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Users' perceptions on social impact of the colaboration project of the More Doctors Program: a case study

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The study presented in this paper identifies probable changes generated in the care process of a primary healthcare service in a municipality of Santa Catarina, Brazil, part of the Collaboration Project of the More Doctors Program. This was a qualitative study conducted in 2015 that employed semi-structured interviews and a field diary as data collection instruments. Data analysis was performed through the ethical-political method, revealing: a) consistent creation of caring relationships, mediated by a humanistic mode of thinking and practicing medicine and internalization among members of the community of the belief that they were being cared for by an equal who was also a human being; and b) insecurity regarding the project's end, based on misinformation. This study concluded that a solidary disposition is essential to the creation of caring relationships, and that the federal government needs to implement ethicalpolitical guidelines to ensure quality information about the project.

Keywords: Medical Care. Primary Care. Right to health.

Introduction

Unequal distribution of physicians in Brazilian primary health care is a historical product of the development model adopted in the New Republic in 1985, following the military dictatorship. Above all, it is a product of historical medical corporative hegemony[1], the productivity-focused perspective on education[2] inherited from the dictatorship and the biomedical sciences[3]. Thus, such inequity constitutes a social issue[4].

Since the implementation of the National Primary Care Policy in 2006[5], the fight to ensure primary medical care in unassisted Brazilian territories has continued. Unequal distribution of this care, expressed in the historical reality of the map of Brazilian life, exposes the current need to defend the right to health. However, besides defending victory in the right to health, new battles must be fought to effectively implement this right. In Brazil, the individual process of choosing a location rarely coincides with socially just distribution, as most physicians choose more seductive “Brazils”[6].

The emergency supply of primary care physicians ensured by Provisional Measure no. 621 of July 2013, in addition to the creation of the More Doctors Program (MDP) in July of the same year[7], can be understood as the recognition of the need for new initiatives that are aimed at expanding the right to health. In particular, it was a response to the demands of lower-middle-class youth in the 2013 protests[8], and those of several mayors, in Brasilia, also in 2013, who asked: “Where are the doctors?”[9], Approved by the National Congress and sanctioned by the Presidency of the Republic, Law no. 12.871, of October 22, 2013 implemented the MDP[7].

Chapter IV of the More Doctors Program Law establishes the implementation of the More Doctors in Brazil Project (MDBP). This project contemplates: a) physicians with degrees earned in Brazil or foreign degrees validated in Brazil; b) Brazilian physicians who have earned foreign diplomas and have been licensed to practice medicine abroad, and c) foreign physicians licensed to practice medicine abroad[7]. Article 23 addresses the possibility of Brazil establishing collaboration agreements with international organizations to realize these

actions. According to the MDP webpage, as of May 2016, of the 295 municipalities in Santa Catarina, 217 had received physicians through the MDP[10].

The aim of this paper is to analyze, from the ethical-political perspective, how users perceive the social impact of the MDBP in a municipality of 2,900 inhabitants in the macro-region of Vale do Itajaí (Santa Catarina) that did not have primary healthcare physicians for over a year[(c)] before the beginning of the project. Social impact is defined as "changes produced through interventions in the context of real life[11]."

Methodology

This was a qualitative, exploratory, and comprehensive single-case study[12] conducted in a young municipality in the macro-region of Vale do Itajaí, Santa Catarina, Brazil.

In its design, the interaction between factors and events was considered the central nucleus[13]. The three phases that characterize a case study were followed: a) choice of a theoretical framework[14], selecting a case and designing data collection; b) conducting the study, with data collection and exploration of transcribed material; and c) analysis based on the selected theory, with data interpretation[12].

