

Analysis of the experience of Cuban physicians in a Brazilian metropolis in accordance with the Paideia Method

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Abstract *We had hoped that the Mais Médicos Program (More Doctors Program) would have generated several changes and reflections in each municipality in which it was deployed. In order to observe those changes, we sought to analyze the experience of Cuban physicians in the Mais Médicos program from an actor-centered perspective, based on the Paideia Method – an approach that seeks to enhance the ability of the subjects to analyze and intervene in their practice. We performed semi-structured interviews to analyze our research object that consisted in the experience of those actors included professionally in the Mais Médicos program in a metropolis with unique characteristics. In order to assess the interviews, we applied Content Analysis followed by Thematic Analysis. From the discourse of the actors, of which illustrative excerpts are transcribed in this article, we can affirm that the program's potential surpassed any initial barriers, presenting itself as fine-tuning instrument for replacing the biomedical model in line with the Paideia Method.*

Key words *Foreign graduate physicians, Medically deprived areas, Anthropology, Health care, Paideia method*

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Introduction

For the Unified Health System (SUS), the *Mais Médicos* program (More Doctors Program) represents a political achievement during the course of a long process of guaranteeing the Right to Health in Brazil. The Program took physicians to areas of the country that lacked any health care. These locations were among the most remote in the country, the poorest (the group of the 100 poorest municipalities in Brazil) and the most socially vulnerable. Faced with a lack of physicians, the Program also proposed to improve the quality of Primary Health Care (PHC), and in particular, to promote changes in the Brazilian medical training system¹.

On the basis of providing emergency care and international recruitment, it was decided to enable, firstly, Brazilian physicians, secondly Brazilian physicians who had qualified abroad and, finally, foreign physicians, to participate in this Program. In this last group, most of those participating in the Program were Cuban physicians – resulting from the agreement between Brazil, Cuba and the Pan-American Health Organization (PAHO) – as well as participants from other countries, including Spain, Portugal and Argentina. At the end of 2015, there were around 14,500 professionals working in the *Mais Médicos* Program, of which 11,400 were Cuban physicians².

We already know that, up until 2015, the Cuban exchange physicians represented nearly 30% of the total number of physicians working in the family health teams in 2014. Cavalcanti et al.³ estimated that nearly 60% of the Brazilian municipalities were covered by at least one physician belonging to the exchange program. The authors compared data from DATASUS and from the PAHO in relation to the distribution of these professionals, and found that, proportionally, most of the municipalities in the Northern region of Brazil were covered by Cuban exchange physicians (78%) followed by the South (69%), the Northeast (68%), Central West region (59%) and Southeast (50%).

Study issue and objective

The scenario for our investigation was a town recognized as being a paradigm location for the implementation of the Unified Health System (SUS), namely a (re)invention laboratory of healthcare in Brazil⁴. It was in this place, and in view of the living testimony of the history of collective health care, that we proposed to find

out how foreign physicians viewed the work of the SUS, based on the traditional liberal-public health care or Flexnerian-biomedicine in health care, even within a public subsystem^{5,6}. This legacy co-exists with counter-hegemonic movements, among which we examined the Paideia Method and Expanded Clinical Practice or the Clinical Treatment of the Individual⁷.

We started with the proposition that the *Mais Médicos* Program is not simply the result of an anonymous dynamic between supply and demand that takes place merely as the result of administrative procedures and pre-defined protocols, even if its implementation on a local level occur in a universal and anonymous form. On the contrary, we understand that the procedures and events are made by and between people, who also have their own ambitions, visions and interpretations, but who are at the same time inserted into and are active within institutional structures (including institutional action protocols and ethics) and social structures (which include, especially in the case of physicians, professional positions and belonging to social hierarchies, for example, according to class, skin color/ethnicity and gender). The subjectivity of the reality of these social actors is the scope of this study. The Cuban *Mais Médicos* Program exchange physicians played an institutional role in two public health systems, on the one hand, they fully intended to eliminate their subjectivities, and on the other hand, were socially stigmatized for being ‘foreigners’ and ‘communists’.

At this crossroads of ideas and ideologies, and by using the Paideia Method, we analyzed the experiences of these individuals from an ethnographic actor-centered perspective. For this reason, we did not omit to discuss the potential of the *Mais Médicos* Program as a project to change the biomedical paradigm and consolidate the Right to Health in Brazil.

