

Apprehension and Understanding of the Health Needs Concept for Students of an Active Curriculum

Apreensão e Compreensão do Conceito de Necessidades de Saúde para Estudantes de um Currículo Ativo

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KEYWORDS

- Teaching.
- Medical Education.
- Nursing Education.
- Curriculum.
- Problem-Based Learning.
- Public Health.

ABSTRACT

Introduction: The 2001 National Curriculum Guidelines value the biopsychosocial aspects of the health-disease process and student accountability through training and active performance in health services. This study was carried out at a college in the countryside of the state of São Paulo, which has the concept of health needs as a theoretical guide. To understand the experience of medical and nursing students in relation to the concept and operationalization of the integrated curriculum. Theoretical-practical developing of the relationship between students and other health actors was carried out to identify reasons for the divergence in the understanding of the theoretical framework between them, providing subsidies to identify these inequalities in the context of teaching. **Methods:** 33 students from the aforementioned courses were interviewed. The study was performed using the methodological framework of Grounded Theory and theoretical context of health needs. The semi-directed interviews were recorded, transcribed in full and coded line by line, according to the microanalysis process. The codes were grouped into elements, subsidies for the creation of categories. **Results:** There were five emerging categories: (1) "Understanding that there are differences in approach between the groups of the Systematized Educational and Professional Practice Units and between the educational units, with difficulties for effective theoretical-practical articulation"; (2) "Identifying that there is a discrepancy in learning and experiences of the concepts of health needs among students"; (3) "Understanding that the apprehension of health needs is more effective when theory is associated with practice and vice versa"; (4) "Assimilating that the concept of health needs is related to the extension of the integrality of care focus" and (5) "Recognizing the link as essential in the school years and teaching-learning scenarios to identify health needs and practical care success". These constitute the theoretical model: "According to the student's perspective, the apprehension and understanding of health needs depend on the theoretical-practical articulation in the different groups of students and teaching-learning scenarios, having as essential elements the link and the integrality of care". **Final considerations:** For the effective apprehension of students' health needs, discontinuity of learning and discrepancies in how it is conducted must be avoided, a process that depends on links and comprehensive care in order to be viable.

RESUMO

PALAVRAS-CHAVE

- Ensino.
- Educação Médica.
- Educação em Enfermagem.
- Currículo.
- Aprendizagem Baseada em Problemas.
- Saúde Coletiva.

Introdução: As Diretrizes Curriculares Nacionais de 2001 valorizam aspectos biopsicossociais do processo saúde-doença e responsabilização dos estudantes por meio de atuação formativa e ativa nos serviços de saúde. Conduziu-se este estudo em uma faculdade do interior paulista que tem o conceito de necessidades de saúde como norteador teórico. O objetivo deste estudo foi compreender a experiência de estudantes de Medicina e Enfermagem em relação ao conceito e à operacionalização do currículo integrado. Realizou-se aprofundamento teórico-prático sobre a relação de discentes com os demais atores em saúde para identificar razões da divergência do entendimento do referencial teórico entre eles, propiciando subsídios para identificar essas disparidades no contexto do ensino. **Método:** Entrevistaram-se 33 estudantes dos cursos supracitados. O estudo foi elaborado por meio dos referenciais metodológico da Teoria Fundamentada nos Dados e teórico de necessidades de saúde. As entrevistas semidirigidas foram gravadas, completamente transcritas e codificadas linha a linha, segundo o processo de microanálise. Os códigos foram agrupados em elementos, subsídios para formação das categorias. **Resultados:** Obtiveram-se cinco categorias emergentes: 1. “Percebendo que há diferenças de abordagem entre os grupos das Unidades Educacional Sistematizada e de Prática Profissional e entre as unidades educacionais, com dificuldades para efetiva articulação teórico-prática”; 2. “Identificando que há discrepância de aprendizagem e vivências dos conceitos de necessidades de saúde entre os estudantes”; 3. “Entendendo que a apreensão das necessidades de saúde é mais efetiva quando se associa a teoria à prática e vice-versa”; 4. “Assimilando que o conceito de necessidades de saúde diz respeito à ampliação do foco da integralidade do cuidado”; e 5. “Reconhecendo o vínculo como essencial nas séries e nos cenários de ensino-aprendizagem para a identificação das necessidades de saúde e um sucesso prático do cuidado”. Essas categorias constituem o modelo teórico: “Segundo a perspectiva discente, a apreensão e a compreensão de necessidades de saúde são dependentes da articulação teórico-prática nos diferentes grupos de estudantes e cenários de ensino-aprendizagem, tendo como elementos essenciais o vínculo e a integralidade do cuidado”. **Conclusões:** Para a efetiva apreensão de necessidades de saúde dos discentes, devem-se evitar descontinuidade do aprendizado e discrepâncias em como é conduzido, processo que depende de vínculos e do cuidado integral para ser viável.

