Portraits of doctor-patient relationship in basic health care

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Abstract

This article analyzes results of a study comparing the speeches of professionals and of the Single Health System (SUS) users in public health units, providing primary health care services. The element used in the analysis is these two groups' lines, through which the evaluation is shown that they have about the care provided, considering the characteristics attributed to the physician-patient relationship. The analysis shows that professionals clearly identify the patient's desire to be heard while users claim persistently this caring, revealing the importance of subjective aspects on the quality of service rendering.

Key words: Women. Primary health care. Comprehensive health care. Humanization of assistance. Bioethics.

Resumo

Retratos da relação médico-paciente na atenção básica

Este artigo analisa resultado de pesquisa que compara falas de profissionais e usuárias do Sistema Único de Saúde (SUS) em unidades de saúde da rede pública, que prestam serviços de atenção básica. 0 elemento utilizado na análise é a fala desses dois grupos, por meio das quais é mostrada a avaliação que têm sobre a atenção prestada, considerando as características atribuídas a relação médico-paciente. A análise demonstra que os profissionais identificam nitidamente o desejo da paciente em ser ouvida enquanto as usuárias reivindicam persistentemente esta atenção, revelando a importância de aspectos subjetivos para a qualidade da prestação do serviço.

Palavras-chave: Mulheres. Atenção primária a saúde. Assistência integral a saúde. Humanização da assistência. Bioética.

Resumen

Retratos de la relación médico-paciente en la atención básica

Este artículo analiza resultado de investigación que compara discursos de profesionales y usuarias del Sistema Único de Salud (SUS) en unidades de salud de la red pública, que rinden servicios de atención básica. El elemento utilizado en el análisis es el discurso de esos dos grupos, por medio del cual se demuestra la evaluación que tienen sobre la atención rendida, teniendo en cuenta las características atribuidas a la relación médico-paciente. El análisis demuestra que los profesionales identifican nítidamente el deseo de la paciente en ser escuchada mientras que las usuarias reivindican persistentemente esta atención, revelando la importancia de aspectos subjetivos para la calidad de la suministración del servicio.

Palabras-clave: Mujeres. Atención primaria de salud. Atención integral de salud. Humanización de la atención. Bioética.

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The doctor-patient relationship has been a constant theme of both bioethical and medical ethics thoughts, expressing the concern of the Single Health System (SUS) professionals, managers and users in developing and applying parameters that could guide this relationship, so as to look on the perspective of humanization and respect for human rights.

This article is based on the results of a quali-quantitative field research designed to gather information about the satisfaction of users and professionals with health services directed to women, offered by the public system. In this analysis, we chose to work with only one question of the research form applied to the users: "In your opinion what is a good health care?", because it is an open question and allows the user to express herself. Concerning the professionals, questions/responses of semi-structured interview were especially selected, reporting the work routine.

Despite the wide period elapsed since the survey (11 years), the data obtained is considered relevant, based on subjective aspects, sensations and emotions of users and professionals on their inter-relationship during the health care. In spite of the efforts aiming at the improvement of services in recent years, such aspects remain critical points of basic health care, as evidenced by the results of a recent research undertaken by the Ministry of Health (MOH)[1], that indicated the performance of the system. It is hoped, thus, to contribute to the reflection on bioethics and to stimulate health practices that collaborate with the satisfaction of both groups, consolidating the principles of SUS[2].

Method

This comparison is based on seven cases of users and professionals from public health, studied during the second semester of 2000 and the first of 2001, the project Quo vadis[3]. The study was coordinated by the Center for Studies in Public Health (NESP), which integrates the Multidisciplinary Center for Advanced Studies – University of Brasilia (CEAM/UNB).

Field work, designed to raise awareness of women and professionals about primary health care services, was implemented in each of the five regions of the country – the Southeast and Center-West regions were subject to two studies. The survey was made possible due to a partnership between NESP and various institutions (listed at the end of this article), which allowed for data collection and tabulation of interviews.

