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Implementation of the Residency Program in Family and Community Medicine of the Rio de Janeiro Municipal Health Department, Brazil

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Abstract *The reform of Primary Healthcare in the city of Rio de Janeiro created various needs for improvement of the network, one of which was professional training/qualification of doctors to practice at this level of care. To respond to this the Municipal Health Department took the initiative of structuring the Residency Program in Family and Community Medicine. This paper aims to describe the experience of implementation of this program in the context of the reform of primary healthcare. It also reports on the process of structuring of the program to meet the objectives proposed by the reform, and how this is reflected in the network, and suggests investments in studies that can indicate impacts generated by the Program.*

Key words *Family and community medicine, Primary healthcare, Medical education, Internship and residency*

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Introduction

Family and Community Medicine is a specialty clinical practice oriented to primary care, that is to say: "They are personal doctors, principally responsible for the provision of wide-ranging and continued care to all the individuals who seek them, independent of age, gender or condition. They take care of individuals in the context of their families, communities and cultures, always respecting the autonomy of their patients"[1].

Since 1976, although it has not had the name of Family and Community Medicine, the specialty has been working on identifying its space as the medical specialty responsible for medical care in primary healthcare. The three first initiatives in formation of the General and Community Medicine specialty date from this time: The *Murialdo Health Center School* in Porto Alegre, in the southern Brazilian state of Rio Grande do Sul; the *Vitória Project* in Vitória de Santo Antão, in the state of Pernambuco; and the *Integral Medicine Service* of the State University of Rio de Janeiro (UERJ). The Brazilian General and Community Medicine Society (SBMGC) was created in November 1981. Five years later, in 1986, the Federal Medical Council recognized the specialty and the SBMGC as its representative. As from 1995, with the institution of the Family Health Program, the specialty received a new boost, and in August 2001 it was decided by an Internet vote to adopt the new name: Family and Community Medicine (FCM)[2].

Some residency programs in FCM have become important training and learning instruments, such as the *Conceição Hospital Group*, with 22 student places each year, and the *Municipal Health Department of Fortaleza*, which initially offered 100 places and now offers 76[3,4].

In relation to our recognition of the specialty, there are various reasons why at present FCM does not have all the prestige or recognition that it deserves. On the one hand, both society and the medical collective in general continued to categorize it as the "Medicine of the poor", mainly due to the way in which the Family Health Program was implemented in the country[5,6], as if it were possible ethically to distinguish between doctors for rich people and doctors for poor people. In countries such as Canada, Spain, Holland and England the Family Doctor is recognized not only by his specialist colleagues but also by the population, completely independent of what social class he belongs to[7]. For the population, the family doctor is the doctor of reference for any health problem, since primary healthcare is established as the structuring basis of the health system.

In Brazil, it is commonly believed that family doctors do not have sufficient qualification and potential to deal with the population's demands. At the same time, this situation generates, among specialists in family medicine, an 'inferiority complex', when they compare themselves to their hospital colleagues and the processes of qualification for the two different professional groups. However, FCMs are the professionals of primary healthcare that are best qualified to deal with non-specific complaints, multiple illnesses in a single patient, and illnesses that undergo transformation over time[8].

Thus, the perception that many academics and interns have during their internship or residency in primary healthcare is of a medicine that is practiced in precarious facilities, without much 'technological shine', with professionals who are little qualified, and have little decision capacity, who refer many of the clinical situations that they attend to, to other levels[9]. This picture, added to attractive offers from the private market for secondary-level specialists, results in Family and Community Medicine being the last option among students.

This model has clear negative repercussions for the health system and for society, because it offers a fragmented care, without coordination between the levels of care, and one that increases the potential for polymedication and iatrogenesis for an increasingly aging population, with problems that are more complex and who have a greater need for coordination of care[9,10].

To change this scenario, the Municipal Health Department of Rio de Janeiro (*Secretaria Municipal de Saúde*, or 'SMS–Rio'), as well as carrying out a reform of primary healthcare, sought to implement its own Residency Program in Family and Community Medicine, and incentivize the programs that already exist in the municipality, for the purpose of training medical professionals for this level of healthcare.

