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Reflective Portfolio: philosophical contributions to a narrative praxis in medical education

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The Reflective Portfolio has been used as an evaluation tool to stimulate critical and reflective thinking and create conditions for the exercise of an ethical sense in medical education. This essay aims to analyze the Reflective Portfolio as a pedagogical device for the exercise of narrative in medicine. By producing a theoretical analysis about the portfolio, we have built an epistemological dialogue between Public Health, Education and Philosophy, in order to provide elements to think about the exercise of fundamental relational technologies for health care. Hannah Arendt's Philosophy potentiates this study, addressing the narrative action in a political perspective. Teacher and student (reader and narrator) establish a dialogue through portfolios, unveilling developments to bring new pedagogical meanings to the Reflective Portfolio.

Keywords: Medical Education. Evaluation. Reflective portfolio. Narrative medicine.

Introduction

The portfolio has been considered one of the most important contributions to an efficient evaluation of teaching in Anglo-Saxon countries[1]. Since the 1990s, it has been disseminated in the university environment, where it has been used to qualify both formative and summative evaluations. In Brazil, with the advance in discussions about Medical Education and the construction of curricula based on active teaching-learning methodologies, formative evaluation and portfolios have been gaining ground and contributing to the monitoring of students' individual progress, although with little institutionalized recognition[2].

In spite of the stimulus to **critical** and **reflective** education provided by the new National Curriculum Guidelines for Medicine Undergraduate Courses[3], Schraiber[4] highlights at least three aspects that indicate a "Medicine crisis":

- rupture of interactions at several levels: between doctor and patient, between the doctor and other professionals, and between the doctor and his knowledge; the latter is responsible for loss of reflectiveness, that is, annulment of the doctor's ability and ethical willingness to reflect on his own action in the application of scientific-technological knowledge to each case/context;
- a crisis of bonds of trust among doctors, patients and other professionals – and the doctor's loss of trust in himself –, generating inability to reflect critically (judging and making clinical decisions) on unpredicted situations or on situations for which there is no protocol; such situations used to be largely based on the pragmatic character of doctors' intervention;
- with the loss of the pragmatic dimension of practice, in an attempt to reduce uncertainties and in favor of a certain security that the sciences provide regarding the produced knowledge, the reification of the technological means belonging to technical practice occurs: from means, technological resources have been transformed into ends in themselves.

Certainly, medical culture reflects the culture of its time, manifested in values, beliefs and behaviors that compose a powerful mold of subjectivity

construction from which students emerge as doctors[5]. Scientific and biotechnological development is introduced to contemporary society and requires an ethical counterpart that, in the field of health, presupposes a broad reflection on the right to health – in the spheres of assistance, teaching and policymaking. According to Schraiber[4], technicism is materialized in the excessive importance that is given to technological resources to the detriment of the other dimensions that constitute the encounters among subjects.

Pessoti[6] argues that students develop values based on their experiences; therefore, the main role of medical school would be to enable such experiences through texts, theories and practical activities that apprehend the concrete suffering of the patients' lives.

Traineeship, internship, and residency programs are the main places of the teaching-work intersection. It is in this stimulating environment, from the point of view of education, that the development of knowledge, skills, attitudes and values should be promoted – provided that such attitudes are consistent with the principles of *Sistema Único de Saúde* (SUS – Brazil's National Healthcare System) and with values that are desirable to have in order to be able to work in the field of health, such as solidarity, empathy, imagination, creativity and critical reflection[7].

By reconstructing narratives, the portfolios help us in the task of solving students' dilemmas about their experiences in the form of narrated stories or storytellers. When we decided to undertake a socio-philosophical analysis of the Reflective Portfolio, it was necessary to build theoretical links among the fields of Public Health, Philosophy and Health Teaching. We propose to establish an epistemological dialogue[8] of interdisciplinary nature, in order to offer coherent elements to the inclusion of philosophical contributions in the reflection on the exercise of soft technologies (communicational/relational skills, empathy, affectivity, values, bond construction...), which are fundamental in Medicine. Hannah Arendt's Political Philosophy potentiates this study, as she approaches narrative action in a political dimension.

