

Integral Care and Attention to Emergency: the mobile emergency care service in the State of Rio de Janeiro

Cuidado Integral e Atenção às Urgências: o serviço de atendimento móvel de urgência do Estado do Rio de Janeiro

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Resumo

O inadequado atendimento às urgências é motivo de insatisfação da população e de aumento de morbidade e mortalidade. Para responder ao problema, o Estado implantou o Serviço de Atendimento Móvel de Urgência (SAMU), o primeiro componente da Política Nacional de Urgências que propõe o atendimento integral às urgências. Com o objetivo de analisar a prática de integralidade no SAMU, analisamos a regulação nos SAMU do Estado do Rio de Janeiro. A metodologia baseou-se na análise da conduta estratégica (Giddens, 1984) relacionando as estratégias de ação dos agentes com as dimensões estruturais. A categorização da análise do resultado destacou: *o SAMU bem sucedido*, com práticas de integralidade no seu componente individual e de acesso aos serviços; *sua função de observatório de rede*, que indicou restrição no acesso à atenção básica e ao hospital; *a insuficiência de recursos* e o uso inadequado de ambulâncias; e *demandas não reconhecidas*, em que casos foram recusados. O campo confirmou a potência do SAMU como observatório de saúde. Entretanto, a mobilização de recursos autoritativos e alocativos mostrou-se insuficiente para um sistema integrado de atenção às urgências.

Palavras-chave: Emergência; Atenção pré-hospitalar; Políticas públicas.

Abstract

Urgency inadequate care is a matter of dissatisfaction for the population and increases morbidity and mortality. The SAMU (Mobile Urgency Care Service) was the first component of the National Urgency Policy to be deployed, a public policy that proposes integral care of urgencies. In order to examine the practices of integral care at SAMU we analyzed its regulation in the state of Rio de Janeiro. The methodology was based on strategic conduct analysis (Giddens, 1984), relating agents and their strategies with the structural dimensions. The categorization of the analysis highlighted: the *successful* SAMU, with integral care practices in their individual component and access to services; its *function as network of health services' observatory*, indicating restriction on access to the Family Health Program and hospital services; *shortage of resources* and inappropriate use of ambulances; and unrecognized *demands*, in which cases were refused. The field work confirmed the power of SAMU as a health care network observer. However, the authoritative resource mobilization and allocation were insufficient for an integrated system of urgencies care.

Keywords: Urgencies; Pre-Hospital Care; Public Policy.

Introduction

Brazilian National Policy for Urgency Care (Brasil, 2003a), a priority in the decade of 2000, was elaborated in order to answer to a major dissatisfaction of society with the quality of care given by public services to hospital emergencies (O'Dwyer, 2010). It proposes integral care to urgencies through the integration of services and the adoption of a widened concept of urgency, in which are considered both the technical concept of professionals and also the user's expectations.

Mobile Urgency Care Service - SAMU (Brasil, 2003b) - was the first structure of this Public Policy to be deployed. It is a service of pre-hospital rescue: through free dial calls (192) the users can ask for urgency care. It is structured in a regulatory component (Regulations Central) and an operational component (ambulance service).

Medical regulation of pre-hospital care represents a communication channel open to the public, through which calls for relief are received, assessed and classified according to severity. Under this perspective, Brazilian National Health Service - SUS - gets a permanent health observatory (Santos et al., 2003).

In the regulation there is power for offering integral care in its different meanings: a first one lies in the encounter between health professional and patient; another one is related to the structure of health services and practices; the third deals with governmental answers to certain health problems (Mattos, 2001).

From 2004 onwards, there was a major expansion of SAMU services. In 2010, according to the site of Health Ministry. In May, 2010, there were 151 SAMUs in 1.286 municipalities, covering 55% of Brazilian population (Paim, 2011).

