DOI: 10.1590/1807-57622016.0540

The More Doctors in Brazil Project and the construction of myths: a Barthean reading

Giovanni Gurgel Aciole [a]

(a) Programa de Pós-Graduação em Gestão da Clínica, Departamento de Medicina, Universidade Federal de São Carlos. Grupo Quíron, Campus São Carlos. Rodovia Washington Luiz, SP 310, KM 235, S/N. Monjolinho. São Carlos,SP, Brasil. 13565-905. gescufscar@gmail.com

The aim of the More Doctors in Brazil Project (MDBP) is to supply human resources to the Brazilian National Health System by improving the infrastructure of the healthcare network; expanding educational reforms in medical courses and residencies; and supplying physicians to vulnerable areas. The implementation of the MDBP faced strong opposition, especially from Brazilian medical institutions. Inspired by the concept of "myth," the present study conducted a reading of the discourse used by the Brazilian Federal Board of Medicine to support its arguments, by analyzing editions of the Medicina newletter published by the Board in the first 24 months of the project's implementation. The myth reveals how discursive practices introduce allegories into the collective imagery that define ideological spaces and enable an analysis of the process of social dispute and the historical conditions behind the formulation and implementation of a government program.

Keywords: Health policy. Planning and administration. Government programs. Government Health Plans. Primary Health Care. Brazilian National Health System.

Introduction

Health professional allocation and retention can be an element of social inequity, sentencing some populations to lack of access to health services, while also hindering the establishment of strong health systems in affected countries[1-3]. Currently, over 400 Brazilian municipalities face shortages of physicians, a priority

issue for the management of the Brazilian National Health System (SUS). A study conducted by the Institute for Applied Economic Research (IPEA) in 2011 investigated how the population perceived these shortage: Of the 2,773 individuals interviewed, 58.1% highlighted lack of physicians as the main problem faced by the SUS[4].

Attempts to mitigate this problem include the Family Health Strategy (FHS), which expanded the problem-solving capacity of services and impacted the health condition of individuals and collectivities by reorganizing the healthcare model[4]. However, this program has not yet been able to respond to other challenges, and there is a gap between its plan and the incorporation of that plan into effective political action[4,5-7]. One of the central issues preventing the full success of FHS are care voids, i.e., places that have not been able to supply and secure primary healthcare professionals, especially physicians, leaving the population with no access to primary health services[8-11]. High turnover rates among professionals, especially physicians, is an obstacle to the development of comprehensive health care[12], reinforcing the need for actions within the scope of management of health work and education[13].

Mobilized by this issue, in 2013 the Brazilian federal government instituted the More Doctors in Brazil Project (MDBP), whose aim was to allocate physicians to regions suffering from care voids and address lack of access to quality health actions and services among vulnerable populations. Now that three years have passed since its creation, its symbolic dimension must be investigated, i.e., the degree to which the measure has affected/affects social and cultural imagery, and what it has added to primary care actions, and consequently to the SUS, especially for one of its most acute issues: providing unassisted populations with access and embracement. The aim of the present article was to clarify the logical-discursive reasons and motivations present in the initial debate that arose at the time of the program's implementation and the mythology presented about and because of this project.

Notes about the concept of myth

The present paper used the concept of myth formulated by Roland Barthes[14].

According to Barthes, myths are allegorical forms of discourse or legendary narratives; a means to an end—the imposition of an ideology that is the point of view of a given class; or a partial view of the world that is intended to be universal. Myths are a system of communication, messages. They can be objects, concepts, or ideas. They are modes of signification, forms that take on different shapes: texts, images, photographs, performances, or advertising. Myths are messages, and all possible presentations support the mythical form. Myths cannot be defined neither by their objects nor by their content, since any content can be assigned meaning arbitrarily. An arrow presented to signify provocation is speech; photographs can be considered speech just the same as news articles. Images and writing, however, do not elicit the same type of awareness, and images themselves suggest different readings. An image can be transformed into writing, and vice versa, from the moment it becomes meaningful; the written form, however, requires lexis, i.e., the organization of rational and logical discourse through a signifier and the signified. Thus, language is defined as any type of discourse, speech, etc., or any unit or synthesis of meaning.

Myths are values; they are not limited by the truth. Nothing prevents them from being a perpetual alibi: signification always exists to present form; form always exists to keep signification at a distance. Myths must be at the same time invisible and natural, because their identification would unveil the attempted manipulation. Myths are neither lies nor confessions: they are distortions. What matters is not interdiction, but exposure. And most importantly: myths need phraseology, and slogans play an essential role. Clichés help comprehend and justify the world in a much simpler way, enabling immediate observations that require no greater reflection.