In the first part, we will present a panorama of evaluative methodologies in medical education; then, we will approach the Reflective Portfolio as an evaluative tool, viewing it as a pedagogical device for a reflective practice. Afterwards, we will outline epistemological links between Hannah Arendt's philosophical thought and Medicine education, arguing that a type of narrative competency is a fundamental element to healthcare.

Evaluative methodologies in medical education

To be consistent with medical education targeted at comprehensive care, the evaluation system must value the continuous improvement in skills and attitudes, in the same proportion that it values knowledge acquisition. To follow the orientations of the National Curriculum Guidelines, it is necessary to assume that the competencies involved in the practice of Medicine constitute complex skills[9].

However, a document published by ABEM[10]– resulting from two forums held in 2007 and 2008, with the participation of dozens of teachers, students and professionals involved in the management of Medicine courses from different institutions in Brazil – states that

> the current scenario of the Brazilian medical education, although heterogeneous, allows characterizing the predominance of a relatively poor evaluative culture that focuses on summative aspects and has little consideration for the educational impact of evaluation on students and institutions. Specifically, students' personal characteristics are rarely approached, and the same happens with their progress in the attainment of skills, competencies and attitudes that favor the practice of the profession.[10] (p. 30)

The same document recommends that the students' evaluation should be comprehensive and focus on the entire variety of attributes that compose their personal and professional education. In the evaluation, the dimensions that compose the competencies must be prioritized, that is, cognitive, psychomotor and affective skills, as well as aspects related to clinic, management and decision-making. To achieve this, an authentic evaluation must presuppose the production of an

educational impact. It is not sufficient that the method has good indexes of validity, reliability and reproducibility; it must foster reflections on practice and enable educator and student to give visibility to weaknesses and potentialities, outlining a pedagogical path to be traveled in the teaching-learning relationship.

Therefore, we should implement evaluation methodologies that are formative and summative[11]. The main way of concretizing the formative evaluation is to guarantee an effective feedback on practice and allow the student to revisit the scenario of difficulties he had in order to improve his performance.

The summative evaluation, in turn, occurs typically at the end of the course and is used to check whether the objectives were attained for certification purposes. The summative evaluation's role is to measure, while the formative evaluation is committed to significant learning. It is important to note that the same evaluation method can be used as formative or summative, depending on the focus that is prioritized.

Traditionally, the educational evaluation systems are related to content-based pedagogical models, focusing on acquisition of knowledge compartmentalized in disciplines and disconnected from practice. In many Brazilian medical schools, knowledge tests are the pillar of the evaluation of formative processes. Menezes[12] has identified frequent characteristics of evaluation processes: they are not planned along the curriculum; the tests' psychometry is unknown; they are centered on the teacher; they are limited to the cognitive domain; they use a single instrument to evaluate different competencies; and their results are not analyzed and interpreted in the context of the educational process.

With the advance of the trends that are currently visible, the need of methodological and conceptual changes in the evaluation systems has been reaffirmed[12,13]. Taking into account the students' previous knowledge experiences and distancing the teaching-learning process from sheer memorization enable the development of values and attitudes.

The benefits of the technical-scientific advance have guaranteed legitimacy to Biomedicine[14], but mainly from the mid-twentieth century onwards, changes in

the society and in knowledge produced in the area of health have generated new demands to which there were no answers. It was perceived that these ruptures had created gaps in medical knowledge and insufficiencies in dealing with subjective aspects referring to health, illness and care[4,15].

The inclusion of disciplines called "Medical Humanities" – an area that agglutinates knowledge from philosophy, ethics, psychology, anthropology, art, sociology, history and politics in the sphere of Medicine – gradually gained ground in the discussions about curricular reforms in Brazil and in the world. The objective was to "educate doctors with ethical and relational competency, and to overcome the unproductive antagonism between technicism and humanism"[5] (p.1726). In spite of the institutional resistance[5,16] of the medical schools, one of the elements pointed as most challenging is the need to develop a system to evaluate humanistic education in medical school[5].