In the state of Rio de Janeiro, SAMUs had an early start in comparison with the national network: it was set between 2004 and 2005, exclusively in metropolitan areas. Deployment throughout the state was regionalized, whereas in the rest of Brazil it happened in a rather municipal form (Machado et al., 2011). Rio de Janeiro stands out also in other aspects of pre-hospital care: for having the first regional SAMU in Brazil; for having set two of the

three biggest SAMU services; for being a pioneer state in pre-hospital care in the country, through Fire Brigade Corporation; for having a state coordination for urgencies, and finally for having the largest network of UPA in Brazil.

This study had the objective of analyzing the practice of integrality in the service of mobile treatment to urgencies in the state of Rio de Janeiro. Since this policy is recent, there are few published studies on the theme of pre-hospital treatment in Brazil. Regional studies are necessary as the regional standards of treatment vary according to local influences (Minayo e Deslandes, 2008).

There are other specificities at Rio de Janeiro that justify this study: the complex public hospital network has its management divided between municipal, state and federal spheres, and also charities and universities, which creates difficulties for the integration of services among them and with SAMU; there is a low level of resolvability in the urgency care due to a disproportion of hospitals in comparison to primary care network. A scenario of primary care low coverage (25%) has been modified and increased since 2009, with crescent deployment of Family Health Strategy.

The biggest expectation for the fulfillment of integrality (in one of its most traditional meanings) by SAMU is related to the integration between different services. A more systemic meaning, of governmental answer to a public need, was accomplished after the deployment of the pre-hospital care component. The powerful meaning of integrality - the well succeeded encounter between patient and health professional, was suggested by the guiding documents that proposed the adoption of widened concepts of urgency and of user-centered care.

In order to analyze the integrality of urgencies care, we studied the work of the medical regulator of SAMUs Regulations Central, since it is this regulatory space that takes the calls are taken and allocates resources for assistance.

The chosen methodology was the Structuration Theory (Giddens, 1984). For this author, social practices are actions executed adequately by social agents using rules and resources that are part of the structure. Resources are facilitating and coercive characteristics of the action contexts which are

accessible to the agent, and which he/she manipulates in order to influence the interaction with the other. These resources may be authoritative or allocative. Therefore, the "circumstances of action" are analyzed through the observation in act of the action influenced by material and social phenomena (Giddens, 1984). The work in act of the actors in this new space of urgency care was observed for 36 hours.

Regarding the structural resources defined by legal acts, when this research was made Rio de Janeiro's SAMU had a sufficient number of ambulances, but two of them did not fulfill the minimal number of regulators according to the population criterion (Brazil, 2003a).

In spite of having been conceived to attend to more severe urgencies, studies have shown that the majority of calls was clinical and home-based (Tannebaum e Arnaold, 2001; Chomatas, 2005; Almeida, 2007; Meira, 2007). For this study, indicators to which we had access indicated a percentage of 59% to 73% of clinic and home-based care. Dyspnoea was the most frequent complaint in this period. There were no such data available for other SAMU services managed by states or union.

The different contexts observed at SAMU produced the following categories: the first one, **apparently successful SAMU**, regroups cases where SAMU's action corresponded to what is determined in the policy, including the fulfillment of the caller's expectations and, therefore, the principle of integrality; another category - **SAMU and its function of health network observer** - established a diagnosis of the insufficiencies of the system. A third category, **SAMU and the lack of resources**, highlighted the practice of regulation in scenarios of shortage of Advanced Care Unit ambulances and, ultimately, of medical doctors; next category, **Unrecognized and/or missed demands**, exposes conflicts in the meaning attributed to urgency and in the dispatch of Basic Care Unit (which carry no doctor) instead of Advanced Care Unit ambulances (which carry doctors).

The questions apprehended in these contexts came out particularly of the registries in screen or of comments made by the regulator. The attribution of categories being qualitative, it was always a sign of observed attendances, not characteristic of a single SAMU or even of a single work shift.

