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Reflections on changes in medical training in Brazil

Reflexões sobre as mudanças na formação médica no Brasil

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ABSTRACT

Introduction: This essay aims to review and analyse the changes that have occurred in education medical care with a view to humanisation in the care model and promote critical reflection on the training of medical professionals in the country. The discussions highlighted are derived from an analysis reflective criticism of publications available in the literature on the subject.

Development: Recent discussions regarding a proposal to reformulate the national curricular guidelines for undergraduate medical courses raise analyses of the historical period of medical training. We point out as important milestones of change the 2001 and 2014 National Curriculum Guidelines (DCNs) for the medicine course, the multidisciplinary and interdisciplinary approach as a pedagogical model based on comprehensive care as organisational principles of the Unified Health System and the political framework with the implementation of the More Doctors Programme since 2013.

Conclusion: Given the initiatives implemented in the curriculum, medical graduates still prioritise medical practice based on biomedical rationality, there is an evolution of the skills and abilities of the professional practice component, in the interdisciplinarity of care, but still focused on a medical science and with the impact of advancing the use of digital medicine in the 21st century. In order to have significant changes in the training process, an educational praxis is necessary that prioritises welcoming and the humanisation of health care for different patients and individualities.

Keywords: Medical training; Higher Education Policy; Health.

RESUMO

Introdução: *Este ensaio tem como objetivos rever e analisar as mudanças ocorridas na educação médica com o olhar sobre a humanização no modelo assistencial e promover uma reflexão crítica sobre a formação de profissionais médicos no país. As discussões apontadas são derivadas de uma análise crítica reflexiva de publicações disponíveis na literatura sobre a temática.*

Desenvolvimento: *Recentes discussões para uma proposta da reformulação das Diretrizes Curriculares Nacionais para o curso de graduação em Medicina suscitam análises sobre o período histórico da formação médica. Apontamos como marcos importantes de mudanças as Diretrizes Curriculares Nacionais para o curso de Medicina em 2001 e 2014, a abordagem multidisciplinar e interdisciplinar como modelo pedagógico pautado na integralidade para a assistência como princípios organizativos do Sistema Único de Saúde e o marco político com a implementação do Programa Mais Médicos desde 2013.*

Conclusão: *Diante Apesar das iniciativas implementadas no currículo, o egresso do curso de graduação em Medicina ainda prioriza um fazer médico baseado na racionalidade biomédica. Contudo, nota-se a evolução das competências e habilidades do componente de prática profissional na interdisciplinaridade do cuidado ainda focado em uma ciência médica e com o impacto do avanço da utilização da medicina digital no século XXI. Para termos mudanças significativas no processo formativo, é necessária uma práxis educacional que priorize o acolhimento e a humanização do cuidado em saúde das diversas formas de vida e das individualidades.*

Palavras-chave: *Formação Médica; Política de Educação Superior; Saúde.*

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INTRODUCTION

This essay addresses fundamental issues in the 21st century regarding health and the changes that have taken place in medical training in Brazil. Training processes are not static and undergo changes. So much so that, ten years after the implementation of the National Curricular Guidelines (DCNs) for undergraduate medical courses in 2014, a discussion has re-emerged with the Ministry of Health and Education to reformulate them in order to propose improvements to professional training[1,2].

We therefore set out to reflect on the following: after the publication of the DCNs for undergraduate medical courses in 2014, have there been any significant changes in relation to the humanisation of care in healthcare practices? With this guiding question, we searched the scientific literature published on the Scielo database using the descriptors: "humanised care" and "medical education" in the last ten years and other studies that reflect on the training and curricula in force over the last few years, with a look at the humanisation of care practices, in order to contextualise and propose reflections on the subject. We used other studies that address this subject[2,3-7].

Changes in society require new scenarios for health professionals and care models. From the 1980s onwards, with the 8th National Health Conference, the concept of health for all began to take shape, based on the understanding of health as a right. This concept was consolidated in the following decade with the implementation of a universal, humanised and quality care model within the Unified Health System (SUS)[3-5,8].

In this context, health services have demanded other professional profiles for the care model[3,4,8]. From the 2000s onwards, there were discussions involving the Ministry of Education and the Ministry of Health on the implementation of the DCNs, which consolidated and supported the implementation of the first DCNs for health training in 2001. These guidelines advocated a professional with generalist, humanist, critical and reflective training, to work at all levels of health care. In view of the various transformations in society and in the health sector, and with the challenges of training qualified medical professionals suitable for the SUS, the DCNs were revisited and new guidelines were implemented in 2014 [1,2,6,7].