This study was evaluated and approved by the Research Ethics Committee of the University of Vale do Itajaí, Santa Catarina, carried out in accordance with Resolution, no. 466/2012 of the Brazilian National Health Council, Ministry of Health. This was an extension of state research in progress, funded by the Foundation for Research and Innovation of the State of Santa Catarina (Fapesc), Public Notice 2014/1, whose general objective was to analyze the social impact of the More Doctors Program in Santa Catarina, from the ethical-political perspective. Participant anonymity was ensured using code names based on authors

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[(c)] This information was gathered from the municipality's internal human resource records. After obtaining permission from public administration, the researchers had access to hiring and termination files of physicians since the municipality's emancipation in 1997.

from Brazilian literature.

Chosen by convenience, the sample consisted of 12 participants of various professions, such as farmers, traders, independent professionals, and retirees, with different levels of education (elementary, secondary and tertiary) and ages ranging from 23 to 82 years old. All had resided in the municipality for over 10 years; 7 were women, 5 were men, and 8 had been born and raised in the municipality; 1 was pregnant and received prenatal care from the unit; 3 had grandchildren, and all had had children.

The 12 users were indicated by the workers of the municipality's primary care unit, based on the following criteria: a) being over the age of 18 and cognitively competent; and b) being a primary care unit user. The indicated users were contacted via telephone, followed by home visits, when they were officially invited to participate and given informed consent forms to sign. The users received information about the research in adequate and careful language, and were made aware of the implied and procedural ethical issues of the study.

Data collection took place between November and December 2015. Semi-structured interviews were chosen to gather data, as they allow for the inclusion of questions as deemed necessary during data collection[15]. The interviews were conducted individually and in private, lasting approximately one hour. The data were audio recorded and later transcribed with ethical rigor.

The guiding axis of the interview script was: "What changed with the arrival of physicians through the Program?", developed in three themes: 1) User perceptions of medical care; 2) establishment of relationships between physicians and the community and 3) transformations in primary healthcare practices. Field diaries were kept throughout the research process, which broadened the range of information, generating a "free and creative flow process" for data processing and analysis[16].

Based on the frameworks suggested by Minayo[17], Assis[18] and Gramsci[19], content analysis was organized in four steps:

1. Data organization: Accurate transcriptions, followed by organization of the material through codenames and free and thorough readings;
2. Data classification: Based on the empirical data, research objectives, and theoretical assumptions, the central ideas in the nuclei of meaning were identified, classified as Group I – caring relationships, or Group II – uncertainty about the end of the More Doctors Program;
3. Categorization: Based on the intersection of the epistemological, instrumental, and reflexive components of the central ideas (Group I/Group II): From "He's so simple, he's part of the municipality, he doesn't even seem like a doctor!" to "fear about the project's end";
4. Analysis method: Data analysis employed the ethical-political method, which is based on a reflexive-critical dimension of understanding, exploring how the arrival of a physician through the MDBP, ensuring basic medical care, affected the primary care of users. This method, which investigates how, is an adaptation of the humanist method of analysis, called by Antonio Gramsci the "given that" method, whose analysis is anchored in the historical dimension of reality and the interpretation of its contradictory trends[19].

Results and discussion

The category from "He's so simple, part of the municipality, doesn't even seem like a doctor!" to "fear regarding the project's end" represents the movement between the elements that constitute the patient-physician relationship, a process generated through the integration of social relationships. This category also expressed uncertainty due to the emergency nature of the physician's stay:

> He's so simple, he's part of the municipality, he doesn't even seem like a doctor! (Casimiro de Abreu).

> This program really helped our town. They say it's going to end. I'm afraid. (Martha Medeiros)

Participants expressed the idea that creating bonds requires a pedagogical relationship, guided by humanistic values[19]. This category represents the prerequisite for producing relationships in times when: the "inversion between means and ends" persists; the dream of a dignified life still occupies the space of means of survival; money is not a means to enjoy a dignified life, but an "end in and of itself"; and social relations are enslaved to an anonymous system[20] (economic, primarily). These relationships cannot be based on formal, bureaucratic medical rationality[21], but must be based on value-centered[22] and ethical rationality[20], in which the use of collective values enables the production of relationship-based care. Within the scope of this study, the values "being simple" and "physician" presented by the Cuban physician generated the necessary social relationship for good interactions between the caregiver, individuals receiving care, and the community.

