interface
comunicação, saúde, educação
https://www.interface.org.br
eISSN 1807-5762

Open space

Narrative of an educational path: providing a (new) meaning to medical education

Graciela Soares Fonsêca[a]
<graciela.fonseca@uffs.edu.br>

João Victor Garcia de Souza[b]
<jv.garcia1997@bol.com.br>

[a] Curso de Medicina, Universidade Federal da Fronteira Sul (UFFS). Campus Chapecó, Rodovia SC 484, km 02, bloco dos professores, sala 317. 89815-899. Chapecó, SC, Brasil.
[b] Graduando do Curso de Medicina, UFFS. Chapecó, SC, Brasil.

The need to rethink the education of health professionals, particularly doctors, is increasingly evident. This research aims at reporting the experience of a medical student of a federal institution that offers undergraduate course seats provided by the More Doctors Program. The student was encouraged to reflect upon his trajectory in the course by writing a narrative. The positive aspects indicated by him were: development of a critical attitude, knowledge integration, presence of Collective Health from the beginning of the course and use of active methodologies. Regarding the negative issues, the following was emphasized: the extensive course workload, maintenance of traditional assessments and resistance to innovation by some teachers. The student's narrative reveals tensions, ruptures, crises and achievements that contribute to understanding the "new" medical education model and offers subsidies for its improvement.

Keywords: Medical education. Narrative. Undergraduate medical education.

Fonsêca GS, Souza JVG. Narrative of an educational path: providing a (new) meaning to medical education . Interface (Botucatu). 2019; 23(Supl. 1): e180059 https://doi.org/10.1590/Interface.180059

Introduction

The debate over the changes in the education of health professionals was intensified in the 1970s, with historical and social roots involving education and work. The need for changes became more evident in the beginning of the Healthcare Reform and with the creation of the Brazilian National Health System (SUS). Back then, the technical, biological and hospital-centered profile of professionals, particularly doctors, was already not consistent with SUS.

Under this context, a series of changes are being experimented and implemented. They are mainly influenced by the National Curricular Guidelines of undergraduate health courses and by interministerial strategies that induce changes, such as the National Reorientation Program in Professional Health Education (Pró-Saúde)[1] and the Education through Work Program for the Health Area (PET-Saúde)[2].

Since 2001, when the first National Curricular Guidelines were implemented in undergraduate medical courses, medical schools were mobilized in a more intense way in order to transform education guided by competencies, prioritizing the use of active learning methodologies and ensuring an approximation with public health services[3,4]. In 2014, the new National Curricular Guidelines were published. They emphasized primary care as an education scenario and future work sphere, and fostered interprofessional education and teamwork, focusing on healthcare and wishing for a human, critical and reflective profile[5].

In this conjuncture of transformation, Law 12871, of 2013, which instituted the More Doctors Program, plays a fundamental role, since it foresaw the reorganization of medical courses in Brazil and placed criteria for distribution of seats, prioritizing scarcity areas and health inequalities[6].

In order to comply with this criteria, Universidade Federal da Fronteira Sul (UFFS), Chapecó campus, in the state of Santa Catarina, Brazil, was contemplated, in 2015, with 40 annual undergraduate medical course seats. The course's pedagogical project is based on the 2014 National Curricular Guidelines. The access to the course is democratized through the Unified Selection System (Sisu), by the Brazilian Ministry of Education. The course is developed by different agents, including teachers, students, academic community, health professionals/managers and the city's primary healthcare system users.

As in other institutions that have been breaking the traditional medical education model[7,8], the medical course of UFFS, Chapecó campus, has been facing challenges and uncertainties that require efforts by those involved to overcome them.

Identifying the need to further understand this reality in order to find answers to problems that arise, the creation of educational itineraries makes sense. The use of these devices in medical education can show paths, issues that affect the students' knowledge and practice, as well as dilemmas that arise in the education process, helping improve it[9].