Compared to the 2001 recommendations, greater emphasis was placed on humanistic aspects during training, and there was an attempt to transform teaching based on a concept of care through professional practice with empathy and solidarity. At the same time, the aim was to meet the care demands of the poorest population within the SUS, to increase access to medical care, driven by the *Programa Mais Médicos* (More Doctors Programme) with the opening of new medical courses across the country. Currently, the undergraduate Medicine degree is the course that trains the most health professionals in the country and this is trending upwards with the expansion of vacancies and the authorisation to open new courses[3,6-9].

DEVELOPMENT

In Brazil, the first significant change in medical education was to implement a rigorously scientific education based on the Flexnerian model. Medical schools in Brazil were previously based on the French model. The Flexnerian model was based on advances in medical science itself, consolidated by anatomical-physiological knowledge about bodies, medical specialities, the technical-scientific resources available for caring for and curing diseases and the expansion of fragmented discipline-based knowledge in medical schools worldwide, replacing the core professorship subjects[10,11].

Changes have also taken place in the organisation of the course and in methodologies. From the 1960s onwards, the following happened in Brazil: the core professorship subjects were definitively replaced by medical departments; the latter began to bring together the different disciplines; medical teaching was divided into a basic cycle and a vocational cycle, divided into medical specialities and clerkship; and new teaching methodologies began to be used. The new methodologies were not only based on oral teaching and within the school walls, but medical training began to take place concurrently with hospital practice, based on medical specialities and full time, within the departments of each area[11].

From the 1960s and 1970s onwards, a whole set of political and social forces demanded changes in the field of medical education, with a new understanding based on the principle of comprehensive care, and a whole discussion about the importance of humanisation and the biopsychosocial aspects of disease and health. The principle of comprehensiveness presupposes that people are cared for based on meeting their needs, through health promotion, disease prevention, treatment and rehabilitation [4,5].

According to Mattos (2004), this principle is one of the main objectives of the Public Health Movement and was woven into the 1970s in Brazil, at the same time as in Europe and Latin America. From then on, a new concept of health was called for, based on the social dimension of the health/disease process[12]. The new demands gained momentum for a social demand in medical education, at the level of ideas, and made it possible to "(...) adopt a curriculum in response to the demand from healthcare institutions for a certain type of doctor", a more humanist one[4,6].

In Brazil, since the creation of the SUS, the demands for care based on the figure of the general practitioner and more humanised doctors have taken off with the assumptions of

community medicine, so that it would be possible to provide more humanised care aimed at meeting the practical day-to-day needs of the population, especially in the context of a public health system. They have consolidated two domains: the more humanised and comprehensive approach and the perpetuation of discourses on biomedical-based, super-specialised care in practice and in medical school training[4].

With the consolidation of the principles of the SUS and the understanding among health professionals and managers of the importance of more humanised care – that which prioritises the individual as a whole – there was greater concern about the training of these professionals to respond to this demand since the turn of the 21st century.

Among many other considerations and reflections in the field of education and health, the emergence of teaching that responded to the new reformulations underway in health has supported the formulation of guidelines for the teaching of these professionals.

The curricular changes for health courses, with the first DCNs for undergraduate courses, were consolidated in 2001 and prioritised generalist, humanist, critical and reflective training, especially in the context of the SUS. The 2001 DCNs for the medical course brought changes to the curriculum structure and instituted the inclusion of subjects in the basic cycle such as Medical Psychology and Collective Health and greater integration with health services. Medical training continues with medical specialities such as clinical medicine and semiology, and is usually conducted in a university hospital[1,2,7,8].

As a result, in 2001 other possible changes were listed through a joint initiative between the Ministries of Education and Health with the creation of the Incentives Program for Curricular Changes in Medicine (PROMED). PROMED aimed to diversify teaching-learning scenarios (from the first term onwards, as well as using new active teaching methodologies)[4,5,8].

In 2013, with the creation of the *Programa Mais Médicos* (More Doctors Programme) by Law No. 12,871 on 22 October 2013, new discussions prompted changes in training. As well as boosting the expansion of undergraduate courses throughout the country, the programme sought to settle health professionals according to the needs of the health system in the country's regions[7] and to internalise and establish doctors in underserved areas. The programme also provided an emergency supply of medical professionals in uncovered areas through the exchange of foreign doctors or Brazilian doctors trained abroad, which generated a lot of discussion in the media and within the medical profession[13].

Another important reformulation was the consolidation of the multidisciplinary approach based on the paradigm of interdisciplinarity, with a view to implementing interprofessional education. To this end, it is worth highlighting the 2001 DCNs, the 2005 National Programme for the Reorientation of Professional Training in Health (Pró-Saúde), which sought to redirect the training of Medicine, Dentistry and Nursing courses, as these were the professionals who made up the health team of the Family Health Strategy and the More Doctors Programme at the time[1,3,13].