Myths naturalize history and make the world a more rigid place, preventing transformation. They serve to conserve the status quo. Their essential nature is, therefore: well-fed, glossy, expansive, and talkative; they are continuously inventing themselves. They take over everything: justice, morals, aesthetics, diplomacy, domestic arts, literature, and performance. In sum, myths and ideology are close cousins: they intertwine, blend together, and are unavoidable categories when unveiling the process that legitimizes bourgeois society. Myths are a product of a dominant social class that

ends up being incorporated by members of the dominated class, even when contrary to their interests. The function of myths is to produce this acceptance through naturalization, by which individuals accept social facts as natural facts, eclipsing the role of history and its social implications.

One form of analyzing discourse is to identify the mythology it conveys. Books, articles, films, photographs, and images are vehicles for myths, depending on the context in which they are seen or read, and the uses they acquire according to who employs them.

However, non-mythical language also exists; it is the language of individuals who produce, i.e., the language of individuals who act to transform reality instead of conserving it. Every time they associate language with production, metalanguage is re-conveyed to an object-language, and mythification is not possible. Through non-mythological language, the dispute about the full realization of politics can be outlined. Regarding politics, the semiological definition of myth is complete in bourgeois society, because in such society, myths are depoliticized speech. If myths are depoliticized speech, then there is at least one type of speech that can counteract it: speech that remains political, i.e., that does not naturalize history or coagulate in temporal immobility.

The rhetoric of myths constitutes a set of fixed, established, and insistent figures, in which the forms of signifiers can be classified as follows.

- Inoculation, through which the collective imagery is made immune, inoculating an acknowledged evil, and thus defending the status quo against the risk of generalized subversion.
- Removing history, in which, through this inoculation, history evaporates and silently disappears: The myth can be enjoyed without questions about its origins, since it can only come from eternity.
- Identification, through which the other is reduced to the self. Performances, courts of law, and places in which others are exposed become mirrors for the self.
- Tautology, which consists of defining a thing with the thing itself, a refuge for those who are at a loss for explanation, creating a dead and motionless world.

- Neither-norism, which involves presenting two opposites that cancel each other out, in order to reject them both (neither this nor that)
- The quantification of quality, which reduces all differences in quality to differences in degree, economizing intelligence: the truth is presented at a lower cost[14].

As readers of myths, the authors of the present study conducted an exploration of several editions of the Medicina newsletter, which is the voice for the positions taken by the Brazilian Federal Board of Medicine (CFM). The CFM is a self-managed federal entity that regulates professional medical practice, and all practicing physicians must be registered with the board; this provision is different from other organizations (unions and specialty associations), in which affiliation is optional. Every month, they send their publication to an army of registered professionals throughout the country. With the goal of capturing official positions, the present study selected the sections "Editorial," "Message from the President," and the cover story of the monthly edition for analysis. The analysis follows the responses and official board protests published in the newsletter following developments in government actions.

Government actions

The MDBP launched never-before-seen efforts by the Brazilian government to change and transform the existing situation. The goals of this project were to:

- Reduce the shortage of physicians in priority SUS areas
- Strengthen the provision of primary care services throughout the country
- Improve medical training and provide greater practical experience during the training process
- Expand the insertion of physicians in SUS care units during training, so they can learn about the realities of the Brazilian population;
- Strengthen the policy of ongoing education by integrating teaching activities and health services, through the academic supervision of physician training actions carried out by higher education institutions
- Promote the exchange of knowledge and experiences among Brazilian and foreign

health professionals

- Qualify physicians to work with national public policies and the organization and operation of SUS
- Encourage research applied to SUS[15].

The goal of supplying and retaining health professionals, coupled with measures related to tutorial support and training for SUS, resulted in an interweaving of issues regarding health education, management, and work and worker regulations. This scenario is mainly based on the progress of the FHS, which brought with it numerous challenges to the field, such as the mismatch between education in health and the need for primary care. At this point, the main concern that would provoke reactions to the government program by the mythologists can be identified: In one swoop, the program upended the established territories that had housed comfortable arrangements that catered to the interests of the agendas involving medical education in Brazil.

