Introduction

The 21st World Congress of Family Medicine, Wonca World 2016, took place in Rio de Janeiro, Brazil, from November 1st to November 6th. More than 100 countries were represented, with nearly 5000 enrolments. Family doctors with different clinical practices and from different socio-cultural contexts met each other there allowing an exchange of experiences and, therefore, a great personal and professional enrichment. My participation on this Congress, thanks to a Wonca Europe Bursary grant (Image 1), turned out to be a huge learning and growth opportunity, not only because of the medical knowledge, but also due to the cultural shock and to the social and political context by which the community was affected. Regarding this aspect, besides the congress sessions, I could observe the healthcare provision in two Clinics in Rio de Janeiro (one in a *favela* and the other in an urban area), and had the opportunity to contact with the country's culture through both the observation of the city and the social interaction with the citizens.

Image 1: Bursary Ceremony

Brazil, above all Rio de Janeiro, is going through a very changeable moment. The old leftist Government was replaced by a radical right one in September and, consequently, the SUS (*Sistema Único de Saúde)*, the Brazilian universal healthcare system is threatened, with a visible opposite reaction from the medical community and from general people. There were several demonstrations against this decision, mainly in the Opening Ceremony, when the Health Minister could not give his speech because of the audience protests against the political regime, also during the break times, with a protest against healthcare privatisation, and through the expression of entertainment musical events at the end of the days. Besides health, corruption is heavily present and it concerns the poorest population, with the weakest quality of life conditions.

With a speechless natural beauty, Rio de Janeiro has places that give us energy and peace, such as the *Corcovado* and its *Cristo Redentor (*Image 2), the *Monte da Urca* and its *Pão de Açúcar* (literally Sugar Bread) (Image 3), the *Pedra da Sal* and the origins of samba (Image 4), and the *Arpoador* with its sunset behind the surfers (Image 5). The streets are full of colours, like in *Escadaria de Selarón (Image 6)*, or in the S-curves of *Santa Teresa*, or in the colourful clothes sold in *Ipanema* and *Copacabana*. Nevertheless, this happy environment is hidden when one goes deep in the city and meets its people: that is when the poverty that also lives in Rio is noticed. There are many homeless and you may feel insecure if you walk by yourself or with some material objects that may attract unwanted attention. Although the southern part of the city is safer, poverty determines survival and robberies may occur. The *favelas* are the base of this social context, and, being disadvantaged independent communities

that stay many times near urban areas, they enlighten the socioeconomic contrast in the society.

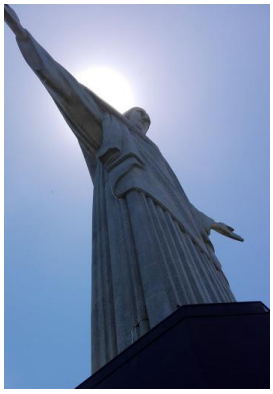

Image 2: *Cristo Redentor*

Image 3: *Pão de Açúcar's* view

Image 4: *Pedra do Sal*

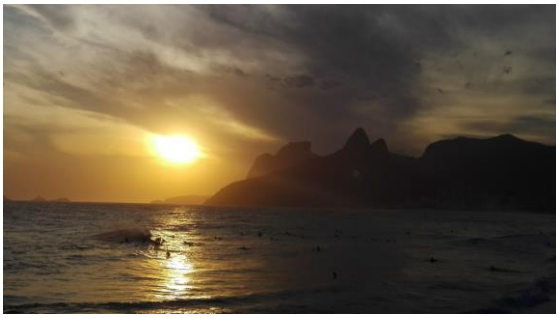

Image 5: Sunset in *Arpoador*

Image 6: *Escadaria de Selarón*

In order to know better the community and the services provided, I visited two healthcare clinics: the *Clínica da Família Maria do Socorro Silva e Souza,* located in *Favela da Rocinha* (SUS teams promoted the visit, in collaboration with Wonca Rio 2016), and the *Clínica da Família José de Souza Herdy* (an urban clinic, visited by my personal initiative).