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INTRODUCTION

With the advent of a new training model, the National Curriculum Guidelines¹ (NCG) for the Nursing, Medicine and Nutrition courses were instituted in 2001. These guidelines aim to integrate theory, practice and determinant aspects of the health-disease process (biological, psychological, environmental and social) and student accountability through training and active performance in health services. Expanding these needs, the 2014 NCG interconnect teaching, research and extension, advocating three areas: Health Care, Health Management and Health Education². In spite of the advances proposed by both guidelines, Medical Education is not unified, but a dynamic process to be built in the different scenarios of professional practice every day³.

When seeking a significant restructuring of the medical and nursing course curricula, the Marília Medical School, between 1997 and 1998, developed the educational project called FAMEMA 2000. The model started to focus on the student, implementing the strategies of “Problem-based Learning” (PBL), Problemization and through the community itself. In 2003, in turn, there was a new development with the implementation of the integrated and competence-oriented curriculum project, integrating the institution’s medical and nursing courses⁴. In the “Curricular Organization” section of this project, it is discussed that the curriculum proposal is based on the concept of integrality of care from the perspective of health needs, valuing the reflection and the transformation of practice through active, critical and reflective training⁴.

Currently, the six years of the medical course and the four years of the nursing course at this institution use the framework of the health needs concept as a guide, being called: “Educational Unit 1: Professional Practice Unit and Systematized Educational Unit”, “Health Needs and Professional Practice Unit 2” (both with the 1st and 2nd years of the Medical and Nursing courses together); “Health Needs” and Professional Practice 3; “Professional Practice Unit: care of hospitalized individuals”; (3rd year of the Medical and Nursing courses, respectively); “Attention to the Health Needs of the Individual, Family and Community in the Health Surveillance Model”, “Professional Practice Unit 4” (4th year of the Medical and Nursing courses, respectively); and “Integrated Internship: Adult Health and Maternal-Child Health I and II” (5th and 6th years of the Medical course)⁵.

The academic activities, in turn, are guided by three units: Systematized Educational Unit (SEU), which consists of tutoring and conference scenarios guided by the PBL model; Professional Practice Unit (PPU), consisting of practice activities in the scenarios (Primary, Secondary and Tertiary Care Units), the Professional Practice Laboratory (PPL) and pedagogical cycles, all guided by the problematization model; and, finally, the Elective Educational Unit, of which elements are mandatory internships in areas of knowledge chosen by the students themselves⁵. Therefore, the Marília Medical School reaffirms through these units that the curriculum is a construction in society in which the different actors experience limits and advances for the implementation of a new health education model^{6,7}.

Regarding the training processes, there is a scarcity of scientific studies on the assessment of the articulation between the curriculum and the health needs framework in higher education institutions with active methodologies. Thus, considering the mission of the Marília Medical School:

“Train professionals committed to people’s health needs according to the SUS principles and provide care based on the integration of teaching, research and assistance”⁷.

We intended to verify the consonance of the apprehension and understanding of medical and nursing students in relation to the inclusion of the health needs concept in all stages of education and training, of which focus is the operationalization of an integrated curriculum. This study was created through the analysis of the perspective of students involved in health care and a theoretical-practical expansion about their relationship with teachers, users and professionals, aiming to identify the reasons that cause divergence in the understanding of the theoretical framework among these students, providing subsidies so that the disparities found can be understood in the context of teaching. We also aimed to contribute to medical and nursing schools in their curriculum development process so that there is a strengthening in training and care for all involved individuals.

