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Project More Doctors for Brazil in remote areas of the state of Roraima: relationship between doctors and the Special Supervision Group

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This article aims at discussing aspects of the Project More Doctors for Brazil's Special Supervision Group in areas of difficult access in the Brazilian state of Roraima. It is focused on the relationships between supervisors and doctors, identifying potentialities and difficulties, and highlighting strategies to overcome them. This is an experience report from a thematic content analysis of documents produced by supervisors in 2015 and 2016. Three key categories emerged: potentialities, challenges of the process and constructions based on supervision. Based on the analysis, this is an innovative relationship in healthcare, where academia and services hardly ever come together. It is a complex relationship with structural, cultural and educational limitations. It requires creativity and planning to play all different roles under construction.

Keywords: Continuing education. Primary care. Indigenous health. Project More Doctors for Brazil. Academic supervision.

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Introduction

The More Doctors Program (PMM) is a solution to the shortage of doctors in the Brazilian National Health System (SUS), particularly in primary care, and to the poor distribution of these professionals throughout the country[1]. One of PMM's axes, the Project More Doctors for Brazil (PMMB), provides an emergency supply of doctors in priority regions. Through the project, primary healthcare teams of Brazilian cities become complete[2], strengthening longitudinal care in the most vulnerable populations. Academic supervision is conducted every month through local visits paid by supervising doctors from supervising institutions. It is an investment in the education and qualification of health work, individualizing experiences and improving the supervised doctors' competencies[3]. Each group is comprised of approximately 10 supervisors and is coordinated by a tutor. Tutors oversee dialogs with local managers and the managing body of the Brazilian Ministry of Education (MEC).

The expansion of access to medical care in indigenous areas where the emergency supply was most significant[4] resulted in the challenge of regularly transferring supervisors, particularly in the Brazilian Legal Amazon. Therefore, the Military's logistic support was articulated between MEC and the Ministry of Defense for transportation to hard-to-reach areas. Since 2014, this strategy, which was subsequently called Special Supervision Group (GES), has been applied in four Brazilian Amazon states. It now has a permanent group of supervisors and tutors from Universidade de Brasília. It built partnerships with local supervising institutions and other sectors of each state[5].

In 2015, Universidade Federal de Roraima requested assistance from MEC to ensure academic supervision in indigenous areas of difficult access and in the city of Uiramutã. GES-RR was then created, comprised of one tutor and seven supervisors able to handle pedagogical and intercultural issues. Some of them had experience in indigenous areas, while others were family and community doctors. There was also a midwife doctor and a doctor with experience in Roraima's territory. Visits are conducted every two or three months to supervise *in loco* (going to the locations), hold annual regional meetings (collective meetings to discuss different topics, conduct debates and encourage continuing education) and conduct longitudinal supervisions (distance follow-up by phone, electronic messaging, videoconference and other tools)[3].

Supervisors write monthly reports on the work process and its different contexts, amounting to a series of gross material. After two years of work, GES-RR's components considered it was necessary to systematize this material and reflect upon the relationships built in this context. Besides the geographical isolation's challenges, supervising indigenous areas presents other complex issues that are not sufficiently analyzed. This study aims at understanding the relationship between supervisors and subjects supervised by GES-RR based on the supervisors' point of view.

Methodology

This experience report results from a documentation analysis. The focus on the human production universe is acknowledged here, particularly that of relationships, representations and intentionality, which are the qualitative research's objects[6]. These aspects, along with the fact that all those involved in the text production also played their part (supervision or tutorship), enabled to deconstruct the idea of neutrality.

In order to do so, all reports of general aspects of all supervisors who worked in indigenous areas in 2015 and 2016 were selected, amounting to 61 reports. These reports are GES-RR documents, not official PMMB documents. They contain open questions that provide a discussion about: supervision type (in person, distance or regional), positive supervision points and difficulties, recommendations for the next supervision, supervision's potentialities in the indigenous area. They are sources of data limited to the supervisors' experience in this relationship.

The researchers analyzed the documents and simultaneously read all materials. They searched for excerpts in the documents that would be related to the following issues: relationships between academic supervision and PMMB doctors; relationships between academic supervision and municipal management or Special Indigenous Health District (DSEI); relationships among supervisors, tutor and MEC RR supporter; and relationships between academic supervision and community.

