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Professional recognition and neoliberal rationality in medical education based on the 2025 National Curriculum Guidelines (DCN)

Reconhecimento profissional e racionalidade neoliberal na formação médica a partir das DCN de 2025

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ABSTRACT

Introduction: This article investigates the role of the 2025 National Curriculum Guidelines for Medicine (DCN) in formalizing a professional recognition regime permeated by neoliberal rationality. Medical socialization is understood, based on George Herbert Mead's notion of the "generalized other," as the incorporation of community expectations that provide intelligibility to professional conduct.

Objective: To analyze how the regulatory provisions of the 2025 DCN reorganize the discourse of recognition in medical education, problematizing performance imperatives and the ethical dimension of care.

Method: A theoretical-analytical study based on a discursive document analysis of Resolution CNE/CES No. 3/2025. The corpus comprised the full text of the regulation, focusing on provisions regarding the graduate profile, competencies, curricular organization, student monitoring, and assessment, all examined through the theoretical frameworks of George Herbert Mead, Pierre Dardot and Christian Laval, and Gilles Deleuze and Félix Guattari.

Result: The discourse of competencies, progressive development, and individual accountability brings undergraduate education closer to logics of auditability and self-management. Ethical-humanistic discourses, such as person-centered care and commitment to the Unified Health System, coexist with mechanisms of continuous assessment and correction, inscribing the educational trajectory within a logic of performance legibility.

Conclusion: Medical identity constitutes a space of dispute between standardization and variation. The notion of becoming makes it possible to problematize the claim of full curricular codification and to argue that the relational dimension of care is not exhausted by performance criteria.

Keywords: Medical Education; National Curriculum Guidelines; Neoliberalism; Professional Identity; Care.

RESUMO

Introdução: *O artigo investiga a participação das Diretrizes Curriculares Nacionais (DCN) de Medicina de 2025 na formalização de um regime de reconhecimento profissional atravessado pela racionalidade neoliberal. A socialização médica é compreendida, a partir da noção de "outro generalizado" de George Herbert Mead, como a incorporação de expectativas comunitárias que conferem inteligibilidade às condutas da carreira.*

Objetivo: *Este estudo analisa como os dispositivos normativos das DCN de 2025 reordenam o discurso de reconhecimento na formação médica, problematizando imperativos de desempenho e a dimensão ética do cuidado.*

Método: *Trata-se de um estudo teórico-analítico fundamentado na análise documental de caráter discursivo da Resolução CNE/CES nº 3/2025. O corpus compreendeu a íntegra do texto normativo, com recorte nos dispositivos relativos ao perfil do egresso, às competências, à organização curricular, ao acompanhamento estudantil e à avaliação, articulados aos referenciais teóricos de George Herbert Mead, Pierre Dardot e Christian Laval, e Gilles Deleuze e Félix Guattari.*

Resultado: *O discurso das competências, do desenvolvimento progressivo e da responsabilização individual aproxima a graduação de lógicas de auditabilidade e autogestão. Discursos ético-humanísticos, como o cuidado centrado na pessoa e o compromisso com o Sistema Único de Saúde, coexistem com mecanismos de avaliação e correção contínua, inscrevendo a trajetória formativa em uma lógica de legibilidade do desempenho.*

Conclusão: *A identidade médica constitui um espaço de disputa entre normatização e variação. A noção de devir permite problematizar a pretensão de plena codificação curricular e sustentar que a dimensão relacional do cuidado não se esgota nos critérios de desempenho.*

Palavras-chave: *Educação Médica; Diretrizes Curriculares Nacionais; Neoliberalismo; Identidade Profissional; Cuidado.*

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INTRODUCTION

Contemporary medical training forms part of a system of recognition that legitimises discourses and practices from the very beginning of a clinician's career[1,2]. This system operates through formal assessments and expectations within teaching and service settings, giving meaning to the forms of presence accepted as characteristic of the profession[3–6]. Professional socialisation involves the internalisation of shared expectations that guide both the formation of medical identity and the criteria by which performance comes to be recognised[7,8].