METHOD

This research has a qualitative nature and is guided by the methodological framework of Grounded Theory (GT), of which objective is to understand a phenomenon in the environment where it occurs, considering the meaning that a given context represents for that actor, based on the direct observation between the action and these meanings. This allows the construction of theories, as the method investigates a given phenomenon to determine the conceptual model that explains it⁸. In turn, the theoretical references used were Cecilio’s Health Needs⁹⁻¹⁰ and institutional products, such as the Year Notebooks¹¹⁻¹⁸ and pedagogical projects⁴⁻⁷ of the medical and nursing courses of the institution.

The sample consisted of students from the Marília Medical School, an institution of which curriculum is organized by active methodologies and the constant participation of students in academic bodies (collegiate meetings and with managers). The selected actors belong to the 1st up to the 6th years of the medical course and 1st to 4th years of nursing course and all respondents signed the Free and Informed Consent Form (FICF). Data collection was in accordance with the favorable opinion of the Research Ethics Committee (REC) under number 2272195 and PIBIC/CNPq scholarship number 129621 / 2017-0.

To closely understand the students’ experience, semi-directed interviews were carried out with each participant in an private environment, aiming to guarantee confidentiality, such as rooms at the School itself and at the care units of the HC Complex of the Marília Medical School, with one or two interviewers present at that moment. A script was used with each interviewee, including demographic data (gender, age and teaching-learning scenarios in which they were interns) and two guiding questions (“Considering the educational units proposed in the active curriculum, based on the concept of integrality of care, and from the perspective of health needs, tell me: 1- your understanding of health needs; 2- your theoretical-practical experience articulating these concepts in the teaching-learning scenarios”), making it possible to record methodological and observation notes.

The participants were selected by drawing lots in all years for both courses. The sample was defined by theoretical saturation in each of these years, that is, when no new data ceased to appear in the interviews. The learned concepts were used to build the theoretical model of the experience⁸. In this context, Barros et al.¹⁹ condition and associate the number of sufficient interviews in qualitative studies to what one intends to discover and show with the interviews, the available resources and how the findings are incorporated into the study, considering there are no more new or relevant emerging data, that the dimensions show variation, that the categories are well developed and that the associations between them are well defined.

Table 1

Demographic data of the study participants

	Course	Medicine					Nursing				
		1	2	3	4	5	6	1	2	3	4
	Year	1	2	3	4	5	6	1	2	3	4
	Total	3	4	3	5	3	4	2	3	3	3
	Women	100%	75%	67%	80%	67%	25%	100%	67%	100%	67%
	Men	0%	25%	33%	20%	33%	75%	0%	33%	0%	33%
	Mean Age	21,7	20,0	24,3	23,6	23,3	24,0	19,5	19,3	20,0	25,3
Specialties Studied	FHS	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	BHU	0%	25%	0%	80%	100%	75%	0%	0%	0%	67%
	Specialty Outpatient Unit	67%	75%	67%	100%	100%	100%	0%	0%	33%	33%
	Child Health	0%	0%	67%	100%	100%	100%	0%	0%	33%	100%
	Women’s Health	0%	0%	67%	100%	100%	100%	0%	0%	100%	100%
	Mental Health	0%	0%	0%	100%	100%	100%	0%	0%	33%	33%
	Adult Health	0%	25%	0%	100%	100%	100%	0%	0%	67%	100%
	Surgical Center	33%	25%	67%	40%	67%	100%	0%	33%	67%	33%

Source: Created by the authors

Two pilot interviews were carried out to validate the guiding questions; the study theoretical saturation occurred at the 33rd interview and ten students refused to participate in the research. All authors participated in the process. The interviews were recorded, transcribed in full and then coded line by line before contacting the next interviewee, strictly following the microanalysis process, which allows generating the initial categories with their properties and dimensions. For this process, tables and colors were used to more easily identify the information described therein (Chart 1). Thus, the first letters correspond to the interviewee's initials; the first number is the year they are attending; the subsequent letter corresponds to the course and the number after the period represents the page of the transcription.

For the coding, concepts were identified, developed and correlated. The categories comprise the phenomenon conception through its data and constitute the main analysis unit. The other steps described in the GT (Microanalysis, Open coding, Axial coding and Selective coding) were carried out concurrently in order to transform preliminary codes into conceptual ones. These, in turn, were listed in tables of elements (Chart 2), which were used as subsidy for the formation of the study subcategories and categories, allowing the creation of the phenomenon's theoretical model. According to Strauss and Corbin⁸, it was verified by means of comparison with the raw data that the graphic representation is capable of explaining the phenomenon, validating the model that will be demonstrated in the results.