In this pre-analysis, five files were produced. These files provided three other moments: ordinance of these documents, Bardin's thematic content analysis adapted by Gomes[7] and interpretive synthesis. These moments enabled a dialog among the axes identified with the supervisors' experience, objectives and research's initial issues.

Three thematic categories arose after processing this data: potentialities, challenges in the process and constructions based on supervision. Sense nuclei across PMMB's scenarios of practice were also identified. These nuclei are expressed in the relationships established by the supervision in the field.

Supervisors were identified below by letter "S" followed by a random number, in order to ensure their anonymity. This research was approved by the Research Ethics Committee of Universidade Federal de São Carlos (opinion 1.953.459).

Results and discussion

In the Brazilian state of Roraima, there are two DSEI (Indigenous Healthcare Subsystem's decentralized managing unit[8]): East, and Yanoami and Ye'kuana. The indigenous territories in this state and the people who live there are diverse, as are the common political and socioeconomical challenges in border regions.

During the study period, most of the doctors who were incorporated into Roraima's indigenous health teams through PMMB were Cuban or Brazilian graduated overseas. This is due to the fact that hard-to-reach places are unwanted by Brazilian doctors[9]. There were about 30 professionals. None of them had previous experience with indigenous populations. However, they were taking the Indigenous Health specialization distance course in their time off from the village, when they had internet access. This participation was the condition to remain in PMMB.

The hierarchical and authoritarian characteristics of medical education of most countries (including Cuba and Brazil) and the relationship of power established in the experience were reflected in the relationship between supervisors and supervised subjects, and in medical practice. Some professionals seem used to a reality of clear division of roles and tasks in which doctors hold most of the power and knowledge. This reality results in anxiety. Professionals feel powerless and little respected in this scenario of interdisciplinary work and bring this up to the supervision as a requirement.

However, in the critical pedagogical perspective, there is also an effort to understand this space as a construction of knowledge by supervisors and supervised subjects, where everybody can teach and learn in a horizontal way[10].

These issues influence and diversify the supervision's characteristics. They point towards powerful aspects in this process, faced challenges and constructions that arose in the relationships.

Potentialities

In the perspective of a relationship under construction, little consolidated and regulated, and despite the previous judicious and individualized planning of meetings, the creative process' potentialities can be more latent than tangible results. The greatest challenge in this recently-created relationship is to break the possibilities' limits and overcome limiting situations. This is the boundary between simply being, and going beyond and finding the untested feasibility[11].

Supervisors realize that supervised subjects expect support from them and that they intermediate conflicts with the team, management or community, acknowledging some positive aspects in this relationship:

> Knowledge of the work reality of the professionals who work in that area. Demonstration of support and "protection" to doctors who work in DSEI. (S2)

> Giving a voice and legitimizing the community's point of view about the health sector presence in their area. (S5)

> [...] dialoging with management for better work conditions as demands arise. Collaborating in the work process of teams, not forgetting the central focus of our practice: doctors. (S6)

The local presence seems to consolidate the importance of knowing the reality where doctors work at. It is also brought up as a way of timely questioning work improvements:

> [...] Supervision in the base center certainly improved the activity's quality. I was able to experience with the doctor and the team the care routine in the health unit and indigenous village. (S4)

> In this supervision, visiting the community made me realize the need and importance of knowing the territory and environment where doctors work at. (S2)

By accepting the questioning characteristic of the work routine, supervision strengthens a dialogical relationship of exchange:

> Talking to community members to assess the doctors' practice. Encouraging dialog between doctors and healers/shamans, combining traditional medicine to the indigenous health team's therapeutic arsenal. (S7)

> In indigenous areas, it is a lot easier to observe and suggest improvements in the work of doctors and teams. Dialog is easier, as is following up activities, visits, care and routine. (S3)

In this category, untested feasibility arises as part of the sense nucleus "what one envisions to build and what the relationship provides." There is a relationship of bond and trust that expands the construction of new knowledge in these intercultural scenarios. This new knowledge, in turn, results in non-hegemonic practices and welcomes traditional medicine.

Bond and trust also seem to be related to the time of contact and to the communication's modality and frequency. Supervision is, most of the times, remote: by electronic messaging and telephone. The most frequent and continuous it is, the stronger this bond will be, according to supervisors. However, supervisors seem to worry about the feedback from these contacts, since some supervised subjects tend to undertake a passive behavior: "(it is required to) Further improve communication. Reinforce the need to reply to emails and messages" (S3).