The aim of this paper is to describe the experience of implementation of the Residency Program in Family and Community Medicine of the Rio de Janeiro Municipal Health Department (*Programa de Residência em Medicina de Família e Comunidade da Secretaria Municipal de Saúde do Rio de Janeiro*, or PRFCM–Rio), in the context of the reform of primary healthcare.

In this report of experience, data from the National Registry of Health Establishment (*Ca-*

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dastro Nacional de Estabelecimentos de Saúde – CNES) were used to locate those graduating from the first class of the PRFCM–Rio. Data were also obtained from the municipal health network itself through public websites of the Rio de Janeiro municipal prefecture.

Role of the reform of Primary Healthcare in the emergence of the Residency Program in Family and Community Medicine

The municipal management of Rio de Janeiro believes that primary healthcare should be the port of entry to the health system, and since 2008 has invested in the Family Health Strategy (*Estratégia Saúde da Família* – ESF), as directed by the National Primary Healthcare Policy[11,12].

As from 2009 the municipality of Rio de Janeiro, which had a history of a health system strongly based on hospital attention and with low coverage by the ESF, began an intense transformation by increasing the number of family health teams from 124 in 2009 to more than 780 complete teams in 2013. In four years there was a leap in its coverage from less than 7% to more than 40% of the 6,390,290 inhabitants of the city. However, the target of the expansion is to reach 70% coverage of all Rio de Janeiro citizens with the ESF by 2016 [13,14].

As a way of ensuring equitable treatment, the expansion was begun in the areas where there was no type of health coverage and in areas with population at the greatest risk[15]. The main objectives of the expansion of primary healthcare are to improve the access for, and quality of service to, the city's population, through implementation of Family Clinics, restructuring of the traditional Primary Healthcare Units, including those of secondary level that used to offer this type of care, and above all the qualification of their professionals.

With the implementation of the Family Clinics, a differentiating factor emerged from what until that moment had been understood in Rio as primary healthcare. The clinics had five or more teams on average, they had a distinguished physical structure, as well as incorporating appropriate technologies for programs to provide more solutions and patients to have more comfort, offering radiography, ultrasound, ECG examinations and lab tests collected in the clinics themselves[15].

All this innovation was built on the basis of provision of adequate funds for providing primary care. Thus, most of the Family Health teams, whether of Family Clinics or of restructured Municipal Health Centers, have electronic patient records, Internet access, air conditioning, multiple rooms equipped for attending adults, pregnant mothers and children; an observation room, a bandage room, a procedures room, an auditorium, oral health teams and rooms, as well as materials that facilitate compliance with the portfolio of services and increase the clinic's professionals' capacity to decide and resolve, such as cryocautery, materials for insertion of IUDs, and materials for carrying out small-scale procedures.

Another line of action that is complementary to the expansion of primary healthcare was the creation of Network of Observation Stations for IT and Communication Technologies in Health Systems and Services (OTICS) [16], which provides a full physical and technological support such as auditoriums, libraries, IT laboratories for qualification of professionals and for assessment of primary healthcare indicators.

In 2011, SMS-Rio established its Portfolio of Services. The portfolio of services aims to standardize the supply of care given in the Primary Healthcare Units, and determines what type of consultants and procedures these units need to carry out, because it has sufficient structure and materials for them to be executed[17].

After the consolidation of this structure, there remained the difficulty in SMS-Rio of retaining professionals in the network, in spite of Rio de Janeiro being the capital with the best proportion of doctors in the country (2.7 doctors/1,000 population, in the city, compared to 1.8 for the country as a whole)[13]. Further, to complete the teams, which grew fast in number in the municipality, SMS-Rio needed to contract doctors that did not have a specialty, because the situation in the employment market did not favor contracting of family and community doctors, due to their scarcity.

As a strategy for improving the reality of contracting, SMS-Rio started to offer competitive salaries and incentive systems for payment by performance[18], which began to adopt highly qualified family and community doctors, training in Rio de Janeiro and in other states of Brazil. Further, so as to contribute to resolving the scarcity of family doctors, in 2011 SMS-Rio began to plan its own Residency Program in this specialty.