This research was submitted to IMS/UERJ Ethics in Research Committee and approved under the number CAAE 0006.0.259.000-08.

Results' Analysis

Apparently successful SAMU

A distinction is made within this category through the inclusion of the word “apparently” - this expresses the fact that the evaluation was made only through the regulations component, and not by its care end.

The most legitimate situation for the SAMU service is the dispatch of Advanced Care Units for severe cases. Observations showed typical demands for Advanced Care Units that, in spite of varied results, were successful in the sense that they answered rapidly with adequate resources. Another foreseen demand, observed as successful, was the dispatch of Basic Care Units to less severe patients, or to those who needed removal to another hospital. This type of care is frequent in the regulations practice. Last, there are attendances that do generate instructions and orientations to the patients, that have to be

well understood: if their call for an ambulance is frustrated,....

This category of analysis allowed identifying integrality when regulators used available resources as facilitators in the interaction with the other (Giddens, 1984).

Due to the low coverage of primary care in the state of Rio de Janeiro, SAMU ended by assuming demands which are typical of out-patients care. Besides the short range of Family Health Strategy, it was possible to identify situations in which there was a disruption in the continuity of care in this sphere: that's why the SAMU was set as an intermediate between the caller and primary care services. The lack of opportunities for communication between the patient and his/her doctor beyond out-patient care setting became evident; in these cases, the intervention of SAMU provided a compensatory answer, fulfilling integrality.

Care regulation is powerful to qualify services offered, and is being discussed regarding care fragmentation and difficulties of access. Technical knowledge requires light technologies in the production of care (Baduy, 2011).

Figure 1 - Describes some examples of cases successfully attended to

User's demand	Regulator's answer	Context of action and resources mobilization
81 years old patient with high fever. He is registered at a Family Health Program (PSF). He went there today and was informed that they could not give him an appointment because his doctor was on holidays.	Regulator says that the responsibility for this appointment is of PSF, since SAMU attends to urgencies, and that he will call PSF in order to guarantee that the patient is seen. After he's done that, he calls the patient and instructs him to go back to PSF.	Regulation central contacted PSF and got them to give the patient an appointment, taking responsibility for him and establishing a dialogue with primary care services.
Patient inebriated, vomiting, complaining of headache	Basic Support Unit sent. Technician finds patient dirty and chooses to give her a shower, alleviating her state and headache	This case depicts how a personal professional posture, that mobilizes material and social resources, may result in changes
80 years old patient, presenting bronchitis and acute coronary syndrome, has fallen	Advanced Support Unit sent, nebulization given with improvement	Regulator has put ambulance at disposal with necessary resources and solution was reached in place.
50 year-old man has fallen from a ladder, is bleeding from head and ear. Fracture of basis of skull is suspected.	Fire Brigade was called in. There is an agreement that firemen will attend to trauma in public places.	Emergency care given; agreement with fire brigade offers resources and work process.
46 years old, hypertensive with strong precordial pain	Medical doctor of Advanced Support Unit ministered medicines and asked transference for hospital admission	Urgency care given and hospital bed granted

These first cases presented above were assessed as successful when one looks to the needs in each situation and to the resources employed. Integrality was evident in the relationship between individuals, in the integration between services and in the offer of an adequate answer to health needs.

SAMU and its function as a network observatory

Because the SAMU is an open channel, available 24h/24h, its communication with the population allows a wide perspective of the difficulties faced at the health system. As a network observatory, it may contribute to integrality - expressed as integration of services - when able to generate information that can be used to propose specific actions.

The main finding in this analysis was the difficulty of access to other levels of care. This want was centered in primary care, in reference hospitals and in institutional resources, including transport and mental health.

Lack of Access to primary care was compatible with PSF low coverage in the state of Rio de Janeiro (25%), in spite of differences among regions: SAMU Rio 3%; SAMU Metro I 13%; and SAMU Metro II 40%.