It seems clear that, in the context of the ongoing changes in the schools,[5,11,13,16,17], the discussion of evaluative methodologies that go beyond the verification of content acquisition has gained new ground in educational research. However, this fact has not generated a consensus among specialists yet[10].

The reflective portfolio as a pedagogical device: formative evaluation and evaluative formation

Maia[18] has produced a relevant review of the international literature, identifying the use of the Reflective Portfolio in different contexts of Medicine education: undergraduate courses, Master's courses, specialization courses and medical residency in diverse areas, such as Geriatrics, Family and Community Medicine, Surgery, Endocrinology, Radiotherapy and Anesthesiology. Although this review has not included studies in Brazil, an increase in the number of publications can be noted, [2,18–21] like experience reports or preliminary studies on the use of portfolios in Medicine courses, especially in those that have been developing active teaching-learning methodologies.

In her systematic review, Maia[18] surveys and groups the objectives of the use of the Reflective Portfolio into five categories: a) to evaluate and/or monitor learning; b) to evaluate clinical skills; c) to evaluate and/or document competencies; d) to enable continuing professional development; and e) to stimulate reflection. In this essay, we will focus on the last category.

The author has found an increasing use of the portfolio in medical education as a tool that aims to encourage students to reflect on their experiences. However, she mentions a certain divergence among the studies in relation to the use of the portfolio to stimulate reflection and explains that this divergence can be justified by the doctors' (educators and students) lack of familiarity with the reflective practice. This finding reiterates what Schraiber[4] calls the doctor's "annulment of reflectiveness", that is, the property, competency and ethical willingness to reflect on his own action in relation to the patient. This seems to be one of the main elements of contemporary Medicine: the rupture of interactions also occurs between the doctor and his knowledge, as with the higher technical complexity that has been brought by focal specialization and by the instrumental resources of the intervention, there has been a loss of the pragmatic dimension of practice. Placing his entire trust on technological means and scientific evidences, the doctor ceases to trust his tacit knowledge – or the "art of curing" – deriving from his personal clinical experience and clinical judgment.

We believe that it is fundamental to re-establish the character of *reflectiveness* in Medicine, as "experiencing is, above all, being open, actively accepting creation, invention and transformation"[22] (p. 17).

Deleuze[23] uses the Foucauldian concept of "device" as a set of elements and means heterogeneously disposed in order to produce a specific range of effects. These effects derive from the relations among the components of the device, and the disposition, time, constitution and order of these means and elements would be remade in the very process of production of subjectivities[24]. That is, the concept of "device" does not deal with a closed, organized structure whose elements at stake

are previously given; rather, it deals with the level of the unpredictable and of creation: the happening and *experientiation*.

To Deleuze[23] (p. 158), the devices' components are lines of visibility, lines of enunciation, lines of strength, lines of subjectivation, lines of rupture, which intertwine and mix, some lines ending in others, or evoking others, by means of variations or even mutations of agencing.

By employing the term *device* to characterize the Reflective Portfolio as a pedagogical resource, we unfold two immediate effects: the first is that a device is not universal. It designates a configuration or arrangement of elements and forces, practices and discourses, power and knowledge, that is both strategic and technical. What is operated by devices in the Foucauldian philosophy is the singular processes of production of subjectivities. The second effect is the possibility of looking away from "eternal" towards "apprehension of the new" [24], which, in this case, would be to understand and outline paths of creation which "do not cease to fail but, in the same proportion, are recaptured and modified until the rupture of the old device"[23] (p. 159).

Therefore, attributing the character of pedagogical device to the Reflective Portfolio, on the one hand, means determining and preserving the *status quo* (because it is still intended to be used as an evaluation tool) and, on the other hand, allows for transformation (because it potentiates that both the educator and the student have new ways of viewing the formative pathway).

The dialogic potential of the Reflective Portfolio is emphasized also by Batista et al.,[25] who analyzes the process of evaluating formative experiences presupposing evaluation practices that represent moments of dialogue between teachers and students. Sá-Chaves[26] refers to the portfolio as an instrument to reduce the distance between educator and student. Portfolios need to be continually constructed in the process of action-reflection-action and shared to give visibility to students' other ways of interpreting the learning paths, enabling self-evaluation about decision-making, definition of criteria to make judgments, and the provision of space for doubts and conflicts.