Establishing bonds implies closer relationships and accountability[12]. In the meantime, trust becomes essential to supervised subjects, so that they are open to jointly build learning and detach from the know-it-all vanity.

> The conversation circle enabled a greater approach between supervisors and doctors [...] and an improvement in the bond and relationship between supervisors and cooperative members. It also facilitated the pedagogical supervision process and general support. (S3)

In order to do that, supervisors suggest the following as essential in their work:

> Assess activities with the team and doctors during a closer follow-up when visiting base centers. Keep trying to obtain demands from some doctors and support doctors in their course completion essays. Closely follow mainly doctors who have not been working for a long time in indigenous areas. (S1)

Recommendations to future supervisions mentioned in the reports express concern with the work's growth and continuity:

> Foster interconsultation and home visits. Ask for adequate medical records in Portuguese. Request team meetings with more frequency and shared decisions. (S7)

> Try to find out about professionals' topics of interest to discuss or suggest materials. (S2)

The point of view of supervisors and external agents can be an encouragement to permanent education. It can favor intercultural dialogs and adaptation of health practices, exploring topics related to the development of social sciences competencies, which are not sufficiently developed in these places[13]. The supervision's power also seems to be the encouragement to seek new knowledge by mutual questioning and learning, not being limited to an automatic supply of materials to supervised subjects. This would be what Freire calls knowledge by experience, which is different from its transmission, when educators only offer their knowledge to students[11].

In experiences with collective supervision spaces with regional workshops and meetings, it is also possible to notice who requires more attention: "Regional supervision shows that some of them still need more attention. Two of them seem to have important demands to be observed *in loco*" (S6).

Finally, this pedagogical relationship enables a cultural, technical and scientific exchange that brings innovation and a "mosaic of possibilities" to public health policies and medical education in the country[14]. Some professionals, for example, have experience in management, teaching and research, and could contribute with scientific production in the area, with indigenous health protocols or supervising interns from Rural Residency[15], not being restricted to healthcare in the villages. However, this broader practice is not provided by PMM's guidelines yet.

Challenges in the process

Among the difficulties identified in the sense nucleus "weaknesses and challenges faced in the supervision process," the following are highlighted: lack of interest and motivation of professionals; difficulty with the language, particularly by foreign doctors, and with communication in longitudinal supervision; difficulties of access to the area and *in loco* supervision; structural adversities in the indigenous health context, such as precarious work conditions and healthcare network; and difficulty in the approach and intercultural dialog.

> Several times, I asked them to suggest a topic to be discussed. I sent emails and messages questioning their lack of contribution, but I did not get an answer. [...] My question still is: to which extent their absence in the discourse can be considered an omission due to embarrassment or lack of interest? (S6)

> Doctors do not understand yet the importance of supervision and prompt reply of emails and messages, maybe because it is still something new. (S3)

As an obstacle in telephone conversations, some doctors have insufficient domain of Portuguese; although studies show that most people in indigenous communities do not have problems in communicating with professionals[4]. Additionally, there are internet limitations and a weak initial bond:

> Poor internet connection mentioned by doctors, which hinders web conferences, the use of websites and heavy platforms [...]. Difficulty to understand Cuban doctors when speaking to them over the phone. The bond between supervisors and professionals is still under construction [reference to the beginning of the work]. (S6)

> The distance is rather symbolic in this process. Not being able to see each other, feel the reactions in a conversation, sometimes even hear (when messages are exchanged), somehow does not facilitate the paths towards a professional and pedagogical relationship. (S2)

Recurring difficulties were also reported in in-person moments: "Difficulty in conducting a more powerful and less superficial process. Difficulty in questioning structural issues and issues that involve change in a practice that is being performed by doctors for a long time" (S1).

It is also necessary to consider that PMMB's pedagogical proposal involves several institutional arrangements and complex articulation and coordination processes. Some records show conflicts and negative aspects in the relationship between supervisors and supervised subjects, particularly when supervisors have no governance over the problem presented by supervised subjects, such as in administrative issues or issues related to service management. These conflicts result in frustration, since a real and legitimate expectation is not met.