When asked about their relationships with the physician supplied through the MDP, users stated:

> We are a simple people here, [...] most of us make a living in the fields, on farms, in tobacco plantations [...] this doctor gets along well with the people because he knows what they are like. (Martha Medeiros)

> [...] He's humble [...] Even though he's not Brazilian, he's already familiar with [...] the reality of our population. (Cecília Meireles)

According to the interviewees, the physician's willingness to "know what the people are like" created a bond with the local community, as they internalized the belief that they were being cared for by an equal. Furthermore, on reflecting about the simplicity that characterizes the community, the physician relates with the community at the human level, expanding his field of possibilities for providing quality care. By showing humility and familiarity with humble people, the physician broadened his scientific horizon, appropriating the social determination of the health-illness process, and effectively shifted from representing a professional from a given category (physician) to a "producer" of health[19].

In this context, the population's way of life and forming productive relationships seem to compose the central axis of the work process. It is worth noting that the users demonstrated awareness of health and illness as socially determined processes, which points to the current need for recovering the social medicine movement of the 19th century[23] to establish quality work processes between physicians and users: quality resulting from a focus on a caring patient-physician relationship.

In 1845, Engels demonstrated that the working class in several cities in England established relationships through a capitalist process of production, which forced them to lead uncertain lives. Inaugurating the theoretical model of social determination, his studies demonstrated that the emptiness of the relationships between the working masses and productive relationships were the determinants of work-related illnesses and physical and moral nonexistence. To some extent, Engels reinforced what Bernardino Ramazzini had already stated in 1700: The social condition of a given community, generated by its living conditions, established through modes of social organization, determines the path toward understanding individual and collective health and illness[25].

An interview was conducted with the physician allocated to the studied municipality, and showed that he was a Cuban physician who was not registered with the Brazilian Federal Board of Medicine: a collaborator. He was hired through a collaboration agreement mediated

by the Pan American Health Organization and signed by Brazil and Cuba in 2013[26], supplied through the MDP Collaboration Project.

The physician's conduct was guided by "knowing how people are." This leads to a reflection about the place of humility and solidarity in the Brazilian and Cuban socialization process. Within the scope of medical education, Cuba adopts a sociopolitical and pedagogical culture, based on humanism and solidarity[27]. If solidarity is understood as a social value that results from the encounter of individuals who recognize each other as equals in their rights as citizens[28], it is likely that the basis of Cuban life has been historically based on solidary relationships, given the socialist dimension of the country's historical process: [...] Even though he's not Brazilian, he knows the town [...] goes to the same places we do; he's always at community festivities (Cecília Meireles).

The Brazilian National Health System (SUS), which was established at the 8th National Health Conference in 1986, was based on socialist principles. Several factors explain its current unsustainability, related to the inability of the capitalist mode of production to: a) materialize health as a universal right; b) provide comprehensiveness when ensuring universal right to health; and c) break with historical inequities in health distribution as a right for all.

This social victory and its guarantees have developed as a process. The fight for the right to health dates back to the 1960s, during the military dictatorship, and is still occurring in the present. The health system reform movement and popular organizations have gained momentum. In 2013, for example, the June protests and the March of Mayors to Brasilia with the slogan "Where are the doctors?"[6] resulted in an important social response from the state: the emergency provision of the More Doctors Program.

This progressive battle has reaffirmed an important axis relative to the state's (political and civil society) understanding of the need for collective will[29] to effectively ensure the right to health and form autonomous[28] subjects[30] capable of making decisions about their own lives and exercising social control over the SUS.

Thus, in an individualized society such as Brazil, the concept of risk has priority over the concrete production of health and healthy social relationships, such as those expressed between the Cuban physician and users. In this context, political actions seem to be acting as a kind of conscience that considers the historical need to ensure health in the territory based on the production of citizens, "in light of reality and life"[31]. This reality highlights the epistemological ground in which bonds are democratically created: the encounter of people who recognize themselves as equals in their citizenship. This constitutes democratic and permeable epistemology, based on the democratic value of health production.

