


### Documentary analysis of the pedagogical project of a Medicine course and teaching in Primary Care


**Valter Luiz Moreira de Rezende<sup>(a)</sup>**

<rezende.valter@gmail.com> 

**Bárbara Souza Rocha<sup>(b)</sup>**

<barbarasrocha@gmail.com.br> 

**Alessandra Vitorino Naghettini<sup>(c)</sup>**

<alessandra\_naghettini@ufg.br> 

**Edna Regina Silva Pereira<sup>(d)</sup>**

<ersp13@gmail.com> 

<sup>(a)</sup> Curso de Medicina, Centro Universitário de Anápolis. Avenida Universitária, Km 3,5, Cidade Universitária. Anápolis, GO, Brasil. 75083-515.

<sup>(b)</sup> Faculdade de Enfermagem, Universidade Federal de Goiás (UFG). Goiânia, GO, Brasil.

<sup>(c)</sup> Departamento de Pediatria, Faculdade de Medicina (FM), UFG. Goiânia, GO, Brasil.

<sup>(d)</sup> Departamento de Clínica Médica, FM, UFG. Goiânia, GO, Brasil.

The 2014 National Curriculum Guidelines (DCN) for the medicine course provide for an education that focuses on primary care. The School of Medicine of Universidade Federal de Goiás, adapting itself to the new DCN, has developed a new Pedagogical Course Project (PCP). The objective of this study was to examine, through documentary analysis, the new PCP in the perspective of the 2014 DCN, based on the document "Guidelines for Primary Care Teaching in Undergraduate Medicine Courses". Although the PCP covers most of the aspects related to primary care teaching, there is no reference to the teaching of the person-centered clinical method, popular health education, respect for patient autonomy, and shared decision-making. We hope, therefore, to subsidize changes in the current PCP and to stimulate other universities to approach these issues.

**Keywords:** Primary care. Curriculum. Family and community medicine. Education.

## Introduction

Discussions about the medical curriculum gained momentum in the 20<sup>th</sup> century, especially after the Flexner report was published in 1910. The report has influenced the reformulation of medical education in a large part of the world<sup>1</sup>. This model was the basis for the organization of curricula, creating disciplines and showing the need of preventive and collective knowledge<sup>2</sup>. Flexner recognized that medical education must be configured in response to scientific changes and social and economic circumstances. Flexibility and freedom to change the curriculum, adapting to local social demands, were also part of his message<sup>3</sup>.

Medical education and the graduates' profile in Brazil up to 2000 were targeted predominantly at a hospital-centric and curative model<sup>4</sup>. In response to this, the Ministry of Health, the Ministry of Education and some medical entities joined efforts to discuss the reformulation of medical education. These debates led to the creation of documents like the National Curricular Guidelines (DCN)<sup>5</sup> in 2001. Since then, efforts have been made to change the perspective of medicine courses, so that they focus on the population's needs and on education in primary care<sup>6</sup>. However, the low status of teaching activities outside universities or hospitals and the faculty's insufficient knowledge of primary care activities represented challenges to a significant curricular change<sup>6</sup>.

In this context, the 2001 DCN for the medicine course<sup>4</sup> represented an important step towards establishing a graduate profile more adequate to the population's needs. In 2014, after discussions about the 'More Doctors Law'<sup>7</sup>, new DCN for the medicine course were released<sup>8</sup>. Among the changes, the document highlighted the need of a generalist education, with emphasis on primary care and urgent/emergency services. It also recommended that the course's fundamental contents should be related to the entire health-disease process of the citizen, family and community<sup>8</sup>.

Primary care is the preferential entrance door to the health system and countries with a stronger inclination towards this level of care have better health indicators<sup>9,10</sup>. However, for its full functioning, it is necessary to have professionals who are highly effective, know how to assist people over time, have knowledge of different conditions, and are able to coordinate the care received in different levels<sup>11</sup>.