The implementation of the Residency Program in Family and Community Medicine

The creation of the Residency Program in Family and Community Medicine of the Rio

de Janeiro municipal health department (PRFCM-Rio) had as its objective improvement of the level of qualification of the family and community doctor, and also expansion of the supply of these specialists to work in the Rio Family Health Strategy system. To achieve the objective, 60 places on the program were offered in 2012, and expansion of the number of places to the other programs existing in the city of Rio de Janeiro was incentivized. In the year 2014, this number was expanded to 100 places.

However, due to the present situation of FCM in the country and the high competitiveness of the other medical specialties, certain doubts remain: How to attract young doctors to this program? How to change the existing concept in Brazilian health and show that a country with strong primary healthcare is much more efficient than a fragmented system? How to show that the family and community doctor is considered as a highly decisive and solution-achieving professional in other countries, able to carry out a large number of procedures[19], and an efficient and equitable health system begins with a strong Primary Healthcare?

As a further obstacle to attracting doctors to this specialty, the grant paid by the federal government to the resident is approximately R$ 2,900 (2,900 Reais) in any residency program in the country. With this amount of study grant, a large proportion of residents have other jobs, reducing their time of dedication to and study on the objective that they are aiming for. As a strategy to attract resident doctors to the program, SMS-Rio decided to provide an additional grant of approximately 5,500 Reais as a complement to the residency grant.

Another mechanism of attraction was the quest for better health units, both in relation to access and structure, and qualified preceptors. This would allow the resident to participate in a residency program with a differentiating factor in terms of both the grant payment and the structure, and also 100% in-person accompaniment by a qualified preceptor. Chart 1 shows a summary of the weaknesses, strengthens, threats and opportunities of the program in its implementation, using the SWOT matrix model, as reported and conceptualized by the coordinating management of the program[20].

The proposal is that, when the program ends, the Resident should have at his/her disposal a series of tools that have been learned, to enable him/her to solve 90% of the problems of the population that he/she serves, both acute and chronic, and also be qualified to carry out small procedures.

The structure of the Residency Program in Family and Community Medicine

The residency program lasts two years and over this period offers a series of competencies to develop a highly qualified professional. At the beginning of 2015, the PRFCM-Rio had 63 preceptors, 98 residents in the first year of the program (R1) and 46 second-year residents (R2). Some of the residents later entered maternity leave or formalized cancellation of enrollment in the program for personal reasons. Residents and preceptors work in 20 health units located in different regions of the city, as shown in Table 1.

Certain guidelines were adopted for the course, to orient its organization in accordance with the National Medical Residency Committee Resolution of May 17, 2006[21], such as:

1.The initial model adopted the ratio of one preceptor responsible for two teams, with one first year resident and one second year resident allocated in each one of the teams. The preceptor/team ratio has now been improved, closer to the target of one preceptor for one team.

2.One of the distinguishing marks of the care and teaching model is training on the job with a focus on guarantee of access to users' demands. This proposal was based on both national[22,23] and international[24] experiences.

3.More than 50% of the resident's training time takes place in the Family Health Teams. With the supervision of the preceptors the resident learns the fundamental tools of the FCM, and also develops skills for better clinical performance.

3.Approximately 15% of the resident's training takes place over the course of the two years through a theoretical program comprising: weekly classes in skills and in theory with duration of four hours; quarterly weekend seminars; and clinical reasoning workshops, clinical sessions and discussion of clinical cases in the Health Units themselves.

4.The PRFCM-Rio also involves, over the course of the second year of the residency, a practice workload of 12 hours per week in secondary internships in maternity, and in adult and pediatric emergency;

5.In the second year the resident has the possibility of an optional internship for one month, in which he can optimize some specific area of knowledge and get to know other health systems

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Chart 1. Strengths, weaknesses, opportunities and threats in the implementation of the Residency Program in Family and Community Medicine – SMS-Rio, 2015.