The Rio de Janeiro Healthcare System

The Brazilian healthcare system was reorganised in 2009 by Dr. Daniel Soranz, a reorganisation that was inspired by the Portuguese national healthcare system. The system is based on teamwork, longitudinal care oriented by health indicators (defined by the prefecture) and variable wages according to the accomplished goals and financial incentives, being completely free for all the people. There are also incentives for people going to remote (oil

card) or more violent places. The system organisation is divided in Primary care (Health municipal centre and family clinic), Secondary care (Policlinics, Psycho-social care centre, fast-attention unit, and rehabilitation centre), and Tertiary care (Motherhood, Hospital and Institute). The provided Primary care services to the people from Rio de Janeiro were written down thanks to the effort of managers from the central level and from the Rio de Janeiro Health Municipal Secretary Coordination Planning Area.

The primary healthcare model chosen for Rio de Janeiro was the *Saúde na Familia* (Health on Family) strategy, in which the attention focuses on the patient and in which all geographical areas must be evaluated by the same family health team. Longitudinal care, accessibility and care coordination must be assured through an Organised Access organisation Plan with an ethical clinical practice.

Multidisciplinary teams are formed by a Family Health Team (one doctor, one nurse, one-to-two nurse assistants, health community agents, a dentist, an oral health assistant and administrative staff) and a Family Health Support Group (several professionals from different specialities chosen according to the different local needs).

Activities

Field activities

The *Favela da Rocinha* is the biggest one in Latin America, with roughly 100.000 inhabitants (Image 7 and 8)). It is one of the most organised and safest *favelas* in Rio de Janeiro, having healthcare clinics and schools that give a good support to the residents. I went to the *Clínica da Família Maria do Socorro Silva e Souza* (Image 9), opened in 2010, to the Psycho-social attention centre and the Fast-attention Unit (UPA), being the three centres near each other and covering the *Dionéia, Cachopinha, Skate, Paz, Cidade Nova, Rua 4, Fundação, Vila União, Gávea, Terreirão de Baixo* and *Anibal* neighbourhoods, in a total of 30.000 inhabitants. The clinic has 11 family health teams, with 25 family doctors (including residents). Each team provides health to 3000 people and is constituted by 1 doctor plus residents, 1 nurse, 1 nurse assistant and 6 community agents. The health community agent is a community inhabitant (Image 10), with a 12th year scholarship, whose role is to be the connection between the patient and the health team. Each agent is responsible for nearly 140-160 families (about 400 to 500 people) working as the family doctor's eyes inside the community.

Image 7: *Favela da Rocinha* from de outside

Image 8: *Favela da Rocinha*

Image 9: *Clínica da Família Maria do Socorro Silva e Souza*

Image 10: Health community agents in the reception

The Family Health Support Group (NASF, in Portuguese) has 1 rehabilitation doctor, 1 psychiatrist, 1 psychologist, 1 paediatrician, 1 pneumologist (because of the great prevalence of lung tuberculosis), 1 nutritionist, 1 pharmacist, 1 pharmacy assistant, 2 social assistants, 4 administrative assistants and 4 dentists. The pharmacy is responsible for providing the prescribed drugs for free (up to 70-80% of them can be received here). Other medication has to be bought in popular Chemists, with protocols that make the prices lower or even free. Dental procedures are also free (mainly tooth decay treatment, tooth filling, extraction and periodontics).

Appointments are 15 to 20 minutes long, and most of them are in-day appointments. A patient who demands care for the first time must be attended within 30 days. There are no appointments for periods longer than one month due to the high absense rate. One patient with a controlled diabetes mellitus is observed twice a year, and with controlled arterial hypertension once a year. The nurse appointment and the medical one are alternated. Work timetable has 40 hours a week including Saturdays until the afternoon, and every doctor has a pool of 3000 patients.

Patient refrence to other specialities and complementary exam requests are defined by the regulation of the free places for the speciality, through the Regulation and Health Information System (SISREG). All the doctors are requestors, and one doctor per clinic is also allowed to see the availability of appointments and to schedule them. Some complementary exams can be done in the clinic, such as the ultrasonography and quick tests (HIV, syphilis, hepatitis and pregnancy), whereas blood analysis and X-rays are done in the fast-attention unit (UPA). This unit works as an emergency room: it has an adult and children yellow priority room as well as an orange and a red priority room, with intensive care. It works as a provisional stabilization service until the patient is transfered to a Hospital. The Psycho-social care centre shows the mental health reorganisation by the Arts (Image 11), with daily treatment programs, approaching an individual activity timetable and hospitalization for 9 patients. Nearly 100 patients go in every day for drug administration and to make some activities, like painting and plastic Arts.