To a significant extent, regional disparities relative to the distribution of job posts in primary care across the country occurred in the context of macroeconomic development, in which a crisis scenario was already emerging. But, up to then, this had not fully impacted employability and employment protection among the medical community. The program coupled advances in social policies, such as access to health and health services, with a process of economic growth and reduction of regional inequalities. These two argumentative foundations expose the strategy and agenda behind the opposition of medical entities to the program, which claim that Brazil does not have a shortage of physicians, as will be seen below.

Confronted with this myth, which has been repeated for decades by medical entities, the government carefully gathered information and comparative data to bypass or contradict the positions disseminated by medical entities. This strategy, however, was taken a step further: The government demonstrated that if in a context of minimum unemployment rates and a strengthened economy, physician unemployment was not an issue, the existence of a clear contingency of vacant job posts in all regions of the country, especially in low-income regions such as the

northeastern semi-arid region and the legal Amazon region, fully dismantled the entity's thesis of "enough physicians." Not only were they poorly distributed throughout the country, but these professionals were also insufficient or were not filling certain job posts. The government disseminated this discourse among various audiences, not only in political/institutional populations such as health managers and their associations, or mayors and their associations, but also in academia, taking the debate inside university walls.

Another government strategy was to package the emergency proposal together with a set of actions that structured the policy for supplying and retaining physicians. This policy included actions ranging from distribution and allocation, to improving infrastructure through several lines of funding, enhancing quality of primary care, to transforming medical education for SUS. This set of policies gave the MDBP solidity, placing special emphasis on medical training in the country and the creation of new medical schools, directed according to regional priorities. In 2012, a program to expand vacancies in the medical schools of federal institutions of higher education (IFES) established the goal of creating 1,615 vacancies in existing medical schools or new medical programs created in federal universities in 2013 and 2014[16]. In terms of the creation of new programs, the proposal emerged to create medical residency vacancies in the same locations as the new programs, as a way of enhancing them. As the present paper is being written, new residency vacancies are being authorized, and the list of cities and regions included seems to match those intended by the MDBP.

The mythology present in the discourse of Brazil's main medical entity

Brazil's medical category is organized in a way that grants it special status among independent professions, giving it great social recognition, belonging to the elites. Its cultural image is associated with scientific, technical, and academic production. The profession is based on certain modes of caring for human life and health that are at the heart of the organization of health work processes, care practices that are embodied in the processes of disease treatment and health protection. The

present paper chose to analyze the positions held by the Federal Board of Medicine, since it is a self-managed federal entity that regulates professional practice and with which all practicing physicians must be registered.

In its March, April, June-August, November, and December 2013 editions; January, March-June 2014 editions; and February, April, May, August, and November 2015 editions, the recurrent themes presented by the board were government incompetence, the healthcare crisis, expressed by the chaos of public hospitals, neglected infrastructure, closed hospital beds, and insufficient resources. This represents the monothematic discourse that mythologizes the social process of SUS construction and naturalizes its real conditions in terms of the myth of chaos, crisis, incompetency, insufficient funding, and lack of resources and infrastructure for proper medical work. This myth is constructed through affirmations such as:

> […] There are still insufficient hospital beds, equipment and medications, to the point that most Brazilian physicians hired by the program gave up right on the first day of work [...]. Usually, the only devices available to save lives were stethoscopes and pens[17].

Furthermore, they also accused the government of being inoperative and iniquitous, treating physicians unfairly, and claimed that after ten years in power (this was written in 2013):

> […] over 40,000 hospital beds, 280 hospitals, and 47,000 vacancies in primary care units have been closed, making Brazilian public health an example of negligence and poor management."[Were this not enough] […] it now points its accusing finger at physicians and the institutions that represent them, saying that they are against the health of the population […] at a time when the entire country cries for decent public services, for taxes that are not extortionate, and the end of impunity for the corrupt[17].

The theme reemerged in the edition published when a Provisional Measure (PM)

was issued, creating more vacancies for physicians. Resorting to a scientific basis to counter the government's position, the newsletter cited a study, "Medical demography in Brazil 2: distribution scenario and indicators"[18], that identified the same regional disparities as those indicated by the government, but packaged the information according to underlying interests. The title of the article leaves no room for doubt: "Unequal distribution reaches SUS and regions with the poorest indicators"[18]. The discourse employed was generalized and opaque, mixing sectorial issues with macroeconomic and fiscal elements without providing a direct response to the government's diagnosis and justifications.