This discussion can be examined through the lens of George Herbert Mead's concept of the 'generalised other'[9], understood as the organised attitude of the community which the subject adopts when guiding their actions[10]. This is a process whereby the future professional learns to act in the constant presence of a community that calls upon them, transforming gestures and emotional dispositions into signs of belonging to a shared normative horizon[11,12].

When viewed through the lens of neoliberal rationality, this framework of recognition is understood as a contemporary form of governance over behaviour. By generalising the 'corporate form', as described by Dardot and Laval[13], this logic introduces value criteria based on efficiency, competitiveness and self-management, altering the way in which individuals regulate their behaviour[14]. In medical education, this trend intensifies the use of metrics and protocols, shifting the recognition to a dimension in which the student manages themselves as a constantly appreciating asset, running the risk of narrowing the scope of care due to demands for institutional optimisation[15].

The 2025 National Curriculum Guidelines (DCNs)[16] define the scope of this study, as they constitute the most recent regulatory framework for undergraduate medical studies in Brazil. The corpus of documents corresponds to CNE/CES Resolution No. 3/2025, which has been examined in full, with a focus on the provisions relating to graduate profiles, competencies, curricular organisation, student monitoring and assessment. Drawing on studies of professionalism, medical identity and curricular reforms[4,15], this article examines a connection that has thus far received little attention: the relationship between professional recognition, neoliberal rationality and the ethical limits of curricular codification. The central issue is to understand how a document that advocates humanistic care also organises training through technologies for monitoring, tracking and correcting performance[17]. The perspective of *becoming*, in Deleuze and Guattari[18], underpins the analysis of the movements of differentiation that elude the equivalence between value and performance[19,20]. The perspective of *becoming* enables us to understand aspects of clinical experience that cannot be fully captured by the curriculum[21].

In this study, the regime of recognition refers to the set of expectations, validation criteria and institutional mechanisms through which certain behaviours come to be recognised as medical *per se*. The term encompasses intersubjective approval and the curricular mechanisms responsible for monitoring students' progress and conferring legitimacy throughout their education. The concept therefore links professional socialisation and the regulation of conduct.

The aim of this article is therefore to analyse how the 2025 DCNs contribute to the formalisation of a system of recognition shaped by neoliberal rationality, with implications for the formation of professional identity and the intelligibility of care. It is argued that the competency-based approach makes the recognition of future doctors contingent upon their ability to demonstrate performance and institutional adaptability. At the same time, the formative experience preserves areas of variation that keep the ethical scope of clinical practice open.

METHODOLOGY

This study is characterised as a theoretical-analytical investigation based on a discursive analysis of the literature. The corpus consists of the full text of the DCNs for the undergraduate degree programme in Medicine, established by CNE/CES Resolution No. 3 of 30 September 2025[16]. This document has been chosen because it constitutes the current regulatory framework, which sets out the graduate profile, the key competencies, the organisation of the course and the monitoring and assessment arrangements. Curriculum documents are understood as forming part of the field of production of intelligibility in medical education, because they define expectations regarding patient care, learning methods, assessment criteria and ways of belonging to the medical community. The analysis focused on the discursive materiality of the regulatory text, viewed as a space in which meanings regarding medical training and the expected performance of students are established.

In order to organise the selection and analysis of the statements, a matrix was drawn up with three interlinked axes: (1) the definition of the graduate profile and the normative outlook for belonging, aimed at identifying the attributes, values and expectations that shape the desired professional identity; (2) the curricular mechanisms for monitoring, progression and correction, related to the mechanisms for monitoring and assessing the educational pathway; and (3) the clinical relationship, care and the limits of the curriculum codification, aimed at analysing the ethical and relational dimensions and the possibilities that go beyond the full scope of the curriculum

codification. Formulations were selected that met at least one of the following criteria: identifying graduate attributes or competencies; establishing methods of monitoring, progression or correction; and defining the meaning of care, professional identity or the clinical relationship. Table 1 summarises the analytical axes, the methods employed and the guiding questions for the analysis.

