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Articles

Reflections on the National Curricular Guidelines of undergraduate medical courses based on the National Health Promotion Policy

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The objective of this article is to analyze the National Curricular Guidelines of medical courses based on Foucauldian discourse analysis. This analysis goes even deeper under the scope of health promotion presented by the National Health Promotion Policy (PNPS), since it is closely related to a comprehensive care proposal. The new National Curricular Guidelines are in accordance with PNPS, since it aims at a general, human, critical, reflective and ethical education that is able to prepare medical students to work with social responsibility and commitment to advocate for citizenship and human dignity in different levels of care in the health-disease process. On the other hand, the analysis reveals that, although there is an attempt to place graduates as active subjects in their educational process, there is no sign of inclusion of these social agents in the creation of their educational practices.

Keywords: Higher education. Health human resources. Health promotion. Comprehensive care. Medicine.

Introduction

The health reform in the 1990s, materialized with the creation of the Brazilian National Health System (SUS), resulted, in Brazil, in the expansion of the public sector, implying in new ways of working, mainly for doctors[1,2]. Consequently, higher health education has been going through changes aimed at reorienting the education of professionals in this area.

In Brazil, enactment of the National Education Guidelines and Framework Law, in 1996, triggered curricular reforms that culminated in the creation of the National Curricular Guidelines. The National Curricular Guidelines guide the education of health professionals, ensuring equal competencies and skills for professional practice. The latest National Curricular Guidelines of medical courses were ratified by the National Education Council through Resolution no. 3, of June 20, 2014[3]. They legitimize the bases for current medical education, which must be human, critical, reflective and ethical, capable of preparing professionals to work in different levels of care in the health-disease process, with social responsibility and commitment to advocate for citizenship and human dignity, working as promoters of comprehensive care to human beings[3].

The health promotion ideology has been influencing public policies and health education models in different countries since the 1970s[4]. Given this overview, the objective of this article is to analyze the National Curricular Guidelines of medical courses based on Foucauldian discourse analysis. This analysis goes even deeper under the scope of the National Health Promotion Policy (PNPS), of 2006[5], reviewed in 2014, since it is closely related to the proposal of comprehensive care and intersectoriality based on innovative solutions. The Brazilian Ministry of Health established PNPS as an effort to face challenges in health production, requiring reflection and qualification of healthcare and public health system practices. Therefore, this study's challenge is to critically analyze if the medical teaching and education process meets PNPS' objectives.

Medical education under discussion

In Brazil, with the 1968 university reform (resulting from the 1967 MEC/USAID agreement and Law 5540/68), Brazilian universities officially started following the North-American model, known as Flexner's biomedical model[6-9]. Some authors[6-11] tend to assert that this model emphasizes early professionalization prone to specialization and sub-specialization, in which hospitals are the main scenario for practice. This education model was applied in Brazil after the Flexner Report, which was published in the United States in the 1910s. According to Pagliosa and Da Ros[7], this report enabled the organization and standardization of medical schools. However, it killed off other healthcare formats, such as alternative medicine. On the other hand, Almeida Filho[8] highlights the importance of this report to the introduction of scientificity and institutionality criteria required to the regulation of academic and professional education in health.

Parallel to this educational model, there was a proliferation of conferences and seminars to rethink the population's healthcare starting in the 1970s. The Lalonde Report, in 1974; the Declaration of Alma-Ata, in 1978; and the Ottawa Conference, in 1986 are some examples. The first document questions doctors' exclusive role in

treating diseases, evidencing its high cost and poor effectiveness, mainly in chronic problems. The Declaration of Alma-Ata is an important political milestone in primary healthcare. Its objective is: "health for all the people of the world by the year 2000." It suggests a primary healthcare services package in practice and incorporates the right to comprehensive care and equality in the access to health system[1,12].

However, starting in the Ottawa Conference, the health promotion proposal was officially formulated, linked to a more complex conceptualization of the health-disease process. Therefore, based on a broad conceptualization of the health-disease process, health promotion started being treated as a group of theoretical, political and traditional knowledge that aims at facing the population's health problems[1,12,13].