	Strengths	Weaknesses
Internal	Total support from the central management	Low number of family and community doctors in the municipality's primary healthcare network
	Physical structure of high standard. Climatized units with IT	Initial proportion of 1 preceptor for each 4 residents
	Extra balance of study grant for resident equivalent to salary	Some services' lack of knowledge about primary healthcare medical residency
	Units well located and with easy access by public transport	
	Rio de Janeiro Observatory for Information and Communication Technologies in Health Services	
	Opportunities	**Threats**
External	Strengthen primary healthcare	Change of management
	Attract family and community doctors from other municipalities of the country	Dimension/scale of the program
	Train doctors with quality; strengthen Family and Community Medicine in the municipality and for the country	Low demand for the program from medical undergraduates in Brazil
	Consolidate the primary healthcare model based on the Family Health Strategy	

Source: Prepared by the authors on the basis of experience, and the history of primary healthcare in Rio de Janeiro.

outside Brazil (Spain, Italy, Portugal, Uruguay, Peru) or the realities of other family and community doctors in Brazil (homeless population teams, river-borne health teams, etc.).

6.Units with Residency in Family and Community Medicine are offered a matrix experience in dermatology and mental health, to optimize the residents' qualification in these areas.

7.As a mechanism of communication a blog has been created with publications of periodicals, recommended articles, readings in primary healthcare, videos and lessons[25].

Thus, over the course of two years, the program enables professionals to be educated and qualified who will later work in the network and continue to contribute to qualification and expansion of primary healthcare in the municipality.

Some results achieved after two years of implementation of the Residency Program

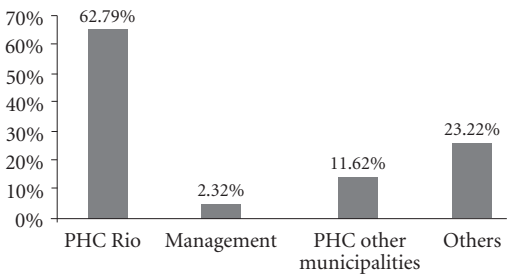
Although it has existed only a short time, the PRFCM-Rio already offers some positive data. In 2014, primary healthcare in Rio de Janeiro absorbed 27 family doctors from the PRFCM-Rio. These are now allocated in primary healthcare units of Rio de Janeiro as preceptors (6) or as team Family and Community Doctors (21). The others came from primary healthcare of other municipalities (5); central management (1); other levels of care (3); maternity leave (2); or were

not linked to any service in the year in question (5). This distribution of origins of the first-ever class of resident doctors is expressed in Graphic 1.

In terms of destination planning area (PA) of the city adopted by graduates of the program in the first half of 2015 (Table 2), the area with the best proportion between (Number of Family Health System teams with residents) and (Total number of family health teams) was PA 2.1, although the region that received the highest absolute number of residents was the North Zone.

Another result found is that insertion of the PRFCM-Rio into health units was reflected as the requirement to obtain improvement in the quality of the other professionals and also the organization of the service, a fact which perhaps was justified because the course is a space for constant reflections about the work process.

Due to the requirement to train a new medical profile to operate in the Family Health System, another effect of the PRFCM was that units that have residency receive different material, such as: material for small procedures and insertion of IUD, portable pulse oximeter, and electrocauterization and cryocautery equipment. This investment has an effect on improvement of the supply of services, that is to say the population



Graphic 1. Work situation chosen by 2014 graduates of the PRFCM-Rio.

PHC = Primary Health Care.
Source: Prepared by authors based on records of graduates in the National Registry of Health Establishments / Datasus, 2014.

Table 1. Distribution of residents in the municipality. November, 2015.

AP	District of the city of Rio	Name of the Unit	Nº of residents
1.0		CF Nélio de Oliveira	4
2.1	Gamboa	CMS Manoel José Ferreira	8
	Catete	CF Santa Marta	6
	Botafogo	CMS João Barros Barreto	4
	Copacabana	CF Maria de Socorro	14
3.1	Rocinha	CF Felippe Cardoso	6
	Penha	CF Assis Valente	10
	Ilha do Governador	CF Aloysio A .Novis	8
	Penha Circular	CF Zilda Arns	6
3.2	Alemão	CF Barbara Starfield	6
	Del Castilho	CF Anthídio Dias da Silveira	2
	Jacarezinho	CF Sergio Nicolau Amin	6
3.3.	Del Castilho	CF Dante Romano Júnior	4
	Marechal Hermes	CF Marcos Valadão	5
	Acari	CF Maria de Azevedo R. Pereira	1
4.0	Anchieta	CF Padre José de Azevedo Tiúba	9
5.2	Jacarepaguá	CF Ilzo Motta de Mello	4
5.3	Paciência	CF Dalmir de Abreu Salgado	10
	Guaratiba	CF Alkindar Soares P. Filho	3
	Guaratiba	CF Sônia Maria F. Machado	4
	Santíssimo		
		Total number of active residents	**120**

Key: PA = Planning Area (*Área de Planejamento*); CF = Family Clinic (*Clínica da Família*); CMS = Municipal Health Center (*Centro Municipal de Saúde*).
Source: Rio de Janeiro Municipal Health Department Family and Community Health Residency Program, October 2015.