RESULTS AND DISCUSSION

The analysis process identified five categories with theoretical associations between them, allowing the development of the model that explains the students' experience.

Category 1

It comprehends the students' perception of how the concept of health needs is approached at the SEU and PPU. In the tutoring activity, some students identify a satisfactory approach to the concept and others feel that it is not addressed, or it is insufficiently addressed, in addition to an overly theoretical context, with a predominant focus on the biological aspect. The PPU, in turn, manages to be effective in the theoretical-practical articulation, although some students highlight weaknesses in the theory approach.

The tutors usually did not stimulate health needs in theory that much, but we saw it at the PPU and applied it [...] during visits. In some scenarios, it is really very difficult. [...] we did not always have the possibility to practice the entire theory of needs, to identify needs and to propose a care plan.” (A1M.1).

It was different like that... because we have the practice at the PPU, right? Experiencing this concept thus facilitates our understanding much more. Especially because we can see how it really is, not only as it is written on paper. (C1M.2).

Chart 1

Interview Transcription and Coding Example

Excerpt from the interview	Códos
<p>Interviewer 1 (I1): So, the guiding question is: considering the educational units, the SEU and the PPU, proposed in the active curriculum, based on the concept of integrality of care, from the perspective of health needs, tell me: your understanding of health needs.</p> <p>M.C.: It is what the person really needs to know for their health and disease process, you know? And it does not include only the biological part, I think it involves the entire biopsychosocial part. I think that is it.</p>	<p>Considering health needs as what the individual needs for their health-disease process. (MC1M.1)</p> <p>Affirming that the concept of health needs applies to the biopsychosocial spheres (MC1M.1)</p>

Source: Created by the authors

Chart 2

Example of element: “Understanding what health is”.

- I understand health as the person's complete well-being, being well with oneself in all personal spheres, doubting that there is ideal health (T2M.1)
- Understanding health as feeling well, not only in the absence of the disease process. (G2M.1)
- Understanding health as the person's way of life, without being restricted to the disease only (IA3E.1)
- Understanding that health is not being sick. (LB1M.1)
- Understanding health not only as the absence of disease, but also the person's well-being, with complaints and concerns as interference in health. (IM3E.1)
- Believing that health is the adequate organic function and working on the limitations that prevent the development of normal activities of the daily living. (IB4M.1)
- Trying to define health as the provision of basic things for the patient (JA5M.3)
- Understanding that health is not the absence of disease, it is being well with oneself and being able to perform the activities of daily living. (W2E.1)

Source: Created by the authors

In a competence-oriented curriculum, it is necessary to invest in the dialogue between the desired profile and the concept of health needs, as the contents that guide the training process must include problems and challenges that are prevalent in practice, taking into account the people under the care²⁰ of the professional.

The students identified that the PPU and the PPL are favorable scenarios for the theoretical and practical approaches of the concept, as they experience elementary aspects of health needs since the first years of the courses. This corroborates the idea of Chirelli et al.²¹, who value the student's inclusion into professional practice, providing meaningful learning through contact with the population since the beginning of the undergraduate course.

[...] the time we spend to have this view of health needs is practically the entire PPU activity. Unlike tutoring, in which we depend more on raising questions about the biopsychosocial aspect. Thus, I think that the PPU was the scenario in which I was able to perceive the most, because when you are going to treat a family, you address not only a health need, as in tutoring cases, you address several [...] and [...] the personal contact [...] is quite different, so that it gives you a much broader perception. (IB4M.1).

Nonetheless, the students find it more difficult to understand the concept in the first two years of undergraduate school. This weakness can be caused by the lack of a clear intentionality of each educational cycle based on the expected competencies, promoting a better understanding of the phenomena of interpretation of the user's health needs and construction of therapeutic projects¹⁰ for the user. For the interviewees, this difficulty in understanding the concept is associated with the insufficient articulation between the student groups and the educational units. The students identify that health needs references are present in the didactic materials and in several activities offered during the undergraduate course; however; they realize that the theory of this concept must be better consolidated and addressed during undergraduate school. In this sense, academic organization and management must constantly plan and evaluate the curriculum, so that there is consistency between the theoretical and practical aspects of health needs in the production of knowledge and in health care practice²¹.