Regulators observe that, in order to bypass these difficulties, population believes that getting to primary care unit brought in by SAMU will help them to be classified as priority for care. In this case, SAMU is not only establishing the difficulty of access, is also being asked to compensate lack of assistance of a needy patient. A form of answering to this situation is to transform this demand for primary care in information to be used in the planning and management of the system. Corrective actions for increasing access would offer the integrality of care sought for in government proposals for the health sector.

Intersectorial articulation was identified as important in large cities' typical situations, such as problems in entering *favelas* or related to social admissions. In order to offer integral care to urgencies, the most serious situation identified was the lack of access to a hospital bed and inadequate compliance to reference terms agreed with hospitals, of which one of the most evident is the lack of specialists in hospitals. When there is no professional in the premises, the hospital refuses to offer care to the patient, and SAMU has to take the person to a less resourceful hospital or one outside the service area.

Another way of using regulator's authority in order to face the lack of resources in the reference hospitals was to confront on duty medical doctor and to impose regulators' decision. In one of the SAMU, relationship with one of the hospitals was so bad that the supervisor recommended that the patient was taken there and, in case of refusal of care, ambulance crew should threaten to call the police.

This frailty of the reference hospitals results in a delay in procedures which compromises the final prognosis of many patients. Lack of resources in hospitals has made the agreements with them difficult and subjected patients to a decrease in the safety level of care given.

Beyond institutional processes and reference agreements, people are the ones responsible for work arrangements; they build affinities, relationships and bonds. Lima and Rivera (2010) suggest that personal relationships are fundamental to networking, which is not in conflict with the legitimacy of established process flows. These authors highlight the importance of agents' actions in order to face lack of resources.

One of the consequences of hospitals not taking in patients brought by SAMU is an increased period of unavailability of transport and professionals. In conflict situations, network managers were asked to intervene, which shows regulators lack of governability. Many times, reference agreements are established by managers that do not include professionals in this decision.

The last cases depict the shortage of medical doctors in hospital emergency services. Reasons for that are complex and have been discussed (Mattos, 2009). Among them, we highlight the precariousness of work management that emergency workers have to face, recently indicated by O'Dwyer (2008, 2009).

This category shows that the regulator can face difficulties arising of different levels of health care with attitudes somewhat more friendly, but always with more risk to the patient. The reach of SAMU becomes fragile if it does not happen in spaces where there is a regionally organized network. Besides the damages to the patient, these deficiencies are a great source of conflict. Another finding is that the management of the network in its different levels can be potentiated by all the information gathered by SAMU services as a network observer.