The Paideian Method and Expanded Clinical Practice

The Brazilian Sanitary Reform Movement (RSB) initiated the debate of prioritizing PHC as a strategic issue for the construction of a national health system. As noted by Starfield⁸, this involves a movement common to industrialized nations and upon which the World Health Organization (WHO) launched the Ljubljana Charter, a proposal to reorganize health care networks that were aimed at generically optimizing the health of the population. This Charter proposed a ser-

vice that would be directed towards protecting and promoting healthcare, focused on individuals, so that citizens could influence the services and be responsible for their own health; and that focused on quality, including a cost-effectiveness relationship, among other issues. In order to succeed in this role, PHC should consider all health determinants, that is to say, the means and social and physical conditions in which individuals are inserted, rather than just concentrating on their individual illnesses.

Brazil and Cuba both share aspirations for universal and egalitarian medicine. However, even though they have successfully managed to deploy a universal health system that is centered on PHC as being responsible for health care⁸, in order for the SUS to be effective in carrying out its principles, it will be necessary to supersede the biomedical model. This is because there is countless evidence that the deployment of a model centered on PHC has not been sufficient in itself to supersede a hegemonic biomedicine rationale. It has become abundantly clear that clinical practice cannot forgo considering the individual as the central purpose of its work, no longer disassociating illness from the significance and meaning attributed to it by the patient^{9,10}. A model has prevailed in which life is not the central scope of clinical practice and a person's body is seen as a place for intervention, like an extremely complex machine, divided into parts that are inter-related, satisfying natural and psychologically perfect laws¹¹. A physician treats this machine as a mechanic does, making constant inspections and adjustments, so that the individual feels fragmented, one of the most visible consequences of this being an estrangement in the physician-patient relationship¹².

In this sense, discussions related to the failure of the biomedical model and proposals for a model that can replace it have been a regular subject for debate in the field of Public Health in Brazil since the 1970s, when Social Medicine began to approach health-illness as a socio-historically established phenomenon. Subjectivity entered into the question at an even later date, when the inter-relational dimension of health work and analyzing the affective and power relationships that are established in this encounter were included in the agenda¹³⁻¹⁶.

Among the different proposals that seek an alternative that embraces all these issues, we would highlight the Paideia Method, proposed by Campos¹⁷. Inspired by the Paideia concept – a Greek idea linked to the ideal of educational training,

which sought to develop a man's full potential, in such a way that he could become a better citizen¹⁸ – this author proposed a method where strengthening the Individual and democratizing institutions are the two main paths to reformulate and supersede the hegemonic management rationale^{17,19}. Opinions have been voiced from the field of politics and management together with those that originated in teaching, psychoanalysis and institutional analysis, in favor of the democratization of organizations based on organized collective training that, in the case of the SUS, are aimed at three objectives: the enhancement of health; the professional and personal fulfillment of members of staff; and the replication of this same ideal as a democratic policy and comprehensive system. Thus, the Paideia Method seeks to increase the capacity of individuals to analyze and intervene in this practice. This will be reflected not only in the management of systems, but also in the construction of the network, formulation of policies, including the training of professionals, as well as in daily clinical practice, forming health teams, and the construction of a therapeutic project.

There is an understanding, in the Paideia Method, that this type of clinical practice depends on the existence of an ongoing liaison between professionals and patients, families or communities, which means that this cannot be exercised in emergency health posts or in random locations, but rather in districts belonging to that particular community. Community Medicine and Extended Clinical Practice represent a joint effort to increase the self-care and self-sufficiency coefficient of patients, families and communities. They seek to fight against the medicalization, institutionalization and excessive dependence of individuals on professionals and health services, in contrast to the biomedicine model.

Methods

Outline

This study was constructed using qualitative methods, which we worked on from an actor-centered perspective and that were influenced by social anthropology²⁰⁻²². We understand this method as an intentional legitimation movement by the researchers of the subjectivation processes of reality by the social actors, namely individuals who are simultaneously inserted in and acting within institutional structures.

We decided to use this study perspective in order to distance ourselves from the goal-narrative constructed by the medical missionary worker without, however, detracting from the legitimacy of the 'institutional' language. We included questions in our semi-structured research that embraced the narrative of an individual worker and actor. We dealt with three types of questions: (a) experiences from an immigrant's standpoint; (b) working on the *Mais Médicos* Program; (c) health care in the SUS. We were interested in the perspectives and interests of the actors within the institutional demands and procedures and the basis for their positioning within the social structures. We considered this qualitative approach as an attempt to establish an essential and intimate relationship with the individuals and the object of research^{23,24}. Since we propose to study the subjectivation of the reality of the main actors in the *Mais Médicos* Program, we will present this singular location of the co-production of the Program as follows.