The interpretative analysis was structured in three analytical stages. Initially, the attributes and expected behaviours of graduates were identified and examined as part of a shared outlook of recognition. Next, the mechanisms for setting learning outcomes, monitoring and programme evaluation were analysed in terms of their effects on student accountability and self-management. Finally, the notion of becoming guided the critical analysis of the limits of identity stabilisation and of the variations inherent in the formative experience that elude normative stabilisation.[9,13,18].

The frames of reference were not treated as components of a unified theoretical system. Mead focuses on understanding the social constitution of the self and the community expectations that shape recognition; Dardot and Laval contribute to the analysis of neoliberal rationality and the enterprise-form; Deleuze and Guattari provide a mechanism for questioning the limits of identity stabilisation and curricular codification. Its structure is therefore situated, complementary and guided by the research problem, rather than by the aim of establishing a single theoretical system.

As this was a documentary study based on a publicly available regulatory act, involving no human participants and making no use of personal data, the study did not require review by a Research Ethics Committee.

MEAD AND THE 'GENERALISED OTHER' IN THE PROFESSIONAL SOCIALISATION OF DOCTORS

Professional identity can be understood as a consequence of participation in a symbolic community[9]. Students learn to recognise certain ways of speaking, listening, caring for others and managing emotions as being characteristic of doctors, because their behaviour comes to be guided by the group's established attitudes. The 'generalised other' brings together this shared horizon of expectations and provides the points of reference through which the student becomes recognisable to lecturers, fellow students, supervisors, patients and institutions[10,22].

The 2025 DCNs set out this regulatory outlook by defining the doctor as a professional with a "broad, sound, critical and reflective education, committed to the ethical, humanistic, scientific and social principles of medicine" and by linking professional practice to "care centred on the individual, the family and the community"[16](pp. 1–2). The curriculum

Table 1. Analytical matrix for the selection and critical examination of the statements in the 2025 National Curriculum Guidelines (DCNs).

Analytical axis	Selected statement clusters	DCN articles engaged	Main theoretical reference	Focus of the question
Identification of graduate profile and outlook of belonging	A comprehensive, sound, critical and reflective education; ethical, humanistic, scientific and social principles; person-centred, family-centred and community-centred care; qualified listening; commitment to the Unified Health System (SUS); equity; social justice; professional identity	2nd, 4th, 8th, 11th and 29th	Mead[9]	What forms of a sense of belonging and professional recognition are shaped by the attributes, values and dispositions attributed to the graduate?
Curricular mechanisms for monitoring, progression and correction	Competency-based curriculum; progressive competency development; programme-based assessment; systematic performance monitoring; mandatory individual feedback; classification by domain; individualised action plan	18th, 19th and 36th	Dardot and Laval[13]	How do mechanisms for competencies, monitoring, progression and correction shape the visibility of a student's educational journey and link performance, accountability and professional recognition?
Clinical relationship, care and the limits of the standard	Care as a relationship; qualified listening; uniqueness of contexts; mentoring; mental health; self-care; development of professional identity; contingencies of the clinical encounter	4th, 8th and 29th, as well as related statements on care and training	Deleuze and Guattari[18]	How does the normative text link the curricular codification for care to the relational, individual and contingent dimensions of clinical experience, and what limitations arise from this link?

Source: Prepared by the authors (2026).

document plays a part in establishing a system of recognition that produces criteria for belonging and legitimacy. By identifying expected attributes, attitudes and competencies, the DCNs help to define the scope of what is recognised, establishing a discourse through which the future doctor learns to assess themselves and to be assessed[16].