Apart from self-knowledge, the Reflective Portfolio seems to allow students and residents to tell their stories and mix them up with the stories told by patients. One of the objectives of stimulating narratives by means of portfolios is to be able to mobilize students to be responsible for their learning process, as they favor the analysis of the singularities and peculiarities of the development of each individual[27].

The narrative in hannah arendt: philosophical subsidies for medical education

A philosopher and political scientist of the 20th century, Arendt dedicated herself to the theme of the activities that we practice in the world, especially to political *praxis*, action and public space. However, the perplexities the thinker experienced since the Holocaust of the Nazi Germany until the polemical judgment of the officer Adolf Eichmann at the beginning of the 1960s determined the course of her questionings concerning human action and the relations between ethics and politics: How could these facts occur in a civilized German society with moral standards that were allegedly firm and stable? How is it possible to understand that many "turned their backs" to facts and became collaborators of the engineering of the "factory of corpses" at concentration camps? How could Eichmann, a war convict, and so many others, serve such machinery as gear cogs, saying they were innocent and pleading, bureaucratically, "obedience to superior orders"?

> The acts were monstrous, but the agent – at least the one who was being tried – was fairly common, banal, neither demoniacal nor monstrous. There was no sign in him of firm ideological convictions, nor of specifically evil motivations, and the only remarkable characteristic that was possible to perceive both in his previous behavior and during the trial itself and the indictment that had preceded it was something entirely negative: it was not stupidity, but *lack of reflection.*[28] (p. 18)

The philosopher proposes an analysis of the faculty of thinking and questions if it would be possible to avoid evil with the activity of thinking as a "habit of examining whatever happens or calls our attention, independently of results and contents" [28] (p. 20). Arendt assumes the Socratic maieutics making three elements emerge. Firstly, the Socratic thought brings with it the capacity for provoking

perplexity and astonishment, taking us out of the automatism of daily life and making us scrutinize established standards and habits that are taken for granted. The second element is self-consciousness, that is, the capacity to think and relive experiences we have witnessed. From this attribution, we can *appear* to ourselves and, in a kind of reflection-alterity, we evoke plurality of as lonely an activity as thinking. Thinking encompasses other points of view within ourselves and dissipates any vestige of solipsism. Finally, the Socratic faculty of thinking affirms the primacy of dialogue, of a diversity of points of view and of plurality in the formation of our *doxa* or opinion, that is, our singular way of seeing the world and producing our existence[29].

The image of *human plurality* is presented as a twofold condition: a condition to political action – in which actions need to appear to the others and be shared with the others – and to the Arendtian thought – in which enlarging imagination is transformed into *thinking from the point of view of another person*. Here, we highlight a sharp criticism against the virtues valued in modernity intensified by the current stage of capitalism: competitiveness, liberties grounded on individualities and the invasion of the public space by privativity.

In Medicine education, the discussion about ethics and values must lead directly to a greater awareness of social relations and of the political dimension of health work. Or, more importantly, to the understanding of the need to value responsibility – both personal and collective –, which requires a positioning before the other in the exercise of one's practice.

Most certainly related to ethics, the valorization and construction of this commitment are tasks that demand multi-directional efforts. One of them concerns education itself: How does the construction of ethical values occur in the teaching-learning process? What pedagogical devices are used for the development of these virtues?

In Brazil, the discussion about ethical-moral education was on the agenda as an action of the authoritarian and dictatorial State until the 1990s, a period during which the disciplines of "Moral education and Civics" composed governmental

strategies in an attempt to reinforce behaviors. Nevertheless, corroborating Rego[16], we believe that the main objective of discussing moral education is to favor the development of the human faculties of thinking, judging and deciding.

According to Arendt, it is through the narrative discourse that Men express themselves permanently about them and the others, building their stories and manifesting themselves narratively in the world: "action and discourse are the ways in which human beings appear to one other, certainly not as physical objects, but *qua* men"[30] (p.220).