Semi-structured questionnaires (open and closed questions) were administered, 159 of them to professionals and 634 to users – as much as possible the survey was made on the same days to both groups, in order to apprehend the relationship between the care provided and its evaluation. The amount of evaluations applied to users was divided as follows: Goiania (79), Maraba (146), Brasilia (90), Blumenau (93), Recife (105), Santo Andre (61) and Divinopolis (60).

Users were interviewed preferentially after consultation, and after verbal informed consent had been offered. Approximately, one third of the interviews was conducted with pregnant women, seeking to represent in the survey other assistance necessary to provide comprehensive care to women in all stages of life.

The various categories of top-level professionals whose work in health facilities is essential to provide minimum full health care to women were interviewed: general practice, obstetrics, gynecology and obstetrics, nursing, social work and psychology. We tried to capture their perceptions on comprehensive care policies on women's health, both in terms of management and performance, as well as the needs and difficulties encountered in the implementation of this policy and in the administrative structure in daily work.

Results

The interviewed users' profile is outlined by four characteristics: age, race, education and number of living children. As the number of women interviewed in each location is different, user's general profile is given only by frequency. Thus, the interviewed users' profile in the localities covered by the survey is as follows: they are 19 to 34 years old, brunettes, they attended basic education, whether having completed it or not, and have one or two living children. Low schooling allows us to infer that the socioeconomic status of these users is poor, even though this information was not directly raised in this study.

Concerning the instrument, age is coded by age groups ranging from early adolescence to maturity. The color gradation is defined by white, brown, black, making room for the inclusion of self-reported categories. The educational level goes from illiteracy up to college graduates, and intermediate degrees are possible answers. The number of living children is explicitly counted to four, leaving open the last option " five or more ".

The concentration of respondents aged 19-34 years, in all regions, is due to the proposed cut. Approximately a third of the total is in the gestational period, selecting thus the range in which is concentrated the sexual and reproductive health assistance, which focuses much attention to women's health. It is important to note that the ages embraced represent from pre-adolescence to maturity.

Regarding color, it is observed that the combination of closed and self-reported categories contributes to profile opacity. It is not possible to correlate the closed category "mulatto" and the open category "brunette". In Brasilia, Maraba, Goiania , Recife and Divinopolis, most respondents opted for the open category, in which the color brown, with different gradations, is most cited (39.58%). Although in the group contemplated there have been at least one area where most of the population is white – Blumenau (74 users) –, other areas can be framed in a similar pattern, with the majority of users identifying themselves as brunettes.

Users' level of education is the part of the profile that best reflects reality. Composed of blocks of objective answers, it is represented by a regular curve which focuses from 5th to 8th grades of elementary school. If we compare the most frequent range with the immediate one, it is difficult to move from basic to secondary education, which is amplified in this passage to the upper level in which there are only five users, less than 1 % of total.

The number of illiterate users in all cities is small, corresponding to only 5.99 % of the total, and are concentrated on the areas of catalyst migrants. Although this amount is low, if we add to these figures the amount of users who have not completed primary education, i.e., have indicated that they attended school until what was known as 4th grade of elementary school, we find almost half of the users in a condition of *reproductive social risk*.

When it comes to professionals, their identification includes gender, age, expertise/role at the health unit, time of practice, time of work at the surveyed unit, the labor journey/contracted working hours at the unit and identification of where the interview took place, among other data. In addition to filling in the questionnaire, interviews were recorded, transcribed and given through verbal consent.

We interviewed 76 physicians, 47 nurses, 14 social workers, 17 psychologists and one nutritionist. There are four social workers / psychologists in one survey. Interviewed medical professionals are GPs, gynecologists and obstetricians. The division of these respondents by region accounts for 13 professionals in Divinopolis, 16 in Santo Andre, 21 in Goiania, 24 in the Federal District and Maraba, 30 in Recife, and 31 in Blumenau.