The link between other individuals and the 'generalised other' helps us to understand that professional recognition depends on a broader normative outlook than immediate interpersonal relationships. A teacher's conditional approval or a mentor's occasional observation form part of a shared perspective for action, from which certain practices become predictable, certain values come to be taken for granted, and certain behaviours acquire the status of professional legitimacy[10,23].

By gradually embracing these expectations, the student anticipates what the medical community values and organises their practice around this repertoire. Assessments and day-to-day monitoring practices give substance to this process, as they define the parameters of legitimate professional conduct[10]. In the 2025 DCNs, this outlook is reflected in the integration of technical excellence, human sensitivity, qualified listening, a commitment to the Unified Health System (SUS) and continuing professional development[16]. By setting out these provisions, the document helps to establish the criteria by which students assess their own conduct and are assessed throughout their training.

This process contributes to the formation of the professional self by transforming collective expectations into benchmarks against which the student assesses their own conduct and guides their actions. Curriculum statements are part of this dynamic by establishing standards of merit that define criteria for suitability and belonging. Accordingly, this gives rise to the normative field within which the relationship between internalised expectations and the student's individual responses is established.

Mead's distinction between 'me' and 'I' enables us to examine the relationship between normative stabilisation and variation in medical training. The 'me' refers to the structure of internalised duties and expectations that makes the subject socially recognisable; the 'I' refers to the individual's unique response and preserves the possibility of bringing about shifts in experience[9]. In medical training, this analytical distinction is crucial: professional identity is constituted by normative stabilisations and remains interwoven with unique responses that prevent it from being reduced to mere repetition. The 2025 DCNs reinforce this approach by incorporating, on the same plain, humanistic principles and requirements for continuous professional development[16].

In Mead, the response of the 'I' becomes accessible after its realisation, when it can be incorporated into the 'me' and reorganise social experience[9]. This temporal gap defines the scope of curricular anticipation: the profiles and competencies organise expectations prior to the action, whilst the response produced during the encounter can only be assessed once it has been translated into a recognisable language. Uniqueness is therefore formed within the socialisation, although it cannot be entirely predicted by it.

The professional 'me' is now shaped by an increasingly codified curriculum-based discourse, which defines what should be recognised as excellence and protagonism. A reading of Mead[9] supports the argument that medical socialisation produces a communal intelligibility that induces the sense of belonging and regulates forms of recognition. This intelligibility defines the boundaries of legitimate conduct and due care. From this normative perspective, neoliberal rationality exerts a profound influence, reshaping the community's organised attitudes and aligning professional recognition with a discourse of performance and continuous professional development, and it is precisely within this outlook of recognition that neoliberal rationality begins to reorganise the criteria by which performance is produced, monitored and legitimised. Accordingly, the issue centres on the specific way in which the shared normative perspective is reorganised when performance is tracked by monitoring mechanisms that call on students to exercise self-management and take centre stage in professional recognition.

DARDOT AND LAVAL: THE NEOLIBERAL SUBJECT, THE ENTERPRISE-FORM AND THE REORDERING OF PROFESSIONAL RECOGNITION

Neoliberalism can be understood as a form of governmental rationality that extends beyond the economic sphere and establishes itself as a principle that governs behaviours, institutions and the ways in which individuals come to relate to one another[13]. This is a framework that redefines the very criteria for understanding action, shifting the value placed on experiences towards factors such as performance, adaptation, self-investment and continuous development. From this perspective, the company ceases to be merely a production unit and begins to operate as the overarching organising principle of society, producing the 'neo-subject' – an individual who manages themselves as capital in a state of perpetual appreciation[24].

This rationality is not primarily imposed through external coercion; its functioning depends on the individual's subjective engagement in their own conduct. Governing and self-governance now form part of the same normative framework,

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within which the individual is called upon to engage, take responsibility and continually improve. Benchmarking and productivity requirements no longer play a peripheral role, but instead shape the very ways in which value is attributed to practices, thereby consolidating the enterprise-form as a diffused ethos that reorganises experience around the legibility of the productive return[25].

