Longitudinality and comprehensiveness on the More Doctors Program: an evaluative study

Longitudinalidade e integralidade no Programa Mais Médicos: um estudo avaliativo

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ABSTRACT This study aims to investigate influences of the More Doctors Program regarding the attributes of longitudinality and comprehensiveness in primary care, by means of a case study in two cities using ethnography, interviews, and focal groups. The results indicate positive effects regarding the longitudinality, coming from the relation of the doctors with the health users, humanized reception, therapeutic bond creation, availability to make home visits, and supporting the healthcare team. Despite the doctors of the program recognize the importance of the principle of comprehensiveness of care in the relation with the users, the effective consideration of such attribute is restrict, which is explained by the excess of daily attendance, perspective conflicts with other workers, and limits in the structure and working method of the healthcare network. In conclusion, the characteristics of the doctors associated with the format of their contracting for the provision of doctors in the health units contribute to reach of longitudinality. On the other hand, to reach comprehensiveness, structural changes are required, such as the continuous training of the teams and a rearrangement of the work, and it remains barely influenced by the addressed program.

KEYWORDS Program evaluation. Health consortia. Integrality in health. Continuity of patient care.

RESUMO *Este estudo teve como objetivo investigar influências do Programa Mais Médicos sobre os atributos de longitudinalidade e integralidade na atenção básica, por meio de estudo de caso em dois municípios, utilizando etnografia, entrevistas e grupos focais. Os resultados indicam efeitos positivos em relação à longitudinalidade, proveniente da relação dos médicos com usuários de saúde, acolhimento humanizado, criação de vínculo terapêutico, disponibilidade para realizar visitas domiciliares e apoiar a equipe de saúde. A despeito de os médicos do programa reconhecerem a importância do princípio da integralidade do cuidado na relação com os usuários, é restrita a efetiva consideração desse atributo, explicado pelo excesso de atendimentos diários, conflitos de perspectivas com outros trabalhadores e limites da estrutura e modo de funcionamento da rede de saúde. Conclui-se que características dos agentes médicos associadas ao formato de sua contratação para o provimento de médicos nas unidades de saúde contribuem para o alcance da longitudinalidade. Por outro lado, o alcance da integralidade, que exige mudanças estruturais, como a formação contínua das equipes e reorganização do trabalho, permanece pouco influenciada pelo programa abordado.*

PALAVRAS-CHAVE *Avaliação de programas e projetos de saúde. Consórcios de saúde. Integralidade em saúde. Continuidade da assistência ao paciente.*

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Introduction

Changes in the health care model in Brazil, from the end of the 1980s, have focused on the increase of medical facilities, partly due to the expansion of primary care throughout the development of the Unified Health System (SUS). The implementation of the Family Health Strategy (FHS) favored this process through the expansion of health care coverage[1], so that training and work themes became strategic axes for the development of this system[2]. From the point of view of the functioning of SUS, there is an understanding that problems related to the unequal geographical concentration of health professionals hinder the materialization of its principles, such as universalization, comprehensiveness and decentralization[3].

The so-called global crisis of the health workforce is determined, among other factors, by changes in the demographic and epidemiological profile of the world population[4]. These changes have created distortions in the global health labor market with regard to the unequal distribution of professionals, in a logic of workforce allocation based on better remuneration for professionals, especially doctors, rather than on regional health needs[4].

In Brazil, there was an increase in the density of doctors in recent years, while the regional distribution and even the lack of these professionals in some localities draws attention[5]. More recent data on medical demography in Brazil indicate that the Southeast region accounts for 54.1% of doctors and a population of 41.9% of the Country, while the North and Northeast regions have 4.6% and 17.8% of Brazilian doctors, with, respectively 8.6% and 27.6% of the total population[6]. The number of positions and medical courses is also higher in the Southeast region, which has 120 courses and 13.222 positions in 2018, which represents 45.2% of all positions available in the Country[6].