Faced with the government's insistence on importing physicians, the newsletter pointed to what it called "short-sighted" interests of SUS[19]. Even though it claimed that it was not against importing physicians, it expressed reservations regarding diploma revalidation, questioning whether physicians from other realities would have the knowledge and technical skills required to work in precarious locations, with no infrastructure regarding medical supplies and adequate equipment. The newsletter also asked how these physicians would ensure their patients access to necessary tests and care actions, in remote places away from other physicians in large cities. This shines a spotlight on the myth of the qualification and material precariousness of SUS, ideologically placing it in the distant corners of precariousness, lack, and insufficiency. The paper adamantly stated that there are enough physicians, and none need be imported, nor any medical schools created. Technical data countered the failures of the government, which had been incapable of implementing medium- to long-term measures to prevent internal migration and the tropism of physicians who preferred to settle in the country's most central and wealthier regions.

The paper went on, stating that far from lack of physicians, there were too many. The authors said that instead, there should be concern over lacks in the criteria applied to the entry of foreign physicians, always alleging that the first victim would be SUS itself. Furthermore, they pointed out contradictions in government actions, which authorized the creation of new vacancies in medical programs in regions based on arbitrary criteria, or admittedly with no pressing need. The government's plans were

refuted with the myth of arbitrary criteria[19].

The following edition[20] echoed the category's mobilization to defend SUS, broadly fed by slogans stating that the country did not need more physicians and that there were too many medical schools – Brazil was short on quality. Once again, the appeal was direct: Physicians could not be held accountable for the country's healthcare problems, which were due to lack of sector funding and absence of government healthcare policies capable of distributing and giving due value to professionals in the area. Once again, mismanagement and insufficient funding were mythified. Neither the distribution of professionals nor their regional allocation were included as part of the equation for the system's problems. The newsletter also observed that the goal of the board's mobilization was to discuss criteria for the entry of foreign physicians to work in Brazil and sensitize members of Congress to the creation of a state medical career, a leitmotif that led about 500 physicians and scholars to go to Brasilia, or more accurately, to the halls and auditoriums of its legislative bodies.

One change in the medical entity's approach to the MDBP was to present an alternative proposal, which it called the inland expansion program. Adding interesting reservations to the allocation process, again without recognizing its exceptional nature, the publication attacked essential points of what would be a Houndinian government action: the combination of low levels of SUS funding, precarious infrastructure of public services, and the nonexistence of prior validation of the diplomas of "imported" physicians[21].

Although it presented issues that require more in-depth discussion, the entity's positioning and political narrative only achieved the simplistic result of clamoring for more funding for health, criticizing the precariousness of existing infrastructure in the most remote corners of the country, and, above all, opposing the entry of foreign physicians without the revalidation of their diplomas. And thus, another important myth is presented: We have nothing against the arrival of physicians, we are against how it is being conducted by the government[22]. Medical entities are not in the least corporativist or xenophobic, oh no! All foreign and Brazilian physicians trained in other

countries are welcome, given that they prove that they can get the job done by passing exams at the level of the current Revalida (a program created by the government in 2010).

The reasons for defending the exam are mythologically illustrative. In Brazil, there is no such thing as "half a physician." All those who study medicine must solve challenges at all levels of complexity, from diarrhea to emergency procedures. But what happens when most prefer to treat emergencies in Intensive Therapy Unities instead of diarrhea in remote areas? Bringing doctors in merely to provide consultations in health centers is, at the very least, a palliative measure.

> And what happens if in one of these remote areas Mr. John has acute appendicitis? Won't the mayor and the health center physician send him in an ambulance to the next municipality? Such fraud has a name: pseudo-care. And those who agree to be part of this hoax are pseudo-physicians.[22].

The next government action was to edit a PM that created a special registration and authorization regime for medical practice for the Ministry of Health, restricted to the scope of the care practices encompassed by the program. The CFM responded promptly and took to the streets in the form of protests, acts and demonstrations. The reasons for the protest were dramatic: The entity would not accept the government's decision and was against this special regime. The appeals were evident: protests throughout the country left no doubt. In the first week of July, the country wore white: thousands of physicians, teachers, residents, and medical students took to the streets to protest the federal government's decision to promote the importation of physicians trained in other countries without due revalidation[23].

A country dressed in white took to the streets to tell the government that it was not listening to the cries of its people. A more perfect mythical image is yet to be found, with the added institutional and symbolic support of lawyers and dentists. It was this group that, after 11 long years of making its way through Congress, watched approval of the law that instituted the Medical Act, a corporative measure to corner its market[24]. The measure still needed to be signed by the president, the same president

who was now being accused by physicians of not respecting them and slaughtering them before the Brazilian population.