In the field of education, this shift extends to universities by restructuring education in line with institutional technologies that link the governance of institutions to self-governance. Education is now managed in accordance with the performance principle, according to which becoming an entrepreneur of oneself means taking on, as a personal duty, both the investment in one's own abilities and the management of failures and diversions[24].

Some provisions of the 2025 DCNs can be examined in the light of this rationale[16]. The document retains provisions on person-centred care, human dignity, equity, active listening and a commitment to the SUS. At the same time, it introduces a "competency-based curriculum", "progressive competency development", "systematic performance monitoring" and "compulsory individual feedback"[16](pp. 6–9). This interconnection embodies a logic of continuous progression and correction, the effects of which depend on the institutional forms of implementation[26].

The convergence between a competency-based curriculum and neoliberal rationality occurs when continuous monitoring shifts the responsibility for correcting their own educational path onto the student. Competency, when considered in its educational role, can integrate knowledge, practices and attitudes. Its governing effect becomes apparent when constant assessment becomes a prerequisite for a student's recognition and when learning difficulties are primarily interpreted as individual shortcomings. When these mechanisms operate in tandem, the assessment process contributes to the creation of a subject who is called upon to make their career path institutionally visible and open to continuous improvement. The governing nature of the competency depends on the institutional framework within which it operates. When assessment, feedback and an action plan form a continuous process, the learning difficulty begins to shape the student's future progress. The allocation of responsibilities therefore becomes a key issue: the onus may lie predominantly with the individual, or it may also extend to teaching conditions, supervision and integration into health services.

The incorporation of ethical values is now accompanied by the requirement to present them in a clear and comparable form, transforming the educational journey into a continuous process of demonstrating conformity[13,16]. The dialogue with Mead enables us to understand how this rationality reshapes professional recognition. Whilst the 'generalised other' refers to the organised attitude of the community that governs membership, neoliberal rationality alters the content of this attitude by reframing recognition in terms of criteria of measurability and traceability[10,27]. Within the learning community, adherence to a shared ethical tradition comes to coexist with validation criteria based on demonstrating progress and managing oneself as a unit of productivity. In this context, the 'good doctor' can be understood as someone who demonstrates proven competence and takes responsibility for continuous professional development.

At the heart of this reorganisation lies the institutional mediation of recognition. The judgements formed in interactions with teaching staff, supervisors and patients are channelled through the institutional system when they are converted into performance records, feedback reports and action plans. Legibility thus ceases to serve merely as a complement to learning and rather plays a part in validating the student as a future doctor. Under this arrangement, professional recognition depends on the ability to translate learning experiences into evidence that can be communicated within the institution.

Article 36 of the DCNs[16] sets out this connection by establishing a system of 'systematic monitoring of student performance', conducted in an 'institutionalised, continuous, comprehensive and integrated' manner, with "mandatory individual feedback"[16] (p. 9). The educational journey is now accompanied by mechanisms that shape the student's institutional legibility, filtering the Meadian 'me' through dense systems of classification and correction. Learning difficulties and subjective obstacles can be recodified as individual shortcomings in the face of curricular demands. From this perspective, the interplay between monitoring, correction and individual accountability provides an insight into the reorganisation of humanistic discourse in accordance with a rationale that links the value of the student to their institutional visibility.

DELEUZE AND GUATTARI: BECOMING AS THE LEVER THAT PROBLEMATIZES THE LIMITS OF CURRICULAR CODIFICATION

The concept of becoming is used to question the limits of curricular codification[18]. Having examined the formation of a shared horizon and its reorganisation through the lens of performance, it is now appropriate to shift the discussion of professional identity – understood in its normative aspects – towards the processes of variation that underpin professional development.