The emergence of health promotion throughout the world was followed by an advance in neoliberal politics in European and North-American capitalist countries. The economic development slowdown/stagnation, i.e., accumulation of capital by countries, was allegedly due to exacerbated spending with social security. Therefore, the solution for this stagnation would be a "State Reform," limiting social spending and creating a tax reform to reduce taxes[4,14,15].

In this perspective, some authors have supported the idea that health promotion can be considered an ideological strategy aimed at reducing the State's influence in the health sector, transferring the healthcare responsibility to subjects, based on concepts of empowerment, community, social participation and quality of life. Consequently, behavioral changes towards healthy habits would not be the State's obligation anymore, but rather the subjects'. The subjects would need to mobilize to find solutions for their health needs[4,15].

As opposed to the neoliberal perspective, the health promotion conceptualization present in the healthcare reform movement is articulated with the social determination of the health-disease process. Therefore, it does not consider health exclusively according to its individual factors[1,15].

Thus, with the civil constitution, in 1988, and the approval of the Organic Health Law, in 1990, the State enters into an agreement regarding the population's health. Health then becomes a civil right and a State duty. SUS is then determined as a State policy to the health sector, as provided by the Organic Health Law. It is also the Brazilian State's responsibility to ensure an education system of human resources in health[9,16-19].

As a reply, in the early 1990s, the Brazilian Association of Medical Education (ABEM), along with the Federal Council of Medicine (CFM) and other nine medical-related institutions, created the National Interinstitutional Commission for Evaluation of Medical Education (CINAEM). CINAEM was developed in three stages, in which the medical schools' profile was raised based on a script of the Pan American Health Organization (PAHO), of the institutions' faculty and of the adopted pedagogies. The results found evidenced unprepared professionals when faced with the population's health needs, as well as an education focused on teachers and an exacerbated knowledge specialization[9,20].

Simultaneously, the unleash of curricular reforms motivated by the approval of the new National Education Guidelines and Framework Law, in 1996, was also observed. This law enables higher education institutions to design innovative curricula according

to regional realities and schools' vocations. The old basic curriculum is then replaced by the National Curricular Guidelines[21].

Therefore, besides the creation of the National Education Guidelines and Framework Law, the discussion developed by CINAEM generated proposals that were incorporated into the National Curricular Guidelines of undergraduate medical courses through Resolution no. 4, of November 7, 2001, of the Brazilian Ministry of Education[8,20-22].

Soon after that, in 2002, the Incentive Program to Curricular Changes in Medical Courses (Promed) was created by the Ministry of Health and the Ministry of Education, PAHO, *Rede Unida* and ABEM. The program's objective was to continue the movement that began with CINAEM through a technical collaboration to foster curricular reforms aimed at adapting medical education to the population's health needs. In other words, the program advocated for an alignment with a broader concept of health, greater articulation with primary care, National Curricular Guidelines and SUS[20,21,23].

Other initiatives emerged to reorient health professionals starting in 2003, with a better integration between the Ministry of Health and the Ministry of Education. Among these initiatives, the following can be highlighted: creation of the Health Education Development (DDES) as part of the Management Department for Work and Education in Health (SGTES); the VER-SUS and AprenderSUS programs; the National Policy for Permanent Health Education (PNEPS); and Pró-Saúde, inspired on Promed[9,20,21,23].

According to Lampert[6], the main initiatives of reorientation of health education date back to the late 20th century and become deeper in the 21st century, aiming at health promotion. However, they are not totally successful, because they are not able to transform these proposals into medical education. Health promotion was announced after the creation of SUS. However, it only became an institutionalized policy in 2006, through Directive no. 687, of the Ministry of Health[5]. Recently, the document was updated with the challenge of achieving a greater intersectoral articulation, admitting that the public health sector is not able to, by itself, tackle all conditions that influence health. Indeed, the discussions that resulted in PNPS consolidated the need for a broader concept of health that provides comprehensive care to individuals through articulate actions among different levels of care (comprehensive care) and sectors through intersectoriality[12,24]. Therefore, effective policies are essential to SUS consolidation, both regarding work relationships and workers' relationship to the system, and to aspects related to education and development of health workers[25]. Additionally, this was already expected since the publication of the Final Report of the 8th National Health Conference (1986). The report recommended structuring health services and determining qualified professional profiles to meet the country's needs. The education of health professionals should thus be integrated into the regional and hierarchical health system.