Characterization of the field of study

We developed this research in the largest municipality of a metropolitan region in Brazil, with a population estimated by the Brazilian Institute of Geography and Statistics²⁵ to be a little over 1,100,000 inhabitants in 2015. The town has two schools of medicine, which probably contributed significantly to the ratio of 5.11 physicians per inhabitant (2.45 in the metropolitan region)²⁶.

Prior to the deployment of the Family Health Project in the municipality, the district already had a background of investment in PHC in the form of community healthcare programs since the 1970s. In the following decade, Health Centers were built and staff hired. As a result, the capacity for care of the network was extended, so that by 2001 there were already 46 health centers in the town, providing healthcare for adults, women and children, as well as mental and oral health programs. In tandem with this, the town provided adequate support in the area of image and laboratory diagnosis and broad distribution of medicines.

Despite this, the way in which this embryonic network was organized did not meet Primary Health Care (PHC) objectives. The health center teams had insufficient capacity to handle demand, especially with respect to adult health care, little work was done as regards health promotion and there was also a low level of home and community care. Furthermore, even though

the local teams were multi-professional, their work was carried out in an isolated, vertical fashion and they had great difficulty in creating inter-disciplinary work procedures.

Therefore, the city continued to work with this model until 2000, without Family Health Strategy (FHS) teams. These were established the following year, using a model that was different in some aspects from that recommended by the Ministry of Health. In addition to broadening access to the health system, the local project sought to establish a new way to ensure health based on the triple objectives of Participative Management, Extended Clinical Care and Public Health.

Using a hybrid model, the Health Centers were re-organized into Local Reference Teams with FHS teams, which were responsible for comprehensive basic healthcare to families, as well as for maintaining the organization by means of specialized areas (health programs for children, for adults, for women, as well as oral, mental care) that existed before the local project was established. The aim of this was to serve as a matrix support structure for the FHS, by supplying a variety of resources related to team organization, the construction of care and the education of staff members. However, in practice it served, and continues to operate until today, more by providing direct care to the population than by being a matrix structure.

At the present time, the city has 63 Basic Health Units (UBSs), in which 181 FHS teams operate. These teams include 94 physicians from the *Mais Médicos* Program, divided equally by municipality. With the Program, the coverage by family health physicians has risen from 27.78% to 55%. Only one unit is comprised exclusively of Cuban exchange physicians, whereas all the other units are staffed by Brazilian as well as immigrant health professionals. In its Annual Management Report for 2014, the Department of Health noted that there had been a significant increase in family health coverage after the *Mais Médicos* Program was established that year.

Interviews

We interviewed Cuban exchange physicians belonging to the Brazil-Cuba-PAHO cooperation program who had already been part of the program for over a year. The participants, who were professionals allocated to basic health units involved in the field of research, were included based on the institutional and affective network created between our research group and a group

of professionals during the course of the *Mais Médicos* Program.

Four male physicians and four female physicians with at least one specialization took part in our survey. They were all between forty and sixty years of age, had graduated more than five years previously and had served at least one mission abroad before joining the *Mais Médicos* Program. The profile of our interviewees was in keeping with that which Cavalcanti et al.³ had already established, based on a PAHO data analysis related to the work profile of the Cuban physicians inserted into the *Mais Médicos* Program in the whole of Brazil, which is why we believe that these individuals are representative of the national context of the Program.

We approached these individuals during their working hours between November 2015 and February 2016. This research study was approved by the National Commission for Research Ethics (CONEP).

Analysis

The primary source of our research material was based on the interviews staged with the Cuban health professionals. We also included secondary sources (the local population, physician/inhabitant relationships, coverage, management reports) and, to configure the research field, our sources, who we did not identify so as to guarantee the anonymity of the individuals concerned, came from the Municipal Health Department.

We applied Content Analysis to evaluate this empirical material. We then conducted Thematic Analysis, which consists in discovering the nucleus of the meaning of a communication, the presence or frequency of which represents something for the analytical object targeted²².

During the pre-reading and reading stage, we defined the following nuclei: 1. The actors: profile of the physicians interviewed; 2. Migration experience and relationship with Brazilians; 3. Professional work within the *Mais Médicos* Program and perceptions about the health network encountered. We structured the results based on these nuclei.

As a benchmark for analysis, we sought a model that has the centrality of the individual as one of its pillars, namely either someone who works for or is a user of the health system. Once this is established, we assume that the Paideia Method per se legitimizes the process of subjectivation of the reality of individual health workers, while also obliging these workers to acknowledge

the subjectivation of the experience of falling ill of a patient. We again returned to the study question to provide evidence that, in the analysis we performed, we moved between the inseparable universes of the professional and the individual, from the institutional and the subjective of the individuals-actors in choosing the spoken statements shown in the results and discussed as follows.