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Becoming[18–20] refers to a relational process of variation that shifts established positions and produces transformations without directing them towards a final form. When applied to medical training, this concept allows us to examine the clinical encounter as an event capable of altering the student's perception and the way they act during the clinical encounter. During the session, the student and the patient interact through forms of knowledge that are also displaced by experience. *Becoming* thus introduces a concept of time distinct from curricular progression: progression organises demonstrable learning outcomes, whilst the becoming pinpoints transformations produced in the encounter that cannot be reduced to measurable terms. In this paper, becoming refers to the gap between the profile anticipated by the curriculum and the response produced in an actual clinical situation. This concept upholds the requirement for competence and emphasises that the protocol is adapted to the unique nature of the encounter, without predetermining all possible ways of perceiving, responding and caring.

The 2025 National Curriculum Guidelines provide institutional clarity regarding the educational pathway by linking competencies with systematic monitoring and assessment of performance[16]. This framework defines the profile of the ideal professional and structures their professional development in accordance with institutionally verifiable criteria. The normative profile anticipates attributes and organises expectations, whilst the learning experience continues to be shaped by events that the curriculum cannot determine in advance. Between the regulatory text and its adaptation in clinical settings, hesitations, readjustments and unique responses arise, all of which contribute to the formation of the professional identity. As the corpus is documentary in nature, these variations are treated as analytical possibilities within the educational experience, the empirical occurrence of which requires investigation in the various settings of DCN implementation[16,18,21,28,29].

This tension becomes apparent when care is reframed in terms of performance. Translating the clinical encounter into observable competencies and evidence of readiness may subordinate the uniqueness of the encounter to predefined criteria of pedagogical effectiveness. Drawing on the concept of becoming allows us to critically question this equivalence, because medical training continues to be shaped by variations that go beyond the curricular codification.

Conceived as *becoming*, medical training is a relational process open to variation and enables us to recognise, in clinical encounters, an ethical issue linked to otherness and the singular. Between protocol and suffering, between the expected and the unexpected, compositions emerge that reintroduce indeterminacy into a framework organised by mechanisms of competency, monitoring and assessment. Care re-emerges as a practice that involves exposure to otherness and responsibility towards the individual – dimensions that cannot be fully anticipated or captured by measurement tools[30–33].

RECONFIGURATIONS OF THE 'GENERALISED OTHER' IN MEDICAL TRAINING AND THEIR EFFECTS ON IDENTITY AND CARE

The 2025 DCNs[16] help to shape a normative outlook by defining the attributes, competencies and modes of practice through which the future doctor becomes recognisable to the professional community. The document does not cover the entirety of the 'generalised other', because community expectations are also shaped by relationships with teachers, tutors, colleagues, patients and institutions. It does, however, provide a formal record of some of these expectations, setting out criteria for membership and legitimacy. The analytical link between Mead[9] and Dardot and Laval[13] enables us to examine how this shared prospect comes to incorporate requirements for performance, monitoring and self-management.

In the DCNs, ethical and humanistic terminology is linked to the mechanisms for monitoring pupils' progress. Qualified listening and a social commitment to the SUS are linked to programme-based assessment, classification by domain and action plans in response to learning difficulties[16]. Competency retains its educational role of integrating knowledge, practices and attitudes. Its governing effects come to the fore when the repeated demonstration of these provisions becomes a condition for recognition, making the student increasingly visible and subject to institutional correction. Care remains a formative value, whilst its validation now depends on institutional forms of observation and record-keeping.

The requirement to demonstrate progress is also part of the constitution of the professional self, because internalised expectations now include the need to demonstrate continuous progress and the ability to meet explicit pedagogical goals. Students are encouraged to manage their educational journey as a project of ongoing self-improvement, moving closer to the model of the entrepreneurial subject described by Dardot and Laval[13]. The regulatory text itself contains elements that challenge this rationale, including qualified listening, mentoring, mental health support and recognition of the unique nature of each context[16]. Whilst these statements do not guarantee that the logic of performance will be overcome, they do introduce points of tension that reconnect training with the ethical, relational and subjective dimensions of care.

