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Academic tutorship of the *Mais Médicos para o Brasil* (More Doctors to Brazil) Project in Santa Catarina: the ethical-political viewpoint

Rita de Cássia Gabrielli Souza Lima [1]
Denis William Gripa [1]
Elisete Navas Sanches Prospero [2]
Marco Aurélio da Ros [1]

Abstract *This study aims to identify the fundamentals that drive the academic tutorship of the* Mais Médicos para o Brasil (More Doctors for Brazil) *project in Santa Catarina, based on the unit of analysis entitled* values achieved. *It is an exploratory and comprehensive study carried out in 2015, with tutors of the State of Santa Catarina, decentralized reference professionals of the Education and Health Ministries, and key reference professionals of the Education Ministry. Focus groups were used as the instrument for collection of data, through semi-structured interview. Based on the category* Emergency care as a force of innovation in the Mais Médicos Program, *the analysis was conducted from an ethical-political approach. Three fundamentals emerged:* 'Putting out fires', 'Qualification of the Project', *and* 'the procedural point of view'. *It was concluded that academic tutorship of the productive activities of doctors in emergency care is not an isolated pedagogical approach, since it is a part and a consequence of the historic development of the theory and of the practice. The activity corresponds, dialectically, to movements of rupture, resistance, emancipation and also requires collective reflection about the values chosen and achieved in the acts of decision.*

Key words *Basic health care, Bioethics, Tutorship, Medical care*

[1] Universidade do Vale do Itajaí. R. Uruguai 402, Centro. 88302-202 Itajaí SC Brasil. rita.lima@univali.br
[2] Universidade Federal de São Paulo. São Paulo SP Brasil.

Introduction

The analysis of possibilities of transformation of the real, whether at molecular and/or universal level, calls for attentive interlocution of two devices: The historic approach to the real and the questioning of its contradictory tendencies. Based on this conception, thought follows a path in which a new question is generated in the expectation of a new response for new analyses and considerations. This humanistic method of analysis of the real, proposed by Antonio Gramsci as "the method of 'sense'"[1], can be recovered for a study of the recent initiative of the Brazilian State in instituting the *Mais Médicos* Program.

Brazil faces two robust historical issues in the struggle for concrete achievement of the universal guarantee of the right to health, generated, among other factors, by the hegemony of the procedure-centered practice (technicist and productivist) of attention to the market [2]: to construct a pedagogical, ethical and political culture for training in health and to challenge the historic inequality in distribution of doctors and basic healthcare between the various states of the Brazilian Federation, and also between prosperous municipalities and those that have a high index of social vulnerability in the interior of the states. In terms of the second question, in contrast to the 'luminous' aspect of the country – the 'luminous' or 'illuminated Brazil – 'the opaque' elements of the country (the 'dark Brazils')[3] clamor, historically, for inclusive policies and programs that are sufficiently capable of rupturing the situation of marginalization of the healthcare to which they are exposed in their process of daily life[4].

Considering that the historic development of basic healthcare placed on the 'opaque' Brazils the impossibility of realizing their right to health in full[4], and that this fact cannot be comprehended as a theoretical truth *per se*, but in correspondence with a given historical practice, questions emerge: would some incorporation into the historic development be possible, to transform the real and to create a new reality? How, and with which instruments?

Recognizing this need in Brazilian basic healthcare, Provisional Measure 621, in July 2013, made provision for emergency care for Brazilian municipalities. In October that year, Congress approved and President Dilma Rousseff sanctioned Law 12871, known as the *Mais Médicos* Program Law (or the PMM Law), in which the *Mais Médicos* program (PMMB) is outlined. Coordinated by the health and education ministries, this Project covers: (a) Brazilian or foreign doctors with registration in Brazil; (b) Brazilian or foreign doctors trained outside Brazil and without registration in Brazil; (c) The supervisor (a medical professional to carry out continuous and permanent supervision of the doctor); and (d) the academic tutor (a medical teacher/lecturer providing academic orientation)[5]. Basic healthcare in Santa Catarina was included in the program with new doctors, and currently has 374 active doctors. Information supplied via email by the Managing Center of the *Mais Médicos para o Brasil* Project – Department of Health Education Development – Education Ministry.

This article aims to understand the fundamentals that are driving the academic tutorship of the PMMB in the state of Santa Catarina, based on the unit of analysis *Values realized in the decisions*, and based on discourses of decentralized reference professionals of the Education and Health Ministries and technical reference professionals of the Education Ministry. The analysis will be made from the ethical-political point of view.