Discussion

Reading the questionnaires, there was a perception in various occupational categories of desire for communication between users. Social workers, psychologists, nurses and physicians seem to live with the daily demand for a type of care that translates physiological limits and extends the social dimension. According to them, half the clients who seek services demonstrates the need to talk, express themselves, be heard and answered. The consultation in the clinic became the elected forum for expressing everyday life pressures and anguish. In the doctor's office, complaints and lamentations emerge in relation to disorders of the body and the turmoil of life:

"Look , I think most of it is a guideline , you know , it is the space to talk, to expose her problems. I think they complain much of not being heard, no one has time to listen to them, they can't rely much on doctors' understanding. I think this is a place where they can talk about problems, troubles, afflictions, and most often it is a general guideline, you know?" Gynecologist – Santo Andre

"I understand, in fact, she wanted to meet someone, talk, to complain about something. I think most women have this need, and the place where she can complain about is the hospital. In fact she's got a very bad life, she needs to complain about something, someone, everybody. And when she is fed up of it, she talks a little about herself." Clinician – Divinopolis

If the user's perception of this need appears strongly in physicians' speeches, their training and the way that health care system is operated makes it hard to respond to that need. The technical criteria for consultation recommend examining only the patient's physical status and its best operating condition. Because of that, so often, professionals feel unable to answer to this kind of demand, which causes discomfort over their own professional practice: "*I should be worried* (...) *about the person as a whole and not just offer only bad medical care* (...) *regarding the emotional, social person*." Health professional – Blumenau.

When users seek a kind of attention that goes beyond the maintenance of proper body functions, they subvert the operational logic of care in health services. The need to be evaluated by professional both in moments of pain and suffering is a sign that they want to have their anguish recognized by someone with moral authority to do so[4]. When they affirm their will to be perceived in their human and social dimension, they create a deadlock for professionals who have to meet significant number of patients in a short time[5], and, as it is prescribed by their background, to prioritize technical aspects in the characterization of diseases.

The emotions that users report at clinics, their grievances and complaints come from social life, power relations[6] and the assignments and responsibilities of their own multiple social roles. Conflicts of their daily lives are expressed to professionals in an attempt rising their awareness is significant and legitimate. Just as the doctor diagnoses the disease, giving meaning to the malaise, crisis or disorder, the user expects the same thing to be done in relation to their suffering[7]. Even when the professional understands this need of women, the absence of symptoms baffles and makes him feel perplexed and intimidated. The difficulty in answering user's expectations and fulfill their role is evident when it is not possible to provide medication, even though it is considered part of their treatment:

"I find it hard dealing with women, because (...) *women are very plaintive and mostly... sometimes I even play up about the issue of pain. Pain is in the entire body. A woman complains about that and let us kind of embarrassed, because in most cases it is not a* (...) *you do not think, you do not have a diagnosis for so much of the pain the woman complained about. And that makes me kind of frustrated..."* Clinician – Divinopolis

"I mean, I think the big problem about women I see here is a lack in the hospital. She has come here looking for some support. And some of them summarize their feelings and require much examination, so it is more difficult. You start refusing these tests, I deny them, but it is difficult because if you start denying she feels once more rejected and misunderstood and starts taking a lot of medicine. It is a vicious circle." Clinician – Divinopolis

The medicalization of health and the technification of medicine reduced the subject of medical practice to a body size. The history talking and diagnostic examinations process and the idea of healing with the use of drugs should handle treating all symptoms of diagnosable pathology in the individual. The suppression of the social dimension and power relations demonstrates how inadequate health care is perceived and practiced[8]. It alienates the individual from the social aspects, transforming social processes in physiological ones, and thereby shifts the responsibility for the conflict of the social plan for the individual:

> *Reducing, however, the functions of these medical standards of behavior in relation to sick individuals means deforming the great hypochondriac teaching. Such teaching is about, above all, recognizing that there is continuity between individual diseases and diseases of the collectivity.* (...) *The complicity between medicine and the social order, on the contrary, even if unjust and pathogenic, distorted these teachings*[9].