Chiesa et al.[16] highlight that the different ways of organizing a curriculum have gone through paradigmatic changes. The more we advance in this sense, the more the work of graduates will change. According to the authors, a dialogical process occurs through participation, in which education should be bidirectional, being both parts involved, committed to transforming their own knowledge. In the dialogical principle,

theory and practice need to be connected to bring professional education closer to the population's health needs. In this perspective, the National Curricular Guidelines of undergraduate courses should be particularly taken into consideration, since they guide university curricula with the necessary competencies and skills for a higher professional education. In the case of Medicine, they aim at preparing medical graduates to "observe the dimensions of the biological, subjective, ethnic-racial, socioeconomic, cultural and ethical diversities that differentiate each person or social group"[3] (p. 4). However, in this sense of critical reflection, it is necessary to question if discursive practices or forms of action passed by language, which are implicit in the new National Curricular Guidelines, enable the changes mentioned (or wished for) by PNPS.

Method

This article is a documentation analysis of the National Curricular Guidelines of undergraduate medical courses. These guidelines are recommendations, since, in Brazil, universities are autonomous, as determined by the National Education Guidelines and Framework Law.

Initially published in 2001, the National Curricular Guidelines were revised and reformulated in 2014, being approved by the National Education Council through Resolution no. 3, of June 20, 2014[3]. In order to be applied, medical courses must be in operation for at least one year starting from the date of publication.

The document was created by the Ministry of Education's Higher Education Chamber Committee, has 19 pages and is divided into 3 chapters. Chapter I introduces the guidelines to be followed in the organization, development and assessment of medical courses of higher education institutions in Brazil. Chapter II introduces the competencies required to transform the guidelines. The last chapter lists the fundamental curricular content of undergraduate medical courses, as well as guides on how to organize the pedagogical project.

The document was analyzed using Foucauldian discourse analysis method. Discourse analysis was introduced by Anglo-American Psychology in the 1970s. Based on Foucault's ideas on the relationship of power and knowledge[26], psychologists started to explore the relationship between language and subjectivity. This approach essentially influences Carla Willig's work[27] that, based on Foucauldian point of view, focuses on the relationship between discourses and institutions, since these discourses are connected to institutional practices, i.e., with ways of organizing, regulating and administering social life.

Through discourses, relationships of power and social control are established, imprisoning subjects to a naturalization of these discursive relationships and to a reproduction of practices based on control and power, producing subjectivities based on discourses and that legitimize them. Therefore, since discourse has a decisive effect on the way the social world is configurated, discursive practices are social practices produced through relationships of concrete power in a given time[27].

Additionally, this type of analysis questions the relationship between discourse and the way people think or feel (subjectivity), what they can do (practice) and the daily routine in which these experiences occur.

The analytical process

The language analysis created for this study under Foucauldian discourse analysis' scope used by Carla Willig[27] aims at understanding the arrangement of the discourses used in the official document and how they can influence the way people think or act[27].

Willig[27] structures Foucauldian discourse analysis based on six stages: 1) identification of discursive constructions related to medical education; 2) type of discourse that groups these constructions into broader categories; 3) action orientation of these discourses considering their functional characteristic; 4) study of positionings provided by discourses to social agents; 5) study of practices or forms in which discursive constructions and subject positionings contained in these constructions open or close opportunities for action; and 6) possible ways of subjectivity based on action orientation, positionings and practices present in the text.

These stages enable the researcher to map some discursive resources used in the text and the subjective positionings they contain, as well as explore their implications to subjectivity and practice[27]. The first author read the texts at least four times in order to become familiar and engaged with it. Discourses were identified and discussed with the second author. The second step was to design an analysis plan using the six stages described above in order to present the discourses identified in the study.