Given that background, the Federal Government instituted, through Law nº 12.871, of October 22, 2013, the More Doctors Program (PMM), with the objectives of reducing the shortage of doctors in priority areas for SUS, increasing and distributing positions for medical training and residency and strengthening the permanent education through the teaching-service integration[7]. The Program has an emergency provision axis of doctors in regions with a shortage of these professionals, called the Project More Doctors for Brazil (PMMB), whose distribution took place in priority localities, characterized by low social and economic development, as peripheral regions of large cities, interior regions – especially in the North and Northeast, indigenous and riverside populations[7].

The results of the PMM have been observed in different dimensions, such as its impact on the shortage of doctors, mainly in the North and Northeast regions and in the small size municipalities[8], the increase of procedures in regions of high social vulnerability[9], the satisfaction of the users in relation to the service of the doctors of the program[10] and tensioning of the biomedical model of health work within the teams, based on a clinical performance sensitive to elements of culture, territory and living conditions of patients[11]. Although relevant to the understanding of the reach of the Program, production-centered analysis, such as the number of monthly consultations performed by doctors and the number of referrals[12], as well as satisfaction studies of the population assisted, subject to the so-called gratitude bias[13], may constitute a restricted parameter, since the occurrence of a large number of procedures and high satisfaction, if taken in isolation, may not be equivalent to the quality of care offered.

It is necessary, therefore, to deepen the analysis of the possible changes produced in the work of the teams from the implementation of the Program, considering the set of interactions that allow to understand how the strategy produces certain effects. In this sense, this study aims to investigate influences of the PMM on the attributes of longitudinality and

comprehensiveness in primary care, through a case study in two municipalities, using ethnography, interviews and focus groups.

Comprehensiveness and longitudinality in the evaluation of the PMM

For Starfield[14], the attribute of longitudinality is characterized by the existence of trustful interpersonal bonds, which are reflected in the long-term cooperation between users and health professionals. Cunha and Giovanella[15] recognize three dimensions of this attribute: a) the recognition of a regular source of care in Primary Health Care (PHC); b) the establishment of a lasting therapeutic bond between service users and professional staff; c) informational continuity.

The attendance to this attribute is related to the greater effectiveness of actions and user satisfaction with the health service[15]. Longitudinality also contributes to the creation of co-responsibility between professionals and users over time, besides representing in itself a therapeutic component[16].

The attribute of comprehensiveness, in turn, implies a wide offer of health care services by primary care, even though some of these are not offered within it[16]. From the point of view of the SUS, comprehensiveness has as objectives: the integration of programmatic actions and spontaneous demand, articulation between actions of promotion, prevention and rehabilitation, multiprofessional, interdisciplinary work and the centrality of the work process in the users[16]. Kalichman and Ayres[17] systematize four axes of comprehensiveness: a) needs: with regard to the capacity and sensitivity to understand the demand for health care, in order to respond in the broadest possible way; b) purposes: offer integrated actions between different levels of care, with synergistic, resolutive and efficient attention; c) articulations: interdisciplinary, multiprofessional and intersectoral work; d) interactions: construction of intersubjective relations of quality, which develop in the daily work of health.

The two attributes contain dimensions that materialize in interpersonal relations, understood here as aspects of the humanization of care and as light technologies used in living work and in health act[18]. These dimensions constitute as criteria for the evaluation of the extent of the attribute of longitudinality and comprehensiveness of the care because they are related to the quality of care and the perception of satisfaction of the population assisted[19].

Methods

A case study was carried out, whose understanding of a phenomenon is based on the inseparability of its real context, in which the boundaries between knowledge and reality are not clearly evident and whose approximation requires the use of multiple sources[20]. The case study seeks to contribute to a broad understanding of the problematic in question, based on possible theoretical generalizations[21].

Emphasis was placed on understanding the experience of the subjects in real contexts in which they give meaning to their practices and operationalize their knowledge[22]. The study was guided by an ethnographic approach, which presupposes the production of a 'dense description' for an in-depth understanding of the context studied[23]. In this approach, the search for meanings of human experience does not refer only to the 'object' of research, involving also the researcher, in a relation between different subjectivities[24].