Figure 2 - Presents case examples of SAMU in its function as network observatory

User's demand	Regulator's answer	Context of action and resources mobilization
Diabetic, insulin-dependent patient, calls referring that SAMU has been to his house and measured blood sugar, but he cannot get care nowhere. Has been to primary care and to hospital and asks for a new visit of SAMU.	Visit has been refused: "This is a social problem. He's been three times to Primary Care Service".	Lack of outpatient care is seen as a social problem. Actually, the patient has a well defined clinical problem, but is not in an urgent situation that can be thus classified by the regulator.
Pregnant woman in 4th month, refer being hypertensive. Is in use of diuretics and captopril and cannot get a schedule for pre-natal care. Went to emergency but couldn't get care.	Regulator suggested other places where to look for care, patient complied. "It's so sad because they try and sometimes cannot get treatment. The ambulance becomes admittance room. There are people doing the whole pre-natal care at SAMU". Basic support ambulance sent.	Regulator gave the correct answer regarding technical definition of urgency, but did not harbor patient's need.
Psychotic 20 years old patient tied in bed.	Basic Support ambulance sent	Basic Support ambulance arrives at favela and is not authorized to go up by drug dealer. The patient's father tries to negotiate, but refusal is sustained. Adequate action was prevented by violence common to large cities. Typical problem of this SAMU.
Precordial pain, history of angina, dyspnoea, pain facies. BP 200 X 90 mmHg	Doctor applies morphine and diuretic. Asks for admission.	Regulator called closest reference emergency, which refused the patient because they only had one doctor in this specialty. Second reference service was full and more distant. Patient sent to a closer emergency service that was not a reference for this type of case.
Medical doctor from surgeonless PAM asks for transfer of patient with diagnosis of hernia.	Regulator calls closest reference hospital and the team chief of staff estates that hernia is for ambulatory care, refusing to receive the patient. Regulator says that this hospital always refuses everything. Second hospital called cannot receive patient, so regulator calls the first one again, which is willing to take the case if it is chirurgical (strangulated or incarcerated hernia). Regulator accepts.	Difficulties are related mainly to shortage of human resources, but lack of cooperation among professionals and of solidarity with the patient can also be found.
Patient presenting precordial pain, is covered by private medical insurance	Doctor from Advanced Support Unit asks for admission. Regulator contacts the insurance company, which does not accept patient coming in an ambulance and does not offer home care. Regulator is oriented to take the patient to an emergency service where insurers will provide transfer, and calls Emergency service. Regulator calls hospital director asking him to intervene with on duty doctor in emergency, in order to release the ambulance doctor.	On duty doctor, on hearing that will receive a patient from private insurance, hangs up on regulator. When the patient arrives at the hospital, on duty doctor prevents ambulance and medical doctor from leaving until arrival of transfer from private service. Ambulance doctor complains about the time spent in emergency waiting, and from the treatment received from on duty doctor.

SAMU and the lack of resources

This category translates the shortage of resources in the regulation, in the work in act when it is defined as acting from given material circumstances.

In the case of the Advanced Support Units, which answer to situations in which time is determinant of prognosis, the lack of resources is worse - it is a shortage that interferes with SAMU's very ability to act (Machado et al., 2011).

During field observations, many times it was possible to register route modification instructions for ambulance crew as a strategy for privileging more severe cases. Besides, shortage of resources observed have contributed to make professionals adopt attitudes that strain the relationship with the population that demands SAMU services. There are evidences that social criteria influence decision making in limited resources situations (Fortes et al., 2001).

When care is prevented by lack of ambulances, the solicitants may think that refusal was motivated by lack of consideration for their needs; in an extreme situation, they can learn that it is not worth it to ask for ambulance service. When SAMU professionals share the information that there are no ambulances available, they do so expecting families to be cooperative in name of their relative's best

interest. Theoretically, this information shouldn't be shared, but it is a negotiation that happens, particularly when shortage is chronic. Delays of up to 7 hours have been observed due to unavailability of ambulances.

Besides the difficulties in sending units to answer the demand, another type of problem was related to losing calls due to insufficient telephonic and information systems for the volume of calls that reach the regulations central.

Of the three SAMU services observed, only one had managed to expand its premises and structural resources. Frustration of the population who demanded SAMU services was evident, due to delays and unavailability. There is no way of establishing the clinical cost of these problems.

SAMU is a service where urgent demands compete with not so urgent ones, in a scenario of shortage of resources. Because of that, the high demand of psychic work results in identifications, fantasies and defense strategies against suffering that may be levered by unfavorable working conditions and interfere with the quality of work (Sá et al., 2008). Therefore, in the situations described in this category, structure was coercive to the regulator's actions contexts.