The educational series are guided by institutional documents, the so-called "Year Notebooks" (*Cadernos de Série*)¹¹⁻¹⁸, listing the theoretical references of the Units, objectives, expected performances and the curricular structure of that year. The analysis of these texts allows us to identify that, even though all of them include the term "health needs" in their content, only those of the 1st and 3rd years of medical and nursing schools and the 4th year of nursing school conceptualize the term, mention the theoretical framework (Cecílio and Stotz) and stipulate the identification of these needs of the population as student performances; the notebooks of the 2nd year of medical and nursing schools and 4th, 5th and 6th years of medical school only mention the term in performance tables as one of the student's expected clinical skills, but they do not describe or base their conceptions on any theoretical framework about the concept of health needs. This shows a discrepancy between the courses and their years, noting that there is a greater focus on the nursing course

and that the greater the expected clinical complexity, the less importance the years identify in defining the concepts of health needs as theoretical-practical curriculum guiding aspects.

Therefore, the category is named:

- Understanding that there are differences in approach between the SEU and PPU groups and between educational units, with difficulties for effective theoretical-practical articulation.

Category 2

It comprehends how students perceive the concept of learning from their experiences. At the SEU, there are students who identify good receptiveness from peers to address the topic; others perceive little openness from colleagues in this regard. At the PPU, assessment is divided into whether or not students accept the approach. The participants identified the roles of tutors and facilitators as important when discussing the concept of health needs in the scenarios.

In tutoring, at the end we always had to think about the health needs of that problem, which had been addressed regarding that patient's problem. But, sometimes, we did not remember to retrieve that during the discussions, and ... So, I don't know if it is because it is something they insist on a lot, mainly during the first year, and then people find it boring, or if it is because there is no awareness of the need for that or the way it is approached, [...] varying from group to group in the discussion. (R3M.2).

I think there are many teachers who really invest in this development so that we can assess the patient's health needs; they question, they encourage us to think based on the case that we present; they encourage us to think about what could be changed, what could be improved. (L4M.2).

In the teaching-learning process, teachers and students must build the training based on reflection and motivation in search for affirmations, favoring the solution of problems in a broad and human way²². Thus, the teacher has the role of offering experiences and opportunities that arouse the student's curiosity for the significant learning of their experiences²³.

In this sense, it is verified that students who constitute the same group have the same level of learning and experiences, while there are differences in stimuli and experiences regarding health needs between the different groups.

Because we talk between the groups and my PPU group [...] we were able to consider this part of health needs very well. [...] But there is a specific group, which comprises closer friends of mine, and they did not get it so much, in being effective in that part, no. (J1E.2).

Pio et al.²⁴ found similar results from the teaching perspective, observing heterogeneity in the conduction of the pedagogical process due to factors such as: unpreparedness, lack of knowledge or interest in the active methodology, diversity of training and weaknesses in the educational process management, which also generates weaknesses related to teachers, students and curriculum.

Even so, despite the resistance of any actor in the teaching-learning

process, students value the approach to the health needs concept.

[...] but we are able to try to address as much as possible of what the patient needs, [...] a lot is due to the fact that we want to do something for the patient [...] (A6M.2).

Therefore, the category is named:

- Identifying that there is a discrepancy in learning and experiences of the concepts of health needs among the students.

Category 3

It comprehends the importance that students attribute to the theoretical-practical articulation for the effective understanding of the concept. The students report that they were able to understand it better when they aligned practice to theory. They report, however, that several times it was not possible to apply the concept, since the type of the teaching-learning scenario organization did not allow the theoretical-practical articulation for such.

[...] during home visits, it was the sort of an articulation of the health needs theory that we studied, [...] those things that, on paper, sometimes it is difficult for you to understand, but when you apply it in practice it is a little more palpable. (R4E.1).