> The educational itinerary mainly refers to issues faced by students in the education path that can qualify education under the perspective of a comprehensive care practice in health and of care as a value[9]. (p. 164)

This article aims at reporting the experience of an academic medical student in the second year of the course at UFFS, Chapecó campus. He was encouraged to narrate his educational course itinerary, reflecting upon the challenges and achievements in his path towards "becoming a doctor."

Methodology

The narrative exercise was understood as a method to revive and record past experiences, which are configured as a mediating element, being able to rebuild and provide (new) meanings[10,11]. Under this context, the experience is understood as happenings that "touch" people, contributing to the generation of knowledge. That is, knowing the experience "acquired in the way a person responds to what happens to them throughout their life and in the way we provide meaning to what happens to us"[12] (p. 27).

The narrating student was encouraged to write about his educational itinerary. Besides recording his experience, he was asked to describe its meanings throughout the course and the resulting reflections. The medical students of UFFS, Chapecó campus, build critical and reflective portfolios[13,14] as part of the assessment of the Collective Health Regular Curricular Component (CCR) from the very first year of the course. That is, the narration of experiences, reflection upon them and self-analysis are a continuous practice throughout the course. This practice helped the student create his narrative.

The student was in the fourth stage of the course, participating in a medical education research project, when he wrote his narrative. As a result of the discussions related to the theme, the student had a keen eye to the aspects related to the course and to medical education.

This is the student's second experience in higher education. He has also taken the first periods of the Nursing course in a private institution. Before entering the undergraduate medical course at UFFS, Chapecó campus, the narrating student had experienced only traditional education models based on the transfer of knowledge[15]. This was the model he experienced in elementary, middle and high school, technical school, and higher Nursing education. His contact with a course in a different format from what he had experienced so far motivated and impelled him to seek help from a teacher to systematize his reports and provide deeper reflections. This motivation resulted in the development of this work.

It is important to highlight that the student has experience in health work. Since 2015, he works as a nursing technician at a large hospital in the region where he lives and juggles work with the undergraduate course.

The narrative was written at once. Subsequently, it was systematized, analyzed and discussed by a teacher of the course, who also wrote the initial version of the manuscript. The student's narrative excerpts were reproduced *ipsis litteris*, preserving verbal tenses in the first person singular. The text's final version was adjusted by the teacher with the student's approval in order to "validate" the expressed meanings.

Results and discussion

The narrative exercise represented a moment of reflection upon the experience and enabled the student to see it clearly and project it towards his future "becoming a doctor." With his narrative, the subject provided a new meaning to his own experience[12,16].

Positive and negative aspects related to the course emerged from it. This article will now present and discuss these items.

The development of a critical attitude was the first point mentioned by the student as a differential of the course. Differently from traditional undergraduate courses, pedagogical projects and curricular designs based on the National Curricular Guidelines, particularly the 2014 ones, value the construction of competencies and skills in order to consolidate a general, human, critical, reflective and ethical education[5,8].

Aimed at breaking the prevailing fragmented education model in Brazil and in other countries, the medical course's curricular matrix of UFFS, Chapecó campus (as well as of other undergraduate courses offered by the institution), is organized by CCR. This has been done since the publication of Flexner's report, in 1910[7,17]. CCR aims at providing a comprehensive education, instead of a fragmented one, that characterizes the organization of the disciplines[4,18].

In the student's words:

> I did not come across isolated disciplines marked by a basic cycle, separated from a specific/clinical cycle. The organization into curricular components, grouping different disciplines into a single block, contributed to the integration of areas of common knowledge, such as Anatomy, Physiology and Histology, in a clear attempt to break with the teaching fragmentation. (Student's narrative)

However, in the student's opinion, the curricular structure's organization into CCR demands an excessive class workload and a density of themes and content disproportionate to the time he has to independently organize the learning process, as explained below:

> Obviously, there were some obstacles. Similarly to students, teachers were not prepared in or for this model. Despite all this positive load, the components end up taking an extensive workload, besides contemplating a long list of themes and content. (Student's narrative)

Collective Health CCR is present in the curricular matrix from the first to the eighth phase of the course. It aims at contributing to create the graduate student's profile provided for in the National Curricular Guidelines and helping articulate knowledge, skills and attitudes required to the future doctor in the areas of care, management and education in health[5].