If this shift of focus meets the interests of the pharmaceutical industry[10], because it enables individual medicalization to try handling the adverse consequences of aspects of social life, and what users say reaffirms their displeasure at such a prospect. While affirming the importance of the drug in the therapeutic process, for them the idea of medical care is not restricted to technical resolution of injuries and illnesses. The need to talk about themselves comes from different levels of concern and it occupies, in the imaginary, wide range of meanings. Therefore, the behavior expected from the health service, and particularly physicians, covers much more tangible elements, such as technical expertise and consultation time, as well as emotions such as love and affection.

As perceived by professionals , the user expects to receive some comfort in relation to other aspects of her life beyond physical health, as evidenced stretches of open questions that indicate what they believe is a good service. These statements seem to reflect what happens in consultations. While some users showed satisfaction about the care received, others have clearly stated cries of protest, a striking manifestation of indignation: "*More attention! Attention from physician to patient*."

Regarding the characterization of emotions, users point to a desire to establish an affective relationship with the professional. Love appears as an important element in the discourse, and the need for physical and emotional contact is expressed by the idea of caring:

"*More understanding and love from professionals*";
"*Having love, caring for others, have understanding and patience*";
"*Professionals attention and care for the patient*";
"*Meet people more carefully, very carefully*";
"*The doctor has to be devoted to the patient, he has to know what's going on, be friendly with the patient*";
"*When doctor treats you well. You're needy, so the doctor treating you badly makes it worse*";
"*There are physicians more attentive and caring with patients*";
"*Meet your needs with ease and affection*";
"*We sense good hearts*";
"*If the doctor is in a good mood, the friendly word is worth everything. The heart has its value*"

Out of the desire to be seen and heard the need to be seen and heard, users' speech of reaffirms the importance of subjectivity in the relationship with the professional. It denounces the desire to nod in this regard, recognizing themselves as individuals, "Listening to my story and need." It expresses a desire to establish a mutual relationship that prioritizes trivial but extremely significant and determinant aspects of human communication, such as looking and talking: "If the doctor is attentive, he listens to us", "Stop to listen to the patient", "First, the doctor pays attention, listen to what we say and talk later", "The doctor listens to the patient, order tests and then gives the diagnosis", "The doctor has to speculate about the life of the patient. It is important to ask for every detail".

This need makes it evident that to the user it is essential to receive a professional attention of quality, which goes beyond the current boundaries of technical training: "*They respect and trust*". For the woman who uses the health system services, the proper care entails, first, being considered a human person, "*someone*" with power to speak and listen, tell and listen. It means she wants to be recognized, understood and having her sense of reality respected: "A person must have the opportunity to expose his or her problems". The desire to have one's emotions considered and valued reveals that the desire for recognition itself is embodied in speech and is also represented in the other:

"When we arrive, we have to say everything we feel, and they, nurses and doctors, have to listen";
"Talk to us, look at us, see if we're on it, listen, explain it right";
"It's about us talking about what we feel, and the doctor paying attention and sorting out what we are feeling";
"Listen to the patient. The patient is the one that knows what he or she is feeling " ;
"When the doctor asks the pregnant patient follows a healthy diet, talk to her in an adequate way";
"When the doctor is good, he talks right";
"When they understand our problems";
"The doctor has to be patient and talkative";
"A sense of understanding and companionship from the professional is very important when you have serious health problems";
"When the doctor is not ignorant and examines the patient right";
"The doctor is not ignorant and says what's going on";
"Being able to tell the problems and be well cared for, without them thinking that you are making it up. Some doctors are stupid."

To sum up, health services users want to have what they say truly believed, consolidated, strengthening their humanity. She wants to be perceived as a person and as an individual who knows she has rights. Although the notion of such rights is widely represented in all speeches, it seems to be related to user's educational level.