The process of construction of the information was based on constant dialogues with the participating stakeholders, through triangulation of methods[25], seeking to group the maximum of possible perspectives in order to establish temporary consensus about the object of evaluation[26]. Based on the literature,

the following criteria were defined for attribute evaluation: longitudinality: a) development of relationships that allow patient follow-up and accountability; b) creation of therapeutic bond; c) perception of the satisfaction of the population with the constancy of care. In relation to comprehensiveness, the following criteria were defined: a) creation of intersubjective relationships between team members and of those with users; b) the sensitivity of the health team in recognizing and responding to the needs of the population; c) development of prevention, promotion and care; d) development of joint actions with professionals from other professions and sectors.

Characterization of field activities

The case study comprised two municipalities in the state of São Paulo, selected from intentional sampling. Three Family Health Units (FHU) distributed in two municipalities in the Baixada Santista region constituted the cases monitored (*chart 1*). The identification of municipalities will be kept confidential to protect the identity of health units and those involved with the study. In total, four doctors from the Program were involved in this study: FHU1 – a Cuban doctor; FHU2 – a Brazilian doctor with training in Cuba (D1); FHU3 – a Cuban doctor and a Bolivian doctor (D2, D3).

Chart 1. Cities, health units, participants and construction strategies of the information

Municipality 1	**Municipality 2**	
FHU 1	**FHU 2**	**FHU 3**
Participant Observation (PO1) in the period of May 2016 (approximately 50 hours)	Participant Observation (PO2) from July to September 2016 (approximately 100 hours)	Participant Observation (PO3) from July to September 2016 (approximately 100 hours)
Semi-structured interviews with: head of the primary care division (I1), two advisors who work in the MDP (I2, I3), head of the health care division (I4), nurse (I5), two Community Health Workers – CHW (I6, I7), and unit manager (I8)	Workshop of validation of information with doctor of the MDP (W1: D1)	Workshop of validation of the information with CHW (W2)
Focus Group (FG1) with Community Health Workers – CHW		Workshop of validation with two doctors of the MDP (W3: D2, D3)

Source: Own elaboration.

Field diaries were elaborated with intensive and descriptive notes on the ethnographic experience, as well as transcripts of the interviews, focus groups and workshops. The analysis of the constructed empirical material involved the judgment of value on the evaluated object, based on the established criteria[13].

The study was approved by the Research Ethics Committee of the Faculty of Medicine of the University of São Paulo under registration nº 13332, Project 223/15, in compliance with the provisions of Resolution nº 466/2012 of the National Health Council.

Results and analysis

Longitudinality

RELATIONAL WILLINGNESS FOR FOLLOW-UP AND RESPONSIBILIZATION

The relational characteristics of doctors are frequently reported by other team members, who assert that the users maintain a good relationship and value the doctors of the Program (PO1, PO2 and PO3). The discourse of doctors converges with the practice observed in the consultations, home visits and other spaces of interaction with the users.

> *I understand that we have to treat how I or we would like another doctor to treat us as patients. First we have to create a good relationship with the patient. Say good morning, say 'how are you Is it everything all right?'. Then the patient, with this, will feel more dear. Because many comment that when they go to other doctors they are not well received.* (W3: D1).

It is a consensus among the interviewees that the longer consultations, in which patients have more time to talk with doctors, are a source of satisfaction among the users, who consider it an advance of the PMM. Interviewees reported that some patients reacted with surprise to the difference between the doctors of the Program and those who previously acted in the unit regarding the consultation time (I2 and I3).

The good relationship of the professionals of the Program with service users and team members is constantly mentioned, as is their dedication (PO1, PO2 and PO3). There are speeches that refer to a greater proximity to the population, to the territory and to the health teams, as shown in the following excerpt from the speech of an advisor accompanying the work of the doctors:

> *[...] they are very involved with the community. They are people who get very involved with unit employees, with workers. If they invite you to have lunch at their house, they go, go to a little party, they go, it does there is no such difference.* (I2).

One of the major challenges around the medical work within the FHU teams, among the municipalities studied, refers to the exclusive dedication to work in services (I1, W1: D1 and W2). In addition to the turnover of doctors in health teams, there is a history of doctors working in other locations; and, therefore, they did not meet the schedules properly (I4 and I8). The exclusive regime of dedication in the PMM seems to facilitate the participation of the doctors in many work-related activities (PO1, PO2 and PO3).