Imbued with this role, the physician was not only an instrument of a collaboration agreement who went to the municipality out of professional interest and for income possibilities, to care for the sick, request tests and prescribe medications. His attitude was one of a promoter of health, someone who belonged to the community and was willing to fill a current void: interaction. This context of social interaction composed of close bonds is the prerequisite for the possibility of establishing patient-physician relationships: "He's part of the municipality [...] (Aluísio de Azevedo); [...] He gets along well with the people (Casimiro de Abreu)".

It is important to state once again that this municipality went over a year with no primary care physicians before the emergency provision of the MDP. This context, in which medical care and the local population were not dominated by the biomedical model, favored the establishment of bonds. The presence of these bonds paved the way for an "ethics of recognition"[30,28] in the public sphere of primary care: Users recognized each other and the physician as citizens having rights that are part of a universal totality, based on the motto of health as a democratic value that is a right for all.

In this type of bond, in which the local population constructs the theoretical model for medical care, which is a social determination, care is a product of concrete social actions, generated by equally concrete social players and through specific historical processes. In this "cultural melting pot of processes involved in health production"[32,17], the local community's

way of life gains medical continence and medicalization ends up operating in its positive biopolitical character: promoting a culture of shared medical care.

Another issue that came up in the interviews was the security generated by the consolidation of the relationship. When physicians take part in and are part of the local context, representing the social environment and the lives of people under their care, and being part of their daily relationships, a sense of security is transmitted to the population. In other words, the hallway meetings in life strengthen affective, personal, family, and work relationships and generate sociability that mitigates the sense of risk. This result, coupled with the guarantee of health as a democratic value, enables residents to feel they are completely healthy, even in the presence of high blood pressure or diabetes, for example.

In 2007, a study was conducted in the province of Rome, Italy, with the goal of investigating the relationships between health and society in the context of Italian family medicine. The researchers found that the production of caring relationships between family physicians and service users found fertile ground in small municipalities, in which life "hurries up slowly." Contrary to the results from metropolitan and industrial areas, villages demonstrated that the production of care took place based on a specific idea of temporality that legitimizes horizontal solidary relationships[33]. In such relationships, users are respected in their freedom to make decisions about their own health care[6]. This study corroborates the data from the present investigation, as shown in the following excerpt:

> Our municipality is small, people know each other, visit each other, work together. If you treat them well, they sing your praises. And that's what happened with this doctor. (José de Alencar)

Physicians hold performative authority, making potentially strong performative statements to convince users to act in favor of instrumental solutions in their health-illness process. However, in the context of the relationships in this study, the physician also

depended on his way of being, which favored the emergence of people confident in their cultural capital[34].

The analysis of this category reinforces that any approach to health care, instituted in any given historical era, is the result of the style of thought circulating in the context of those historical, social, and cultural relationships. According to this logic, the humanistic approach used by the physician in this study, and his willingness to establish relationships, were a result of his style of thought, created at a given historical moment in his life. This historical moment corresponds exactly with a time that had previously conditioned and established the horizon that could be contemplated by him: practicing humanistic and solidary medicine. By guiding the relationship between the physician and users, these characteristics resulted in an approach that legitimized how the local community understood health: as horizontal and democratic[35].

Thus, the relationship demonstrated by the community with the collaborating physician nurtured the hegemony of social determination. In other words, the understanding of health on the part of the physician and the community, in practice, became the baseline for ensuring care: the supremacy of social determination became the dominant style[36] of medical care. In this consistent approach to care, the probable limitations imposed by the physical and technological structure of the primary care service, in addition to the macro context, in which municipal resources suffer the effects of the ethical, political, and economic crises occurring in Brazil, flowed in the human horizon in a village with time for life.

In the daily life of the relationships in the studied social space, the patient-physician relationship was not limited to discourse, but represented a social construction based upon the encounter of individuals, in which no person is subjugated[36]; an ethical-political encounter. The basis of this mode of encounter can be perceived through the excerpt “works at the health center,” which was not expressed in a demeaning manner, but with a subtle expression of greatness, because the physician “[...] is simple (Martha Medeiros)”.