This study allows us to establish a relation between the education of women and how they analyze and claim the quality of service. In towns with larger amount of illiterate users or those who do not have a high school diploma, the expression of this desire can be identified only by widespread complaints about the quality of care provided. But, in those places where the majority of respondents have higher education, speeches claim rights morally consensual or legally imposed:

"Treat people better, as human beings";
"And we want to be treated as human beings";
"Doctors should pay more attention to patients, not treating them like dogs";
"The doctor has to be a nice person, respect our rights. There are people who don't";
"Good service at reception, treating everyone of all classes – middle, low, high – the same way";
"The doctor should pay some attention to the human being. It's not because the person is poor that she can't claim a good service. This isn't free. We pay our taxes".

We could say that their perception as individuals belonging to a specific social context is directly related to cultural conditioning derived from formal education. The importance of education can be measured by the ability of the user to articulate the care received in the citizenship perspective on rights and duties. This is also seen in professional speech:

"*I did a search on my own, there is such high degree of illiteracy that I thought I wouldn't find. When you ask if a patient can read, they usually cannot. And they also have a deficiency (...) they have an affinity with tranquilizers, something violent. I understand, I've also researched it seems that everything is about family problems. It's an unemployed husband, a drunk husband, a son who is involved with drugs, an unemployed son, a daughter who is separated, who went back home and dropped the child at home. And those family problems, the social, economic conjuncture there".*

Besides these more subjective aspects, compared emotions and notions of citizenship, users speak of "*politeness*" in the provision of services, demonstrating their expectations for better quality. The idea of politeness is evident not only in the expectation of professionals' commitment and dedication, but in anticipation of the delivery and pleasure with the exercise of affection. The politeness expected by the users by providing all health care units is associated with the idea that pleasure in the performance of professional practice ensures the quality of service .

This pleasure that the user expects to see as a result of professional work is well done in their speech, translated as "*trust*", "*patience*". "*calm*", "*kindness*" "*respect*" and "*dedication*". From the answers to open-ended question, it is not possible to define how these expectations reflect the actual reality or just a dream: "*And they get to speak and meet with me, they do it with happiness and delight*", "*And a person meets with you enjoying it*", "*The doctors loves their profession; there is patience when meeting with the patient, examining right the patient*".

Professionals also need to consider the user's formal education, so that he/she understands the diagnosis and proposed treatment. Besides the basic school education, many realize the user's lack of specific knowledge on health, which should be resolved at the hospital during examinations and consultations. This is evident in statements of general practitioners, nurses, psychologists and social workers. It is remarkable, in studies, that specialists, gynecologists and obstetricians are inclined to a more fragmented image of the woman, especially considering the attention given to sexual and reproductive health. This fact allows us to infer that specialization in vocational training tends to limit the perception strictly to "work area".

The importance of considering socioeconomic, sanitation, employment and nutrition factors in maintaining health and quality of life is also remarkable speech of the identified professional categories. For them, social aspects are as crucial as the technical level to improve the quality of care provided:

"*Most are illiterate or semi-illiterate, then you have to (...) come and give an idea about what is pregnancy, how the baby is ...* " Nurse – Recife;

"*When you have to guide a person and you see that she is poor and needy, you might not know what to do. Because of the financial issue, we also handle very mentally retarded people to whom you cannot speak to – they do not understand, as much as you talk, talk, they will not understand. So it's more like... people really, really dumb and their bad financial situation*" Nutricionist – Recife;

"*I think it should start in school, family , and complementary health care... That's for life*" Nurse – Blumenau.

Another aspect related to education and rather demanded by users as essential to a service of quality is *patience*. The notion of patience in the speeches of the users can be interpreted from two perspectives: on one hand, it means kindness and politeness; on the other hand, it is associated with time.