> Difficulty in prioritizing pedagogical demands related to structural issues. (S1)

> Receiving requests and complaints that cannot be solved through the supervision process. (S2)

However, knowing and identifying some problems and demands can be essential to the process of construction of solutions not previously discussed, even if they are not part of the supervision team's governance. This point is also mentioned in other works, which suggest some possibilities of advance in this process, such as using active methodologies in regional meetings[16] and conducting Balint-Paideia groups in practical supervision[17].

This situation is similar in other realities, such as the one described in an experience in the state of Roraima[18]. This experience indicates the involvement of supervisors in structural issues related to management, housing situation and aid costs of doctors, as well as local difficulties with access and communication, particularly related to riverside communities. In some moments, these subjects can be the only extractable demands: "Being aware of difficulties, both in clinical practice or work process issues, faced by supervised subjects in their daily routine, since they tend to require little supervision. (S8)

The indigenous health context itself and the challenges faced by supervisors when dealing with the implications of the suggested work conditions can be added to that. For example, difficulties of access to running water and electricity, internet, telephone line and other technologies[13]. Professionals who are used to a medical practice that uses instruments and complementary routine tests complain, in supervision, about the lack of access to these resources, particularly in services as prenatal.

Some authors deal with the complexity of inserting professionals in indigenous territories. This complexity can be due to structural and organizational issues, as well as cultural issues faced when dealing with different worldviews when trying to decode the meanings of each issue to the health-disease-healing process[13,19].

In this sense, the supervisor's role also seems to involve encouraging discussions on these agendas, which would not be spontaneously brought up. Medical education in Brazil and Cuba does not seem to prepare professionals to some of these challenges: "Doctors' difficulty to broaden their view on the community's perspectives to beyond the biomedical's one, since they believe other actions should be taken by other government sectors" (S7).

Supervisors frequently notice a relative disbelief by professionals as to traditional indigenous medicine's care practices. Denial of these practices as potential partnerships in healthcare seems to result in distancing from the community. The shock between two medical rationalities can result in a new domination, maintaining the process of colonization and regulation of indigenous groups[19].

In this sense, supervision can feel like a nuisance to some professionals when supervisors deal with topics as intercultural relationships, interaction with the team and community approach. To some doctors, these discussions are not part of their professional functions:

> [...] seemed often bothered with the supervision's conversation, claiming that the work difficulties in the area would never change. (S7)

> I think it is difficult to talk about Anthropology topics, because they say they have already seen a lot of it, then we are not able to proceed. (S5)

As a new process, supervision has a different work dynamics and proposal. It is still being adapted and involves different agents and institutions in a continuously creative path. This characteristic can hinder the understanding of a pedagogical proposal of permanent education, resulting in different interpretations, including among supervisors: "Are we teachers, preceptors or inspectors?" (S3).

Despite the process' difficulties and the several, and oftentimes different, interpretations about academic supervision, constructions are being conducted in this path. These constructions are highlighted in the next category.

Challenges based on supervision

Based on data focused on the sense nucleus "roles and skills built in the supervision process," some partial results were observed.

According to the directive that regulates academic supervision[3], the supervisor's role is to follow the activities of participating doctors, apply assessment instruments, and follow and assess, with SUS manager, the execution of teaching-service activities, being constantly available remotely. In practice, we can sum up the supervision's work with the following roles: control/assessment, support and technical-clinical improvement[20]. In the experience analyzed in this article, these roles were achieved based on some constructions. Embracement is a path towards qualification in the supervision process and a bridge to other affections.

> [...] despite the geographical distance, doctors were more welcoming to supervision contacts. Professionals feel embraced. (S2)

As a technology in SUS, embracement involves relationships of care, welcoming and listening to people. It can be focused on users or on workers themselves[21]. In the supervision process, it emerges in each contact, enabling to identify the supervised subject's needs. As relationships become closer, the supervision's interactivity, through which the construction of autonomy and new practices is potentialized, is evidenced[13].

> Embracement makes professionals feel supported. Professionals show interest. (S2)

In the indigenous health context, the isolation feeling common to health professionals who work in remote or hard-to-reach areas[22] is potentialized by poor articulation with healthcare networks[23]. In remote rural regions, this is also a challenge for effective comprehensive care and articulation among different levels of care, even the supply of doctors in primary care[24]. In Roraima, the fact that services provided in outpatient clinics and hospitals, focal specialties and diagnostic means are mainly concentrated in the capital, Boa Vista, makes a difference[25].