However, despite its transformative power, Collective Health CCR does not have all the answers required for a comprehensive education of future health professionals. The effective participation of all areas in the construction of this innovative proposal is essential[19].

From Collective Health I to VIII, students are inserted into the healthcare network, focused on primary care. The objective is to enable the construction of knowledge and

competencies by problematizing the health work reality and breaking with the "practice as a theory proof" logic or with the need for "understanding theory in order to understand practice," which prevail in traditional courses[19]. According to the graduate student:

> Another great differential of the medical course at UFFS, Chapecó campus, are the Collective Health components present from the first through the eighth semester. They provide moments of experience and immersion into the Brazilian National Health System. During these activities, the service is used as a learning and education scenario. Actions are jointly developed, integrating the community and the university. Thereby, I am able to build my learning closer to the population's reality and to the nuances of a complex and broad system, contributing to its construction and maintenance. (Student's narrative)

In the health services reality, the student (with the team of professionals) finds users in their social context, with their life organizations, affective connections, social networks, demands, semiotics and different ways of living. This experience enables to overcome disciplinary boundaries in order to build a practice that goes beyond specialties and favors collaborative work[20].

A medical student from another Brazilian higher education institution reports her experience in the course by highlighting the "magical" discovery in the contact with human beings in the disciplines throughout the undergraduate course[21]. This experience enables to develop a critical view focused on real problems faced by the population and to perform social practices that result in solidarity, search, criticism and experimentation[7]. According to this academic student, the experiences of approximation with the community and the reality reveal an understanding of people's real needs and desires, enabling reflections and the search for a unique practice[21].

Since the early 2000s, with the publication of the National Curricular Guidelines, several undergraduate health courses have been searching for ways of including education strategies in health services and in their curricular structures[22]. Along with this search, policies that induce changes and provide new guidance in health education, such as Pró-Saúde and PET-Saúde, to name but a couple of them, were created and fostered by the federal government. They generated relevant information that "evidenced" the in-service education's potential and helped higher education institutions organize their teaching practices in real-life scenarios[23-28].

However, the diversification of scenarios of practice and the "de-hospitalization" have been resulting in resistance by some teachers and students, representing a challenge for medical education[29] based on the National Curricular Guidelines[5].

In Collective Health CCR, students are inserted into research and/or extension activities, having the opportunity to experience the development of investigations with different objects, slices of life, scenarios and methodologies. This practice is expected to add knowledge to education and develop a sense of curiosity, which will help in the development of a scientific evidence-based practice in the future.

According to the student, the use of active learning methodologies by the course's CCR is significant, as reported below:

> [...] other teachers are able to promote rich debates, activities as round tables and seminars, which foment an active construction of knowledge. I am clearly fascinated by this second model, and support it, because it is able to contribute to the development of the necessary skills for being a professional and it takes better advantage of the extensive workload intended for curricular activities. (Student's narrative)

The active learning methodologies denote interactive processes of knowledge construction aimed at the professional's comprehensive growth and development, covering the intellectual, affective and emotional spheres, skills, attitudes and values[29]. According to Freire's point of view, active learning methodologies are opposed to his banking concept of education. This perspective considers education as a deposit of information transferred by teachers to students and refutes knowledge as a construction process, resulting in a fragmented view of the world comprised of "deposited" pieces[30]. When simply retained or memorized, information favors a reproductive attitude, placing students as "world viewers"[31].