Regarding kindness, the idea of education implies that the relationship with the professionals is lacking the parameters of courtesy that integrate the rules of social interaction. Concerning the waiting period for care, the notion of patience relates to the length and the way the medical consultation is performed. Complaints from users of both doctors and assistants indicate that they feel offended, disdained, and diminished by the "treatment" received. They lack clear information, transmitted courteously:

"*A clear exchange of information*";
"*The professional has be nice to be calm and patient when meeting the patient, but they are usually not*";
"*The elderly are abused, the attendants do not have much patience*";
"*Everybody has problems (...) they neglect people*";
"*A doctor with more patience, paying attention and explaining things*";

"The person who attends must have patience, has to be humble and polite";
"Doctor and nurse with good manners, no rudeness";
"You have to have polite people attending";
"And attending well, no frills. If you yell at me, I'll yell back, my education depends on it. I paid INPS and it is not free , I will not be mistreated";
"It's good when we women are treated well, since today is a difficult day".

Regarding time, the idea of patience is also directly linked to delays in waiting rooms to receive the "passwords", the delay to the consultation and the speed with which it is conducted. This combination of factors causes irritation of the user, perceived as someone who *should* expect and is considered to be, in fact, in the position of "patient". The difficulty to get "attention" accentuates their dependency, making them subject to a model of social order that concentrates power in the hands of professionals and demands their surrender:

"It shouldn't take long to get an appointment";
"There should be a lot of vacancy; be quick";
"There shouldn't be much waiting time";
"Being able to schedule a consultation and being attended at it";
"Get here and not having to wait long";
"Having organized schedules, not this mess of arriving at 6 in the morning only to be met at 10, facing huge queues just to get an appointment. If they fix it, the rest you follow";
"Attention and punctuality from the doctors";
"The doctor being present, seeing the professional attending at work";
"Fewer lines, more doctors";
"The doctor should dedicate more time to the hospital, more time to the consultation";
"Not letting us waiting in line and not attending us quickly";
"It shouldn't take so long and we should understand what the doctor say";
"Let us waiting too long isn't good. Consultation should take a while. There shouldn't be a waiting line the health problem should be solved";
"Emergency cases take too long. People almost die waiting";
"It should be easier to get an appointment, the professional should understand us and explain right, where you do examinations and stuff";
"Quick attending, more ease when doing the exams and the possibility of performing these tests at the same time".

The user resents the delay to be consulted and the speed with which the service is performed. After a long wait and stress until she gets access to care or receives a service of quality, with enough time to express her doubts and problems. Professionals reaffirm these difficulties when reporting the time they devote to consultation:

"Unfortunately, we attend 20 patients per day in only two hours, two and a half hours, not longer than that because there are many turns or only forwarding patients (...) Although the contract is for four hours, no one spends so long here. I'm being honest. Here at the municipal hospital, I spent five to ten minutes at most when it comes to a new patient. When it's just to check the result of examination and refer to the medical specialty, I take two or three minutes" GP – Recife;

"Officially I work four hours a day, but it never takes four, but two or three. A new consultation lasts five to eight minutes. The return consultation is faster; if it's just to show an exam, it takes a blink" Gynecologist , explaining how a query performed in three minutes in the presence of the interviewer herself – Recife.

In order to boost the flow of patients during the consultations, two opposite strategies are used: infantilization of language or use of professional jargon. In the first case, the explanations are usually transmitted superficially and quickly, without the real concern of informing all the particularities of the health of the user, but merely prescribing medication and dosage. The professional jargon tends to be used in a ritualistic manner, to intimidate the patient or shutting her up, if she feels embarrassed about not understanding. The professional thinks that using medical categories in conversation with the patient confers credibility to his or her speech, increasing the symbolic effectiveness and efficiency of its healing power. However, this process hinders the understanding of interviewees, as well as it contributes to its inhibition in seeking for more explanations.