Methodology

This is a qualitative, exploratory and comprehensive study, approved by the Ethics Committee of the University of the Vale do Itajaí, SC, in accordance with the provisions of Resolution 466/2012 of the MS/CNS (Health Ministry / National Health Council). The survey was conducted in three scenarios: Itajaí (Santa Catarina State), Florianópolis (Santa Catarina) and Brasília (Federal District). It is a development arising from a study in progress in the state, financed by the Santa Catarina State Research and Innovation Support Foundation (Fapesc), Tender 2014/1, in which the proposal is made to analyze the social impact of the *Mais Médicos* program in Santa Catarina.

Chosen for convenience, a representative of the State Coordinating Committee of the Program for Santa Catarina (CCEP/SC) personally informed the details of the institutional and pedagogical subjects of the PMMB/SC: who were the decentralized technical reference professionals of the Education and Health Ministry, who were the tutors, where they were allocated and which segment they represented. The meeting with this person took place in the State Center of the Health Ministry (NEMS), in Florianópolis, in September 2015, and lasted one hour. Based on the information, an invitation was formalized

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by email to: the tutors of the PMMB allocated in the Federal University of Santa Catarina; the tutor of the PMMB allocated in the Southern Frontier Federal University; the technical reference professionals of the General Coordination Department for Expansion and Management of Education and Health (CGEGES) of the Health Education Development Directorate (DDES) of the Higher Education Department (SESu) of the Education Ministry; the decentralized reference professional of the DDES/SC; and the decentralized reference professional of the Health Work and Education Management Department (SGTES/MS) in Santa Catarina. In the invitation, it was informed that the participation would be made official through signature of an Informed Consent Form.

The sample was constituted by convenience and comprised nine participants (all Brazilians): three women and six men. One tutor no take part. Of the total of subjects, three are family and community doctors.

The instruments used for collection of data were: the semi-structured interview, for the tutors and decentralized reference personnel; and focus groups, for the technical reference people of the CGEGES/DDES/SESu/MEC. The semi-structured interview enabled flexibility for incorporation of new questions. The focus group technique, by making possible a single meeting with three technical representatives of the Education Ministry, enabled the data to be collected in a dialog interaction, with a view to examination of the collective comprehension of the historic process of the Program and of the pedagogical outline guide[6].

The instruments comprised two blocks. The first brought together questions relating to the historic development of a guarantee of medical care and basic healthcare, in search of probable relationships with prior policies/programs and perceptions about consensus, points of non-consensus and impasses reported by the media and involved in the social conquest of achieving emergency care. The second block of questions aimed to find out flows, routines and processes of the pedagogical guidance given.

The data were registered in audio and later transcribed.

Exploration, Organization, Codification, Categorization and Analysis

After the transcriptions, the materials were carefully and attentively explored, based on the various readings, to choose units of analysis (*variables*). This moment generated six *variables* (Chart 1): *Values achieved; Roles of institutional subjects; Medical care model for basic healthcare; Qualitative monitoring; Capacity for providing solutions*; and *Ethical conflicts*. This article describes the analysis of the pedagogical guidance of the tutoring function taking the variable '*Values achieved*' as point of departure.

The material was then organized in the Atlas.ti® software, in a hermeneutical unit named Pedagogical Guidance SC. The third phase, that of codification, corresponded to the selection of the quotations (*record units*), attribution of codes (*codes*) for the units of record selected, and the production of memory statements (*memoranda*). The greater part of the codes originated from the theoretical epistemological framework of the study, but some were generated in the exploratory readings of the material. From the aggregation of 22 codes, the analytical category (family) explored in this article emerged. It is: *Emergency care as an innovative force of the PMM cultural operation*. Anonymity of the subjects was guaranteed by letters, to which numbers were

Chart 1. Units of analysis and indicators by object, dimension and category of analysis.

Object	Method	Category of analysis	Analysis unit	Indicators
PMMB/SC	Ethical-political	Emergency care as an innovating force of the PMM cultural operation	**Values achieved**	**Value modes**
			Roles of institutional subjects	Types of role
			Care model	Types of care model
			Monitoring	Types of technique/instrument
			Capacity for resolution	Modalities of techniques/instruments
			Ethical conflicts	Modalities of ethical conflicts

added, for their identification: T for tutor, IC for members of the GEGES/DDES Coordination, and RD for decentralized reference professionals of the Ministries.