Table 2. Distribution of number of teams with residents from the PRFCM-SMS-Rio, by health planning area – first half 2015.

Planning area (PA)	Total number of teams	Total number of teams with residents	% ratio: teams with residents / total teams
1.0 (Central zone)	53	3	5.66
2.1 (South zone)	61	16	26.23
3.1 (North zone)	153	22	14.38
3.2 (North zone)	87	10	11.49
3.3 (North zone)	123	9	7.32
4.0 (West zone)	44	4	9.09
5.2 (West zone)	125	11	8.80
5.3 (West zone)	114	3	2.63
Total	760	78	10.26

Source: SUBPAV/SMS-RJ, 2015.

has more access to differentiated services. Over time this should a snowball effect, expanding to the other units, since as and when graduates of the PRFCM-Rio take positions in new spaces without residencies, they will demand guarantee of the differentiated input materials and thus these procedures will be increasingly available in the network.

Outlook for the program

For the year 2016 there is an application to the National Medical Residency Committee for expansion from the present 100 first year residency places to 150. The process of expansion aims for the regions of the North and East zones of the city, areas which have greater difficulty in receiving family doctors since their concentration is in the South Zone and the central region of the municipality. It is known that this is a strategy adopted for fixing professionals in locations where it is difficult to provide them[26]. The increase in places aims to help with the process of expansion of the Family Health System in the municipality of Rio, with the incorporation of doctors that are specialists in Family and Community Medicine into these teams.

In 2015 the Brazilian Family and Community Medicine Society published the *Competency-based Curriculum for Family and Community Medicine*[27], a base document that aims to orient the quality of training of those graduating from the medical residency programs in this area. This document is also an important source for the FCM residency programs to be able to use as a guide to formulate their curricula and/or policy-pedagogical projects. This begins a new discussion for the structuring of the program, aiming to cover the principal competencies of the family and community doctor.

Another action that the PRFCM-Rio has been strengthening is the qualification and training of its preceptors. At the moment there is a program of continuous training with the preceptors which takes place over the course of the whole year and the product of which is the theoretical lessons that are developed and put before the residents. At least two classes have completed the EURACT[28] Course (European Academy of Teachers in General Practice and Family Medicine), which is the European training for being a preceptor in Family and Community Medicine. The coordination of the Residency Program is also working to develop a Master's degree program targeting these preceptors, to strengthen their educational and qualification process.

Final considerations

The PRFCM-Rio has provided a significant increase in specialist doctors for primary healthcare in the municipality of Rio de Janeiro. The strategies adopted, such as the extra payment in addition to the grant, and input materials, work in favor of residency doctors entering the program. Another factor perceived is that the securing and implementation of professionals (preceptors and residents) for the West and North zones of the municipality has been a challenge for the coordinators of PRFCM-Rio, due to the territorial dimension of the municipality, the areas of social risk and the concentration of doctors in the south and central zones.

Experience has shown that implanting a residency in the middle of an intense restructuring of primary healthcare calls for a planning that is appropriate to the existing reality. As a form of management it is necessary to reflect on the results so as to achieve the proposed objectives. To some extent, the PRFCM-Rio is at its beginning, and some challenges remain, such as: the need for improvement in the proportion between preceptors and number of residents, and for increasingly appropriate articulation with the Planning Areas (Health Districts); further improvement of the theoretical-practical contents; and strengthening of the healthcare network with the second-

ary and tertiary levels for a better coordination between them[29].

The significant volume of training of specialists in FCM in the country is considered to be a historical fact, and principally the contribution of this process to the expansion of primary healthcare in the city of Rio de Janeiro, by facilitating the population's access to a quality primary healthcare network. As a suggestion for future publications, we emphasize the need to carry out studies that indicate the impacts generated by this residency program over a longer period of time.