For Salvador et al.²⁵, the practice scenarios must be selected to allow the students to immerse themselves into reality and learning, aiming to establish a new network of meanings based on what they already have. However, this requires a teaching-service integration that allows support for the student to articulate previous experiences to the context of care in which they are inserted, thus favoring the effective understanding of the health needs concept from the theoretical-practical viewpoint. Pinheiro et al.²⁶ identified that the observation of health professionals' practice is not synonymous with "to be learning from practice", considering that they may be immersed in the scenario problems, having difficulties to establish a commitment with the service and create effective projects within their reality.

The students perceive that there is an evolution in their understanding of the concept and that it changes over the years, as it develops as the student progresses through the years and apprehend more of the contents; however, the practical application of health needs follows an opposing logic, being more valued and stimulated during the first two years and finding less opening to it in the others, either due to the curricular organization, the organization of the scenarios or the valorization of a purely biologicist practice, preventing the application of the concept during their contacts with the health user.

I think that, in practice, there is a lot in the first and second years, that the health needs are applied, they emphasize it a lot, so we can develop this concept and be able to apply it. [...] from the third year onwards, this will be lost a little in practice. [...] you can see there is a fine line between the first and the second; cut, go to the third and now you start the fourth. I think there is a lot of difference. (L4M.1).

The students mention as the main practical example of the approach to health needs the scenario of home visits during PPU1 and PPU2, which

provided more time for contact with the user due to the organization of the scenario in Primary Care.

It was in the HVs [home visits] that we had to promote, we had to identify the health needs of our... of the families we treated, and how we could help them [...]. (LB1M.1).

In this way, it is understood that the complementary relationship between the axes that organize the curricular structure should aim at expanding significant learning by favoring the construction of meanings and bridges with reality, allowing an effective theoretical-practical apprehension.

Thus, the category is named:

- Understanding that the apprehension of health needs is more effective when theory is associated with practice and vice versa.

Category 4

It reaches the different meanings of integrality in health by demonstrating that students understand that, addressing the individual's health needs allows them to value their biopsychosocial dimension and identify that each person has their own needs: the professional must engage in actions aimed at such in order to individualize care.

[...] you cannot think about a care plan, for instance, without thinking about co-accountability. So, you must have a logic related to the welcoming of that patient, that individual, so that they understand what you are trying to convey, but that you are also open, as a professional, to understand the limitations, difficulties and accountabilities of that patient too. [...] I understand that I, inside the outpatient clinic, inside the hospital, will not be able to interfere in this patient's social life, [...] but I need to know what life condition this patient has in order to formulate a better plan with them. [...] And I need to understand that it is going to depend a lot on the patient's will [...] to trust me and follow what we are talking about [...]. (AF4M.2).

The students associate the term "health needs" to what the user needs in the biological, social, spiritual, psychological and financial spheres.

[...] Nowadays I can identify that health needs would be everything that the person, the patient or the population in that scenario have as a need, even for their well-being, that concept of health that we can also see, that physical, emotional well-being [...]. (C6M.1).

However, the participants identify that there are still difficulties in "overcoming" the notion associated to the curative and biologicist model of the past, which constitutes a great barrier to understanding the concept and, consequently, identifying the patient's health needs.

This is what happens in the third year now, from my viewpoint, that [...] in the secondary or tertiary scenario, different from Primary Care, it gets closer and closer to this method of objectification. (C3M.1).

For Pinheiro et al.²⁶, the biomedical model, with a decontextualized and individualistic approach, emphasizes a biological-mechanistic

approach, a fragmented view and a hospital-centered modeling; decreases the ability to perceive the users' needs by replacing listening with exams and procedures. This still occurs due to the predominance of internships in university hospitals and specialty clinics that use semiological methods associated to high technologies, which induces the student's "early specialization" and a distorted view of the health network.

Stotz²⁷ understands that the individual's "health needs" are determined according to historical and social variables; however, it is only possible to apprehend and develop them in the individual sphere. In turn, Cecílio and Matsumoto¹⁰ seek to broadly define care, configuring the mapping of four major elements that are essential to meet the health needs of the user: "good living conditions", "access to technologies", "link with health team" and "autonomy". Cecílio⁹ complements those with four denials that are necessary to expand comprehensive care: "Health is not only the absence of disease"; "Health care cannot be carried out in isolation"; "It is not possible to think about care without those who will be cared for" and "There is no 'moral worker' in health".