In units where there is more than one doctor, users usually request service with the same professionals (Program participants), which indicates the creation of bond (PO1, PO2 and PO3). During vacation periods, for example, patients often complain about the absence of these professionals, sometimes refusing to be cared for by other doctors, as reported by a unit manager, a doctor of the Program and health secretary advisors (I2, I8 and D2).

The possibility of being assisted regularly by the same professional in routine procedures is one of the requirements for the creation of a longitudinal bond[15], and the population's demand for care by these same doctors, due to the quality they recognize in their care, is a component that demonstrates the reach of this attribute. It has been reported by Community Health Workers (CHW) that the availability of doctors of the Program to carry out home visits is related to the increase of the frequency of users in the service and greater acceptance to the proposed treatments, once the patients feel more valued with the visit of this professional (W2 and FG1).

CREATION OF THERAPEUTIC BOND

The doctors of the Program affirm that the creation of a bond with patients is essential for health care, and are unanimous in stating that this is a premise of the work of the FHS (W1: D1, W3: D2, D3).

> *The bonds are in all pillars. In the individual consultation, in the home visit, in the collective lectures, in the capacitation, so all the professionals are creating bond all the time. In the reception. Reception is the first part of the bond. We see that the bond worked out is when the patient sees that the health unit is his second home. When he has the trust of the health unit as his second home.* (W1: D1).

The time availability and attentive listening are characteristics of interpersonal relationships that contribute to practices that favor the creation of bonds, since it allows users to express themselves freely, to heal any doubts and to feel valued and respected[15]. On this question, the monitored doctors emphasized that the first contact with the patient is essential to effect a trust relationship (W1: D1, W: D2, D3).

> *Sometimes you have to say something that has nothing to do with medicine, talk about something else. This first contact is very important, because from this first contact the person decides whether or not to return. Or how he will you come back next time. From this first contact is derived whether the patient is going to do the treatment, or if he is not going to do the treatment, whether he will follow his indications or not.* (W3: D1).

A challenge frequently reported by professionals of the Program is to insist on the performance of attentive listening in the face of the great demand for care (W1: D1, W3: D2, D3). Doctors agree that this is an excessive number and that this makes it difficult to perform other activities related to prevention and health promotion from the groups approach (W1: D1, W3: D2, D3, PO1, PO2 and PO3).

INTERACTION WITH THE TERRITORY AND HOME VISITS

The community involvement is pointed out by the interviewees participating in the study as a characteristic of the performance of the doctors of the Program. As they were willing to take part in events in the territory, make home visits more frequently and accept invitations from the population to, for example, 'having a coffee' or 'partying', doctors develop a very close relationship with the patients (I1, I2, I3, I5, FG1, PO1, PO2 and PO3). According to the interviewed actors, this relationship is valued by both the population assisted and by the members of the health teams. One of the participants connected to the management level reports that *"the best way of expressing the characteristic of the doctors is the high degree of community involvement"* (I4).

The doctors of the Program understand visits as part of the routine and are readily available when requested by other team professionals (W1: D1, W3: D2, D3, PO1, PO2 and PO3). The experience with the doctors of the Program, nurses and CHW allowed us to understand that home visits represent important moments in health care, with several meanings (PO1, PO2 and PO3). It was possible to follow numerous situations in which people welcomed doctors, nurses and CHW in a warm and friendly way, inviting them to stay in their homes for longer (PO1, PO2 and PO3).

During an on-campus monitored visit, the doctor was invited to lunch at house of an elderly couple, and it took a lot of insistence and explanation that there were more visits to be made to convince these people that the doctor could not stay for more time (PO2). On another visit to accompany an adult man bedridden with many leg wounds, the family and the patient himself were also thrilled to acknowledge the attentive manner in which the doctor of the Program dealt with his case, especially because he not seemed to bother with the aspect of his leg and examine it (PO3).

These manifestations of the good

relationship and receptivity of the patients are convergent aspects with the attribute of longitudinality, as it provides the creation of a therapeutic bond based on affectivity and trust and a perspective of satisfaction with the constancy and quality of the care received[15]. The journey of the doctor to the territory where people live also seems to contribute to less horizontal relations, besides favoring an understanding of everyday aspects of their lifestyles, favoring the creation of bonds.