However, participants also stated:

> They say that [the project] is going to end. I'm afraid [...]. At my age, I can't leave in the middle of the night to go to another town for a consultation. [...] Before this doctor, I had leave at three in the morning from my house to get an appointment somewhere else. (Martha Medeiros)

This dialectical relationship is a historical and social issue, as synthetically described above: the interference of the concept of risk linked to probabilistic life in the concrete production of health, socially determined by the conditions of the possibilities of the present time. The population could not fully enjoy the victory of receiving medical care without the threat of the project ending. This flow between security brought by presence, and insecurity caused by the threat of absence, represented a negative element in the health of the local population. This insecurity is rooted in a risk-based society[37], a society that masterfully conditions the health of present time to the uncertainties of tomorrow. This understanding allows for the deduction that even though health continence in the territory provided by the physician was an ethical good, systemic pressure was exerted by the dominant mode of thought of capitalist societies: unpredictability.

It is important to highlight that the fear of losing humanistic, democratic, comprehensive, and solidary medical care ends up weakening the work process in primary care. This could be overcome if the ministries responsible for the emergency provision effectively provided quality information. For example, as institutional subjects, the supervisors of collaborating physicians could qualify the right to information. Thus, they could communicate that in 2018, when the collaboration agreement is terminated, Brazil excepts to have trained residents to replace the staff supplied by the emergency measure.

Access to quality information opens broad avenues and constitutes a social right. However, the weakness with which information circulates in the current processes

experienced in primary care territories has limited the ability of those services to meet the concrete health needs of the territory[38]. This social factor requires critical reflection and positioning, i.e., the architects of this emergency provision need to treat the initiative ethically, clarifying the meaning, objective and duration of the program.

If users were familiar with the meaning of emergency provision and aware of the duration of the agreement and to what extent they may face dark times (regarding the transition between the end of the collaboration agreement between Brazil and Cuba and the arrival of residents), this sense of risk could be mitigated. The problem is that the process of policy and program implementation follows a path of limited communication. This is the course of events in a time that does not allow time for sharing information.

The municipality received its primary care unit in 1998, which was the year of its emancipation. According to local records, primary medical care was the responsibility of 19 physicians between 1997 and 2014, an average of one physician each year. At some times during this period, the local community had no physicians available. This turnover rate, and the occasional absence of medical care, probably generated a social representation of the risk of lack of available care. This risk produced overwhelming materiality: “leave at three in the morning from my house to get an appointment somewhere else (Martha Medeiros)”.

In a context of macro ethical, political, and economic crises, the risk of losing physicians is maximized, haunting the social space of primary care:

> I’m afraid of when the program ends! Today we have a professional here, right...When the program is over, who’s to say there’ll be a doctor? (Machado de Assis)

> With every passing day he wins over more residents [...], when he leaves he will be sorely missed (Martha Medeiros).

The participants expressed feelings of insecurity and the unpredictability of facing life based on the uncertainty of tomorrow. The guaranteed presence of a physician who resided in the municipality provided comfort and security to the population of this town, ensuring an essential dimension of comprehensiveness of care: understanding the dynamics of the territory.

The results showed that the participants viewed the collaborating physician as a social victory for the territory. He was positively assessed by the community, not because of his mere presence or resume, but because of the solidary personal relationships he established with municipal residents.

Bernardino Fantini, director of the History of Medicine and Health Institute of the Faculty of Medicine at the University of Geneva, masterfully explained the ideas about medical care presented by Giovanni Berlinguer, Italian physician, bioethicist, politician, and humanist. Berlinguer dedicated his life to the fight against "the dramatic realities" associated with health, labor, and law, and viewed medical care as an architectonic space of production and application of medical awareness, a humanistic exercise (ethics) in the face of daily (political) decision-making, with solidarity at its core[25].