Work approximation, support and encouragement through *in loco* visits can value practice and contribute to motivating professionals who remain in PMMB, even under these adverse contexts. Similarly to what Castro[20] points out, *in loco* is also the time when tensions in the work process are captured by directly observing the daily routine of professionals, health teams and communities:

> Motivation in the doctors' work, because they realize they are being supported, and due to the encouragement to identify weaknesses and doubts, even with difficulties. (S1)

> Building spaces to think about caregiver's care, considering that conversation circles between professionals and us, in which they were able to open up and expose their anxieties, also had a therapeutic effect. This should be taken into consideration by professionals who work in areas with poor structures and work processes. (S6)

Supervisors' motivation varies according to the doctor's perception of the work's nature. It can be humanitarian, mainly based in solidarity and internationalist vocation

to some Cubans[14,26]; temporary, mainly among Brazilians who want to work in medical residency or between foreigners and Brazilians graduated overseas who want to revalidate their diploma; or realistic, as real agents in a public health system under construction.

An important aspect is that contact with different cultures has intensified supervisors' interest in learning more about indigenous people, particularly about the ethnicities of places where professionals work at, in order to broaden discussions with doctors and teams. This may be one of the most important results of supervision: raise awareness of supervisors and supervised subjects to look beyond a strictly biomedical horizon, encouraging intercultural dialog in the reality where they are inserted at:

> I noticed an interest to keep the work in indigenous communities, despite the structural difficulties they face. When questioned about doubts, at first, they say they do not have any. However, when they start talking about their intervention projects and practices, some issues start to emerge. We are able to develop some interesting discussions based on them, even if by telephone. This makes up for the challenges in distance supervision. (S6)

Nevertheless, supervisors observe a frequent dismay among professionals when they say that the Indigenous Health specialization offered by Universidade Federal de São Paulo does not meet the technical-clinical education's expectations. Therefore, GES collaborates to valuing this space by including theoretical issues in the discussion of complex practice cases. Likewise, it encourages and supports an adequate use of the Portuguese language and the construction of a better relationship with DSEI management.

In order to carry out these constructions during this period, creative solutions were necessary. These solutions used active methodologies, (real or virtual) spaces in discussion groups and conversation circles:

> We conducted a meeting in DSEI-Yanomami and Ye'kuana [...] and decided it was a productive moment, even richer than the individual supervisions, since we broaden views related to the work process in villages. (S4)
>
> This month, we were able to conduct a virtual, real-time discussion and stress the importance of contact between doctors and supervisors for improvement. (S3)

In this construction, it is important to highlight the supervisors' experience and dynamism and the relationship built with managers. Additionally, a learning process was developed and is continually reassessed throughout the experience in assessment meetings and permanent education spaces regularly conducted between supervisors and tutorship.

Final remarks

The documentation analysis enabled to access different issues involved in the relationships between PMMB's doctors and supervisors based on the latter's point of view. Due to the innovative and complex characteristic of this relationship in GES-

RR, limitations and potentialities still seem unclear. In distance and *in loco* support, supervisors continuously and longitudinally welcome clinical-pedagogical demands (and eventual anxieties) of the doctors' daily routine. Consequently, trust, bond, acknowledgement and encouragement of professionals to work in teams and towards the community arise. The follow-up process provides spaces of exchange of different knowledge in a horizontal and mutual way and raises doctors and supervisors' awareness as to indigenous health-related issues.

However, this relationship can be improved by honing communication tools, promoting more regional and caregiver care meetings, and recognizing the supervisor's role.

Some challenges remain: geographical distance, difficulties in encouraging the study of the Portuguese language, work conditions, doctors' motivation to stay in the indigenous health area and change of paradigm of the biomedical model. Nevertheless, records suggest these professionals are able to overcome adversities, facing lack of resources and working while remaining critical. GES-RR's role, in turn, supports the development of broader notions of individual and collective care in these peculiar scenarios, respecting cultural differences and building new paradigms based on these differences.

This study enables to learn more about the universe of relationships in GES-RR's supervision. It can be similar to what occurs in other PMMB's supervising institutions, which should also be studied based on the supervised subjects' point of view. It also shows the need for a better integration between academia and healthcare services in indigenous areas. This integration could result in a better understanding of this complex scenario of practice and the possibility of identifying and developing the necessary competencies to health professionals in these locations.

Authors' contributions

All authors participated actively in all the stages of the preparation of the manuscript.

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