Discourse analysis of the National Curricular Guidelines

Based on the discussions presented so far, it is important to highlight that readings and analyses of educational systems should be followed by reflection and self-reflection processes, since people tend to reproduce symbolic parameters to which they are conditioned[18,27]. The need for this analysis is justified by the moment of transformation and change of paradigms in medical education.

In this sense, the power of health promotion in the medical education reorientation is acknowledged. It questions the biomedical model, particularly in the healing perspective centered in the individual, creating opportunities to shift biomedicine centrality from the students' educational process. Therefore, students are connected to an interdisciplinary health conceptualization, being an intrinsic condition to health promotion and dialog with other scientific or popular knowledge in the provision of healthcare[4,28].

In the study of the National Curricular Guidelines[3], the Foucauldian discourse analysis strategy was thus adopted, synthesized by Willig[27] and used in the analysis of the European Commission's 1996-2000 Health Promotion Programme[29] and of PNPS[18].

Discursive constructions

In this first stage of the analysis, the objective was to identify the way each discourse was built. According to Willig[27] and Foucault[26], all forms of knowledge are built through discourse and discursive practices. Based on the organization of the guidelines according to competencies, the discussion related to medical education is organized through three discursive constructions, in accordance with the National Curricular Guidelines, as follows:

Healthcare – In this area, medical graduates should have the necessary education to consider the dimensions of biological, subjective, socioeconomic, cultural and ethical diversity that characterize each person or social group. In this sense, healthcare is unfolded based on two areas: individual health needs and collective health needs.

These areas indicated in the National Curricular Guidelines coincide with Art. 2 of PNPS[5]:

> PNPS is based on a broad concept of health and on a theoretical framework of health promotion as a group of strategies and forms of providing health, both individually and collectively. It is characterized by articulation, intra and intersectoral collaboration, and healthcare network education, aiming at articulating its actions with other social protection networks, with broad participation and social control. (p. 26)

Likewise, health promotion is included in PNPS as a strategy to strengthen the principles of comprehensive care, equality, healthcare responsibility, social mobilization and participation, intersectoriality, information, education and communication. In order to make this action feasible, the National Curricular Guidelines indicate competencies in two areas: care to individual health needs and care to collective health needs.

It is clear the relationship between the practice envisaged by the education proposed in the National Curricular Guidelines and PNPS related to the consideration of the subjects' autonomy and singularity, collectivities and territories. However, the individual responsibility towards healthy life styles prevails in the document's discursive constructions. Consequently, it emphasizes on competency to act individually. Individual needs depend not only on individual will or freedom but mainly on conditions determined by social, economic, political and cultural contexts where these individuals live[5]. However, the document's discourse tends towards an education based on competencies in the area of care for individual needs. This type of education does not reflect the current reality of social and health inequities in Brazil. Testa[30] thinks the process of constitution of social subjects is necessary. Based on this process, practice can undergo transformation. If there is no sign of medical education focused on the Brazilian social needs, individual care practice will certainly prevail.

Health management – In the National Curricular Guidelines, the sections related to health management indicate that the ability to undertake management and administration actions to promote the community's wellbeing is essential in medical education. This promotion can be conducted through dimensions as care management, life appreciation, decision making, communication, foreign language domain, leadership and teamwork. Health management can be structured into two key actions for competency effectiveness in this area: health work organization and health work follow-up and assessment[3].

Management is mentioned in PNPS as one of the operational axes that prioritizes democratic and participative processes of regulation and control, planning, monitoring, assessment, funding and communication[5].

Therefore, there is a confluence of ideas in the creation of guidelines to medical education based on democratic and participative processes. However, the National

Curricular Guidelines contain a discourse that prioritizes the creation, implementation, monitoring and follow-up of intervention plans to the work process. Intersectoriality-based work competencies, promoted by PNPS, are not mentioned in the National Curricular Guidelines. Currently, one of the stumbling blocks to public health management is precisely the inability to work in a transversal way[18]. Managers have difficulties communicating with each other and creating transversal work plans in favor of intersectoriality.