In this context, we analyzed the School of Medicine of Universidade Federal de Goiás (FM\_UFG). It initiated its activities in 1960 and more than 5,000 doctors have already graduated from it. The majority of them practice their activities in the region, in different areas, including those of public and private management<sup>12</sup>. The institution has strived to adequate its teaching to the population and, as early as in the 1970s, it implemented a rural internship for the teaching of community medicine. In 2002, FM\_UFG performed a curricular reform to comply with the 2001 DCN and, in the same year, it adhered to the Incentive Program to Curricular Changes in Medical Schools (Promed). In addition, in 2005, it adhered to the National Program of Reorientation of Professional Health Education (Pró-Saúde I and II), and in 2008, to the Education through Work Program for the Health Area (PET-Saúde). By adhering to these projects, the institution started to focus on health teaching activities in the community<sup>13</sup>.

In 2014, aiming to comply with the new DCN for the medicine course, it published its new Pedagogical Course Project (PCP), which is still in the implementation

and assessment stage. The PCP determines the guiding principles and the expectations for medical education in the institution<sup>12</sup>.

Considering the need to review and adjust the curricula of all the Brazilian medical schools based on the 2014 DCN, this study aimed to analyze the PCP of the medicine course of FM\_UFG in light of the determinations provided by the 2014 DCN and by the document “Guidelines for Primary Care Teaching in Undergraduate Medicine Courses”<sup>14</sup>.

## Methods

This is a case study involving a qualitative approach, with data produced by means of a documentary analysis. According to Bardin<sup>15</sup>, 2011, documentary analysis is an operation or set of operations that aim to represent the content of a document in a way that is different from the original, to facilitate, in a subsequent period, its consultation and reference.

As illustrated in Figure 1, three documents were analyzed and two were compared: The “Pedagogical project of the medicine course of FM\_UFG”, published at the end of 2014, was compared to the “Curricular guidelines for the medicine course”, published in 2014.

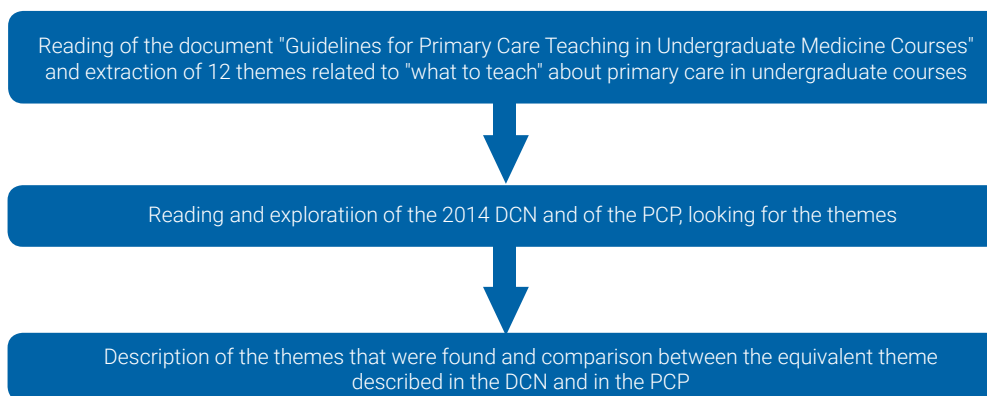
The document “Guidelines for Primary Care Teaching in Undergraduate Medicine Courses”<sup>13</sup> was also analyzed to subsidize and establish the specifications of primary care teaching in undergraduate courses. This document was chosen because it is considered a reference in the area. It was jointly constructed by the Brazilian Association of Medical Education (ABEM) and by the Brazilian Society of Family and Community Medicine (SBMFC), with the collective participation of different Brazilian specialists in the areas of medical education and primary care. It was developed with the aim of supporting medical schools in the structuring of pedagogical projects within the context of primary care.