Because talking and acting just appear among other Men, in the plurality of the public space, narrative as a political activity can only materialize there, as "nothing and nobody exist in this world whose own being does not presuppose a spectator"[29] (p. 35). When the philosopher states that Man, to assure himself as human, needs the company of others who constitute the world, she reveals Man's double condition: being singular and plural simultaneously.

The space of visibility is where Man really singularizes himself. In narration and action, the subject reveals *what* he is – his gifts, qualities, talents and failures – and, at the same time, displays *who* he is, his unique singularity in the midst of human plurality. "Only in complete silence and total passivity can someone hide who he is"[30] (p.192). In short, the process of telling one's life would be the essential act to give it meaning.

According to Aguiar[31], the greatest inspirer of Arendt in the issue of "narrative politics" is the contemporary philosopher Walter Benjamin. Communication and oral discourse are central also in Benjamin's thought, as he understands narrative as the expression of experience and states that it is an artisanal form of communication that is not interested in transmitting the 'pure in itself' of the narrated thing as information or as a report. Narrative plunges the thing in the narrator's life and then takes it away from him"[32] (p. 205). However,

> To him [Benjamin], narration has a utilitarian dimension, as it always proposes 'a moral lesson, a practical suggestion', 'advices', and the great majority of its interpreters understand narrative as the voice of the

> marginalized. (...) [In Arendt,] storytelling is, above all, finding meaning and bringing it to light in the indeterminate and 'chaotic' human experiences.[31] (p. 224)

The storyteller (narrator) transforms experience into a story. However, the figure of the Arendtian spectator defines the dialogic dimension of the story, as, even though his deed deserves to be narrated, the *actor-narrator* needs to share it narratively so that it exists in the others' memory. In this sense, narrating something corresponds to Benjamin's idea of "interchanging experiences", so much so that, when we work with the subjects' narratives, we will be not only participating in their stories, but also in their reconstruction through the profusion of meanings, due to their essential non-closure[33].

In the reading of Reflective Portfolios, the student-narrator needs to be understood as a subject who, in the "act of telling", searches for situations that, many times, he wished to have had or that he only discovered later. With this elucidation, we highlight that a narrative is not necessarily the truth just like it happened, but the person's interpretation of it, which will also be interpreted by us: the truth must be always captured as the beginning of thought, as a condition for the possibility of reflecting, and not as a result in itself.

Thus, the narrative approach, which is a substratum of the portfolios, shares some of the principles of the evaluative learning methodologies but, at the same time, creates ruptures, such as the fact that the lived experience is not something to be measured; rather, it is created in the process itself[33], especially in the dialogues between educator and student during the feedback. This moment is adequate for commenting on the portfolio and for adjusting the formative path, with the aim of promoting a more refined qualification of the pedagogical process. Some elements of feedback can be: highlighting aspects (positive and negative) about knowledge, skills and attitudes; discussing the narratives contained in the Reflective Portfolio; and stimulating the return to educational objectives that have not been attained yet, reformulating the pedagogical plan.

When we assume a narrative perspective to the educational process, we give visibility to experience as a substance typical of *thought*. Arendt[28] helps us to sustain this prerogative announcing the "distinction that Kant makes between *Vernunft* and *Verstand*, 'reason' and 'intellect'" (p. 28). The author appropriates Kant's construction between the reason that thinks and the intellect that knows.

> Thus, the distinction between the two faculties, reason and intellect, coincides with the distinction between two completely different spiritual activities: thinking and knowing; and two totally distinct interests: meaning, in the first case, and cognition, in the second.[28] (p. 29)

Arendt argues that *thought* does not provide a solid conclusion, but regards the *meaning* of what happens to us. That is, thinking emerges from the unpredictability of live experiences and seems to remain linked to them. Thought, enrooted in particularity and in the contingency of experience, is a fundamental way of opening the spirit to the world.