This strategy could contribute to overcoming the lack of new care technologies indicated by Feuerwerker[31]. Prioritizing new health work models that privilege intersectoriality implies reorganizing health practices overcoming Flexner's model, which is still used.

Education in health – In this area, graduates are expected to be co-responsible for their own initial and continuing education to gain intellectual autonomy, social responsibility and commitment to the education of future generations of health professionals, encouraging academic and professional mobility. The objectives of their education should be: to learn how to learn, to learn from mistakes, to become involved in the doctor's education (juggling teaching, research and extension) and to build networks; as well as interprofessional learning and mobility[3].

Referencing the Adelaide Declaration[32] and the Declaration of Helsinki[33], PNPS emphasizes that it is easier to achieve the government's objectives when all sectors incorporate health and wellbeing as central components in the development of policies. This interaction is necessary because it acknowledges that the bases for health and wellbeing are beyond the health sector's scope; they are socially and economically built. Education is directly related to social and economic issues, both basic education, offered at the municipal and state levels; and public higher education. Even having gone through some changes aimed at democratizing its access, public higher education is still an elitist institution. These factors hinder the insertion of individuals from all socioeconomic strata in higher education[34].

Therefore, even though the National Curricular Guidelines have consistent objectives with the priority topics to health promotion mentioned by PNPS, there does not seem to be a correlation with the necessary university reform policies to implement an education focused on primary healthcare practices. This gap shows, once again, the lack of a discourse that privileges PNPS' intersectoriality.

Type of discourse

This stage in the analysis is aimed at explaining the different discursive constructions' bias, giving special attention to the value judgements that go beyond the discourses. Since it is a political document, a single type of discourse is observed: "prescriptive political." A prescriptive political emphasis is observed in most discursive constructions, in order to use them as a standard of action:

> Art. 3. Medical graduates will have a general, human, critical, reflective and ethical education, being able to work in different levels of care in the health-disease process, with health promotion, prevention, recovery and rehab actions, at the individual and collective levels, with social responsibility and commitment to

advocate for citizenship and human dignity, working as promoters of comprehensive care to human beings[3]. (p. 3)

Action orientation

This third stage of analysis involves a more accurate examination in order to analyze how discursive constructions are employed in the document. Under a Foucauldian point of view, discourses engender social practices through concrete power relationships in a given time, building a series of statements that establish different positionings of subjects. The documents' focus related to action orientation enables to analyze the discursive object's construction that provides for what subjects can do (practice) and material conditions under which these experiences occur[26].

Although the National Curricular Guidelines have a prescriptive political discourse that infers a prescriptive hierarchical characteristic, the document fosters the integration of medical education with other professionals. These professionals can be both from education (based on interprofessional education), in the competencies required for collective healthcare needs (encouragement to include the perspective of other professionals and social segment representatives), and from health management (openness to different opinions and collaborative work in health teams)[3].

Therefore, Chapter III, related to the undergraduate medical course's curricular content and pedagogical project, guides towards the design of the curricular structure to achieve the objectives provided by the National Curricular Guidelines. This chapter's discourses are focused on encouraging the inclusion of methodologies that favor students' active participation in knowledge building. The objective is to promote integration and interdisciplinarity consistently with a radical proposal of medical education focused on humanization and comprehensive care, according to PNPS.

Positionings

The subjective positioning observed in the discourses identifies the person's position in the structure of rights and duties for those who use that repertoire[27,35]. Therefore, the ways in which the construction of discursive objects are reflected on the positioning of different agents are observed in this stage of the analysis.

Although the course organization uses "methodologies that privilege student's active participation in knowledge building and integration among contents, besides fostering interaction among teaching, research and extension"[3] (p. 17), there is no sign of how this active role will be implemented in the courses' pedagogical projects.

Some authors[36,37] highlight that the autonomy based on the neoliberal model is always regulated, since individuals tend to follow rules and regulations designed by experts and parameters built by Healthy Public Policies. Thus, despite the National Curricular Guidelines' discourse focused on the subject's empowerment and autonomy, PNPS and the National Curricular Guidelines' strategies do not deepen the discussions on inequalities and inequities in Brazil[38,39].

