population, a "medical consultation", where what the doctor says does not need to be fully understood. Other authors corroborate these findings.[20]

The capacity and ability for a more qualified listening of patients, a longer attention to their life histories and their experiences of illness, seem to be fundamental elements to overcome communication barriers. This implies more consultation time; and was mentioned by the interviewees in the research, even when they claimed that there was time for clarification, even with the help of an "informal translation". Therefore, the language barrier was overcome by the approximation alternatives. Concepts such as "person-centered clinic",[21] "comprehensive care"[22] and "narrative-based medicine"[23] are fundamental to understand how, even among individuals who do not necessarily speak the same language, they can understand themselves in the face of suffering and health care, based on a language that provides them with a shared understanding.

There is a clear symbolic valuation of medical consultation, in some cases, as a mystical ritual, which comes out "improved", simply because he has helped himself with those in power (and know) about what is happening - pain, illness, disability, generally relative to the performance of daily activities. This experience of being sick and needing to talk about what you feel is unique. And, singular here in the sense of personal uniqueness, even loneliness (the patient and his illness experience). The doctor is the "legitimate" professional to "attest" what the patient has, what is the problem, what is the treatment, what is the follow-up; a prescriptive course from diagnosis and therapy to prognosis, all about one person, dictated by another; It is inevitable that this "magic" that involves the hope of cure or relief will not be reflected in the symbolic field.

Therefore, it is not about communication, but about interaction; where the complex relationship is more important than the simple exchange of information. The classic question: "What are you feeling?" by itself, already opens some doors for relief. The multiple attempts and the wait for a medical consultation, where this professional is rare, amplify the expectations that go with the anxiety and suffering of waiting for this moment. In this sense, the perception that is extracted from some interviewees is that the patient-physician "intersubjective relationship" is sometimes moreimportant than the "objective prescription" prescription-medicine. This translates as a possible "symbolic power"[24]

of the medical consultation ritual in the popular imagination or in the social representations of the role of the doctor and Medicine in society, especially in the researched community.

Here there is a fusion of difficulties, foreign and national: in understanding the language, in understanding the medical language, in understanding the medical prescription, even if in Portuguese.

It appears that some arguments for not hiring these professionals lose strength when users are heard. It is said that there is satisfaction with the service received. Whenever it is difficult to understand the doctor's pronunciation or language, assistance was sought from another professional or strategies were used, such as asking the doctor to write down what is being recommended, so as not to leave the consultation without understand the orientations made. On the other hand, the investments also foreseen in the program, aimed at improving the structure, and other resources for carrying out laboratory and image exams, important for patient care, still seem not to have reached the UBS frequented by the interviewees. In many speeches, there is the example of the users' conformity in paying for exams in private laboratories, to continue the consultation, and concomitant indignation of having to wait weeks to schedule an exam, and months to receive the result by the public health system.

User satisfaction was also proven in another study:[25] 95% of users said to be satisfied or very satisfied with the performance of the doctors of Mais Médicos Program. Among the reasons for this positive assessment, 85% stated that the quality of care has improved; 87% that the doctor was more attentive, and 82% that the consultation now solved their health problems better. The communication skill, knowing how to listen and knowing how to speak, is considered a fundamental factor that leads to the effectiveness of educational practices in the field of health.[26] The average rating that users gave to the Mais Médicos Program was nine to a maximum of ten.[25]

This study presents the limitations of the regionality of the data analyzed, as it is a research carried out in a small municipality, in a state in the northern region of the country. It is a municipality with strong socio-cultural characteristics of a rural environment, with a subsistence economy based on fishing, therefore, with the lowest doctor/inhabitants ratio in the country. The main limitation of the investigation is the use of only one source of data collection, since the association with other sources of collection, especially in groups, could give greater reliability to the findings of the investigation.

Even so, the study contributed to reaffirm both the positive impact of the Mais Médicos Program in one of its proposals, the emergency one, of quickly placing doctors in areas of extreme poverty and difficult access, as well as to question the low capacity for regulation and structure of care Basic, whose deficiencies may be linked to dependence on the municipal management capacity and to the difficulties of management and financing of the municipalities.

It would be interesting to repeat this study in other municipalities with similar characteristics and to compare them with studies carried out in municipalities with good management and adequate structure of primary care, in order to isolate this last variable that strongly impacts the results on user satisfaction.

CONCLUSION

The results of this study express that users of the UBS surveyed like the medical care provided by foreign professionals from the Mais Médicos Program. They refer to changes in care caused by the presence of the "new doctors" as they no longer need to face lines in the morning to access the consultation. They point out differences and/or favorable qualities in the care of Cuban doctors. The issue of listening, looking or giving attention, interest and education were highlighted attitudes in the care of Cubans and, according to users, these qualities are not frequent in consultations with Brazilian doctors.

The welcoming in the consultation and the prescribed medications seem to be more important than understanding what the doctor says, emphasizing the symbolic value of the medical consultation. Difficulties in understanding the language are not a problem. Not understanding the prescription is worse than not understanding Spanish, and this difficulty exists even when the language spoken is Portuguese. Patients find strategies to overcome this difficulty, which are "translators", nurses, community health workers or take written instructions, so that others can read at home and help them understand.

Despite the positive aspects evidenced about the Program, the research exposes that the quality in the provision of laboratory and image exam services in the UBS surveyed, remains deficient. It also points out the failures of Primary Health Care in health promotion, disease prevention, health education and guidance for self-care, the so-called "silence of symptoms", exemplified in the dramatic example of drinking urine to know if there is glucose in it. Everything indicates that some of the greatest difficulties encountered in the assistance provided in the Mais Médicos Program are the laboratory and image diagnostic support, which are difficult to access and have a very slow result, and the conceptually incomplete exercise of Primary Health Care, performed as an outpatient clinic, or treatment of exuberant symptoms of SAH and diabetes.

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NOTES

ORIGIN OF THE ARTICLE

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APPROVAL OF ETHICS COMMITTEE IN RESEARCH

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CONFLICT OF INTEREST

There is no conflict of interest.

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