The method of analysis was of the ethical-political type, an adaptation of the method introduced by Gramsci, of "since"[1], choosing the reflexive-critical dimension to understand 'the way of' transforming the real: i.e. the way in which the Brazilian state challenged the scarcity of doctors in basic healthcare, taking the opportunity to insert new medical producers, as an emergency supply, and the method in which the pedagogical guidance has been made concrete in social relations, in the flows and processes established by the social actors (tutors, decentralized reference professionals of the Education and Health Ministry, and technical reference professionals of the Education Ministry) (Chart 1).

Results and Discussion

The PMMB as an innovative force of the PMM cultural operation – *Values achieved*

The analysis of the data generated an understanding of the PMMB as an innovative force of the cultural operation created as an opportunity by the *Mais Médicos* Program. The data signaled that this emergency care "... is 'life' [...] it exposes 'rationality and irrationality, arbitrariness and necessity [...] exposes 'contradictions [...] antithesis': elements of life"[7].

When questioned on which values represented the initiative of the Brazilian government in creating the emergency provision of the PMM, participants declared that this provision expresses *a flag that reestablishes the dignity and citizenship of the Brazilian population* (T1); *an island in the moment of ethical crisis* (T2); *confrontation of individualist values centered on liberal, biomedical medicine* (T3); *political decision in favor of the 'deep' Brazil* (T4). However, they also revealed that the approval of the *Mais Médicos* program by the Brazilian state expresses *clearly other values* [...] *economic values of reproduction of capital* [...] *a cheap way to ensure the workforce* (T1) and that *there are things unsaid; sometimes it seems to me* [...] *that there are things that are not clear, they appear to me to be other things* (T2).

The report enabled it to be inferred that the creation of emergency care of the PMM expresses values that are in the kernel of a contradictory tendency expressed by the real: the provision made an asset (access to medical care in 'dark' regions) legitimate, but at the same time it strengthened the hegemony of capital, making the workforce cheaper, and was not built with total transparency.

This dialectic of the real, put on as a show by the capitalist method of production, in which the social order legitimizes economicist values and creates an obstacle to total transparency, could be confronted in the totality of the intransigent guarantee of permanent provision by the State. For this to happen, other ethical-political highways would demand paving, among which we highlight the need for investment in an 'ethical-political project for the country'[8] for the purposes of an ethical-political State in which popular organizations are unified in a State, based on movement away from the condition of being those who are directed, to the condition of being those directing – conquering space in civil society and organizing themselves as a political society[9].

Even though the right to health is a legitimate social right, because it has been won by all of Brazilian society, through the 'Citizen Constitution'[10], the historical development of the reality expresses the cultural hegemony of the bourgeoisie[11], directed by *liberal, private and corporatist interests* (T3) of the medical community which, by generating the subsumption of the guarantee of the right to health, demands from the Brazilian government social responses to questions indicated by manifestations and demands, as per the following reported statements:

The emergency provision was a *political response to the demonstrations of June 2013 and to claims by mayors* [expressed in the question:] *where is the doctor?* (T1). This *political* response (T1) *opened the PMM as a confrontation strategy* (IC1) for confronting the need to overcome the scarcity of doctors in basic healthcare of the Single Health System (SUS). It was thus characterized as a rational instrumental action[12], executed by the Brazilian government, of which the purposes, means and results were allegedly at the service of an immediate solution for the crisis of unequal distribution of producers of medical care in basic healthcare.

The PMM, in turn, can be understood as a cultural operation of putting into place the Health Reform Movement, in that its institution by the federal government provoked reintroduction of the value 'health' in the political arena. However, this cultural operation also presents a *social ferment* (T1) of a dialectical nature, because it takes place in a scenario of a profound

ethical, political and economic crisis at the macro level, in which *social rights are threatened and withdrawn* (T1) by *a Congress* [...] *that is medieval, that is taking retrograde steps* (T2) and, at the same time in a scenario in which *the population is mobilized, will not accept the end of the Project* (T1), *will not accept any going back* (T3).

The conditions of possibility for fracture of social cohesion[13] of this *ferment* (T1) of a dialectical nature appear not to have been given: the popular organizations do not show themselves to be effectively organic in the contemporary situation[9], and the SUS did not put in place any jobs and salaries policy to ensure permanent provision of doctors, and does not have financing on a dignified scale. According to the World Health Statistics of 2013 of the World Health Organization (WHO), the total of public 'spending' on health in Brazil amounted to 9% of GDP. This percentage is not very distant from the level provided by developed companies – according to the WHO, health services represented 9.4% of world GDP in 2009. However, in the Brazilian case, of the 9% of 'spending' on health of the GDP of two hundred million Brazilians, 47% was public spending and 53% was private spending. Of this total of private spending, approximately 60% was direct spending from the pockets of families and more than 40% was via health insurance plans[14].