Final considerations

The present study sought to understand the qualitative social impact of the emergency supply of physicians provided through the MDP Collaboration Project on the care process for residents of a small municipality of Santa Catarina, Brazil, which had suffered from a lack of physicians in health services for over a year. The data showed that the physician adopted a humanistic and solidary style of thought regarding medical care, in which health is socially determined. He was willing to get to know the population, favoring the creation of bonds, as this willingness helped the community internalize the belief that they were being cared for by an equal: in the case of this study, someone "humble and

simple." This relationship was not present merely in discourse, but also represented a social construction of the ethical-political encounter. This encounter, which was based on a way of thinking and practicing medicine presented by a legitimate producer of health, the collaborating physician, has been presented as the epistemological ground for having an emancipatory impact in the life of users, since they showed confidence in their daily relationships with their caregiver. However, fear of losing this medical care, which was a result of misinformation about the MDP process, resulted in social insecurity, which generated suffering. This suffering can be overcome with the implementation of ethical-political guidelines by the federal government to ensure the right to information about the actions of the MDP regarding the future of emergency provision, described in the program's law.

Collaborators

RG De Liz collaborated in the study conception and design, actively participated in the discussion of the results, and contributed to the approval of the final version for publication. RCGS Lima collaborated in the study conception and design, actively participated in the discussion of the results and revision of the manuscript and contributed to the approval of the final version for publication.

References

1. Spriano P. Antonio Gramsci, Lettere del carcere. Torino: Einaudi; 2014.

2. Saviani D. O legado educacional do regime militar. Cad Cedes. 2008; 28(76): 291-312.

3. Luz MT. Cultura contemporânea e medicinas alternativas: novos paradigmas em saúde no fim do século XX. Physis. 2005; 15(Supl):145-76.

4. Castel R. As armadilhas da exclusão. In: Castel R, Wanderley LEW, Belfiore-Wanderley M. Desigualdade e a questão social. São Paulo: Educ; 2008. p. 21-54.

5. Portaria nº 648/GM, de 28 de março de 2006. Aprova a Política Nacional de Atenção Básica, estabelecendo a revisão de diretrizes e normas para a organização da Atenção Básica para o Programa Saúde da Família (PSF) e o Programa Agentes Comunitários de Saúde (PACS). Diário Oficial da União. 28 Mar 2006.

6. Lima RCGS, Garcia Júnior CAS, Kerkoski E, Chesani FH. Programa Mais Médicos de Santa Catarina: breve relato de experiências iniciais. Tempus, Acta Saúde Colet. 2015; 9(4):67-80.

7. Lei no 12.871 de 22 de outubro de 2013. Institui o Programa Mais Médicos, altera as Leis no 8.745, de 9 de dezembro de 1993, e no 6.932, de 7 de julho de 1981, e dá outras providências. Diário Oficial da União. 23 Out 2013.

8. Boito Júnior A. A natureza da crise política. Le Monde Diplomatique. 1 Mar 2016. p. 4-5.

9. Carvalho MS, Sousa MF. Como o Brasil tem enfrentado o tema provimento de médicos. Interface (Botucatu). 2013; 17(47):913-26.

10. Programa Mais Médicos Governo Federal. Mapa de atuação. Municípios com Médicos do Programa [Internet]. Brasília; 2016 [citado 23 Jun 2016]. Disponível em: http:// maismedicos.gov.br/consulta-por-cidade#.

11. Facchini LA, Piccini RX, Tomasi E, Thumé E, Teixeira VA, Silveira DS. Avaliação de efetividade da Atenção Básica à Saúde em municípios das regiões Sul e Nordeste do Brasil: contribuições metodológicas. Cad Saude Publ. 2008; 24(Supl 1):159-72.

12. Yin RK. Estudo de caso - planejamento e métodos. 2a ed. Porto Alegre: Bookman; 2001.

13. Bell J. Como realizar um projeto de investigação: um guia para a pesquisa em ciências sociais e da educação. Lisboa: Gradiva; 1997.