Initially, the researchers performed the exploratory reading of the “Guidelines for Primary Care Teaching in Undergraduate Medicine Courses” and extracted themes related to “what to teach” in this level of care. After this stage, the researchers selected twelve themes that had correspondents in the 2014 DCN:

- Teamwork competency
- Capacity to act in primary care and know the healthcare levels
- Knowledge of management actions and of the health services
- Competence to work with popular education and with the team’s permanent education
- Respect for autonomy
- Capacity to make shared decisions
- Utilization of scientific evidence
- Decisions based on prevalence and incidence
- Generalist profile
- Leadership in multidisciplinary work
- Social responsibility
- Comprehensive care

Then, the researchers performed an initial exploratory reading of the PCP, to have contact and be familiarized with the text<sup>12</sup>. This document provides the principles and strategies of learning assessment, course duration and curricular structure, including the curricular matrix, the list of modules and the learning contents, with their respective summaries and numbers of hours<sup>10</sup>. All these topics were evaluated in this research.

Finally, by means of the thematic content analysis<sup>15</sup>, the researchers searched for the previously chosen themes in the PCP and, subsequently, described and correlated them. They are presented in tables in the Results section (Figure 1).



**Figure 1.** Methodological steps followed in the documentary analysis.

The study was submitted to the Research Ethics Committee of Hospital das Clínicas of UFG and was initiated after its approval - Opinion no. 1.523.208 in 2016, according to resolution no. 466 of December 12, 2012, of the National Health Council (CNS).

## Results and discussion

The four themes that resulted from the documentary analysis are presented in tables, together with the description and comparison between the documents. Chart 1 compares the documents according to the graduate profile, Chart 2 deals with the healthcare area, Chart 3 refers to aspects of health management, and Chart 4 approaches health education.

### The expected graduate profile

The professional's profile described in the PCP, a generalist doctor aligned with the society's needs, is in agreement with the DCN. Education in primary care and social responsibility are highlighted in both documents (Chart 1).

**Chart 1.** Description of the comparative documentary analysis referring to the expected profile of the graduates of the medicine course of Universidade Federal de Goiás (UFG), Goiânia, 2017.

Teaching guidelines in primary care	National Curricular Guidelines for the medicine course - 2014	Curricular pedagogical project of 2014 – School of Medicine – UFG
Generalist profile	"The Medicine graduate shall have a general, humanistic education, ..." (p. 1)	"The curricular proposal aims at the education of a generalist professional prepared to face the challenges of modern society." (p. 12) "The general objective of the Medicine Course of UFG is the education of a generalist professional [...]" (p. 12)
Capacity to act in primary care and know different levels of healthcare	"[...] with capacity to act in different levels of healthcare, with health promotion, prevention, recovery and rehabilitation actions, in the individual and collective spheres [...]" (p. 1) "Valuing life, approaching the recurrent health problems in primary care [...]" (p. 3)	"To include the student, since the first year of the course, in field activities that contribute to form skills and competencies, in different levels of care, as well as in the management area, within different teaching-learning settings necessary to the exercise of medical practice." (p. 13) "To act in different healthcare levels, with emphasis on primary and secondary care [...]" (p. 16)
Social responsibility	The Medicine graduate should have a general education [...] with social responsibility and commitment to the defense of citizenship, of human dignity, of the human being's integral health [...]" (p. 1)	"the curricular development axis was constructed according to the health needs of individuals and populations, identified [...]" (p. 16) "the objective is to make the graduate's education relevant in relation to the needs of society [...]" (p. 16)

The education of a medicine student with a generalist profile, knowledge of different healthcare levels and with social responsibility is aligned with the principles of the Brazilian National Health System (SUS)<sup>16</sup>. Although the 2001 DCN for the medicine course<sup>5</sup> already contained these orientations, the medical schools have advanced slowly as far as this theme is concerned. Medical teaching in Brazil has had difficulties in transforming traditions and spaces of action<sup>4</sup>. The publication of the 'More Doctors Law' in 2013<sup>7</sup> instituted that medicine courses must comply with the DCN. Due to this, greater transformations are expected in the Brazilian medical education and in the university analyzed here.