Figure 3 - Shows examples of cases where shortage of resources compromised SAMU's action

User's demand	Regulator's answer	Context of action and resources mobilization
Call indicates need of Advanced Support Unit to a city which doesn't have one.	Advanced Support Unit of closest city is not equipped with a respirator. They go to a third town nearby to fetch a respirator from an ambulance. When they manage to get one, a call brings the news of patient's death.	There was a huge attempt to mobilize resources, which did not manage to answer to the demand.
36 years old patient has ingested rat poison, is unconscious and dribbling.	Regulator explains to the caller that an Advanced Support Unit should be sent, but there is none available at the time. He advises the caller to provide a car for transfer, saying "you try and help from there and I try and help from here". Caller gets irritated, and regulator says: "My theory is that if the case is really serious patient is taken to hospital by his/her own means".	Devaluating SAMU's most essential function – granting transfers for very sick patients (as is the case here) in the shortest time possible indicates a professional posture that potentiates the bad use of insufficient material resources.
Woman in labour	Medical doctor of the Advanced Support Unit calls to inform that the baby was born in the ambulance and that they are taking mother and child to hospital. "Family was aggressive because it took us a long time to get there".	Delay in making resource available has created embarrassment for the doctor and increased risk for mother and child.
Patient complaining of chest pain, intensive cough, crying, says that waited 24 minutes to get an answer. Call dropped.	This demand was not answered to during the period of observation.	There was an undeniable frustration of caller's expectation. There are no elements to judge the existing risk for health.

Unrecognized and/or missed demands

This category refers particularly to non-answered calls due to their classification by on duty doctors as “non urgent”. Besides the conflict of criteria about the legitimacy of demands that arrive to SAMU, there are also hoax calls, used by the professionals as a justification for answering only according to technical criteria, which means to stiffen the mobilization of resources. Instead of understanding the extension of demands as part of the shortage of care services, this demand is understood as causing a waste of resources.

Demands presented here rise mainly from a conflict of urgency meaning, translated in inadequate use of Basic Support Unit *versus* Advanced Support Unit. In some cases, the reason for not indicating the second one was that the regulator did not believe in the truthfulness of the complaint. One of most discredited complaints was of being “short of breath”, which was answered to by sending a Basic Support Unit - even though this was the most common complaint for clinical care in the preceding months. Recognizing the legitimacy of this complaint is more than to offer access to an ambulance with adequate resources. It means for the patients the reconnaissance of their social value. The right of access to health services inserts the subject in a network of meaning, and represents a possibility of leaving a situation of diffuse social suffering through the recognition of this suffering (Sá et al., 2008).

Another study about the SAMU showed how the demands can be perceived. In it, professionals have made statements like “SAMU is a fantastic system, too sophisticated for a too ignorant and ill-educated population, who misuses the system” (Meira, 2007, p. 128).

This posture of denial of the patient’s suffering and the feeling of “loosing” time with something that is not relevant and necessary gains greater proportions when traumatic events compete, as it is the case in SAMU and hospital emergency services. Suffering imposes itself to professionals, and hosting it should be the basis for any critics of the practices in health professions (Mattos, 2009).

Independently of the conflict between the doctor’s concept of urgency and the population’s, professionals may refuse care or to offer it even when they do not recognize it as pertinent to SAMU services.

When there is a queue of the incoming calls, the system depicts a list with the complaints as taken by the operators. The ones considered “baloney” by the medical doctor can be kept on hold and stay longer in the queue, as it was seen on observations. Some regulators ask the operator for specific calls, selecting the case. We face here a new type of virtual “queue” in which the same reasons for priorities (or prejudice) selection are lived in a new space of urgency care, with its own strategies for refusal.

The cases seen consisted of refusals, postponements and - what may be worse - an asymmetrical shipment of resources - a Basic Support Unit instead of an Advanced Support Unit - in cases where there was a clear indication for the second type of ambulance.

There is a great mistrust about the reliability of complaints based in “experience”. Doctors’ practical experience deserves respect, but they cannot ignore that the patient faces his own, unique “experience”. It is also a fact that the patient’s care as an out-patient hasn’t been satisfactory, and that this makes him/her insecure and increases the demand upon SAMU. An “experience” that generates mistrust should generate a different learning, one that allows to translate the user’s suffering into more complex demands.