14. Yin RK. Applications of case study research. California: Sage Publications; 1993.

15. Pope C, Mays N, organizadores. 3a ed. Pesquisa qualitativa na atenção à saúde. Porto Alegre: Artmed; 2009.

16. Strauss A, Corbin J. Pesquisa qualitativa técnicas e procedimentos para o desenvolvimento de teoria fundamentada. 2a ed. São Paulo: Artmed; 2008.

17. Minayo MCS. O desafio do conhecimento. Pesquisa qualitativa em saúde. 14a ed. São Paulo: Hucitec; 2010.

18. Assis MMA. Método de análise em pesquisa qualitativa em saúde. Feira de Santana: UEFS; 2003.

19. Manacorda MA. Antonio Gramsci: l´alternativa pedagogica. Roma: Riuniti; 2012.

20. Nabuco A. Michel Lowÿ: por um novo mundo, sem capitalismo. Caros Amigos. Dez 2015 16-20.

21. Sell CE. Racionalidade e racionalização em Max Weber. Rev Bras Cienc Soc. 2012; 27(79):153-72.

22. Cardoso LA. O conceito de racionalização no pensamento social de Max Weber: entre a ambiguidade e a dualidade. Teoria Soc. 2008; 16(1): 256-75.

23. Rosen G. Da Política Médica à Medicina Social: ensaio sobre a história da assistência médica. Rio de Janeiro: Geral; 1980.

24. Engels F. The condition of the working class in England 1845 [Internet]. Delaney T. Moscow: Institute of Marxism – Leninism; 1969 [citado 25 Mar 2016]. Disponível em: https://www.marxists.org/archive/marx/works/1845/condition-working-class/.

25. Berlinguer G. Storia della salute. Firenze: Giunti Editore; 2011.

26. Ministério da Saúde. Secretaria de Gestão do Trabalho e da Educação na Saúde. Programa Mais Médicos – dois anos: mais saúde para os brasileiros. Brasília: Ministério da Saúde; 2015.

27. Mejias Sanchez Y, Duany Machado OJ, Toledo Fernandez AM. Cuba y la cooperación solidaria en la formación de médicos del mundo. Educ Med Super. 2010; 24(1):76-84.

28. Lima RCGS, Verdi MIM. Solidarity in family medicine in Brazil and in Italy: reflecting on ethical issues and contemporary challenges. Interface (Botucatu). 2009; 13(29):271-83..

29. Coutinho CN. O Conceito Gramsci ano de “vontade coletiva”. In: Semeraro, G Oliveira MM, Silva-PT, Leitão SN. organizadores. Gramsci e os movimentos populares: Rio de Janeiro: Editora UFF; 2011. p. 45-52.

30. Fleury ST. Socialismo e democracia: o lugar do sujeito. In: Fleury ST, Lobato LVC. Participação, democracia e saúde. Rio de Janeiro: Cebes; 2010. p. 24-46.

31. Arias PG. La Cultura: estrategias conceptuales para comprender la identidad. La diversidad, la alteridad y la diferencia. Quito: Abya-Yala; 2002.

32. Collicelli C. La salute come processo sociale. Sanità e ricerca sociologica. Milano: Franco Angeli; 2011.

33. Lima RCGS, Verdi MIM. Reflexões sobre a relação entre saúde e sociedade no contexto italiano contemporâneo. Rev Bioét. 2011; 19(1):141-57.

34. Bourdieu P. A economia das trocas lingüísticas. São Paulo: Edusp; 1996.

35. Fleck L. La génesis y el desarollo de un hecho científico. Madrid: Alianza Editorial; 1986.

36. Gramsci A. Quaderni del carcere. 3a ed. v. 1. Torino: Einaudi; 2007.

37. Beck U. La società del rischio. Urbino: Carocci; 2011.

38. Oliveira MAC, Pereira IC. Atributos essenciais da Atenção Primária e a Estratégia Saúde da Família. Rev Bras Enferm. 2013; 66(esp):158-64.

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