Comprehensiveness

INTERPERSONAL RELATIONS

Medical professionals from PMM have an important role in the composition of the teams monitored in this study, but do not reproduce the traditional hierarchy present in the relationship between doctor and other health workers[27] (PO1, PO2 and PO3). The doctors of the PMM seek in their professional practice to establish more horizontal relationships in relation to the other members of the teams in the daily activities, according to the observations made and reports of the interviewees (I1, I2, I3, I5, FG1, W2, PO1, PO2 and PO3).

> *My relationship with my co-workers is very different from the relationships that other doctors had. It changes the perspective of the patients by seeing the doctor and my co-workers as well. My co-workers are not afraid to ask me a question, they do not have the foot behind me, they did not smell a rat, they know they can count on me, they know I will not bother them for something they think is silly. They know that from the moment I arrived here it was to work as a team.* (W1: D1).

It is common for other professionals to call on the doctors of the Program to ask questions or give them information at any time it is necessary. On several occasions, it was possible to witness CHW and nurses come in to talk to doctors in the offices, without creating any constraints (PO1, PO2 and PO3).

The dynamics of the team meetings were conducted by nurses and CHW, so that the doctors collaborated to discuss the cases, but without their speech being the conductor of the actions or overlapping the other professionals (PO1, PO2 and PO3). During the monitored meetings, doctors took the chance to perform tasks such as renewals of prescriptions and requests for examinations, which seems to prevent more active participation in these spaces (PO1, PO2 and PO3). The fact that doctors have to deal with many tasks even during team meeting spaces can indicate the degree of importance that these professionals acquire in Family Health teams, since many team activities depend on their decisions.

On the other hand, it demonstrates how much they are involved in the activities related to the high demand for care, which forces them to fill a very large number of documents. This ambiguity reveals how complex the question is about the role of the doctors in health teams, and how their attributions may end up being limited to the set of secondary processes related to health care demand.

IDEOLOGICAL DISPUTES AND IMPLICATIONS IN THE COMPREHENSIVENESS OF CARE

According to the interviewed actors, there were episodes of prejudice and resistance from other doctors from the municipal network at the beginning of the Program's implementation (I1, I2, I3, I8, W1: D1, W2). In one of the municipalities studied, one of the Brazilian doctors refused to greet Cuban doctors, and still criticized the training of these professionals (I1).

In one of the cases followed, the significant difference between the conception of health work of the Program's doctor and a nursing professional was perceived, which sometimes manifested itself in team meetings and other spaces for dialogue (PO2 and W1: D1). Because they presented different political positions,

there were cases of discussions between these professionals, who ended up disagreeing during the conduction of the cases, in which the doctor manifested a position and political discourse to defend the right to health, while the other professional focused more on the practical dimension and immediate demands brought by the population, stating that the posture of the doctor was more idealistic than practical (PO2 and W1: D1).

These differences in relation to job prospects and political positions may lead to barriers for strategies that need integration between relationships and practices, elements necessary for synergistic group work. The communication among the team members seeks to establish, through constant dialogue, common paths among professionals, in order to ensure a higher quality in the offer of comprehensive care[28].

It is not possible, however, to reduce the conflicts observed to the typical issues of group work. The advent of the PMM transposed within the health teams a fierce political and ideological dispute present in the current Brazilian society, as can be seen in the way media vehicles and medical organizations reacted to the implementation of the Program, especially in relation to professionals coming from Cuba[28,29].

RESPONDING TO THE NEEDS OF THE REGISTERED POPULATION

Aspects such as the centrality of the work process in users, the expanded and sensitive understanding about their needs and the attention to the ethical and political dimension do not seem to guide the daily work in the cases studied (OP1, OP2 and OP3). There is, among the members of the teams accompanied by a moralizing reference in health work, which often blames users for aspects such as their poverty situation, family arrangements considered as non-traditional, absence in proposed activities or offered treatments (PO1, PO2, PO3, FG1, W1: D1 and W2). It is possible to also identify a self-centered discourse, which seems to indicate an individualism regarding the perspective of work within the health teams (PO1, PO2, PO3, FG1, W1: D1 and W2). This tendency to construct identities restricted to their own nuclei of knowledge makes it difficult to interact in spaces formed by professionals of different educations[30].