The 2014 DCNs recommendations for the definitive replacement of the minimum curricula for undergraduate medical courses included: integration between health, education and society so as to consolidate a clinical experience for health professionals focused on the social and psychological determinants that involve the health-disease binomial; an emphasis on humanised care; a multidisciplinary and interdisciplinary approach as a pedagogical model to teach teamwork skills; and the use of active methodologies to problematize real issues in medical care[2,14].

In line with these proposed transformations, Resolution 7 of 18 December 2018 of the National Education Council (CNE) came into force more recently, regulating the goal of the National Education Plan (PNE) 2014–2024 and establishing the guidelines for outreach programmes in Brazilian higher education, which makes it compulsory to complete at least 10% of the total curricular credits in outreach programmes and projects geared towards social demands in all undergraduate courses. This curricular insertion aims to put community outreach on an equal footing with teaching and research, recognising its value in training more complete professionals who are engaged with society. These measures are supported by Article 207 of the 1988 Constitution, which determines the inseparability of teaching, research and outreach as the basis for university activity[15].

All the reformulations mentioned above have been fundamental to the progress achieved in training health professionals, but the issue of implementing a curriculum for the medical courses in Brazil remains a challenge due to its importance to the training itself. According to Barreto and Dal Poz (2024), changes in the role of health services, based on care itself, imply that undergraduate curricula in medicine stimulate the critical sense of students about the living, health and working conditions of the population, enabling graduates to have developed competencies for caring for everyone with dignity and a sense of citizenship[3].

Empirical studies such as Grossenan and Patricio (2004), who in a qualitative study with 25 male and female doctors, aimed to reflect on doctor-patient interaction, the attitudes learned and taught in training, and medical practice to promote humanistic technical competence, emphasise that neither the dimension of humanised care nor the doctor-

patient interaction is given much attention during training. Being centred on the diagnosis and treatment of illnesses, both in the classroom and in the hospital environment, learning does not allow closer contact with patient subjectivities and their living conditions. Because of this inability to interact, they end up failing to provide humanised care to their patients in medical practice. It can be concluded that the dimension of care is fundamental in this interaction and reflects directly on the satisfaction or dissatisfaction of both patients and the teacher-student relationship[16].

Barros and Grosseman (2024) in an exploratory qualitative study with semi-structured interviews with various health professionals at a highly complex teaching hospital aimed to collect suggestions from professionals who worked in health care on how best to prepare them to deal with this context. The results of this study revealed that health teaching institutions have applied the following changes to humanisation in health: a greater emphasis in the curriculum on psychological aspects and comprehensive care for human beings, with an emphasis on humanisation, communication, collaborative teamwork and leadership and people management. It is also advisable for health education institutions to have a greater number of theoretical and practical hours with simulation and practice in real emergency and intensive care scenarios, with aspects related to the contents of "crisis medicine", biosafety, bioethics and care for critically ill patients[17].

Have changes actually been made?

Even though the DCNs (2001 and 2014) have been implemented since the 2000s, according to Pereira et al. (2018) the whole scenario of the changes brought about by the Public Health Reform, with the creation of the SUS and the new paradigms for training, has not yet been consolidated. Those authors maintain that the reforms proposed by the DCNs are not enough to promote significant changes in the training of graduates, because the socialisation of medical students takes place mainly in hospitals and they are influenced by the values, attitudes and behaviour of the doctors who work as teachers. It is therefore essential to reflect on the development of certain competencies that go beyond scientific knowledge, such as communication skills and empathetic attitudes towards patients[18]. Sharing the same impression, we understand that these changes over the years have not guaranteed profound transformations in medical training, which is still dominated by biomedical knowledge and clinical experience.

According to Rios *et al.* (2008), Veras *et al.* (2022), Miguel *et al.* (2023), the excessive biologisation in medical training favours a fragmentation of the concept of health and does not take into account the subjective aspects that involve the relationship between teachers and students, between the individual and their health, or between the person seeking care, a cure and professionals. Likewise, it does not favour aspects of the doctor-patient relationship, which is a key element in health care, and issues relating to knowledge of the human aspects of medical care[19-21].

According to Ceccin (2019), medical students should be taught a practice whereby affective bodies meet in the dynamics of care and escape the paradigm of the doctor/patient relationship strengthened by the biomedical paradigm, since there is a lack of content and competencies throughout the training process. For the author, learning takes place from experiences based on cognition and added to affective aspects and should also prioritise pedagogical listening produced by the multiple encounters between teachers and students and between students and patients that redefine subjectivities, which would produce changes in the recognition of otherness in the form of supportive reception[22].