Image 11: Activities room

I had the chance to inspect closely part of the *favela da Rocinha* with a nurse of the health team which means that this Clinic also provides complemented services allowing a good accessibility and decisive clinical answers for these patients who live in such a poor community and without resources.

The other clinic visited by me, *Clínica José de Souza Herdy* in Barra da Tijuca (one of the richest, safest and most organised neighbourhoods in Rio de Janeiro) provides healthcare for all its population (Image 12and 13). It opened in February 2016 and aroused the author's interested in order for her to understand the efforts of setting up a clinic. The room for the building was given by *Unigranrio* University, a private university which teaches the Medicine, Dentist and Nursery degrees. The clinic started working with only 3 health teams, in order to evaluate the population needs. At the moment of my visit, every doctor had only roughly 1000 patients revealing that there is no need for more teams. In order to recruit the people, the community agent goes door to door in order to inform the population about the clinic, and he can schedule appointments in that moment. Covered people are workers, more educated and worried about their health, who suffered an alteration in their life conditions because of the national economic crisis, which resulted in an increased number of mental health appointments. As it is a richer neighbourhood, the Family Health Support Group (NASF) has only psychiatry, psychology, nutrition and social assistance members. There is an advising relationship with the appointments from different specialities at the Medicine school outpatient clinic, so they are asking both for giving a piece of advice about primary healthcare treatment and for referring patients to the clinic (and in this case the attention is free). This clinic, however, lacks a fast-attention Unit and Psycho-social care centre, and it does not provide oral healthcare, for there is a protocol with an external dental clinic. It develops several projects with external entities, as the *Outubro Rosa (October Pink)* project, which works with a tattoo designer cooperation who tattooes nipples on mastectomized women. As Brazil is an open country for alternative medicine, the author was also able to contact with the Auriculotherapy, a free on-line course provided by the Health Ministry which is based on the same principles of acupuncture but using seeds instead of needles.

Image 12: *Clínica José de Souza Herdy*

Image 13: Health community agents in the reception

Next a shortly description of the congress activities assisted is given.

Congress Activities

I participated in the pre-conference (Image 14), organised by the young doctor movement *Waynakay* (Image 15), where other young movements were introduced (*AfriWon, Al Razi, Polaris, Rajakumar, Spice Route, Vasco da Gama and Waynakay*). An activity was made

in which the doctors were divided into groups and each group had to explain to the others a health topic. I took part of the young doctor health group, which clarified the different modalities of residency in every country represented (Portugal, Brazil, Columbia, Chile, Peru and Luxemburg), and the preventive measures applied for young doctor burnout. The sharing of strategies and activities between residents was presented in the pre-conference discussion, as well as the importance of writing about it in order to promote a reflexion about this problem and to propose some solutions. The other groups were: Exchange, Leadership, Political Issues, Planetary Health, Teaching, Residency and Research. The results of this activity will be written in the Declaration of Rio 2016 *Global Peace: A Pre-Requisite for Attainment of Sustainable Development Goals* (Image 16). During the pre-conference the new global young doctor coordinator, Doctor Ana Barata, from Portugal, was also introduced. Doctor Amanda Howe's speech for young doctors, as the new Wonca World President, was also attended (Image 17).

Image 14: Pre-Conference *Waynakay*

Image 15: *Waynakay* Movement

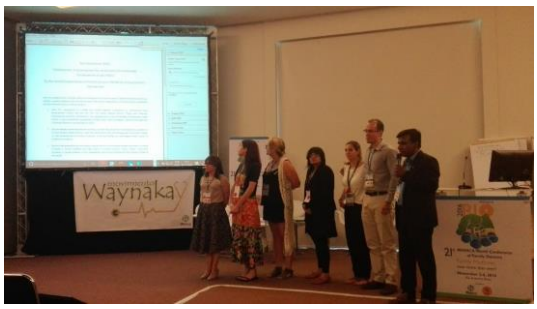

Image 16: Declaration of Rio 2016

Image 17: Doctor Amanda Howe and Doctor Michael Kidd

During the conference I joined several events with clinical and political interest, mainly:

- A panel discussion about *Sustainable Development Goals: which is the role of primary and family healthcare?* where the existence of universal indicators was discussed.
- A workshop about Behavioural therapy for Family doctors, in which the weaker mental mechanisms were treated: mental filter, discredit of positive issues, hurried conclusions, magnification, labelling, emotional reasoning and personalization, with a role play and the audience participation on the approach to the replacement of non-healthy thoughts and to the improvement of coping strategies through the patient's attributes.