> [...] The best way to learn is being a subject of learning, not a receiver of information. Being a learning subject means the person who is learning will actively search, by themselves, the necessary knowledge to find the answer to a question, issue, situation[18].

On the other hand, despite the course "design" provided by the Course's Pedagogical Project, based on active learning methodologies, "class formats" are heterogeneous and coexist in the student's course:

> Therefore, the classes are also completely different from each other. Some of them are totally traditional and expository, where teachers talk for two or three hours about a specific subject and students silently watch, with few moments of interaction. (Student's narrative)

The implementation of a non-traditional curriculum and change processes in consolidated schools can enable the production of "hybrid proposals" that associate characteristics from different political-pedagogical propositions[19]. Additionally, as reflected upon by Feuerwerker[19]:

> [...] it is possible to create situations and orientations that are quite contradictory (and sometimes antagonistic) that confuse students and hinder learning. A proposal can be adapted to such level that is deconfigurated, completely loses its power and is demoralized. (p. 19)

Since they require and incite a democratic relationship between teachers and students, active learning methodologies can give rise to resistance and even violent reactions in medical schools[19]. The student highlights that this resistance is more evidently observed among medical teachers:

> Being in a medical course, it becomes obvious to think that medical doctors will be the example we, academic students, will follow in our educational process. However, from the very beginning, it is clear how they are, most of the time, the most resistant ones to break with the traditional medical education and the ones that most undermine this education. (Student's narrative)

Innovative teaching processes can have negative results due to resistance to changes, which can result in improper adaptations to the traditional model by some teachers[31].

Transformations in the teaching methods require consistent changes in the assessment methods, since the traditional assessment system is based on summative and punitive parameters[13,32]. In two moments of the narrative, the subject expressed an uncomfortable feeling related to the course's assessment processes:

> This (related to the extensive workload of the components), when performing assessments, hinders a lot, since they become extensive and terrifying, given the dimension of knowledge to be assessed. (Student's narrative)

> [...] assessments that are inconsistent with the content that was taught in class. (Student's narrative)

In terms of assessment, the most consistent way of promoting the student's commitment with their education is incorporating educational assessment methods. However, the extracts presented in this study show how the assessments instituted in the narrative scenario are not sufficiently educational, becoming inconsistent with the Course's Pedagogical Project's proposal and the National Curricular Guidelines. Overcoming the consolidated punitive assessment model is a great challenge[33] to higher education courses. However, it should be an always present objective.

Lastly, it is possible to note, between the lines of the student's narrative, words that express tension, ruptures and crises, revealing a feeling of nonconformity with the "normal." Consequently, they indicate a rupture of paradigms[9] that, by itself, reveals an intense movement of changes and transformation in medical education.

Final remarks

The narrative of the student's educational itinerary brings up the challenges, dilemmas, achievements and benefits of an innovative undergraduate medical course under the More Doctors Program and the National Curricular Guidelines. Breaking paradigms and instituted forces requires efforts from all involved agents and enforces conflicts, requiring a dialogical ability and a permanent education focused on the faculty.

The nuances observed by those who take the course reveal aspects that not always are visible to everyone. This revelation contributes to expanding the understanding of medical education and to improving educational processes in healthcare.

The reflections presented here show the imminent need for developing studies related to medical education in this study's scenario. These studies could contribute to the course's management, generating subsidies that can help it overcome obstacles and in its construction.

Authors' contributions

Graciela Soares Fonsêca systematized and analyzed the narrative and started the discussion. She also conducted the final review and approved the work. João Victor Garcia de Souza wrote the narrative, contributed to the discussion and participated in the review and final approval of the work.