To corroborate these orientations, and searching for experiences and standpoints from other countries, it is important to mention that the World Health Organization recommends that approximately eighty percent of the health demands are met in primary care<sup>17</sup>. Furthermore, in White's classic study "The ecology of medical care", 1961<sup>18</sup>, replicated and confirmed in 2001 by Green<sup>19</sup>, it was found that less than five percent of the people who look for medical assistance need hospital care. These data strengthen the need of an education that focuses on outpatient services, especially in primary care.

## Healthcare

Chart 2 presents themes related to the Healthcare area, like care centered on the person, family and community, health promotion and prevention, utilization of scientific evidence, and competencies related to teamwork, development of popular education activities and shared decision-making.

**Chart 2.** Description of the comparative documentary analysis referring to the Healthcare area of the medicine course of Universidade Federal de Goiás (UFG). Goiânia, 2017.

Teaching guidelines in primary care	National Curricular Guidelines for the medicine course - 2014	Curricular pedagogical project of 2014 - School of Medicine - UFG
Approach centered on the person, family and community	<p>"comprehensive and humanized care by means of a continuous medical practice integrated to the other health actions and levels, [...] stimulating self-care and the autonomy of people, families, groups, and communities" (p. 2).</p> <p>"Care centered on the patient, on the family, and on the community [...]" (p. 2)</p> <p>"including the perspective of users, family and community, favoring their autonomy in decisions about the therapeutic plan." (p. 8)</p>	<p>"The first interaction must be between the student and the individual inserted in his/her social context (the family, neighborhood group, and the social foci where his/her social relationships are developed)." (p. 15)</p> <p>"Individual, Family, Community, Society Axis: aims at the development of community-based, integrated action [...], where the student maintains a close relationship with the individual, the family, the community and society, or in environments and structures belonging to them" (p. 46)</p>
Action in prevention and health promotion	<p>"participation in the discussion and construction of intervention projects in social groups, aiming to improve health indicators, always considering their autonomy and cultural aspects" (p. 7)</p> <p>"stimulus to the inclusion of health promotion and education in all the levels of care, with emphasis on primary care" (p. 7)</p>	<p>"acting in health protection and promotion and in disease prevention, as well as in the treatment and rehabilitation of health problems" (p. 24)</p>
Competence to work with popular education and with the team's permanent education	<p>"stimulus to the inclusion of health promotion and education in all the levels of care, with emphasis on primary care" (p. 7)</p>	<p>POPULAR EDUCATION IS NOT MENTIONED</p> <p>"transmission of the knowledge of the health area, whose reach involves the student's education, and the continuous exchange among professionals from the institutions that provide services, mainly the Primary Care Units, reaching, also, the community itself, in a permanent process of education and awareness-raising." (p. 16)</p>
Respect for patient autonomy	<p>"stimulating self-care and the autonomy of people, families, groups, and communities" (p. 2).</p>	NOT MENTIONED
Capacity to make shared decisions	<p>"including the perspective of users, family and community, favoring their autonomy in decisions about the therapeutic plan" (p. 8)</p>	NOT MENTIONED
Utilization of scientific evidence	<p>"Decision-making based on the critical and contextualized analysis of scientific evidence" (p. 3)</p>	<p>"capacity to make decisions [...] based on scientific evidence; (p. 22)</p>
Decisions based on prevalence and incidence	<p>"Analysis of the health needs of groups of people and life and health conditions of communities, based on demographic, epidemiological, health and environmental data, considering dimensions of risk, vulnerability, incidence and prevalence of health conditions [...]" (p. 7)</p>	<p>"correctly diagnosing and treating the main diseases of the human being in all the stages of the biological cycle, based on the criteria of diseases' prevalence and morbidity potential" (p. 24)</p>

The need to consider the person in their totality, including the family and community, is mentioned in both documents. However, the PCP does not mention the person-centered clinical method. This approach has many advantages in relation to the traditional biomedical model, centered on the doctor. Some of them are greater patient satisfaction, higher adherence to the treatment and better response to the therapy, greater doctor satisfaction, lower number of medical malpractice lawsuits, more efficient care, lower number of complementary exams and referrals to specialists, reducing costs to the health system and the patient<sup>20,21</sup>.