This tension was expressed in an editorial signed jointly by several entities representing physicians who were affected by the proposal of opening new vacancies in undergraduate medical programs and changing the supply and distribution of medical residency vacancies throughout the country. For this reason, a National Committee for Mobilization of Medical Entities was established that gathered the CFM, the Brazilian Medical Association (AMB), the National Association of Resident Physicians (ANMR), the National Federation of Physicians (FENAM) composed of physician labor unions, and the Brazilian Federation of Medical Academies (FBAM), representing state medical academies. Throughout the paper, the same positions were echoed: We must face up to and resist the government and its discriminatory measures[25].

This time, the physicians were mythified as victims, and they were invited to commiserate with such obvious ideologization: The government is marginalizing us because:

> […] In the political world, the marginalization of physicians, service providers and patients has become common practice". [In this context, the proposal represents] a brick removed from the foundation of democracy and the universalization of health care, a frontal attack on the constitution, and is part of the strategy of creating two types of medicine in the country.

According to this new myth, higher-income classes would continue to receive care from a network of excellence, with well-trained physicians, state-of-the-art equipment, and first-world infrastructure. Lower-income populations, or the most vulnerable, would be condemned to improvised care provided by professionals trained in foreign countries with no proof of their capacity, or by residents with no proper preceptorship, in places lacking care structure. The symbology of this discourse still lay in the threatening image of a country divided into two types of medicine. The first would be urban and metropolitan, with capable and well-trained physicians. The second would be practiced in forgotten corners of Brazil with vulnerable, worn-out

people who would receive precarious, improvised health care, lacking quality, technology, and infrastructure, from physicians with little or no qualification.

The editorial then addressed the effects of PM 621 with diagnoses of what it considered to be government disregard for health, while warning the population about the risks of unqualified physicians providing care in places without minimum work and care conditions. With the simple editorial title of "only the truth," the article positioned itself against government measures, while emphasizing that no medical entity was against measures involving qualification of and investments in health care, except those proposed by the government to implement the items listed in and authorized by the provisional measure. Instead, medical entities defended the provision of dignified work and employment conditions that benefit patients, professionals, and managers. After all, the MDBP fails because it provides a superficial solution, with dubious results, and that is against the law: weaknesses that must be corrected to place medicine back on track for common sense and legality[26].

In September, the newsletter published news about the developments and negotiated "agreements" with members of Congress to reduce damage to the medical field. It emphasized that negotiations did not equal support, and defended the recovery of the humanist tradition that had always guided the profession. It wove a compelling finale about the political nature of the entity and its limitations, explaining the organization's institutional mission, created through Law 3.268/57 to defend good ethical practice in the profession and firmly act in defense of quality care for society:

> […] These missions constitute the core of the board's actions, which have been carried out through issued resolutions, surveillance actions, judicial proceedings, and political debate. [After all,] […] boards do indeed practice politics, but only in its noblest sense: defining strategies, participating in debates, and making decisions in search of effective gains for the collective.[27].

Feeling threatened by the MDBP, the board piled more myths onto its reservations: At the board's soul lies elevated public spirit and defense of the collective

interest. “What collective?”, one might ask. The text contained no explanation in this regard, merely emphasizing that it was not a matter of “defending the corporation, union, or associations or any interests specific to the category, except when the issues in question resulted in undeniable consequences to professional practice and healthcare conditions as a whole”[27].

Since they must navigate in search of dialogue and harmony with different social interests in favor of health and medicine, they reiterated that “medical entities are self-administered federal entities i.e., arms of the government in the field of professional practice, but not government”[27]. After explaining the reasons why they decided to negotiate with the government, they finally indicated the benefits of such negotiation between different arms of government: opening spaces for listening and intervening in laws being discussed in Congress[27].

Thus, a truce was established through dialogue with the “left” arm of the state, and constructive criticism soon emerged, exposing the underfunding of SUS, which over the previous ten years had lost the significant amount of BRL 94 billion in funding. Again, blaming the administrations responsible for the MDBP, the newsletter linked health expenditures with the quality of medical care in the country, and in this respect the text unequivocally exposes the entity’s position:

> Lack of funding in health has compromised the full practice of medicine and, consequently, the provision of effective patient care. For this reason, the boards of medicine must take care of and fight for this flaw to be corrected, monitoring the health budget, and measuring the impact of this neglect on the quality of care. […] Without investment, the National Health System (SUS) lacks the essential infrastructure for its physicians to help the population. [...] This situation denies patients access to necessary services for disease prevention, diagnostics, and treatment, in addition to hospital beds, tests and consultations[28].