It was not observed, by medical professionals, a specific strategy to deal with the question of the training of other team members (PO1, PO2, PO3), an attribution given to it in the guidelines of the National Policy of Primary Health Care (PNAB)[17]. In many places where such characteristics have emerged (moralizing perspective in relation to the patients, absence of an expanded conception of health that involves consideration of social inequalities), as in team meetings, the doctors of the Program did not carry out mediations, despite their own conceptions and practices point to an expanded understanding of health (PO1, PO2, PO3, W1: D1, W3, D2 and D3). This is a problematic aspect that emerges from the cases followed, since the comprehensiveness of care has as one of its axes the capacity and sensitivity of the team to understand the demand for health care, in order to respond as broadly as possible, or the ability to distinguish different needs from the population and individuals[31].

It is important to emphasize that the doctors of the Program receive professional supervision, besides taking a course on the FHS, unlike other team members[32]. This possibility of training seems to deepen the differences between the perspectives of health work of the other professionals of the teams and doctors of the PMM.

PREVENTION, PROMOTION AND ASSISTANCE

It was possible to follow health promotion and education actions for specific groups of elderly, pregnant women and smokers (PO1, PO2 and PO3). The participation of the doctors of the Program in these groups is restricted, since the high demand for care occupies most of the

agenda of these professionals (PO1, PO2, PO3, W1: D1, W3: D2, D3). Nurses, CHW, trainees and other network professionals are responsible for conducting the groups, which also varies according to the existence of municipal health promotion programs (PO1, PO2 and PO3).

One of the doctors of the Program reports that, since his arrival, there was an effort to plan health care actions and offers that would break with the excessive number of spontaneous demands on the unit and the emphasis on the healing perspective (W1: D1). Demand analysis were carried out for the organization of the agenda in order to organize care for pregnant women, puerperal, people with diabetes and hypertension, besides opening the possibility for health promotion and education groups with the doctor (W1: D1). Even with this effort, it is difficult for the doctor to have adequate time and planning to accomplish these activities.

These actions converge with the axis of the goals of comprehensiveness, which articulates with the axis of needs[17], since the sensitivity of the teams and the capacity to respond to the different demands of the population occur through the reach and the offer of appropriate actions for each case.

In the followed up cases, there is the provision of preventive and health promotion actions through groups, going beyond the immediate care demands, but the medical professionals end up being restricted to individual care given the great demand of the services (PO1, PO2 and PO3). Mattos[31] understands that it is through the articulation between the capacity to offer assistance to a particular suffering and the provision of actions or preventive procedures that the dimensions of comprehensiveness are constituted. Although there are collective spaces for prevention and promotion strategies, the emphasis on the individual care dimension prevails in, given the small number of participants in the established groups and the high daily demand for care (PO1, PO2 and PO3).

JOINT ACTIONS WITH THE SERVICES NETWORK

The offer of comprehensive health care can be articulated with other levels of care, since certain actions may not be offered in the basic unit[14]. The doctors interviewed report a great deal of difficulty in following up the referrals, due to the unavailability of specialists when requested and the difficulty of communication with network professionals (W1: D1 and W3: D2, D3). Reference and counter-reference hardly occur, the latter being almost non-existent in the cases studied (PO1, PO2 and PO3).

The CHW and the doctors of the Program affirm that the users themselves bring the information they receive during care from other professionals and services (W1: D1, W3: D2, D3, FG1 and W2). It was also reported that professionals of the PMM were already victims of prejudice by other medical professionals in the health network, who accused them of being 'unprofessional' and ignored the information passed on from patients referred under their responsibility (W2, W3: D2, D3).

The structural characteristics necessary to achieve comprehensiveness must be taken into account, since the physical limits related to access can create barriers that compromise the reach of comprehensiveness[33]. Given this relationship between the dimensions of access and integrality, it is important to verify the structural dimensions of access, since the existence of resources that can respond to the demands requested are conditions for the provision of integral health care[33].

Given the objectives of this study, an analysis that could evaluate jointly the access attribute and comprehensiveness was not carried out, but the difficulties pointed out by the participants indicate the existence of structural access limits.