In practice, it is possible to identify that the students of the Marília Medical School understand the importance of the concept of health needs according to the aforementioned authors; however, the organization of the school years and the presentation of learning scenarios at "levels of complexity" contribute to the mindset that it is only possible to think about integrality of care in the Primary Health Care environment; regarding the specialty outpatient clinics and hospitals, these are seen as "places of completion, (...) to meet isolated, super-specialized and specific demands, and for this very reason, uncompromised with integrality"²⁸ (p. 6).

We do the rounds and, therefore, what is prioritized during the medical consultation is to ask how the patient is at the moment [...] But the family members, when I have the opportunity when they visit, [...] as they give me the opportunity to understand how the patient lives, what they were like before entering the hospital. [...] Before this patient is a patient, they are the love of someone's life. This is very serious, [...] [because] besides being a sick patient who is here due to a health problem, they have a life outside. (R4E.3).

The integrality of care should be the result of a joint effort by all members of the team aiming to identify, understand and meet the complex needs that the individuals bring with them; "The (maximum) (possible) integrality of care, guided by the (best) care (possible) to the health needs of the people: a synthesis of the integrality intentions within the space of the micropolitics of health"²⁸ (p. 12).

Therefore, the category is named:

- Assimilating that the concept of health needs is related to the extension of the integrality of care focus".

Category 5

It comprehends the students' perception that the link between them and the other health actors is essential to identify the health needs of individuals and their effective care. They state that a good relationship with the teams in the practice scenarios allowed addressing the concept and applying it to users, which occurred in the Primary Care Health Units.

However, the bad or nonexistent relationship in hospitals and specialty clinics was an obstacle for the same to occur in these scenarios.

[...] I did not have a good experience at the PPU [...] It was a [difficult] health unit, the team was very difficult. And in that part, my entire group was badly harmed [to understand health needs]. (C6M.3).

[...] and my PPU had a very special case because the FHU [Family Health Unit] where I was stationed was blocked in the second week of PPU because of sewage problems. We arrived there and the police were closing the FHU, so we had this connection with the team, [...] we experienced how important the social aspect is. (AF4M.4).

Cecílio²⁸ understands that when the health professional or team is responsible for health care, there will not necessarily be a connection with the user. That occurs because it has a therapeutic nature and must be established through a "continuous, personal and non-transferable, warm relationship in time: a meeting of subjectivities" (p. 3). For Ayres²⁹, health practices said to be humanized are committed to the pursuit of building connections with the users, with welcoming, interdisciplinarity, responsibility and the resignification of the other's happiness projects. Thus, in addition to the technical success in identifying health needs, they also have greater potential for effective individual and collective care.

Students believe that establishing a bond with the user is essential for the identification and application of their health needs and the practical success of their integral care.

[...] we have to include the patients in the care plan, because we cannot institute this treatment for them. [...] you need to have a connection with that person, to know their conditions, the context, [...] [for people] to have confidence to externalize their problems and we have to provide a viable care plan [...]. (E3M.3).