Results

The actors: profile of the physicians interviewed

The Cuban physicians who were interviewed stressed their humble and poor backgrounds, as well as the opportunity they had to become physicians: *I was born into a poor, humble home and my family encouraged me to begin my university studies in Cuba. I studied for six years and graduated as a physician. I then specialized in Comprehensive General Medicine (MGI), I am a family physician* (Physician 3).

All the interviewees had completed at least one MGI specialization course and some had taken two or three specialization courses. They had all completed their mandatory civil service in their country, which, as they said, gave them the experience of working in poorer areas: [...] *I graduated in the interior of the country in 2002, I was one of the best physicians in the country that year, and that is when I began my life as a migrant, because I first migrated to the interior of the country. Cuba has a project that pays for the best physician to work in the districts in Cuba that are largely inaccessible, and that is where I went to work. The first job the government gave me was to work in a district that was very poor and very harsh and that is where I spent my first working year. I left after working there for my first year and then went to work in Haiti in 2004* (Physician 1).

All of the interviewees had curriculum vitae that included a mission to Venezuela (other missions mentioned were Haiti and Bolivia), which was considered to be far harder than their mission to Brazil because of the violence and extreme poverty there. On the other hand, they had greater autonomy in these countries from the point of view of the process of medical work, since Cuba had implemented, together with their health professionals (physicians, nurses, dentists) their Barrio Adentro I, II and III programs. One declared: *In 2003 I went to Venezuela on a mis-*

sion, and stayed there for 8 years. I then returned to Cuba and worked there for another 3 years. Throughout this period, I occupied a position in management, and taught medicine [...] I obtained a master's degree in PHC and I have now been here in Brazil for nearly 2 years (Physician 5). In this interview, she mentioned the participation of the Cuban physicians in training physicians in Venezuela: *I worked there training the local physicians. We were the professors* (Physician 5).

Their motives for working in Brazil were permeated with professional altruism and were expressed very forcefully: *The motivation is essentially to set out, help and provide assistance to other countries in the world. You are undoubtedly aware that Cuba is one of the countries that provides support on a global level. We have physicians in nearly all the countries of the world, especially here in Brazil. The missions by Cuba have been conducted for many years. They are to help the countries most in need, because the population of Cuba has more physicians. Nowadays, we have plenty of physicians and can provide care to countries in need, in this case Brazil, which didn't have a sufficient number of physicians for the population in need* (Physician 2). Awareness of the rules and the reasons of why they take part in this work was identical in every interview: [...] *in such a tiny country, which suffers so much for economic reasons, I therefore decided to travel and work a bit, to work so that I can manage to move forward little by little* (Physician 6).

Individual economic motivation was also revealed in these interviews – the *Mais Médicos* Program represents an opportunity to improve their living conditions. It was clear that they were aware of and freely agreed to the value of the training grant they received for working on the *Mais Médicos* Program. The exchange physicians receive 30% of the training grant offered by the Program. The rest is sent by the Brazilian government to the Cuban government to finance health and public education, which is free: *So, the government needs us to work a bit to help to maintain the social project, which offers free education, free health, so this is the country's security project* (Physician 6).

Even though it emerged during these statements that the exchange physicians recognize the contribution they make, we also saw that they questioned the size and duration of this contribution: *In Cuba everything is free, because the population doesn't have to pay to study, they don't pay to play sports and they don't even have to pay for health care. In order to achieve all this, the money has to come from somewhere, so we are*

committed to the people in this way, that is to say, to maintain things as they are in the country. So, we come to Brazil and we now receive 30% of the salary and the other 70% is for our country. To speak quite plainly, we may have made this commitment to help our people, but it's also not fair to receive 30% for the rest of our lives [...] I went to work in Haiti and I was paid 20% [...] people also have to understand that we need to live, we too have our dreams (Physician 1).

At the end of 2015, the monthly financial grant guaranteed by the municipality to cover rent and food in these locations – in accordance with the rules of the Program – was R\$ 2.200,00. This form of guaranteeing their living conditions was well evaluated by the exchange physicians interviewed, because this gave them the independence to live according to their own desires. In addition, the interviewees mentioned that they sent financial help back to their families in Cuba.