RELATION WITH MATRIX SUPPORT TEAMS

In only one of the municipalities was observed the work of the doctor of the

Program in partnership with professionals of matrix support from a Family Health Support Center (Nasf) and a Psychosocial Care Center (Caps). Team meetings were followed by professionals of these services, and it was possible to identify an effort on the part of the matrix support teams in assisting the work in basic care (PO2).

It was possible to verify situations in which the so-called epistemological obstacle occurred, which hampers the work between reference teams and matrix support teams because they confront different standards about the health-disease process[30]. The way as a Nasf professional understood the demand for a case treated jointly was considered by some CHW and nurses as unhelpful and unimportant, even disqualifying her contributions, which drew attention to aspects related to social inequalities for the understanding of the followed case (PO2, PO3 and W2). On the other hand, it was possible to verify a collaborative work between a doctor of the Program and a psychiatrist of a Caps who accompanied a serious case in the territory (PO2). In this case, the psychiatrist made a series of guidelines to the doctor of the Program and the nurse on aspects of psychiatry, assisting in the conduction of the case by the reference team.

The availability of the PMM doctors to work with other network professionals was observed, while other professionals criticized the performance of the matrix support teams (PO2, PO3 and W2).

Conclusions

In this study, the existence of a good relationship between doctors and users, and the valorization of these in relation to the care received was observed. The attentive and humanized reception was one of the notable features observed and reported. Supervised doctors guide their practices towards creating a bond of accountability and respect with the patients assisted, but they deal with difficulties to conduct the follow-up users who are referred to other services or specialties of the health network, due to lack of counter-reference.

The work of the health teams benefited from the presence of the doctors in the units, because the good relation established facilitates the flow of information and decisions about the follow-up of each case, which is done in conjunction with nurses and CHW. The permanence of the doctors in the health units also assists in the monitoring and the creation of bonds with users, since the high turnover and the non-fulfillment of the workload were considered as elements that made the work of the teams difficult before the implementation of the Program. This way, it is possible to assert that the advent of PMM produced positive effects in the practical dimension of the longitudinality attribute of care.

There are still many challenges in order to consolidate care based on comprehensiveness within the health services received by the doctors of the Program. These are structural obstacles: the large volume of medical care, that hampers preventive and educational activities with population groups and reaffirms the emphasis on curative and individual care; problems related to the service network itself, which make it difficult to articulate the different levels of care; and the absence of a comprehensiveness perspective as an attribute of primary care by the teams.

Problems related to the service network were also found, which made it impossible to articulate the different levels of care due to the difficulty of carrying out referrals to specialists and obtaining information on the cases referred. The small number of specialists in the municipal networks, the queues for assistance and a culture of little communication between the different levels were pointed out by the participants as main

challenges. Some successful experiences have been observed in relation to the work with matrix support teams, but, in general, this articulation is poorly structured and there is still a lack of clarity regarding the roles played by each actor.

Managers, teams and users seem to have created a standard of care and dedication of the doctors, based on the humanization of care, longer consultations, availability of the doctor for exclusive dedication work and good relation with the work teams. The concerns of these agents regarding the continuity of the Program and the quality of possible substitute doctors point out that the PMM has increased the expectation for a better and more decisive basic care, which leads to question if this new standard will maintain its influence after possible end of the Program.

The presence of the doctors of the Program in the teams has broadened the access of the population to medical care, but the FHS model goes beyond the assistance care and the capabilities of these professionals alone. There is, therefore, great potential for a teamwork guided by comprehensiveness from the insertion of medical professionals of the PMM who work in this perspective, however, it is necessary to invest in adequate and continuous training, which allows teams to converge to a sensitive action to the health demands of the population, based on an expanded conception of health and its determinants.

Collaborators

Gasparini MFV (0000-0002-5574-9719)* contributed to the conception, planning, data collection, analysis and interpretation of data; elaboration of the draft, critical revision of the content and approval of the final version of the manuscript. Furtado JP (0000-0001-6605-1925)* contributed to the conception, planning, analysis and interpretation of data; critical review of the content; and approval of the final version of the manuscript. ■

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