This means that Brazil has not yet materialized a permanent provision of doctors in basic healthcare because health is not 'an end in itself, a vital good'[15] or 'an intrinsic value'[15], but 'spending' from GDP hegemonized by the market. Approximating Antonio Gramsci's method of analysis of the real to this reality – of the SUS, guaranteed, not expressing realization of the right to health from the SUS that has been achieved – it seems to be necessary for Brazil, for the purposes of long-term policy (permanent provision) to have disposition to go back to the point of departure: the positions won by the eighth National Health Conference[16], to produce a historic awareness –'putting it, in tranquility, back to work, restarting [the SUS] from the beginning'[17].

Another important question to be brought up is that, although the *Mais Médicos* cultural operation has assumed the characteristics of *a project* [...] *which includes access to the SUS* (T2) ~~–t~~*he President was emphatic: it is an untouchable program* (T4) ~~,t~~he conditions of possibilities are very different from those that had been given in the decade when the Health Reform Movement was launched (1970), when Brazil had *a collective project of a society* (T1), manifested in the collective struggle for redemocratization and by the creation of the SUS for all.

Recovering what has already happened in the history, dividing into periods as from the 1960s, various actions were recognized that were taken in favor of *a collective Project for a society* (T1) in the conditions that existed. At the historic moment 1960-1970, the popular organizations were conducting a struggle against the dictatorial State of exception; in the 1980s, they invested in achieving the Democratic State under Law; in the 1990s, they opposed the instruments of action of the minimum State[8]. In 2013, they took to the streets to interfere in the decisions of the State on vital questions that affect the day-to-day life of the cities[18], while mayors went to Brasília to ask: *Where's the doctor?* (T1).

When questioned about which values they realized in the processes of decision in the pedagogical guidance of tutorship, two participants showed difficulty in understanding what the question said: *Could you explain the question to me better?* (T3); *What 'values'? This is a question of ethics, probably* (T1). At first sight, this factual limitation could be representing a reflective emptiness about what values are realized in the decisions of tutorship, since no participant had raised any question when asked about which values were brought up/proposed by the Brazilian State at the time of the realization of the PMM, as demonstrated above. Not only this. The question *Values?* (T1), followed by *This is a question about ethics, probably* (T1), could be producing a peripheral trajectory of exclusion[13] of the ethics dimension, from the pedagogical guidance.

On this line of understanding, if the pedagogical function of a tutor is to make decisions to 'raise the mass [doctors allocated in Santa Catarina for emergency supply] to a given cultural level' [medical care in a Brazilian context][11], the recognition that every act of decision is preceded by values chosen and realized by the subject of the action is the first stage of the exercise of ethics[19]. Max Weber also highlights the importance of rational action oriented by values, so important in the production of social subjects, when saying that the object of an action is not its product or final purpose, but the values that are chosen and realized in the action[12].

However, it was perceived that the questionings emerged from the difficulty of understanding over what 'realization of values' might be in decisions, an expression that is so dear to the domain of applied ethics, but in this study shown not to be universal in the field of collective health.

After the reformulation of the question to the two participants, replacing the phrasing, the following values were gleaned: *universal access, equity* (T1, T2, T3, T4, RD2); *widened basic healthcare, integralness, education, political education, strong diagnostic capacity, democratization of public goods* (T3); *selective basic healthcare* (T2); *social justice* (T2, T4); *the right to health* (T4); *citizenship, dignity* (T1); *cooperation, ethics of life* (RD1) and humanization (RD2).

The consequent result of one of these values – for example, integralness – underlines the importance of sharing of the ethical dimension of the pedagogical process: in the view of one tutor, *the arm of the supply does not guarantee integralness, it is clearly doctor-centered, illness-centered* (T2); in the opinion of another, *integrality is a value of the Program, understanding that the doctor is fundamental in the basic healthcare team* (T3). The divergence of these reports does not show an incomprehension of what integrality is, but a different way of understanding integrality in the target-image of the care. This fact strengthens the importance of the tutors recognizing the values that they give priority to in the guidance and of discussing them, with a view to a qualification of the tutorship.