We observed that the conflict about level of urgency was expressed mainly regarding clinical complaints. Curioni et al. (2009) highlight the impact of these cases upon indicators of morbidity and mortality, and the importance of a rapid care.

Two emblematic questions of urgency care that involve a lot of prejudice are the patients diagnosed as having a PITI (derived from “*pitiatismo*”, hysterical crisis) or as being drunk.

Mattos (2008) has made reference to the framing not by type of complaint but by moral judgment, as it was seen during observations. Another consequence is that resources are withheld when excessive alcohol consumption is identified (Fortes, 2001).

The difficulty faced by non severe patients was shown by another study about SAMU. Professionals who worked there are reported as stating that there would be no tolerance whatsoever with PITI patients. Regarding their expectations as to which cases they want to care for using SAMU resources, they said: “I

just want to see tragedies, people dying; I only want to see people dying, to care for really sick people” (Meira, 2007, p. 98).

The lack of a space for thinking things over is an important issue regarding the care offered and the frustration feelings of SAMU professionals. It is wise not to consider many of the complaints that reach the service as somatization, devaluating patients suffering and, worse, withholding therapeutic resources in clinical situations in which they are necessary.

Many people made reference to swearing and ill treatment during phone calls. This is a difficult problem to face, but some actions can improve this situation. A very effective action is to decrease waiting times, during the calls and before the ambulance arrives. Another one is to spend more time explaining: it is necessary to understand that the caller is distressed and to discuss coping strategies with the professionals to face these reactions. SAMU presentations in different forums, in awareness campaigns, may be effective.

Some cases made the team ill-at-ease due to the neglect of the caller.

This situation in which the regulator controls an essential resource for care and may decide between using technical criteria or prejudices, taking in or disregarding the caller's suffering, is an example of the complexity related to the relationship between caller and regulator through telemedicine.

Figure 4 shows some examples of cases in which there was lack of reconnaissance of demands at SAMU.

A large part of the calls that are not recognized as legitimate by the regulator and regulation team in general are the complaints that have to be treated in the sphere of primary care. Others come from the mistrust in the informed complaint, mistrust that is reinforced by hoax calls. In order to face the conflict of urgency concepts, regulators tend to spare the most expensive resource of SAMU, the Advanced Support ambulance. There is another resource very expensive, which was not spent in the examples mentioned in this category: the listening skills for the demands, a cognitive resource of the agent. Therefore, for these last cases, practices coherent with integrality principles were not observed.

Conclusion

Of all the meanings attributed to integrality, one was most expected to be fulfilled at the SAMU - integration of services, granting access to all the levels of complexity in health care. Unfortunately, our study indicates that integrality is still frail in its organization component, particularly regarding hospital references. It is worth noting that there is an expansion project for primary care in the town of Rio de Janeiro which has potential to improve this integration.

Well-succeeded cases happened in spite of structural conditions. Those can be classified as “integral” by its care value, and reflect the agent's capacity of influencing the “circumstances of action”, of mobilizing available authoritative and allocative resources (Giddens, 1984).

We have seen in some cases a twofold limitation regarding Advanced Support Units: the existing shortage and a parsimonious use of this resource. The strategy of sending the available resource regardless of the indication determined by the complaint makes regulators to “relativize” and question the need for a more complex resource. Banalization of complaints may have as a consequence the routinization of excluding practices due to its recursive character (Giddens, 1984).

Criteria for accepting phone calls (legitimation of the demands) are defined technically, but negotiation is done in a private sphere and depends of the knowledge come from capacity and of values and attitudes of the regulator and of all the team, besides the caller. It depends, ultimately, of a socially constructed relationship among many actors with different attributions. There will be confidence in the service and the consequent legitimacy of SAMU if professionals use well the technical criteria in order to answer to the demand but do not restrain to these criteria when less typical situations arise. It is primordial to the quality of care to urgencies to be open to suffering, an expression of integrality's first sense.