Even though they were prepared to serve in long-term missions abroad, they revealed their concerns about the effects of isolation: *So I said, please God don't let me go to Amazonas, because this is a difficult situation for a woman. Even for a man things are pretty complicated. I had already spoken about the situation that meant we had to stay 20 (twenty) days with the tribes and one week out, so they organized things so that each person should know where they were going, what they were going to do, the type of work, etc. Things were organized so that there are 40 (forty) hours of work and 8 (eight) of study and 32 (thirty-two) inside the post. Those that have this type of work are those who are living in this area and I think their work there is by far the most complicated, so they should be given greater recognition for this, because life there is really difficult* (Physician 2).

The fact that some exchange physicians have the possibility of receiving family members here in Brazil, based on special permission being given for family members to study and work in virtue of their professional participation in the *Mais Médicos* Program, was very well received. This offsets the effects of distance between them and their families in Cuba. In these cases, the travel costs are covered by the participants themselves.

Experiences of migration and the relations with Brazilians

The reception they received in Brazil from the PAHO and Ministry of Health teams was considered to be good. According to the exchange physicians, they were offered decent accommo-

dation and food during the time they were being prepared for this work. However, when they arrived at their target destination, there were serious planning failures, which caused them some discomfort during the first 15 days: *They only had one house, or one or two houses, for 60 (sixty) people. We had to sleep on the floor, they brought mattresses for us to sleep on the floor; it was horrible, really bad* (Physician 1). The local authorities intervened to resolve the problem, but they had to keep on changing hotels for over two weeks, with their baggage stored on the buses.

At first, the Cuban exchange physicians suffered some type of resistance or obstacles to their integration in the work place: *The first few days were a bit difficult, because as people are not used to working with other professionals, it was therefore a bit difficult. Both for them and for us it was a bit difficult; there was a certain resistance, but then everything improved* (Physician 6).

We examined reports about the efforts made by people involved in the *Mais Médicos* Program work to mitigate these effects, which appears to have been well conducted according to the Cuban physicians: *I work in a good health team, in fact a very good one. They gave me a lot of support and they gave me confidence not to be afraid to ask questions about matters I had not yet mastered. This is because this system is totally different to ours, so I received a lot of support, and I am very happy; I work with a very good nurse* (Physician 6).

In addition, we noticed an attitude in their statements that is very much directed towards what is involved in work on a *Mais Médicos* Program mission: *I did not come here to get involved in politics; I came here to work and these barriers were steadily overcome. Some of my other companions had greater difficulties, but I had none, and my communication with my team, with all those who work here, all members of staff is very good. I am pleased with the way I was received here, by the coordinators. They were really very good and very receptive* (Physician 4).

The (ideological) barriers to integration affected the professionals at different levels: *Rejection; at first the physicians faced a great deal of rejection, though in this location it has not been a problem, I no longer sense this feeling of rejection, though the first year was very difficult [...] in the way people behaved* (Physician 6). These barriers varied according to their past experiences, the characteristics of the community and the team to which they belonged: *So, at the beginning, things were a bit constrained because our medical school, which you know, would not accept the program and*

this was something that was debated, discussed until they managed to introduce the program, right? This was one of the first obstacles that delayed the project, as well as the question of language, because people still did not understand that there are some words I do not know and can't make myself understood. However, they try to make contact with us, and if I cannot speak to them, they try to understand what I am saying. Then I ask someone here to help; there is a nurse here who helps me as well (Physician 2). The question of language is a significant obstacle: *The greatest difficulty that we have to serve as physicians is our accents [...] we are always going to have a patient who does not understand something, who cannot fully understand what we are saying, but at least until now I have had no problems with this* (Physician 8). This perception varies between the health teams and the communities.

The relations between the exchange physicians and the community were highlighted by the participants: *Sometimes when there are problems of disorganization within families, involving a family crisis, when they (Brazilians) do not know what to do, we interfere as a team. We make educational interventions; we discuss the situation with the family, and give advice to each one, explaining to each member of the family how they can help resolve the problems they are facing, then the results are plainly visible* (Physician 3). We also asked the participants if the fact that they were Cubans helped them get closer to the community during their health practices, and we were told the following: *It helps, because they know we are Cuban physicians, because many people know that the medical practice in Cuba is good, and this is encouraging, and you feel more confident. This encourages you to commit yourself each day, so this makes you feel good and you do not feel any rejection from any other professional* (Physician 6).