When asked whether the value *solidarity* is at the basis of the care, one participant mentioned this value as a utopia, since *I am unable to see any ethical point of juncture between neoliberalism and solidarity, and we live in a neoliberal country* (T2). It is possible to infer that the tutor is referring to the impossibility of establishing solidarity relationships in the dominion of liberty[20] in a context of dehumanization of the individual and turning social relationships into a 'thing'[21], in which adapting one's self to the given conditions and to the wrong paths and irrationalities imposed by the so-called neoliberal order are seductive choices[22].

However, participants referred to solidarity as the basis of medical training in Cuba: *The Cuban people have a humanitarian formation that is greater than that of the Brazilian people* (T3); *from birth, they live with the word 'solidarity'* [...] *it is impregnated in the way they live* (T2); *it has to do with their humanism* (T4). It is important to point out that a large part of the doctors allocated in basic healthcare of Santa Catarina entered the PMMB through the cooperation agreement mediated by the Pan-American Health Organization (OPAS) and established between Brazil and Cuba[23].

Bernardino Fantini, director of the *Institut Universitaire D'histoire de la Médecine et de la Santé Publique*, of the University of Geneva, quoted by Berlinguer[24], emphasizes that health and illnesses "are fundamentally individual experiences but, having their roots in the collective, they call for solidarity and, for this reason, are, by definition, social". Based on this understanding it can be seen, in the reports, that solidarity is a historic value of the social production of Cuban health.

On this point, the cultural exchanges established in the process of work between Cuban doctors providing health service and other doctors and producers of health in basic healthcare could act as a factor qualifying the Project, motivating, for example, an epistemology that is not 'monolithic', but based on solidarity, creator of a theoretical *corpus* (historic awareness/widened concept of health) and one that is practical (congruence between collective values and decisions for possible and effective results)[24].

Pedagogical guidelines: fundamentals

The pedagogical guidelines of the PMMB correspond to *a strategic attempt to qualify the work of the doctor that exists in the territory* (IC1). This is developed through two axes: *academic tutorship; and supervision of doctors* (IC1) connected to the Project. In its initial phase, put into action *as from the end of 2013* (T1), the guidance for academic tutorship had as its first fundamental *putting out fires* (T1), in the sense of generating solutions for immediate problems that had been caused by the lack of medical attention in basic healthcare, in the 'darker' corners of Brazil[4]. In the present phase, which is understood to be a phase *of transition* (T1, T2), the guidance centers on a second fundamental: *Qualification of the project* (IC1).

From the point of view of Day-to-day Bioethics, an applied ethics reference created by Giovanni Berlinguer, it is possible to perceive *putting out of fires* as confrontation of the 'immediate reality', that which calls for 'creative synthesis', because it is made up of 'day-to-day events and frequently dramatic urgencies', as Fantini puts it, quoted by Berlinguer[24]. Similarly, the pedagogical-political vision of Gramsci helps the comprehension that the initial need for *putting out fires* could correspond to a dialectical movement generated by 'theoretical awareness of the immediate aims'[24] that the real, contradictorily, expresses.

And, further, assuming health and illness is socially determined, expressions of a particular process of the general process of a social life[25], focusing on the historic debit of accumulated

needs in the Brazils that have not received medical attention, it is probable that the initial *putting out of fires* may correspond to the first phase of a planning which, according to Mario Testa, quoted by Giovanella[26], consists of a 'historic practice' for production of health and containment of individual and collective disease.

Interconnected with the second fundamental, *Qualification of the Project* (IC1), reports expressed a third fundamental: the need for comprehension of the pedagogical guidance as a *process* (T1), in such a way that the relationships, decisions and flows comprise a 'platform in movement'[27], construct a process that constitutes itself – in the same way that a person or a group of people are 'beings, being'[28], in a given context, with the means that they have available in a given social organization. This third fundamental explains that the solutions for the difficulties are created in process. For example, some statements expressed the concept that roles and competencies are absorbed in development itself. When asked about the map of distribution of supervisors and doctors in Santa Catarina and how tutorship is constituted and organized in the State, tutors introduced more recently into the Project suggested consulting more long-standing tutors: *Perhaps the tutor that will bring you this information better is* [...] *who has been in the process for more time* (T2). The argumentation was centered on the fact that this tutor entered the Project at a moment that required investment in the first fundamental – *putting out fires* (T1) – and for this reason had not yet succeeded in becoming aware of the program structure that accompanies plans and planning.

Asked about the relationship in absolute numbers between tutors and supervisors and about the content that they work with supervisors, tutors revealed that each one of them is responsible for approximately 10 supervisors and that there is a polarization between prioritization of the instrumental rationality and the rationality oriented by value: *I was thinking of making a sort of skeleton for systemizing the visit* [...] a *checklist* [...] *I was immediately criticized* [...] *I heard: You killed the supervisor's creativity* (T2).