Practices

According to Willig[27], certain practices become legitimate forms of behavior through discourses. According to the author, it is necessary to analyze the type of practice enabled by these discursive constructions in the document.

It is evident that, since it is an official document that guides medical education, it is focused on higher medical education managers. Article 7 dictates that "graduates should be co-responsible for their own initial and continuing education"[3] (p. 6). However, there is no mention to graduates who should have an "active participation" in their educational process. There is no mention to the path to be followed to achieve this objective. Since these agents are not included in the guidance of their educational process, there is a huge distance between managers and graduates, who are the main agents in this process and to whom practices are supposedly designed.

Subjectivity processes

The last stage of this analysis explores the relationship between discourse and subjectivity. Discourses show a specific way of seeing the world and being in the world. They build social and psychological realities through dialogical interanimation or mutual influences[18,27].

The analysis has already been showing that the discourses are not neutral. They are loaded with, in and between their lines, value judgements and positionings that favor or not a certain type of practice as opposed to others. These practices constitute social and psychological realities that represent ways of being in the world[27].

The subjects' subjectivity processes are expressed through positionings and practices to which they are delegated. They indicate the need to comply with the prescribed rules and principles, instituting a forecast and regulation project. The document is a resource to be used by managers in order to reorganize the medical educational process according to PNPS' principles and guidelines. In order to apply PNPS, innovative healthcare practices are required. However, the National Curricular Guidelines' discourses disregard graduates' ability to actively participate in their educational process. This contributes to the hierarchical relationship and passiveness to which the comprehensive care paradigm opposes. Appreciation of autonomy enables individuals to become responsible for their potential competencies.

These positionings provide an understanding of the construction of relationships in institutions and medical courses. The idea of instituted forces thus emerges as a space of power and decision making that previously regulates behaviors, being able to reproduce certain enunciations and realities, and affecting subjectivity.

Final remarks

The new National Curricular Guidelines predominantly follow PNPS' recommendations, since it aims at a general, human, critical, reflective and ethic education capable of preparing professionals to work with social responsibility and commitment to advocate for citizenship and human dignity in different levels of the health-disease process. However, it is important to highlight that the health promotion paradigm has multiple readings. Therefore, it is the responsibility of researchers, teachers, managers,

technicians and students to resignify it in light of Brazilian people's health needs, taking into consideration their explanatory and transformative potential[4,28].

The idea that historical tensions in the construction of the National Curricular Guidelines evidence problems and gaps in the medical education agenda in the country and how they influence current education models and proposals is thus reinforced.

Likewise, the analysis also reveals that, although there is an attempt to place graduates as active subjects in their educational process, there is no sign of including these social agents in the creation of their educational practices. According to Ortega Y Gasset[40], this is one of the essential mistakes of universities that become lost in definitions of culture and science: not taking students into consideration.

However, what should be really highlighted in this analysis is the web of interdependences into which academic education and health work are inserted[41]. In order to consolidate changes in medical education so that they take singularities into consideration, offer care technologies and deal with subjective aspects involved in the process of living and becoming ill, deeper reflection spaces that go beyond the publication of new curricular guidelines are necessary.

Realities built as a consequence of the discourses analyzed here were not considered in the study's object and can evidence other elements that contradict or reaffirm the enunciations. Even though we understand education does not occur a priori and exclusively as prescribed, but rather through encounters and relationships, the text's enunciations certainly activate institutional practices and organize conditions in which experiences occur[18,27].

Paulo Freire's works have been gaining space among the educational proposals based on freedom and emancipation under this perspective[42,43]. This approach gives rise to the creation of strategies to promote the individuals' participation, aiming at an increased control over life, efficacy of public policies, social justice and an improved quality of life[4].

Therefore, by adopting a reflective and relational process in the construction of medical education policies and projects, it is not possible to consider the National Curricular Guidelines as something concluded, but rather as something to become, as an action orientation category. Based on this thought, emphasis should be given to reflectiveness through dialogical relationships and in the critical sense, with new alternatives to social action.

Authors' contributions

All authors participated actively in all the stages of the preparation of the manuscript.

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