In this aspect, the Reflective Portfolio makes us look at the formative process beyond the acquisition of new knowledge. By means of the construction of narratives, the portfolio re-activates the thought about the student's experiences concerning his relations to scientific thought, and also his interactions with the other (patient, healthcare team, tutor) and with himself. When the educator (preceptor, tutor, supervisor or teacher) establishes a relationship with the students, stimulating autonomy and responsibility for their own learning, he illustrates the kind of relationship they are expected to develop with users.

Narrative competency as an element of healthcare

The emerging debate about Narrative Medicine within the field of Medical Humanities has revealed the need to focus on competencies that allow clinical practice to be more receptive to contributions from other areas of knowledge, such

as Philosophy, Literature, Communication and Sociology, among others[34]. However, this does not imply a refusal of the Biomedicine paradigm.

Many authors[35-38] consider Narrative Medicine as a practice and an intellectual willingness that enables doctors to perceive things beyond biological mechanisms. The aim is to add to the reading of body signs a decoding of the narratives and other verbal and non-verbal clues provided by patients, as well as an awareness of the ethical and contextual aspects involved. This ability requires an openness that is not only cognitive, but also of the sphere of values in the experience of the clinical encounter. In this sense, it is fundamental to amplify the elements of the clinician's interpretative universe, so that he is able to recognize the narrative contexts in which patients' discourses, meanings and demands are understood in order to transcend the biomedical logic. Furthermore, people's stories need to be conceived beyond the rigid anamnesis.

Charon[39] argues that health professionals need to have narrative competency. Amplifying the debate about the consultation environment, the author evokes an interpretative repertoire in healthcare, not only to the benefit of a better comprehension of patients' narratives – because it promotes a higher complexity in the perception and understanding of the singularities of each case –, but also because it enables health professionals to open a reflection channel on self-knowledge. Through this channel, they can display their worldviews and place them as an *imaginary dialogue* with themselves and with the others' point of view.

The faculty of imagination plays an important role in Arendt's political theory, as it is the condition for the possibility of the two main activities of the spirit that are involved in it: the activity of thinking and the very activity of judging and making decisions. As the capacity of making present what is absent, imagination transforms the object in a "sensation" to be internalized, in such a way that we can be affected by the object in its absence, as if it were a sensation received from a non-objective sense. In other words, when we represent something that is absent, our imagination prepares the objects for the operation of reflective thinking. To Arendt, imagination

"presentifies" what is absent, because when it articulates memory and experience in the world, it enables an "enlargement of thinking".

To a certain extent, the narrative reveals the exercise of recognition of the *Other* in his singularity, by means of thought and imagination. The perception of the *Other*'s suffering is an element that is capable of mobilizing this imagination. Even if we understand that care is established essentially through the interaction among subjects, it is not possible, objectively, to be in the *Other's* shoes, but it is fundamental to be capable of taking him into account and value his perspective of his own suffering. By considering the *Other* in his imagination, the human spirit opens itself to alterity, exercising "enlarged thinking". In this sense, narratives allow for an exchange of roles: the doctor-spectator of the patient-narrator's stories becomes, now, the one who tells the other's story (and his relation to it).

Enlarged thinking should not be confounded with "enlarged empathy", Arendt warns us. To think critically does not mean creating an enlarged empathy that might lead us to want "to know what is in the others' mind" [28] (p. 513). Thinking critically does not mean simply accepting what is in the other's spirit, as "this would be nothing more than accepting passively their thoughts, that is, exchanging the prejudices that are related to my position for their prejudices" [28] (p. 513). Enlarged thinking requires the suspension of our private interests, which limit our faculty of thinking and making decisions in the perspective of the world's plurality. Thus, it is not about accepting passively the other's perspective, but transiting across different points of view, conferring a public feeling on the act of thinking:

> [The] larger the region in which the wise individual is capable of moving, from point of view to point of view, the more general his thought will be… This generality, however, is not a generality of concept – of the concept 'house' under which we can, then, subsume all concrete buildings. On the contrary, it is intimately linked to particulars, to the particular conditions of the points of view through which we must pass so that we arrive at our own 'general point of view'.[28] (p. 514)