When we asked about perception regarding their professional environment, all affirmed that they had a positive perception in relation to this: *Our integration with the health team was also excellent. There are four health teams here; we have a large population and these teams include a gynecologist, pediatrician, psychologist and nurses. We have three nursing assistants and Community Health Agents (CHA). We have 4 CHA in the teams, which means the teams are well staffed. We have two physicians specialized in community medicine; one Brazilian and myself, so the team operates well. We get the agendas, we get the home visits and independence to meet the existing demand* (Physician 2).

The relationship with the heads of the health units was perceived positively. Even when initial reactions had been less than friendly with some of their medical colleagues, it seems to us that an effort was made by the exchange physicians to create good working relationships, according to them by adopting an attitude of discretion and hard work. They felt integrated into the team and very much valued the multi-professional work: *We get together on Mondays at 5 pm so that's when we have a meeting with the team, and we assess some case that had been evaluated during a home visit that day. Sometimes, it is a case that the pediatrician or the gynecologist is interested in discussing. The cases that are generally discussed the most are those involving mental health, which everyone takes to the meeting and to which the psychologist gives priority* (Physician 5).

Although there have been some signs of unease among their colleagues, they consider their relationships with the Brazilian physicians as being good, and that the latter have a good deal of technical knowledge and are very well trained and willing to share this theoretical knowledge: *[...] we discuss a case here and all the qualified physicians who are dealing with a complex case, who have to operate with a cardiologist, involving some sort of surgery, come to talk to me. We have an exchange of ideas; we discuss the matter here, and every week here at the health post, for example, on Friday, we include some issue, for instance, last week we began to discuss male health issues* (Physician 1). Nevertheless, we saw that there are shortcomings in this relationship: *When a Brazilian physician is explaining something, he is speaking from the point of view of having greater knowledge. He has a different point of view about treatment and another opinion and voices this. He doesn't like it if a physician, who is an outsider, suggests another type of treatment, so this is a negative aspect to my mind* (Physician 8). These barriers also occur with specialists within their own particular areas of knowledge, who find it difficult to work with general practitioners.

Professional activity in a *Mais Médicos* Program and perceptions about the health care network encountered

The *Mais Médicos* Program is in itself a professional training project, which justifies the training-grant that the exchange-physicians receive for their work with the SUS. This training began in Cuba, after the professionals had been selected for the *Mais Médicos* Program and had

signed an employment contract. They first underwent a one month's preparatory course in Cuba that included two lines of work: teaching of the Portuguese language and studies about the SUS. Questions about Brazilian culture were also discussed. Once they had arrived in Brazil, they spent a further month of preparation using the same lines of work, albeit more involved with specific issues concerning the health situation in Brazil and the health programs that are provided in PHC. We noted that the Cubans evaluated the preparation carried out by the *Mais Médicos* Program as being good, even though it could have lasted longer. At the end of this, everyone took an examination, related both to their knowledge of the Portuguese language as well as the work of a SUS physician.

The specialization course was very well evaluated, since the exchange physicians felt that the course provided by the *Mais Médicos* Program added value to their careers: *It was good, it lasted a whole year and involved many complex cases about problems related to the health situation [...] we did an end-of-course work project, it was good [...] but the specialization course per se gave me a great deal more confidence* (Physician 6). *The most important part is to do as much as we can as professionals, this is an important part of the studies of the *Mais Médicos* Program participants, involving research and the problems of the community. Also, knowing the exact moment and situation you are working in is centered on a problem in the Basic Health Unit where you work and is a concern that needs to be constantly examined. The medical knowledge that we had in Cuba need to be put into practice and all of this is very good experience* (Physician 3).

Furthermore, the Cuban missionaries value the training given to the whole team, for instance, in relation to the SUS protocols: *[...] there are many things that we never did in Cuba and which we began to do here, I acknowledge that. They taught us how to take electrocardiograms during our training course and focused on women's health. In other words, they give us ongoing training. I think this is to encourage those of us who are physicians on the Program to be ever better prepared* (Physician 8).

With regards to their work in the SUS, the exchange physicians considered that working conditions were generally satisfactory: *[...] Cubans are used to working in difficult working conditions, so I think the conditions here are good* (Physician 2).