Recent literature frames the update of the National Curriculum Guidelines as part of an effort to strengthen

curriculum governance, educational safety, digital health and student wellbeing[34–36]. From this perspective, programme evaluation serves to monitor progress over time and assess professional readiness. This analysis acknowledges the educational role of these devices and examines the conditions under which monitoring can become a criterion for visibility and recognition. Tension arises when institutions begin to interpret competence as a criterion for individual accountability.

The implementation of the DCNs requires Core Teaching Teams, Pedagogical Support and Teaching Experience Teams, collegiate bodies and managers to examine how assessment mechanisms operate in different learning settings. The educational role of feedback depends on recording the context in which the performance was observed and on the distribution of responsibilities amongst students, the course, teaching staff and health services. Individualised action plans must take into account the teaching and supervisory conditions that contribute to the difficulties identified. Mentoring and student support also require independence from assessment mechanisms, preserving spaces for listening which do not reduce the student's entire experience to evidence of performance.

Like any documentary analysis, this study interprets the possibilities inherent in the legislative text rather than its empirical effects. The formulated hypotheses regarding visibility, accountability and recognition should be examined in research that monitors the implementation of the DCNs in different institutional contexts.

CONCLUSION

The 2025 DCNs contribute to the reorganisation of the conditions under which the future doctor becomes recognisable within the profession. By formalising competencies and monitoring mechanisms, the guidelines generate a curricular understanding that provides a pedagogical structure for the professional identity. The education thus functions as a mechanism for shaping behaviour and validating students' pathways. This interconnection creates the conditions for a system of recognition in which a student's value can be linked to the ability to make their journey institutionally traceable.

The theoretical contribution of this study lies in situating professional recognition at the interface between socialisation and the regulation of conducts. From this perspective, assessment plays a part in shaping professional identity by defining the ways in which a student's academic journey is made visible and legitimised within the medical community. The curriculum design incorporates the formation of subjectivities by defining expectations that link technical excellence to ongoing self-management. This connection allows us to understand how humanistic commitments can be integrated into a performance-based approach without disappearing from the curriculum discourse.

Meanwhile, the educational experience is not limited to the standardisation envisaged by the curriculum, because care remains interwoven with encounters and relational demands that go beyond its codification. The notion of becoming allows us to identify, within this difference, the possibility of conceiving medical training in terms that go beyond the equivalence between competence and value. The challenge lies in monitoring how curricular mechanisms are implemented, whilst ensuring that care is not reduced to a decontextualised measure of performance.

In terms of education policy, this analysis suggests that regulation and monitoring of implementation should take into account the ways in which competencies, programme evaluation, mentoring and student support are incorporated into pedagogical projects. Managers and teaching staff need to monitor the educational quality of these mechanisms and their effects on care, the doctor-patient relationship and students' wellbeing. Future research could conduct a comparative analysis of the implementation of the DCNs at different medical schools and examine, together with students, lecturers, clinical supervisors and users of the SUS, how the new assessment mechanisms contribute to the formation of professional identity and care practices. Ultimately, viewing medical training solely as the acquisition of competencies is insufficient to explain the formation of professional identity. The recognition of a trainee doctor stems from the interplay between processes of socialisation, institutional assessment mechanisms and modes of governance over conducts, whilst pervaded by the very openness of care relationships. It is in this balance between normativeness and individuality that the main challenges of implementing the 2025 National Curriculum Guidelines lie.

CONTRIBUTION OF THE AUTHORS

Lucas Vieira: Conceptualisation, Formal Analysis, Research, Methodology, Writing – original draft, Writing – review and editing. Mateus Signorati: Conceptualisation, Formal Analysis, Research, Methodology, Writing – original draft, Writing – review and editing. Angelo Vitorio Cenci: Conceptualisation, Formal Analysis, Research, Methodology, Writing – original draft, Writing – review and editing, Supervision.

CONFLICT OF INTEREST

We declare no conflict of interest.

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Research data is available in the body of the document.

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