- A session about the 6 family doctor's skills in the American Continent, a collaborative project of *Wonca, Waynakay* and *Polaris*, namely the clinical and assistance training, diagnose and treatment focused on family, community vision, primary level research, management, leadership with training since the degree. In this event not only as the population variability discussed, but also the curricular programs and the importance of teaching the family medicine resident inside his/her diary practice reality: the community.
- A session about Healthcare need for refugees, where the speakers talked about the measures adopted for their care in Turkey, Canada and the USA, as well as its incorporation into the residency training and the need of an approach to the refugee focused on the person.
- A Plenary Lecture with Doctor Amanda Howe about people, politics and poetry – 3 good reasons for the success of Family Medicine – a metaphor about the essential things that allow us to see the purpose of our action.
- A workshop about Diagnose and Treatment of Symptoms which are not explained by clinical features – suggestions for CID 11, with the approach to the creation of a new category that gathers the functional syndromes that are not explained by depression or anxiety, with the incorporation of social and mental problems in a whole and not in parts.
- The ceremony of Wonca presidency replacement, in which Doctor Michael Kidd gave his farewell speech followed by Doctor Amanda Howe's speech and designation. The 5-star Doctor Prize was awarded to Doctor Atai Omoruto because of her inspiring contribution to the control of ebola in Libia.
- The ceremony for the grant holders of *Wonca Europe Bursary*, in which doctors were welcomed by Doctor Anna Stavdal (Wonca Europe President), Doctor Job FM Metsemakers (the previous Wonca Europe President), Doctor Barbara Toplek (Wonca Europe Family Medicine Development Institute), Doctor Michael Kidd and Doctor Amanda Howe.

Final considerations

The 21st World Congress of Family Medicine, Wonca World 2016, was an unbelievable experience due to the proportional reflection, not just because of the several and different events which I attended and the problems discussed on them, but above all because of the direct contact with people, the inhabitants of Rio de Janeiro: their speeches and fears, the life in the *favelas* from the north to the south of the city, the life in the development zones, the feeling of fear and the extreme duality wealth/poverty in a population where healthcare is, in fact, truly free and universal. I realised about the need of a basic service provision by the Government (or non-governmental), with healthcare, education, security and promotion opportunities in jobs, that will allow a constant growing of the society. As a confession, after the contact with this social reality, it was hard to me to visualise all the wealth and magnificence around the Olympic Village and tourism in Rio de Janeiro, living it as a social shock along with the corruption with terrible consequences for the people.

That is why, now, the reflection about our work and our ability to influence the political systems is more important than ever: we cannot get used to, we cannot fear the

unknown, we must be aware about our role in health politic context changes, and in the replacement of a basic healthcare in our community. We must consider showing that we are different, that we have, or at least should have, autonomy on our work and on the way we deal with our patients, that systems with better primary care have better healthcare systems and that there is no winning with an attitude that does not promote the family doctor's practice motivation and interest.

This experience allowed me to realise that the Government politics on family medicine determine good practice conditions. Unfortunately, these politics do not value the importance of a good horizontal base in healthcare systems, and they limit the actions of family doctors forbidding the health opportunity changes in the community. Leadership spirit has to be promoted along with the resilience and the teamwork, for no one becomes a leader on his own. Not everybody has not to be a leader, but inside our communities we must be the leaders in health, with the incorporation of leadership training in the Medicine School and active participation in the scientific community to show the difference and specificities of our speciality – we have to act according to the psychosocial model and the resources and cultural individuality determinants of the society.

There is not enough evidence about what we do. There is a need of knowledge systematisation and collaboration to get universal abilities in formation and performance in Family Medicine. The universality of training programs and practices is important but without forgetting the peculiarities of every region, culture and beliefs. Consequently, there is a dichotomy between theory and clinical practice, being the universality versus the reality on the individual and families the true challenge for the family doctor. That is why the participation in international events in order to improve some social and understanding individual variability abilities is critic. These events give us time for discussion and reflection, with the goal of class identification, motivation and, as a result, improvements in healthcare.