In November, the entities found themselves in the chambers of Supreme Court judges to expose the “illegalities” of PM 621. They contended that as special self-

administered federal entities, boards of medicine must act to defend good professional practice, ensuring conditions for medical practice and providing quality care to the population. For this reason, and based on Article 2º of Law 3.268/57 regarding the Board's mission, "We present readers with coverage of the public hearing held by the Federal Supreme Court (STF), which analyzed different aspects related to the PMMB"[29]. In that hearing, they accused the government of irresponsibility. In addition to this technical critique, the coverage emphasized the legal reading conducted by the representative of the Public Ministry of Labor, which confirmed that the action was laden with illegality[29].

However, this "illegality" was passed by Congress and became a law. Before this occurred, the CFM took on another battle front: labor-related issues, accusing the government of breaking the law and defying labor protection legislation. The entity also accused the government of sanctifying the program's physicians, while demonizing Brazilian professionals. Furthermore, imported physicians (mostly from Cuba) would be no better than slaves, or near-slaves, submitted to work regimes that would chain them to exploitation and precarious employment relationships. They would be innocent beings in the service of the transfer of billions of Brazilian reais for government marketing and propaganda, agents of the most inept populism, delaying the adoption of more effective solutions, such as creating government careers, professionalizing health management, and, of course, obtaining more financial resources. Replete with both depoliticizing and ideological functions, the myth was completed with the images that appeared around the country of Cuban physicians being booed, insulted, and verbally abused by Brazilian physicians during their arrival over the following weeks.

At the same time, the newsletter emphasized that the true victims of injustice were Brazilian physicians, who were suffering gratuitous aggression. They were the group co-responsible for the advances reached in the country in the field of public health, through the SUS: the taxation model represented the dedication of thousands of colleagues who practiced medicine in places where there was nothing. In conclusion: by adopting this injustice, the government is employing marketing, taking advantage

of the population's fragility. Neglecting real solutions, it creates a "make- believe" program, shifting the responsibility for its own failures onto physicians, in order to solve issues that could be resolved with other measures, such as more resources, professionalizing health management, and creating a government career for SUS physicians and professionals.

> [...] Much has been said and little has been done, and the abuse continues: Available money is returned to the government treasury because it is not spent, and instead of modernizing system management, they place their bets on measures aimed at the media, such as the More Doctors Program.[28].

The newsletter vowed to wage a never-ending fight ("We understand that the battle involving this program is far from over"[28]). However, with the gradual allocation of physicians in priority areas and the legal and political solutions given to the main pending issues or controversies, and given that society showed indifference to these effects ("Society will show that, contrary to what biased surveys reveal, marketing has no power to influence decisions made on ballots."[28]), the theme began to be displaced and to no longer be featured monthly or appear in the sections analyzed in this study. It appeared once again in the March, June, August and November 2014 editions, and some months in 2015, containing the same mythology, which associated the MDBP with the images presented above, but without the same emphasis.

The project was widely accepted by the population, and the entity underwent national elections and a new presiding body was constituted for the period 2015-2019. The theme came to light only at special times, accompanying one-off reports on this or that feature of the program. The informative agenda of the entity remained focused on other mythical objects that support it, such as the threat of health insurance plans to medical practice, increasing market demands, and initiatives of specialties in their daily political practice.

Final Considerations

After three years of the MDBP, political effervescence has given way to noticeable normality, with the disappearance of the agenda in mainstream media as well as in the analyzed CFM newsletter. This was a result of circumstances, the historical moment, and the processes that the MDBP mobilized. Above all, this was the result of the mythological production it unleashed. The merit of the government action lay in its reformative nature. For the first time in many years, the government stood up to the status quo, under which the government could touch on issues such as health promotion and disease prevention, but should not be allowed to interfere with the supply and provision of physicians if it ran contrary to their interests. By facing this dimension of the mythical-political struggle, the government showed that it can do much more regarding the organization/disorganization of the "system" than all the markets put together. This action unveiled the issue of physician corporative representation and its political agenda regarding society, or at least the portion of society to which it gives priority.