The main finding in relation to clinical practice involved the difficulties in coordinating healthcare in the municipal health regions, due

to the difficulty they had in receiving feedback about referrals: *The longest delays involve patients who have been given a referral, for cardiology, neurology, orthopedics, which takes a long, long time [...] it is very difficult when there is a need for a referral and counter-referral because, in my case, I have never received a counter-referral for a patient (Physician 4).* They also suffer from the lack of different types of specialists in the health units: *I would like to see here in the primary health care network, here at the health center, other types of specialists, for instance, a rehabilitation physiotherapist, which would mean we would not have to make so many referrals for these lines of patients who have, for instance, suffered a stroke and it takes ages to find a place in rehabilitation for them, and this means we waste time in returning this patient to society, so I would like it if other professionals here interacted with the BHU, to improve this inter-relationship between primary and secondary healthcare, which is not that far apart, but we should be closer, and at times is so distant (Physician 3).*

We noted transversally in the interviews that great value is given to the interventions they make in the district, in the home visits, since the exchange physicians believe that, when they are in the patient's home, it is much easier to instill care. This is similar to the way they operate in Cuba, where they live in the same districts where they work: *For me, the way we work in the community is different; here we only have contact with the community on the day we make home visits [...] I specialized in what in Cuba is called comprehensive medical service for three years. I spent the whole time working in a family physician's surgery. This is a typical surgery located in the community. You live above and work in the lower part of the building. You are open to the community for 8 hours and can also provide care to whoever appears outside these hours. This forges strong ties with the community; it's very good and provides comprehensive medical care in pediatrics, gynecology, and obstetrics. It offers all types of basic care, and you can help a patient with appendicitis, you can identify an acute appendicitis as well as hospital emergencies (Physician 5).* This system both appears to offer benefits – getting to know the population and their health situation better; to be closer to the families and the community – as well as disadvantages – which, according to another physician taking part in the Program, means there are no specific hours for working and for resting, nor any limit to the number of consultations you have to give every hour or every day.

We also noted the value given to the Community Health Agent (CHA) a figure that does not exist in Cuba: *The CHA is very important, because he is only in the streets, since those patients who do not open up with a physician during a consultation, say far more when they are with a CHA. This is what they bring to our team meetings and this enriches the meeting, enriches a consultation, so that for me and the team the CHA is a really good thing [...] because as we know, everyone wants to work according to their own ways, alone and so here this interaction is achieved (Physician 8).*

They perceived that health promotion and prevention are only a small part of their work in Brazil: *I can go out to a place once a week for just two hours – it is a very large area, the area we cover is very, very big – so we simply don't have time for more (Physician 6),* while in Cuba the community is the main focus of their work: [...] *because you live within the community, you give consultations at home, you can establish good communications with the family, you can see the risk factors that they have and that is really important in order to provide complete medical treatment (Physician 7).* One case illustrated the effectiveness, in the view of the participants of community medicine: [...] *I remember that I had more than one patient with severe aortic stenosis who was going to be operated and the diagnosis had already been made at home; it wasn't in the surgery and was not detected there. I went to see another patient who was not feeling well for some other reason, and I then heard that another patient was not well, had a syncope and fell often. I got a stethoscope and in a consultation on the street I detected severe aortic stenosis. (Physician 1).*

We also found differences in the way a physician worked in Brazil and Cuba, which generated different behavior patterns on the part of the Brazilian and Cuban physicians, probably because of their different worldviews on health: *My view is that medicine is not a business, I believe that medicine needs to be respected and dealt with by the government. I agree, for instance, with countries where if you are a physician you first have to work in public health and only after you have worked in public health can you then have a clinic [...] but I think that you have to work with the population first. You have to do what SUS is trying to do now; during the first year you do your residency, then for second year you have to do family health. I think that's best, because in field work if you distance yourself a little from reality, you distance yourself a little from the patient (Physician 1)*

Discussion

We summarize below some of the findings we consider to be important in the subjectivation of the scenario of investigation by the *Mais Médicos* Program individuals-actors who we interviewed: a class culture that is differentiated from the hegemonic culture of Brazil. It is a vision of medicine as a form of self-fulfillment and professional altruism, a perception that people feel uncomfortable with the presence of exchange physicians, and how to practice clinical medicine without negating biomedicine, but by incorporating it in a humanist health project. The missionary altruism coexisted with questions relating to daily life, that represented part of the criticisms made by the physicians about the *Mais Médicos* Program, involving problems about the way they were received in the city and their perception that they could have a better financial return for their services. In the end, a positive transversal assessment was made by all concerned.

For Campos¹⁷, the Paideia Method encompasses general practice, public health and management, namely health production and professional and personal fulfillment. It considers the interests and desires of different groups, calling into question institutional objectives without paralyzing social action in defense of life. The health service is that emerging from the socio-historical context, the individuals involved and the institutional guidelines mentioned. The shared construction with the institutional actors makes it possible for constant changes to be made among these professionals and their teams in collective and reflective spaces⁶. As foreseen by the Paideia Method, strengthening the individual and establishing co-management of procedures can influence other individuals and practices involved, in a growing spiral.