Prevention, health promotion and competence to work with popular education and with the team's education are considered actions the student is expected to per-

form. The expression 'health promotion' was used for the first time in the 1970s by the Canadian health minister Mark Lalonde, in a document called *The New Perspectives on the Health of Canadians*.<sup>22</sup> The influence of environmental factors, individual behaviors and ways of life on the occurrence of diseases and death were emphasized in this document. The Ottawa Charter, published by the World Health Organization in the first international conference on health promotion, strengthens this thesis and adds that individuals must be oriented to have better control over their own health<sup>17,22</sup>.

Although the PCP approaches the concept of permanent education and involves the population in this sense, there is no clear and specific mention to learning about Popular Health Education. Popular Health Education recognizes and faces health problems by interacting with the working classes and respecting their culture and knowledge. The current conception of Popular Health Education, influenced mainly by Paulo Freire's publications, breaks with the previous hegemonic practices of health education. These used to be predominantly instituted in a unilateral way by health professionals. Their nature was essentially biomedical and not dialogic<sup>23</sup>. Therefore, teaching these concepts in the medicine course has become fundamentally relevant<sup>24</sup>.

The DCN mention the need to stimulate patients' self-care, to respect their autonomy, and to encourage the professionals' capacity for making shared decisions. However, it is important to highlight the absence, in the PCP, of any term related to respect for autonomy or shared decision. As shown below, many publications strengthen the DCN's orientation about these matters. The 2009 code of medical ethics<sup>25</sup> establishes, in article 21, that in the professional decision-making process, according to the doctor's dictates of conscience and the legal dispositions, the doctor will accept their patients' choices related to diagnostic and therapeutic procedures, provided that they are adequate to the case and scientifically recognized.

The predominance of chronic degenerative diseases instead of acute diseases will require the reincorporation of the art of medicine, according to Sullivan, 2003<sup>26</sup>. The exclusive objective of curing and avoiding death is replaced by the objective of providing care for people, considering their perspective. Respect for patient autonomy and the importance given to their point-of-view in relation to health and care is a fundamental part of the doctor's action. The patient-subject is being reintroduced in medicine<sup>26,27</sup>.

Evidence-based decision-making considering the prevalence and incidence of different health problems is mentioned in both documents. This form of action ensures greater efficacy and effectiveness to treatments, attention to quaternary prevention, rational use of resources and medicines, and reduction in cases of iatrogenesis<sup>28,29</sup>.

## Health Management

This topic deals with matters like teamwork, leadership in multidisciplinary work, and knowledge of management actions. All these competencies are recommended by the DCN and PCP (Chart 3).



**Chart 3.** Description of the comparative documentary analysis referring to the Health Management area of the medicine course of Universidade Federal de Goiás (UFG). Goiânia, 2017.

Teaching guidelines in primary care	National Curricular Guidelines for the medicine course - 2014	Curricular pedagogical project of 2014 – School of Medicine – UFG
Teamwork competency	“Teamwork, in order to develop partnerships and networks, stimulating and reducing the distance among institutions, services and other sectors involved in comprehensive care and health promotion.” (p. 3)	“Inclusion of the student, since the first year of the course, in practical activities and teamwork, with multiprofessional interaction and action, having the individuals and the community as beneficiaries.” (p. 12) “To promote the formation of the necessary competencies for multiprofessional teamwork, as well as interpersonal and ethical relationship in all the levels of professional action, [...]” (p. 14)
Leadership in multidisciplinary work	“Leadership exercised in the horizontality of interpersonal relationships [...], aiming at the community’s wellbeing [...]” (p. 3)	“[...] in multiprofessional teamwork, they must be able to assume leadership positions, always aiming at the community’s wellbeing [...]” (p. 22)
Knowledge of management actions and of the health services	“[...] to participate in management and administration actions to promote the community’s wellbeing, [...]” (p. 2) “Social participation articulated in the teaching and learning fields of healthcare networks, collaborating to promote the integration of health services and actions, promoting continuous, comprehensive, high-quality care...” (p. 3)	“[...] to know about the doctor’s social role and be willing to act in activities related to health policies and planning.” (p. 24) “[...] must be able to take initiative, manage and administer the workforce and the physical, material and information resources” (p. 22)
Comprehensive care	“[...] provision of comprehensive care for individuals and groups [...]” (p. 8)	“[...] to recognize health as a right and act to guarantee the provision of comprehensive care [...]” (p. 24)