The MDBP mobilized issues such as knowing whether solutions for the SUS include the adoption of government careers; whether the consolidation of primary care as a vector of change in the health model is about to see the emergence of effective potential for action; whether investing in the centrality of interventions by supplying and retaining physicians is not a conceptual mistake, but rather an action that reinforces medical centrality as an instrument of change in health practices; and how to practically ensure that other professional categories are not excluded or "forgotten" that are important and essential to the execution of another mythical object: comprehensive care[29]. There are still issues that need to be resolved!

Regarding the Medicina newsletter published by the CFM, the MDBP stopped being spotlighted and covered, giving way to editorial "silence." The present analysis does not allow for the identification of explanatory factors or hypotheses, except that the loss of editorial and coverage centrality occurred in direct proportion to the project's consolidation and its wide political and social acceptance. The change in leadership at the end of 2014 is also worth mentioning, since it may have led the entity to adopt a different political agenda and communication strategy.

The reformative action of the MDBP seems irresistible and has forced the emergence of new semiology and praxis, by both the successive administration and institutions and organizations directly affected by the government action, including but not limited to those representing Brazilian physicians. Voices must be given to those who have not yet been given the opportunity to speak: other health professionals, municipal managers and, above all, the users who are directly or indirectly benefitted by the access promoted by the project.

There are still many myths that will emerge, be revealed, and be disputed!

References

1. Garcia ACP. Gestão do trabalho e da educação na saúde: uma reconstrução histórica e política. [dissertação] [Internet]. Rio de Janeiro: Universidade do Estado do Rio de Janeiro; 2010 [citado 8 Ago 2013]. Disponível em: http://www.obsnetims.org.br/uploaded/2_5_2013__0_Gestao_trabalho.pdf

2. Roas AC. Experimentos de escolha discreta sobre provimento e fixação de recursos humanos em saúde. [Internet]. In: Anais da 6ª Jornada Nacional de Economia da Saúde; 2012; Brasília. Brasília: Associação Brasileira de Economia da Saúde; 2012 [citado 8 Ago 2013]. Disponível em: http://abresbrasil.org.br/sites/default/files/poster_21_0.pdf

3. Viana ALD, Dal Poz M. A reforma do sistema de saúde no Brasil e o Programa de Saúde da Família. Physis. 1998; 8(2):11-48.

4. Ministério da Saúde (BR). Secretaria de Gestão do Trabalho e da Educação na Saúde. Seminário nacional sobre escassez, provimento e fixação de profissionais de aaúde em áreas remotas de maior vulnerabilidade. Brasília: SGETS/MS; 2012.

5. Dal Poz M. Entre o prescrito e o realizado: estudo sobre a implantação do SUS no Estado do Rio de Janeiro e sua repercussão na política de recursos humanos em nível municipal. [tese] Rio de Janeiro: UERJ; 1996.

6. Pierantoni CR, França T, Garcia AC, Santos MR, Varella TC, Matsumoto KS. Gestão do trabalho e da educação em saúde. Rio de Janeiro: CEPESC, IMS/UERJ, ObervaRH; 2012.

7. Abreu WLJ, Assis M. Acesso aos serviços de saúde: abordagens, conceitos, políticas e modelo de análise. Ciênc Saude Colet. 2012; 17(11):2865-75.

8. Organização Pan-Americana de Saúde. A atenção à saúde coordenada pela APS: construindo as redes de atenção no SUS: contribuições para o debate. Brasília: OPAS; 2011.

9. Ministério da Saúde (BR). Secretaria-Executiva. Subsecretaria de Planejamento e Orçamento. Plano Nacional de Saúde – PNS: 2012-2015. Brasília: MS; 2011.

10. Cruz MM, Santos EM. Políticas de saúde. In: Matta GC, Pontes ALM, organizadores. Organização e operacionalização do sistema único de saúde. Rio de Janeiro: EPSJV/ Fiocruz; 2007.

11. Conselho Nacional de Secretários de Saúde (BR). Atenção primária e promoção da saúde. Brasília: CONASS; 2007.

12. Giovanella L, Mendonça MHM. Atenção primária à saúde. In: Giovanella L, Escorel S, Lobato LVC, Noronha JC, Carvalho AI, organizadores. Políticas e sistema de saúde no Brasil. Rio de Janeiro: Fiocruz; 2012.