The last analyzed element concerns the highly hierarchical contact between professionals and patients[11]. The inequality of knowledge in relation to bodily processes, diagnosis and cure of diseases transforms women who use public health services in passive objects of the rules of operation of the service. Increased dependence and surrending their autonomy predispose them to be the more vulnerable and subordinate side in a power relation. The possibility to choose the treatment that best suits them is circumscribed by the rules that control their social insertion, delegating to them the weakest position in the power struggle, drawing a victim path, which revolves around need and dependence:

“The doctor should be nice, and we shouldn’t be left waiting”;
“When it isn’t fast, you can ask things without forgetting them”;
“The doctor should ask how you feel, be attentive to the patient – there isn’t much time, Explaining the reason for the exams, talking more. My life is in God’s hands. If I depended on the doctor... I’d die!”

In order to make the rules of the facility viable and meet the expected techniques of professional medical practice, doctors end up weakening the woman by providing a service that requires humanization. Although they are based on the theoretical proposal of SUS, studies reveal that humanization is still an empty word, and does not reflect a systematic institutional practice in different locations. In general, the attention given to user is regarded almost as a favor granted by the State, through the professionals. As if it were not for the service intended and the needs and problems of the patients are not the main priorities of the service.

Even when the professional is aware of the importance of a humanized relationship, he encounters difficulties and resistances to make it happen. Often, he wears himself off, feeling too isolated in individual efforts to overcome this flaw. The lack of understanding of the meaning of humanization condemns providers and users to continuously reproduce a power structure and a form of relationship that reinforces the asymmetry between their roles: "*See women as a social being, within society, inserted in the labor market, that has the same problems as her partner does in this market. You have to find out if unemployment reaches her (...) You have to know how to involve the partner in women's issues. Now, I find it very difficult to do that in public service*." Clinician – Recife.

Although the penalty charged to service providers by the dehumanization of care is lighter than the one imposed to users, they do not fail to feel the side effects of the imbalance of power. Facing limited infrastructural resources and the pressuring demand from users, professionals show irritation, confusion and helplessness. This sequel of the operation of the service, which hits hard the professional, causes dissatisfaction about the quality of his work.

This discontentment and professional stress frame exacerbated by structural and operational deficiencies, creating a continuous cycle of shortage/impotence/alienation that undermines compliance and increasingly reduces professional expectations and the quality and results of their performance. Their complaints express a desire to improve the work conditions:

"*Well, first, the doctor should examine right, listen to her complaints, having patience to hear complaints, to examine the patient within their expertise, listen to all they have to say. Take time to think and not be so fast to meet patients, because, you see, if we work five hours, we have fifteen minutes to each patient. So I think the number of patients is too exaggerated. I think the doctor should have more time, have less patients to meet, have patience , pay much more attention to what he does, not rushing so much.*

If the doctor is better paid at a given location, he doesn't have to look for other jobs. I understand, he would not be so stressed. Because it's about a health service, he should be well paid for a single service, so he doesn't need to be looking for others. The ideal health care to women would undergo a decrease in the number of consultations and better remuneration for the professional, it is for him not to have to look for other jobs and run so much." Doctor – Santo André

The users understand the pressures on professionals and assign some responsibility to the government. For them, the ideal service includes the upgrading of facilities, hiring more doctors and appreciating the professional: "*The government should take better care of health*"; "*There should have more hospitals, more doctors*", "*The government should invest more in health and education*", "*There must be more drugs available*", "*In order to have a good health care, you need money*".

Ultimately, regarding the users' access to consultation and treatment are bottleneck points in the provision of basic health, often cited in the answers. The quality of care is also criticized, pointing to the expectation that the service has solvability and efficiency: "*The doctor has to take responsibility, but that's a hard thing to find*", "*The doctor should explained, not scare off the patient*", "*It's when they ask and you say what you're feeling, and they give the right drug for you*"; "*It's when the doctor diagnoses what you have. There is no use when the doctor prescribes a drug without even examining you*"; "*Now it's pretty common to prescribe inappropriate and expensive drugs that are not worth anything to you*".