Collaborations

ALA Justino worked on the conception and final text; LL Oliver worked on the research and methodology; and TAP Melo on the methodology and final text.

References

1. World Organization of Family Doctors. A definição europeia de medicina geral e familiar. Barcelona: Wonca Europa, OMS; 2002. [acessado 2015 jun 01]. Disponível em: http://www.woncaeurope.org/sites/default/files/documents/European%20Definition%20in%20Portuguese.pdf
2. Falk JW. A Medicina de Família e Comunidade e sua entidade nacional: histórico e perspectivas. *Revista Brasileira de Medicina de Família e Comunidade* 2004; 1(1):5-10.
3. Universidade Federal do Ceará. Seleção Unificada para Residência Médica do Ceará. Quadro de vagas. [acessado 2015 jun 1]. Disponível em: http://www.resmedcea-ra.ufc.br/2015/?pag=VerVagas
4. Sampaio PGPRP. *Residência em Medicina de Família e Comunidade: dois programas brasileiros* [dissertação]. Rio de Janeiro: Escola Nacional de Saúde Pública Sérgio Arouca; 2014.
5. Anderson MIP, Gusso G, Castro Filho ED. Medicina de Família e Comunidade: especialistas em integralidade. *Revista de APS* 2005; 8(1):61-67.
6. Costa C. Médica de família 'dirige Chevette e namora Creisom' em apostila para concurso. [acessado 2015 nov 8]. Disponível em: http://www.bbc.com/portuguese/noticias/2014/09/140920_salasocial_eleicoes2014_saude_abre_medicos_cc
7. Vicente VC, Pitz PB, Arenal JMC, Ferrández ES, Gonzales FS. La Medicina familiar y comunitaria y la universidad. Informe SESPAS 2012. *Gac Sanit* 2012; 26(Supl.):69-75
8. Starfield B. *Atenção Primária: equilíbrio entre necessidades de saúde, serviços e tecnologia. Edição Brasileira*. Brasília: Unesco, Ministério da Saúde; 2002.
9. Casajuana J, Gérvas J. Introducción: la necesaria renovación de la Atención Primaria desde "abajo", desde la consulta. El ímpetu innovador contra la rutina y la "cultura de la queja". In: Casajuan J, Gérvas J, organizadores . *La renovación de la Atención Primaria desde la Consulta.* Colección Economía de la salud y gestión sanitaria. CRES-UPF. Madrid: Springer Healthcare; 2012. p. 1-6.
10. Mendes EV. *O cuidado das condições crônicas na atenção primária à saúde: o imperativo da consolidação da estratégia da saúde da família*. Brasília: Organização Pan-Americana da Saúde, 2012. 512 p. [acessado 2014 Jun 30]. Disponível em: http://bvsms.saude.gov.br/bvs/publicacoes/cuidado_condicoes_atencao_primaria_saude.pdf.
11. Brasil. Ministério da Saúde (MS). Secretaria de Atenção à Saúde. Departamento de Atenção Básica. *Política Nacional de Atenção Básica*. Brasília: MS; 2006.
12. Brasil. Ministério da Saúde (MS). Secretaria de Atenção à Saúde. Departamento de Atenção Básica. *Política Nacional de Atenção Básica*. Brasília: MS; 2012.
13. Brasil. Departamento de Atenção Básica. Redes e Programas. Saúde mais perto de você. Atenção Básica. Equipes da Saúde da Família. [acessado 2014 jun 10]. Disponível em: http://dab.saude.gov.br/portaldab/historico_cobertura_sf.php.
14. Prefeitura do Rio de Janeiro. *Plano Estratégico da Prefeitura do Rio de Janeiro 2013 - 2016*. [acessado 2014 jun 30]. Disponível em: http://www.rio.rj.gov.br/dlstatic/10112/2753734/DLFE-241955.pdf/Planejamentoestrategico2.0.1.3.2.0.1.6.pdf
15. Harzheim E, Lima KM, Hauser L. *Reforma da Atenção Primária à Saúde na cidade do Rio de Janeiro – avaliação dos três anos de Clínicas da Família. Pesquisa avaliativa sobre aspectos de implantação, estrutura, processo e resultados das Clínicas da Família na cidade do Rio de Janeiro.* Porto Alegre, RS: OPAS; 2013.