With the population’s aging and the increase in chronic conditions, the complexity of care has been significantly amplified<sup>30-32</sup>. Therefore, the education of professionals to face this new epidemiological profile has become fundamental. Teamwork and leadership in a collaborative, non-hierarchic and coordinated way are indispensable competencies in this process<sup>30,33,34</sup>.

Despite its subjective character, leadership is a competency that can be taught. It involves good communication, knowing how to work in teams, strategic planning and decision-making. In addition, the student is expected to identify needs, set goals and work in teams, trying to involve other professionals in order to share the provision of care with them<sup>35</sup>.

The development and knowledge of management actions - another desired competency - involves the organization of health systems and public healthcare. Educating the student to be familiarized with and manage the macrostructure and also the public policies and services is a measure that will bring better qualified professionals and managers, committed to the improvement in the healthcare network devices<sup>36</sup>.

An action that aims at the provision of comprehensive care is a fundamental stage of medical assistance in primary care. The clinical approach centered on the integral, complex person guarantees that the individual is seen in their totality. It is a strategy to fulfil an assistance targeted at the population’s real needs<sup>37</sup>.



## Health Education

In the section of the DCN referring to the area of Health Education, an issue with an interface in primary care is highlighted: interdisciplinarity. Interdisciplinarity is mentioned in the PCP (Chart 4).

**Chart 4.** Description of the comparative documentary analysis referring to the Health Education area of the medicine course of Universidade Federal de Goiás (UFG). Goiânia, 2017.

Teaching guidelines in primary care	National Curricular Guidelines for the medicine course - 2014	Curricular pedagogical project of 2014 – School of Medicine – UFG
Interdisciplinarity	"To promote integration and interdisciplinarity in accordance with the curricular development axis, attempting to integrate the biological, psychological, ethnic-racial, socioeconomic, cultural, environmental, and educational dimensions" (p. 12)	"Ethical, moral, social and physiopathological aspects in medical practice with emphasis on interdisciplinarity." (p. 97)

Interdisciplinarity, which means the interaction among different theories and knowledge from different areas in teaching-learning processes<sup>33</sup>, is essential for the education of a professional who works in an integrated, interprofessional and efficient manner<sup>34</sup>.

According to Frenk et al.<sup>30</sup>, interdisciplinarity and interprofessionalism are pillars of the last substantial generation of reforms in medical education that deal with the acquisition of competencies for the education of a professional aligned with the population's needs.

## Final remarks

The new curricular pedagogical project was constructed within a context of transformations in medical education and in the care model (after the 'More Doctors Law') and complied with the 2014 DCN in the majority of points related to primary care teaching in undergraduate courses.

Both documents determine the education of a generalist professional who meets the population's health needs and has extensive knowledge of primary care. The documents also describe the need to educate graduates to have a comprehensive approach, skills to work in teams, and knowledge of management processes.

However, it is important to mention the absence, in the PCP, of fundamental themes to medical practice and to the doctor-patient relationship. There is no reference to the teaching of the person-centered clinical method, popular health education, respect for patient autonomy, and shared decision-making.

Thus, we hope that managers of the analyzed course and of other institutions with similar contexts, in a process of assessment and continuous reformulation of the curriculum, can include these recommendations, set forth in the 2014 DCN and fundamental to the practice of a humanized, effective medicine, centered on the people's and population's needs.

## Authors' contributions

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

## Copyright

This article is distributed under the terms of the Creative Commons Attribution 4.0 International License, BY type (<https://creativecommons.org/licenses/by/4.0/deed.en>).