Another striking issue is the delay in treatment. To the Advanced Support Unit, the criterion of time dependency for adequate care is not fulfilled. To the Basic Support Unit, it induces at least a discredit with the service.

Figura 4 - Casos do SAMU com demandas não reconhecidas. Rio de Janeiro, 2008

User's demand	Regulator's answer	Context of action and resources mobilization
24 years old patient, complaining of back pain	Regulator sees in the screen that ... and says "The call will drop!" before hanging up.	There was a non-declared refusal of care. This type of demand was attended to in other occasions through an attentive listening about symptoms and referral to a different service without sending out an ambulance. In spite of that, at least the patient was heard, which is a type of care.
Weakened patient.	Regulator gives orientation and comments after the call "It is a disregard to call because is feeling weak".	In spite of judging the call inappropriate, regulator listens to and gives orientation to the patient.
61 years old patient with diagnosis of CCI and hypertension, complaining of dyspnoea and cyanosis.	Regulator sends in a Basic Support Unit, commenting "The Basic Support Unit will take the patient to the nearest service if there is dyspnoea and call Advanced Support Unit if it is necessary".	SAMU can work as a gateway system, allowing integral care to the urgencies. It has potential for organizing the network due to the observation that it has of the system.
46 years old diabetic and hypertensive patient, presented a seizure and is not responding.	Basic Support Unit sent.	Mobilized resource is not compatible with indication of urgency demanded.
Drunken patient complaining of back pain.	Regulator denies service commenting that "Patient drank by his own will."	Here a moral judgment was used instead of a conflicting concept of urgency.
26 years old patient, diabetic, complaining of headache and unconscious. Has been to the doctor the week before and was told that she had a clogged vein.	Basic Support Unit sent. Regulator said "Clogged vein is PITI".	Regulator did not believe "unconsciousness" of the diabetic patient, as the diagnosis (very likely, but not mandatory) had been established.
Father asks ambulance for his 5 years old son who burnt his foot in a home bonfire.	Regulator says that a Basic Support Unit will be sent, but asks to the caller if the child is in a lot of pain and if there is someone who can take him to hospital, because ambulance will take a while and he doesn't want the child to suffer more than necessary. Father answers that he's having his beer and prefers to wait for the ambulance. Regulator accepts, hangs up and suspends sending the Basic Support Unit.	Urgent care need was identified by the regulator quickly, but, faced to the irresponsible attitude of the father the regulator took another irresponsible attitude. There was a huge malaise in the team and, some minutes later, the regulator sent the ambulance.

Material and social phenomena have acted as coercive characteristics in the contexts in which these SAMU are in. Their practice is still close to the very criticized palliative and symptomatic care of traditional urgency care units. This is related to a structural conditioning related to the shortage of technical and human resources.

The field has confirmed SAMU's power for implementing integrality in its different meanings, as well as its potential in acting as a health observatory - in

spite of the non-existence of a channel of information for planning.

It can be concluded that integrality is a value to be practiced in every health action. The structural precariousness of the health services network is an urgent question to be addressed, since it reinforces the conflicts of urgency meaning between the population and the regulators. This is being answered to through investments in primary care, and an expansion of SAMU in the state is scheduled from 2010.

The routine of not welcoming patients' suffering has to be fought off at SUS in its pre-hospital and hospital components. To 'blame' the patients of undue use of SAMU system is to ignore that they seek care wherever it is available. Studies have indicated that, in hospital, flows and processes have to be more effective regarding the use of authoritative and material resources (Bittencourt and Hortale, 2009), as well as in care (Carret et al., 2009). This paper has discussed the non-effective use of these resources in mobile pre-hospital care in a State where hospitals are little effective in the use of their beds. Information production anticipated in SAMU documents is still not produced and used for planning. The fact that information is not public is a restriction. New studies are necessary to help tackling insufficient and non-integral care that people receive when they face urgency.

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