Marques *et al.* (2020), in a study conducted with medical graduates, highlight the importance of a humanised medical practice to be developed in the training itself, the welcome at university and a reflection on the professional medical conduct of teachers. Students have previously indicated that humanised conduct is not present in the practice of some of their teachers, and that this is a model that should not be followed. In this study, they also identified that the meaning of the concept of Humanisation was sometimes misunderstood and confused with friendship on the part of colleagues with an impact on reception at the university. Another issue raised that reflects positively on training was the relationship between students and teachers. If teachers display affective and more flexible qualities in relation to students, these behaviours help students feel more secure to participate more in classes, which favours their training as future medical professionals[23].

Donnangelo and Pereira(1976), meanwhile, with a nod to Foucault, point out that medicine correlates with power relations and the socio-political contexts of certain historical periods[24,25].

We then return to the concept of the articulation between medicine and society defended by those authors to analyse the current moment, in which two issues capture the medical field: individualism and the advance of technology. Individualism as a predominant ideology in societies implies a lack of interest in individuality, in the other. It also means a loss of legitimacy for human beings as subjects of rights, solidarity between people and respect for human dignity. When technologies are overestimated, they dominate society and subjugate people. Therefore, both individualism and the overestimation of

technology will engage the doctor-patient relationship of today, in which respect and accountability for others can be obscured by the development of biomedical technologies[26].

In dialogue with the aforementioned authors, we understand that there have been changes in some aspects of the training process in medical schools. We can highlight important milestones of the changes, such as: the DCNs from 2014 with the multidisciplinary and interdisciplinary approach as a pedagogical model based on comprehensive care as an organising principle of the Unified Health System and the political milestone, with the implementation of the More Doctors Programme since 2013, which prioritised changes to the training of doctors as a public policy[2,13].

Learning has been (re)constructed for the students from the start of their training, with the changes that supported learning in different care settings to provide contact with different realities within the SUS, with a greater emphasis on primary health care spaces. By practising medicine in these settings, students have the chance to broaden their vision of what comprehensive care means, experience complementary integrative practices, palliative care and mental health care, getting even closer to the biopsychosocial aspects of the health-disease process.

With reference to Ceccin (2013), we reassert the importance of the relational aspects of the educational process of medical training, understanding it as a device that engages other ways of becoming a health professional rather than as a learning model based solely on the transmission of knowledge between teachers and students[22].

An education would only be that which enables affective encounters between individuals through the meaningful nature of interactions that produce marks and changes in the subjectivities. We understand that medical training itself sometimes captures the affective dimension of student subjectivities by overemphasising and overvaluing medical science and technique.

Valuing the affective relationships of medical subjects through changes in pedagogical practices in the field of education could produce graduates who are more committed to humanised care. Even now, when individualism and the "fetishization" of 21st-century technologies and digital medicine reigns supreme.

CONCLUSION

The transformations in medical education to rescue the sense of human dignity in care and humanisation go beyond digital learning technologies and techno-biological specialities.

In this regard, education as a praxis could promote a transformative action, through learning and knowledge, which enables an encounter between affective bodies[27].

As such it should prioritise training in caring not only for that which is knowable – the biological body – but also for an affective relationship that is appropriate to the individual's health needs[27]. An encounter between doctor and patient where they can be affected by the otherness, by the diverse and plural, which expresses the different forms of existence of each person.

The DCNs must be improved to consolidate training based on a different care model, on the concept that the individual – the person – behind their disease is a plural existence and should be offered a supportive reception. Medical work and medical training should be governed by ethics. To this end, these ethics must prioritise reflection on the various forms of life, beyond techno-scientific devices.

Therefore, the pedagogical *becoming* in health courses, and especially in medicine, will only occur with new paradigms that promote the encounter between such diverse demands. This will be based on a dialogical educational device committed to the defence of human dignity, and supportive of reflection and changes in the reception and health care of the various patients – of the subjectivities.

CONTRIBUTION OF THE AUTHORS

Márcia Silveira Ney participated in the conception and development of the study design, literature review, data acquisition, writing of the manuscript, intellectual revision of the manuscript. Mirian Teresa de Sá Leitão participated in the conception and development of the study design, literature review, data acquisition, writing of the manuscript, intellectual revision of the manuscript. Mônica de Cássia Firmida participated in the data review, writing of the manuscript, intellectual revision of the manuscript.

CONFLICT OF INTEREST

We declare no conflict of interest.

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STATEMENT OF DATA AVAILABILITY

Research data is available in the body of the document.

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