## References

1. Marins JJ, Lampert JB, Araújo JG, organizadores. Educação médica em transformação: instrumentos para a construção de novas realidades. São Paulo: Hucitec; 2004.
2. Almeida Filho N. Reconhecer Flexner: inquérito sobre produção de mitos na educação médica no Brasil contemporâneo. *Cad Saude Publica*. 2010; 26(12):2234-49.
3. Cooke M, Irby DM, Sullivan W, Ludmerer KM. American medical education 100 years after the Flexner report. *N Engl J Med*. 2006; 355(13):1339-44.
4. Streit DS, Neto FB, Lampert JB, Lemos JMC, Batista NA. Educação médica: dez anos de diretrizes curriculares nacionais. Rio de Janeiro: ABEM; 2012.
5. Ministério da Educação (BR). Conselho Nacional de Educação. Resolução CNE/CES 4/2001. Diretrizes Curriculares Nacionais do Curso de Graduação em Medicina. *Diário Oficial da União*. 9 Nov 2001; sec. 1, p. 38.
6. Bollela VR, Germani ACCG, Campos HH, Amaral E. Síntese final e as perspectivas para o futuro da educação baseada na comunidade no contexto Brasileiro. In: Bollela VR, Germani ACC, Campos HH, Amaral E, organizadores. Educação baseada na comunidade para as profissões da saúde: aprendendo com a experiência brasileira. Ribeirão Preto: FUNPEC-Editora; 2014. p. 293-7.
7. Presidência da República (BR). Lei 12.871, de 22 de Outubro de 2013. Institui o Programa Mais Médicos, altera as Leis nº 8.745, de 9 de Dezembro de 1993, e nº 6.932, de 7 de Julho de 1981, e dá outras providências. *Diário Oficial da União*. 23 Out 2013.
8. Ministério da Educação (BR). Conselho Nacional de Educação. Resolução CNE/CES 3/2014. Diretrizes Curriculares Nacionais do Curso de Graduação em Medicina. *Diário Oficial da União*. 23 Jun 2014; sec. 1, p. 8-11.
9. Organização Mundial da Saúde. Atenção primária em saúde: agora mais do que nunca. *Relatório Mundial da Saúde*. Brasília: OPAS/Ministério da Saúde; 2010.
10. Organización Panamericana de la Salud. La renovación de atención primaria de salud em las Américas. Documento de posición de la Organización Panamericana de la Salud. Washington: OPAS; 2007.
11. Starfield B. Is primary care essential? *Lancet*. 1994; 344(8):1129-33.
12. Universidade Federal de Goiás. Projeto pedagógico do curso de medicina. Goiânia: UFG; 2014.
13. Naghettini AV, Pereira ERS, Moraes VA. Educação baseada em comunidade: a experiência da Universidade Federal de Goiás. In: Bollela VR, Germani ACC, Campos HH, Amaral E, organizadores. Educação baseada na comunidade para as profissões da saúde: aprendendo com a experiência brasileira. Ribeirão Preto: FUNPEC; 2014. p. 125-36.