We observed many similarities between the way the Cuban physicians practice medicine and comprehensive clinical practice. In their interviews, they clearly showed a greater affinity with the living conditions and culture of their patients, which also come to be considered in the construction of health care. The health care professionals widened this intervention by a strategy of sharing with the individuals the management of their own treatment, applying the Paideia concept of co-management to general health practice. This construction is also visible in the changes in the daily living habits of a community with regards to disease prevention and health promotion, issues to which the exchange physicians would like to dedicate more of their working time.

This wish could be achieved through the concept of horizontal and longitudinal care – a link that is being constructed by the physicians together with the community. The horizontality of care in inter-professional relationships should be, in our opinion, a powerful element of the Program and one that deserves further studies. The statements given by these actors introduce important reflections about the principle of comprehensiveness of the SUS. Although the aim is to provide patients with comprehensive care, with medical specialists forming part of the health care network and PHC being the priority in charge of care⁸, the physicians made it clear that they do not have access to treatment by specialists. This means that health care given to a patient is fragmented. The proposal of Community Medicine in Cuba²⁷, where the family physician monitors patients from the first consultation until they receive specialist treatment, means that there should be co-management of care even with specialist care, which is in line with the principles of the broadened clinical practice and of the matrix support given by teams of reference, who work in the opposite direction. The training given to Cuban physicians is based on district and community²⁸, in a health system that is centered on PHC, which would make the Family Health concept far easier to implement.

The presence of specialists in PHC, as suggested by one of the physicians interviewed, would, in part, respond to the criticism about health care coordination. In the municipality studied, pediatricians, gynecologist-obstetricians, psychiatrists and general practitioners form the basis of the health care network. Although they are responsible for matrix support in FHS teams in Broadened Clinical Medicine, in daily practice they maintain health assistance by areas, so that the general practitioners provide very little care in areas of mental health, child health and women's health. Thus, the specialist physicians are not fully included in the routine of the FHS, and do not, for instance, carry out home visits²⁹. However, it is important that we think about a model that would provide a more effective form of comprehensive health care, be this either through greater articulation within the health care network, or by having specialists work more closely with PHC.

The great interest shown by the *Mais Médicos* Program actors in being able to work in the districts can be interpreted as a form of network training. The construction of care based on the living experiences of patients, and not just on values introduced from another context by a health professional, is in line with the objectives of

Broadened Clinical Medicine. District healthcare was an issue often mentioned in statements given by the professionals as being an important factor for the production of health and as a source of self-fulfillment in their work. In Cuba, health professionals not only work in the community, they also live in the same area where they work, in a building constructed by the government, where their surgeries are also located²⁷.

In addition to providing district health care, another experience introduced by the *Mais Médicos* Program, which was presented as a source of professional and personal fulfillment, and which is part of the Paideia concept, was Ongoing Education. Apart from the specialization course in Family Healthcare that was part of the Program, this course experience was expanded by means of proposals presented by the municipality studied. Different reports were given: matrix support given to a urologist to train for early diagnosis of prostate cancer; participation in multi-professional training promoted by the network, involving different themes over the years; training for cardio-respiratory arrest provided by a SAMU (Mobile Emergency Care Service) team in the health unit itself – all of which were shown to be a source of satisfaction to those interviewed. These experiences serve to bring professionals from different areas closer together and to form part of the same area of knowledge – Primary Health Care, which promotes co-management and creates collective learning spaces, integrating different areas of knowledge and provoking reflections about work practices.

We had hoped that the *Mais Médicos* Program would have brought about changes and different reflections in each municipality in which it is implemented. In the context studied, namely a network that is already well established and well formed, the tensioning was less apparent in the sense of constructing PHC, and more on the need to shape the network and the forms that are used to practice comprehensive medicine. The potential of the program exceeded any initial barrier, because of the way the population has shown how closely connected they are to the teams formed by exchange physicians.

We conclude with the subjectivation of the *Mais Médicos* Program as seen by individuals-actors involved in this study – medical practitioners from Cuba – whose experience in the Program has proved to have great potential, both in a personal and professional sense, as well as bringing about a transformation in the biomedical paradigm. This is achieved without rejecting biomedicine and personal aspirations, along with the tensions between class cultures and different world visions about the physician's duties, which represent factors that are essential in order to reproduce the SUS as a democratic policy and supportive system in accordance with the Paideia Method.

Collaborations

LSV Terra, FT Borges, M Lidola, SS Hernández, JIM Millán and GWS Campos participated equally in all the preparatory stages of this article.

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