13. Pierantoni CR. Reformas da saúde e recursos humanos: novos desafios x velhos problemas [tese] [Internet]. Rio de Janeiro: Universidade do Estado do Rio de Janeiro; 2000. [citado 8 Ago 2013]. Disponível em: http://www.obsnetims.org.br/uploaded/3_6_2013__0_Reformas_da_saude.pdf

14. Barthes R. Mitologias. Tradução de Rita Buongermino. 4a ed. Rio de Janeiro: Difel; 2009.

15. Ministério da Saúde (BR). Ministério da Educação. Ministério do Planejamento. Exposição de motivo 00024/2013 sobre a Medida Provisória 621 [Internet]. Brasília; 2014 [citado 8 Ago 2014]. Disponível em: http://www.planalto.gov.br/ccivil_03/_Ato2011- 2014/2013/Mpv/mpv621.htm

16. Ministério da Educação (BR). Propostas de expansão de vagas do ensino médico nas Instituições Federais do Ensino Superior elaboradas pelo Grupo de Trabalho instituído pela Portaria n. 86, de 22 de março de 2012. Diário Oficial de União. 27 Mar 2012.

17. Jornal Medicina. Brasília: Conselho Federal de Medicina; 2013. n. 216. Jan 2013. [internet] Acesso em mar 2015. Disponível em: http://www.flip3d.com.br/web/temp_ site/edicao-3d779cae2d46cf6a8a99a35ba4167977.pdf

18. Jornal Medicina. Brasília: Conselho Federal de Medicina; 2013. n. 217. Fev 2013. Acesso em mar 2015. Disponível em http://www.flip3d.com.br/web/pub/cfm/?numero=217&edicao=1335.

19. Jornal Medicina. Brasília: Conselho Federal de Medicina; 2013. n. 219. Abr 2013. [internet] Acesso em mar 2015. Disponível em http://www.flip3d.com.br/web/temp_ site/edicao-11c484ea9305ea4c7bb6b2e6d570d466.pdf

20. Jornal Medicina. Brasília: Conselho Federal de Medicina; 2013. n. 220. Mai 2013. [internet] Acesso em mar 2015. Disponível em: http://www.flip3d.com.br/web/temp_ site/edicao-231141b34c82aa95e48810a9d1b33a79.pdf

21. Jornal Medicina. Brasília: Conselho Federal de Medicina; 2013. n. 222. Jul 2013. [internet] Acesso em mar 2015. Disponível em http://www.flip3d.com.br/web/temp_site/ edicao-b60c5ab647a27045b462934977ccad9a.pdf

22. Jornal Medicina. Brasília: Conselho Federal de Medicina; 2013. n. 223. Ago 2013. [internet] Acesso em mar 2015. Disponível em http://www.flip3d.com.br/web/temp_site/ edicao-d8d31bd778da8bdd536187c36e48892b.pdf

23. Jornal Medicina. Brasília: Conselho Federal de Medicina; 2013. n. 224. Set 2013. [internet] Acesso em mar 2015. Disponível em: http://www.flip3d.com.br/web/temp_ site/edicao-ecd62de20ea67e1c2d933d311b08178a.pdf

24. Aciole GG. A Lei do Ato Médico: notas sobre suas influências para a educação médica. Rev Bras Educ Med. 2006; 30(1):47-54. http://dx.doi.org/10.1590/S0100- 55022006000100008

25. Jornal Medicina. Brasília: Conselho Federal de Medicina; 2013. n. 225. Out 2013. [internet] Acesso em mar 2015. Disponível em: http://www.flip3d.com.br/web/temp_ site/edicao-f542eae1949358e25d8bfeefe5b199f1.pdf.

26. Jornal Medicina. Brasília: Conselho Federal de Medicina; 2013. n. 226. Nov 2013. [internet] Aceso em mar 2015. Disponível em http://www.flip3d.com.br/web/temp_site/ edicao-49ad23d1ec9fa4bd8d77d02681df5cfa.pdf.

27. Jornal Medicina. Brasília: Conselho Federal de Medicina; 2013. n. 229. Fev 2014. [internet] Acesso em mar 2015. Disponível em http://www.flip3d.com.br/web/temp_site/ edicao-4d8556695c262ab91ff51a943fdd6058.pdf.

28. Jornal Medicina. Brasília: Conselho Federal de Medicina; 2013. n. 234. Jul 2014. [internet] Acesso em mar 2015. Disponível em http://www.flip3d.com.br/web/temp_site/ edicao-a554f89dd61cabd2ff833d3468e2008a.pdf .

29. Aciole GG. Depois da reforma: contribuição à crítica da Saúde coletiva. São Paulo: Hucitec; 2013.

Translated by Maya Bellomo Johnson