References

1. Ministério da Saúde (BR). Portaria Interministerial nº 2.101, de 3 de Novembro de 2005. Institui o Programa Nacional de Reorientação da Formação Profissional em Saúde (Pró-Saúde) para os cursos de graduação em Medicina, Enfermagem e Odontologia. Diário Oficial da União. 4 Nov 2005.
2. Ministério da Saúde (BR). Portaria Interministerial nº 1.802, de 26 de Agosto de 2008. Institui o Programa de Educação pelo Trabalho para a Saúde. Diário Oficial da União. 27 Ago 2008.
3. Ministério da Educação (BR). Resolução CNE/CES nº 4/2001, de 7 de Novembro de 2001. Institui diretrizes curriculares nacionais do curso de graduação em medicina. Diário Oficial da União. 9 Nov 2001.
4. Aguiar AC. Implementando as novas diretrizes curriculares para a educação médica: o que nos ensina o caso de Harvard? Interface (Botucatu). 2001; 5(8):161-6.
5. Ministério da Educação (BR). Resolução CNE/CES nº 3/2014, de 20 de Junho de 2014. Institui diretrizes curriculares nacionais do curso de graduação em medicina e dá outras providências. Diário Oficial da União. 23 Jun 2014.
6. Presidência da República (BR). Lei nº 12.871, de 22 de Outubro de 2013. Institui o Programa Mais Médicos, altera as leis nº 8.745, de 9 de Dezembro de 1993, e nº 6.932, de 7 de Julho de 1981, e dá outras providências. Diário Oficial da União. 23 Out 2013.
7. Ferreira RC, Silva RF, Aguera CB. Formação do profissional médico: a aprendizagem na atenção básica de saúde. Rev Bras Educ Med. 2007; 31(1):52-9.
8. Adler MS, Gallian DMC. Escola médica e Sistema Único de Saúde (SUS): criação do curso de medicina da Universidade Federal de São Carlos, SP, Brasil (UFSCar) sob perspectiva de docentes e estudantes. Interface (Botucatu). 2017; 22(64):237-49.
9. Silveira R, Pinheiro R. O mundo como fronteira: itinerários formativos de estudantes de Medicina nas experiências de Internato Rural na Amazônia. In: Gerhardt TE, Pinheiro R, Ruiz ENF, Silva Junior AG, organizadores. Itinerários terapêuticos: integralidade no cuidado, avaliação e formação em saúde. Rio de Janeiro: CEPESC, IMS, UERJ-ABRASCI; 2016. p. 163-81.
10. Carvalho ICM. Biografia, identidade e narrativa: elementos para uma análise hermenêutica. Horiz Antropol. 2003; 9(19):283-302.