Regarding to professionals, lack of economic incentives, overworking, lack of infrastructure and charging the user configure a framework against which they feel their authority is undermined, and the effectiveness of expected service is transformed into expecting a paternalistic attitude. The delivery of the decision-making power over oneself to another person, involved in the social role of the user, enhances the professional responsibility – placing him in a situation where the health risk is magnified by the lack of resources.

Conclusions

Although, in the last decade, the allocation of resources in social programs has increased substantially in Brazil, healthcare received no proportional increase, hence it can be concluded that the problems mentioned in this article still occur in several parts of the country. A recent review of services by the Ministry of Health[1], through Idsus, confirms the assumption: *Of the 5.563 municipalities, 1.150 (20.7 % of total) were scored below 5 on a scale of 0 to 10*[12]. By portraying worldviews taken from opposing perspectives – health professionals and users of the public system – this study showed confluences in the worldview of both groups, especially arising from the perception of the poor quality of services, both in infrastructural dimension regarding the administrative process and the dynamics of operationalization.

Users claim humane and dignified treatment, which can be measured by access to consultation; quality of care during the consultation and in the relationship with civilized and courteous professionals who work in service stations. For the workers, the expectations revolve around improving conditions for professional practice: reducing the number of patients to be attended, increasing consultation time and especially improving wages – which would allow greater dedication to activity in a single working place.

The lack of funding available to health prevents them from actually meeting these expectations. To implement the plan outlined in the configuration of SUS, it is essential to increase focus and investment in health. It is crucial to improve training, to train and enabling professionals to meet patients' needs and guide them to work in teams – which reveals appropriate tactics to respond to an increased demand, providing full access to services.

It cannot be overstated that the scarce investment in poorly focused and poorly administered training triggers conflicts between professionals and users, causing discontent and unnecessary suffering to both parties, leading to the loss of quality in the service. This problem reveals itself as an obstacle for the operationalization of the strategies of decentralization, regionalization and hierarchy, which seek to ensure a service of quality and strengthen participation and social control. It is an obstacle against integrity, fairness and humanization of services at different levels attention.

Besides this problem, other factors accentuate the difficulties reported in the services, which seem to aggravate the "clinical frame" presented by the primary care service. According to the perspectives of the two interviewed groups, the identified problems in care are further aggravated by the absence of institutional mechanisms that facilitate the exchange of information, producing poor services and a confused and troubled dialogue between professionals and users. The attention focused only on the technical aspect reduces the physical and emotional contact, a moment in which pain and panic make who is the target of care extremely vulnerable. The absence of a human relationship isolates them into two distinct groups, each seeing the other as something, not someone. Without neglecting the security, this shift of focus provides conditions to minimize fear, anguish and suffering.

Data collection

Region	**City/State**	**Institution**
North	Maraba/PA	*Faculdade de Enfermagem da Universidade Estadual do Pará – Núcleo de Marabá/Secretaria Municipal de Saude*
Northeast	Recife/PE	*SOS Corpo Gênero e Cidadania*
Center-West	Goiania/GO	*Grupo Transas do Corpo*
	Brasilia/DF	*Núcleo de Estudos e Pesquisa em Saúde Pública (Nesp)*
Southeast	Santo Andre/SP	*Instituto de Saúde da Secretaria de Estado da Saúde de São Paulo/Fundap*
	Divinopolis/MG	*Núcleo de Saúde Coletiva (Nescon) da Faculdade de Medicina da UFMG*
South	Blumenau/SC	*Associação Casa da Mulher Catarina/Departamento de Saúde Pública/UFSC*

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Author's participation

Dora Porto designed the analytical cut of selected data, participated in its compilation, tabulation, analysis; she wrote the final report,reviewed and adapted it for this article production. Sergio Ricardo Schierholt collaborated in outlining of the analytical cut of selected data, participated in its compilation , tabulation, and data analysis; wrote the final report and reviewed this adaptation. Ana Maria Costa coordinate the team that designed and applied the survey, as well as teams that separately analyzed data, reviewing the final report and collaborated reviewing this adaptation.

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