In this sense, the narratives that compose the Reflective Portfolio must be preceded by an *existential experience*, either lived by the subject who tells the story,

or by the experience of listening to the others' stories. The narrator does not use only his experiences, but also the others' experiences through the act of listening. This presupposes, *per se*, an openness to dialogue. The narrative thinking operated in the Reflective Portfolios is critical because it gives rise to an exchange of experiences: the *narrator-student* transforms into a story the experience with patients, families and with the very context of the territory where he acts; the dialogue (sometimes imaginary) that is established with these stories is concretized when the *teacher-reader* travels across these trajectories and re-signifies such experiences, using the pedagogical device to read between the lines. Sometimes, emotional narratives aiming to sensitize the reader; other times, formal narratives aiming to fit into a scientific text; sometimes, hesitant narratives that show difficulties in handling complex cases; other times, impersonal narratives, distanced attempts that highlight one's fear of exposing himself or emphasize the fallacious protection of the non-involvement with the patient...

Therefore, the role of narration as the result of a synthesis of political and moral discourses created by people to understand (each other) and judge the circumstances and situations in which they live provides possibilities of creating perceptions, thoughts and judgments throughout the course of life. Constructing narratives with the patients about their stories or illness experiences can represent a powerful form of expression of suffering and the possibility of "amplifying clinical practice, so that it can be capable of transcending the limits imposed by an exclusive approach to illness"[37] (p. 49).

Final remarks

The central question that guided this essay is directly related to the dimension of production of subjectivities in the educational process: In what way can we collaborate with the process of teaching/learning comprehensive healthcare? Or how can we amplify medical teaching beyond the acquisition of knowledge and techniques? How can we promote pedagogical methodologies to develop values?

In this essay, such questions impelled us to the exercise of making Public Health, Education and Philosophy *reverberate*. We refer, here, to Deleuze's[40] thought: we start from the understanding that different "disciplines" – such as the arts, philosophy and science – establish relations of effects, "reverberate on one another"[40] (p. 156), produce mutual resonances that interfere in one another. Interfering does not mean exchanging, sharing, surveilling or reflecting reciprocally. Rather, interfering means interceding: "Creation are the intercessors"[40] (p.156). Although Deleuze did not develop explicitly the concept of *intercessor*, the idea permeates his work and there are clues to the conceptualization of the term. The author argues that concepts are movements constituted from encounters, experiences or problems that instigate a thought to be thought. Therefore, intercessors would consist of agents of thought.

Based on contributions from Philosophy, especially the constructs proposed by Hannah Arendt, in an epistemological dialogue with the fields of Public Health and Education, and making one intercede for the other, we could outline conceptual links to defend the use of the Reflective Portfolio as a pedagogical device for the formation of a certain narrative competency for medical practice. This device opens infinite interpretative possibilities through the readings of the narratives produced by students or residents, especially in the context of clinical practice.

The reading of narratives in portfolios followed by feedback given to the students unveil profitable educational processes from the point of view of clinical communication, development of an ethical sense, and comprehensive healthcare[35–39,41]. Feedback provision must be the most important pedagogical moment, as it enables to grant communicability to the constructed narratives. We refer to Paulo Freire when he argues that every educational process must have dialogue as its foundation: "Education is communication and dialogue. It is not transfer of knowledge; rather, it is an encounter of interlocutor subjects who search for the signification of meanings"[42] (p. 69).

Therefore, for medical education specifically – and for health teaching in general –, we believe that the utilization of the Reflective Portfolio is an important

contribution, as well as the ethical-political potentiality that makes it be a pedagogical device. The composition of narratives presupposing the encounter experience with the *Other* affirms an education for the provision of healthcare in its ethical dimensions, together with the cognitive and communicational dimensions. Furthermore, the use of the Reflective Portfolio enables the production of knowledge by means of this encounter and the possibility of "enlarging" thought in order to include the *Other* into decision-making.

Collaborators

The author Bruno Pereira Stelet designed the study and delimited its object. The authors Bruno Pereira Stelet, Valéria Ferreira Romano, Ana Paula Borges Carrijo and Jorge Esteves Teixeira Junior participated actively in the discussions about the results, in the revision and in the approval of the final version of the text.

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