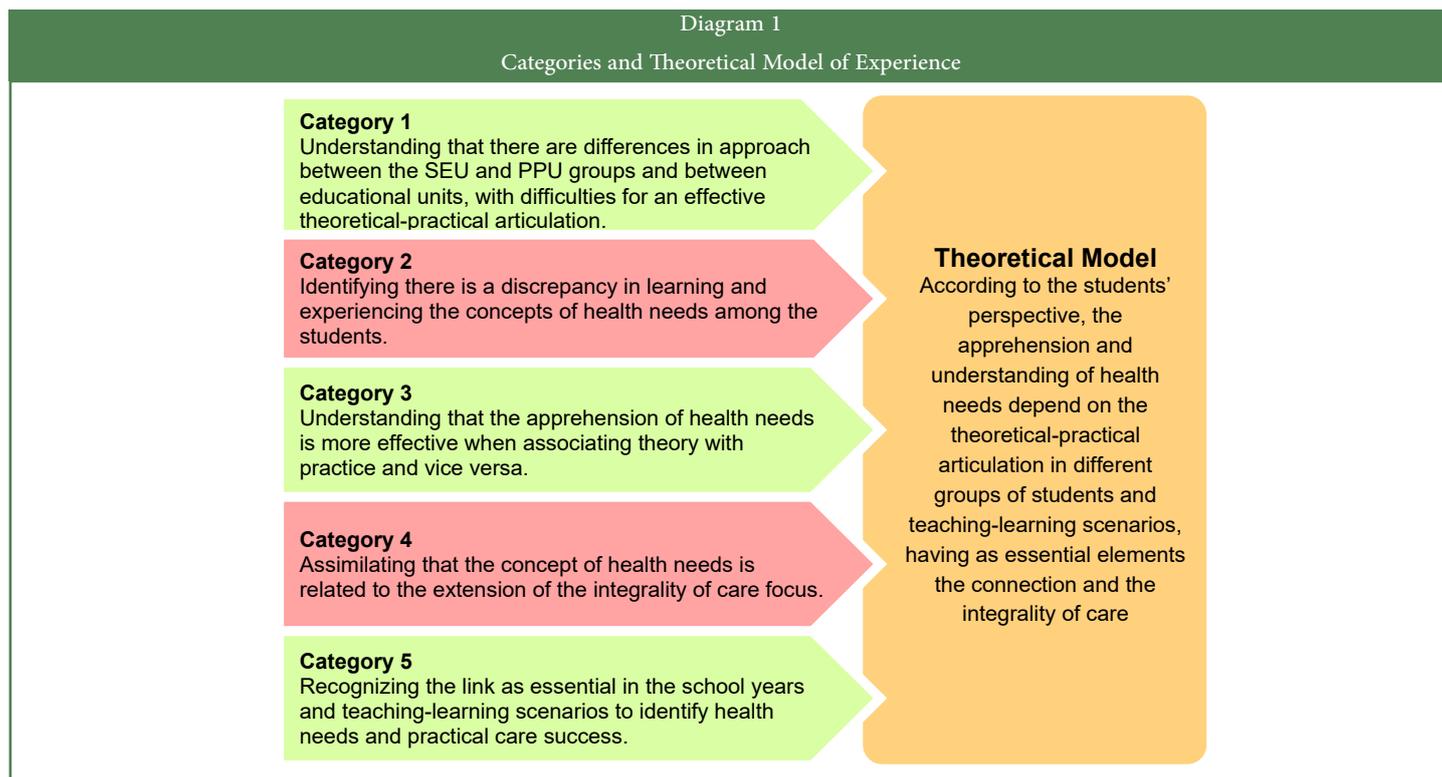
This supports Cecílio²⁸, who defends that the establishment of the connection between the binomial professionals and health service with the user increases the chances of therapeutic success, especially when it stimulates attitudes of greater autonomy in individuals. Although the first meeting with the professional almost always has an objective in mind, if they are well prepared and attentive, they can take advantage of this characteristic to favor the creation of the "link as a reference and a relationship of trust, something like the face of the 'health system' for the user"²⁸ (p. 119) even when the contact is of short duration.

Thus, the category is named:

- Recognizing the link as essential in the school years and teaching-learning scenarios to identify health needs and practical care success.

Theoretical model

Based on the aforementioned categories, it was possible to assume a theoretical model that was worthy of the experience and contemplated the objective of understanding the experience of the students of the Medical and Nursing Courses of the Marília Medical School based on the health needs concept and the integrated curriculum.



Source: Created by the authors

According to the students' perspective, the apprehension and understanding of the health needs concept depend on the theoretical-practical articulation in the different groups of students and teaching-learning scenarios, having as essential elements the connection and the integrality of care.

The Diagram below shows the categories and the theoretical model derived from the experience:

FINAL CONSIDERATIONS

For the students to effectively learn the concept of health needs, the necessary elements are the theoretical and practical articulation in the SEU and PPU scenarios in the different groups of students, aiming to avoid discrepancies and discontinuity of learning, a process that closely depends on links (with users, scenarios and professional team) and comprehensive care of the individual to become viable.

The study was limited to the perspective of medical and nursing students at an educational institution in the countryside of São Paulo; thus, it is suggested that future studies consider as topics the views of the other actors involved in it (teachers, health professionals, residents and users), as well as students from other institutions, for a better understanding of the phenomenon.

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AUTHORS' CONTRIBUTION

All authors contributed equally to the design, creation and revision of the manuscript.

CONFLICTS OF INTEREST

None to be declared.

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