14. Demarzo MM, Almeida RC, Marins JJ, Trindade TG, Anderson MI, Stein AT, et al. Diretrizes para o ensino na Atenção Primária à Saúde na graduação em Medicina. *Rev Bras Med Fam Comunidade*. 2011; 6(19):145-50.
15. Bardin L. *Análise de conteúdo*. Reto LA, Pinheiro A, Tradutor. São Paulo: Edições 70; 2011.
16. Ministério da Saúde (BR). Portaria nº 2.488, de 21 de Outubro de 2011. Política Nacional de Atenção Básica em Saúde (PNAB). *Diário Oficial da União*. 22 Out 2011; sec. 1, p. 48-52.
17. World Health Organization. *The Ottawa Charter for health promotion*. Geneva: WHO; 1986.
18. White KL, Williams TF, Greenberg BG. The ecology of medical care. *N Engl J Med*. 1961; 265:885-92.
19. Green LA, Fryer GE Jr, Yawn BP, Lanier D, Dovey SM. The ecology of medical care revisited. *N Engl J Med*. 2001; 344(26):2021-5.
20. Dwamena F, Holmes-Rovner M, Gaulden CM, Jorgenson S, Sadigh G, Sikorskii A, et al. Interventions for providers to promote a patient-centred approach in clinical consultations. *Cochrane Database Syst Rev*. 2012; 12:CD003267.
21. Lopes JM. Consulta e abordagem centrada na pessoa. In: Gusso G, Lopes J. *Tratado de medicina de família e comunidade*. São Paulo: Artmed; 2012. p. 112-23.
22. Oliveira DL. A 'nova' saúde pública e a promoção da saúde via educação: entre a tradição e a inovação. *Rev Lat Am Enfermagem*. 2005; 13(3):423-31. doi: 10.1590/S0104-11692005000300018.
23. Gomes LB, Merhy EE. Compreendendo a educação popular em saúde: um estudo na literatura brasileira. *Cad Saude Publica*. 2011; 27(1):7-18.
24. Simon E, Jezine E, Vasconcelos EM, Ribeiro KS. Metodologias ativas de ensino-aprendizagem e educação popular: encontros e desencontros no contexto da formação dos profissionais de saúde. *Interface (Botucatu)*. 2014; 18 Suppl 2:1355-64. doi: 10.1590/1807-57622013.0477.
25. Conselho Federal de Medicina – CFM. Código de ética médica; Resolução CFM Nº 1931/2009. *Diário Oficial da União*. 24 Set 2009; sec. 1, p. 90.
26. Sullivan M. The new subjective medicine: taking the patient's point of view on health care and health. *Soc Sci Med*. 2003; 56(7):1595-604.
27. Ribeiro MM, Amaral CF. Medicina centrada no paciente e ensino médico: a importância do cuidado com a pessoa e o poder médico. *Rev Bras Educ Med*. 2008; 32(1):90-7.
28. Manser R, Walters EH. What is evidence-based medicine and the role of review: the revolution coming your way. *Monaldi Arch Chest Dis*. 2001; 56(1):33-8.
29. Oannidis JP. Evidence-based medicine has been hijacked: a report to David Sackett. *J Clin Epidemiol*. 2016; 73:82-6.
30. Frenk J, Chen L, Bhutta ZA, Cohen J, Crisp N, Evans T. Health professionals for a new century: transforming education to strengthen health systems in an interdependent world. *Lancet*. 2010; 376(9756):1923-58. doi: 10.1016/S0140-6736(10)61854-5.



31. Ornstein SM, Nietert PJ, Jenkins RG, Litvin CB. The prevalence of chronic diseases and multimorbidity in primary care practice: a PPRNet report. *J Am Board Fam Med*. 2013; 26(5):518-24.
32. Barreto MS, Carreira L, Marcon SS. Envelhecimento populacional e doenças crônicas: reflexões sobre os desafios para o Sistema de Saúde Pública. *Rev Kairós Gerontol*. 2015; 18(1):325-39.
33. Furtado JF. Equipes de referência: arranjo institucional para potencializar a colaboração entre disciplinas e profissões. *Interface (Botucatu)*. 2007; 11(22):239-55.
34. Matuda CG. Colaboração interprofissional na Estratégia de Saúde da Família: implicações para a produção do cuidado e a gestão do trabalho. *Cienc Saude Colet*. 2015; 20(8):2511-21.
35. Provenzano BC, Ferreira DAV, Machado APG, Aranha RN. Liderança na educação médica. *Rev HUPE*. 2014; 13(4):26-31.
36. Gontijo ED, Alvim C, Megale L, Melo JRC, Lima MECC. Matriz de competências essenciais para a formação e avaliação de desempenho de estudantes de medicina. *Rev Bras Educ Med*. 2013; 37(4):526-39.
37. Starfield B. Atenção primária: equilíbrio entre necessidades de saúde, serviços e tecnologia. Brasília: Unesco, Ministério da Saúde; 2002.

**Translator:** Carolina Siqueira Muniz Ventura

Submitted on 12/14/17.

Approved on 10/08/18.