11. Oliveira MCSL. Narrativas e desenvolvimento da identidade profissional de professores. Cad CEDES. 2012; 32(88):369-78.
12. Bondía JL. Notas sobre a experiência e o saber da experiência. Rev Bras Educ. 2002; (19):20-8.
13. Romanowski JP, Wachowicz LA. Avaliação formativa no ensino superior: que resistências manifestam os professores e os alunos? In: Anastasiou LGC, Alvez LP. Processos de ensinagem na universidade: processos para as estratégias de trabalho em aula. Joinville: Editora Univille; 2006.
14. Cotta RMM, Costa GD, Mendonça ET. Critical and reflective portfolios: a pedagogical approach centered on cognitive and metacognitive skills. Interface (Botucatu). 2015; 19(54):573-88.
15. Freire P. Pedagogia do oprimido. 47a ed. São Paulo: Paz e Terra; 2008.
16. Kolb D. Experiential learning-experience as the source of learning and development. New Jersey: Prentice-Hall; 1984.
17. Flexner A. Medical education in the United States and Canada [Internet]. New York: Carnegie Foundation for the Advancement of Science; 1910 [citado 2 Dez 2015]. Disponível em: http://www. carnegiefoundation.org/files/elibrary.
18. Oliveira GS, Koifman L. Integralidade do currículo de medicina: inovar/transformar, um desafio para o processo de formação. In: Marins JJN, Rego S, Lampert JB, Araújo JGC, organizadores. Educação médica em transformação: instrumentos para a construção de novas realidades. São Paulo: Hucitec; 2004. p. 143-64.
19. Feuerwerker LCM. Gestão dos processos de mudança na graduação em medicina. In: Marins JJN, Rego S, Lampert JB, Araújo JGC, organizadores. Educação médica em transformação: instrumentos para a construção de novas realidades. São Paulo: Hucitec; 2004. p. 17-39.
20. Kastrup V. Um mergulho na experiência: uma política para a formação dos profissionais de saúde. In: Capozzolo AA, Casseto SJ, Henz AO, editores. Clínica comum: itinerários de uma formação em saúde. São Paulo: Hucitec; 2013. p. 151-62.
21. Araújo CS. Dilemas de uma formação médica: relato de experiência. Rev Port Saude Soc. 2016; 1(1):62-6.
22. Feuerwerker LCM, Capozzolo AA. Mudanças na formação dos profissionais de saúde: alguns referenciais de partida do eixo trabalho em saúde. In: Capozzolo AA, Casseto SJ, Henz AO, editores. Clínica comum: itinerários de uma formação em saúde. São Paulo: Hucitec; 2013. p. 35-58.
23. Santos KT, Ferreira LF, Batista RJ, Bitencourt CTF, Araújo RP, Carvalho RB. Percepção discente sobre a influência de estágio extramuro na formação acadêmica odontológica. Rev Odontol UNESP. 2013; 42(6):420-5.
24. Fonsêca GS, Junqueira SR, Zilbovicius C, Araujo ME. Educação pelo trabalho: reorientando a formação de profissionais da saúde. Interface (Botucatu). 2014; 18(50):571-83.
25. Cruz KT, Merhy EE, Santos MFL, Gomes MPC. PET-Saúde: micropolítica, formação e o trabalho em saúde. Interface (Botucatu). 2015; 19(1):721-30.
26. Gusmao RC, Ceccim RB, Drachler ML. Tematizar o impacto na educação pelo trabalho em saúde: abrir gavetas, enunciar perguntas, escrever. Interface (Botucatu). 2015; 19(1):695-707.
27. Madruga LMS, Ribeiro KS, Freitas CHSM, Perez IAB, Pessoa TRRF, Brito GEG. O PET-Saúde da família e a formação de profissionais da saúde: a percepção de estudantes. Interface (Botucatu). 2015; 19(1):805-16.

28. Silva ALF, Ribeiro MA, Paiva GM, Freitas CASL, Albuquerque IMN. Saúde e educação pelo trabalho: reflexões acerca do PET-Saúde como proposta de formação para o Sistema Único de Saúde. Interface (Botucatu). 2015; 19(1):975-84.

29. Feuerwerker LCM. Além do discurso de mudança na educação médica: processos e resultados. São Paulo: Hucitec; 2002.

30. Oliveira GA. Uso de metodologias ativas em educação superior. In: Cecy C, Oliveira GA, Costa EMMB, organizadores. Metodologias ativas: aplicações e vivências em educação farmacêutica. Brasília: ABENFARBIO; 2013.

31. Berbel NAN. As metodologias ativas e a promoção da autonomia de estudantes. Semina Cienc Soc Hum. 2011; 32(1):25-40.

32. Gomes AP, Arcuri MB, Cristel EC, Ribeiro RM, Souza LMBM, Batista RS. Avaliação no ensino médico: o papel do portfólio nos currículos baseados em metodologias ativas. Rev Bras Educ. 2010; 34(3):390-6.

33. Esteban MT. Avaliação no cotidiano escolar. In: Esteban MT, Garcia RL, Barriga AD, Afonso AJ, Geraldi CMG, Loch JMP. Avaliação: uma prática em busca de novos sentidos. Rio de Janeiro: DP & A; 2003.

Translator: Caroline Luiza Alberoni

Submitted on 01/29/18.
Approved on 05/12/18.