This question also exposes a contradictory trend of the real: If the process of academic tutorship is largely based on sustaining the widened concept of health, achieved in the eighth National Health Council meeting, as a target-image, there is no place for this *checklist,* since widened health is not reduced to clinical activity, supply of medical services, attendance to prevalent diseases and one-off treatments. This concept defines health as resulting from the modes of social organization of production[16]; therefore, the relationships between supervisors and doctors and the analysis of the productive forces is that they would be generating 'the way of' carrying out tutorship: the one that comprises and looks at the how and the why of being dependent on the context of the cases reported by supervisors.

However, questions arise: Are the supervisors ready and properly prepared to work the amplified concept of health in the process of supervision of the doctors included in basic healthcare by the Project? Were they trained to execute the amplified concept of health? In the absence of this preparation, would a *checklist* with some statements of priorities not be welcome? Or would it be reductionist? And what about the tutors? Without assuming the ethical dimension as first provision for prudent decisions, will they be disposed to qualify the Project based on investment in a minimally homogenous ethical-political-pedagogical unit on what is meant by *organize supervisors in the territory* [...] *map the formative aspects of the territory* (T3)?

These questionings once again bring us back to Giovanni Berlinguer, in whose opinion the respect for the plurality of ideologies, motivations, values realized in the ethical exercise is a right, but, Berlinguer says[29], a collective construction requires from the architects a common design, in which individual ethics and deliberations are embraced by the requirement of a common purposes, even if, for this, it is necessary to agree concessions and individual renunciations and face ethical conflicts.

Thus, the quality of the process of guidance will not be in the resolution of the *checklist* impasse, and creativity, nor in the quantitative aspect of meetings: [...] *we have a meeting of tutors every two weeks* [...] *the tutor tries to be present at the quarterly regional meetings between supervisor and doctors supervised* (T4), but, (once again) in the collective will[11] to qualify 'how': A process of guidance, in the ethical-political perspective. Stated another way, the qualification of the Project would be in the capacity of the tutorship group to produce an *ethos* for the pedagogic guidance, an identity, for the purpose of the collective construction.[29]

In an interview held by pupils of the Lyceum of Rome with Giovanni Berlinguer, entitled *Etica ed Esperienza*, a group of students asked Berlinguer if it would be possible to think of a universal ethics, in the manner of capital-

istic production. He argued that ethical choices and decisions emerge from the contexts in which they are inserted and that these design the ethical transformation, that thinking of the exercise of ethics outside the space of experience is illusory. He said to the students that it is possible to have, not a universal ethics, but "a universal ethical fabric, with various shapes and colors"[30]. In reality, he underlined in the interview his pessimistic view in analysis, and optimistic view in action, in the same way that Gramsci shared this view, in a letter written in prison to his brother Carlo, in 1929:

[...] *a man has inside himself the source of his moral forces* [...] *everything depends on him, on his energy, on his will, on the consistent coherence of the final purposes that he proposes, and on the explanatory means for achieving them – not to lose hope* [...] *and not to fall* [...] *into that vulgar and banal state of spirit known in two feelings: pessimism and optimism. My state of spirit synthesizes these two sentiments and overcomes them: I am pessimistic in the intelligence, and optimistic in the will* (an expression of the author Ramain Rolland assumed by Gramsci as a motto)[31].

Final considerations

The survey identified three fundamentals, constituting components of the academic tutorship of the emergency supply of doctors for basic healthcare, in Santa Catarina, based on the variable 'realization of values': (a) consciousness of the immediate need, from the reality, to *put out fires*; (b) the need for qualification of the *Mais Médicos* Project; (c) the understanding of the guidance as a process – *the practice and the criterion of truth* (T4). It was concluded that the process of academic orientation of the productive activities of doctors in the emergency provision does not correspond to an isolated pedagogical confrontation, but is part and consequence of the historic development of theory and of practice. In this sense, the activity of tutorship corresponds dialectically to movements of rupture, resistance, emancipation, and also requires reflection on the collective values realized in the act of decision. It also requires the collective group identity, an *ethos*.

Collaborations

RCGS Lima worked on the conception, design, analysis and interpretation of the data, writing of the article. DW Gripa carried out the collection and transcription of the data. MA da Ros participated in the final drafting of the article. ENS Prospero helped with the organization of the data and final drafting of the article.

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