16. Rio de Janeiro. Secretaria Municipal de Saúde e Defesa Civil (SMSDC). Subsecretaria de Atenção Primária, Vigilância e Promoção da Saúde. *Rede OTICS RIO - Observatório de Tecnologias de Informação e Comunicação em Serviços de Saúde no Rio de Janeiro*. Rio de Janeiro: SMSDC; 2012.
17. Secretaria Municipal de Saúde e Defesa Civil do Rio de Janeiro. Superintendência de Atenção Primária. *Guia de Referência Rápida. Carteira de Serviços: Relação de serviços prestados na Atenção Primária à Saúde*. Rio de Janeiro: SMSDC; 2011.
18. Norman AH, Russell AJ, Macnaughton J. O modelo de pagamento por desempenho e sua influência nos princípios e prática dos médicos generalistas britânicos. *Cad Saude Publica* 2014; 30(1):55-67.
19. Kelly BF, Sicilia JM, Forman S, Ellert W, Nothnagle M. Advanced procedural training in family medicine: a group consensus statement. *Fam Med* 2009; 41(6):398-404. [acessado 2016 fev 10]. Disponível em: https://www.stfm.org/fmhub/fm2009/June/Barbara398.pdf
20. Rodriguez RVR *Cómo elaborar el análisis DAFO.* Galicia: CEEI,2012. [acessado 2015 dez 28]. Disponível em: http://www.ferrol.es:8080/activateenelcentro/fotos/biblioteca/CPX_ComoelaborarAnalisisDAFO_cas.pdf
21. Brasil. Ministério da Educação e Cultura. Comissão Nacional de Residência Médica. Resolução CNRM Nº 02 /2006, de 17 de maio de 2006. Dispõe sobre requisitos mínimos dos Programas de Residência Médica e dá outras providências. *Diário Oficial da União* 2006; 19 maio.
22. Tesser CD, Norman AH. Repensando o acesso ao cuidado na Estratégia Saúde da Família. Saude soc. [Internet]. 2014 Sep [acessado 2016 fev 11]; 23(3):869-883. Disponível em: http://www.scielo.br/scielo.php?script=sci_arttext&pid=S0104-12902014000300869&lng=en. http://dx.doi.org/10.1590/S0104-12902014000300011.
23. Norman AH, Tesser CD. Acesso ao cuidado na Estratégia Saúde da Família: equilíbrio entre demanda espontânea e prevenção/promoção da saúde. *Saude soc*. [Internet]. 2015 Mar [acessado em 2016 fev 11]; 24(1):165-179. Disponível em: http://www.scielo.br/scielo.php?script=sci_arttext&pid=S0104-12902015000100165&lng=en. http://dx.doi.org/10.1590/S0104-12902015000100013.
24. Murray M, Tantau C. Same-day appointments: Exploding the access paradigm. *Family Practice Management* 2000; 7(8):45-50.

25. Prefeitura do Rio de Janeiro. Secretaria Municipal de Saúde. *Blog do Programa de Residência em Medicina de Família e Comunidade*. [acessado 2014 jun 24]. Disponível em: http://www.rmfcrio.org/.
26. Wilson M, Cleland J. Evidence for the acceptability and academic success of an innovative remote and rural extended placement. *Rural Remote Health* [Internet]. 2008 Jul-Sep [acesso em 2016 fev 14]; 8(3)960. Disponível em: http://www.rrh.org.au/articles/subviewnew.asp?ArticleID=960
27. Sociedade Brasileira de Medicina de Família e Comunidade. *Currículo Baseado em Competências para Medicina de Família e Comunidade.* [acessado 2015 dez 08]. Disponível em: http://www.sbmfc.org.br/media/Curriculo%20Baseado%20em%20Competencias(1).pdf
28. European Academy of Teachers in General Practice / Family Medicine – EURACT. [acessado 2015 nov 10]. Disponível em: http://www.euract.eu/
29. Castells MA. *Estudo dos Programas de Residência Médica em Medicina da Família e Comunidade: a questão da preceptoria* [dissertação]. Rio de Janeiro: Escola Nacional de Saúde Pública Sérgio Arouca; 2014.

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