Instituting and instituted in medical education: movements triggered by the Mais Médicos (More Doctors) Program

Instituintes e instituídos na formação médica: movimentos desencadeados pelo Programa Mais Médicos

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ABSTRACT The present study focused on mapping the forces involved in implementing the medical programs created from the Mais Médicos Program (MMP) and their effects on training practices and subjects who experience them. The field of research was two new medical programs in the South and Northeast regions of the country. We found that two sets of forces operate in the programs through a qualitative research approach based on the cartographic method, expressions of the instituted and instituting in medical education. The influences of the biomedical model, labor market, and the movements of political polarization underway in the national scenario were highlighted in the field of the instituted. The student movements for change in education, those to reaffirm the Unified Health System and collective health, and those that support training focused on a generalist profile stood out among the instituting forces. In summary, the program's proposal for medical education operated as an interference device in these programs when associated with a group context of collective construction, shared management of the programs, and pedagogical practices anchored in the perspective of the socio-historical production of the health-disease-care process and the medical institution.

KEYWORDS Education, medical. Primary Health Care. Unified Health System.

RESUMO *O presente estudo deteve-se no mapeamento das forças intervenientes no processo de implantação dos cursos de medicina criados a partir do Programa Mais Médicos (PMM), bem como nos efeitos dessas sobre as práticas de formação e sobre os sujeitos que as vivenciam. O campo de investigação foram dois novos cursos de medicina, nas regiões Sul e Nordeste do País. Por meio de abordagem qualitativa de pesquisa, fundamentada no método cartográfico, constatou-se que dois conjuntos de forças operam nos cursos, expressões do instituído e do instituinte na formação médica. No campo do instituído, destacaram-se as influências do modelo biomédico, do mercado de trabalho e dos movimentos de polarização política em curso no cenário nacional. Entre as forças instituintes, tiveram destaque os movimentos estudantis pela mudança na formação, os de reafirmação do Sistema Único de Saúde e da saúde coletiva, e aqueles que apoiam a formação focada em um perfil generalista. Em resumo, a proposta do Programa para a formação médica operou como dispositivo de interferência nesses cursos quando associada a um contexto grupal de construção coletiva, gestão compartilhada do curso e práticas pedagógicas ancoradas na perspectiva da produção sócio-histórica do processo saúde-doença-atenção e da própria instituição medicina.*

PALAVRAS-CHAVE *Educação médica. Atenção Primária à Saúde. Sistema Único de Saúde.*

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Introduction

The strategies undertaken in Brazil in recent decades to bring medical education closer to the needs of the Unified Health System (UHS) have revealed a common point: it is a field in which multiple forces have interfered in the direction this education will take, calling for the analysis of strategies for change and the relationship between medicine and the public health system. When the Mais Médicos Program (MMP) was sanctioned in 2013, medical education was struggling with the reductionist and biologicist hegemonic trend, amplified by the medical-industrial complex that crosses the health sciences. The humanistic education provided for in the Lei de Diretrizes e Bases da Educação Nacional of 1996, which should take place in schooling prior to undergraduate studies, had not been carried out, leaving a heavy legacy for the moral competence and the political exercise of a critical and active citizenship[1]. On the other hand, the lack of vacancies in educational institutions fell on municipal managers as a burden reflected in the lack of doctors in public services, especially in locations with difficult access or greater social vulnerability. The education of specialists, strongly influenced by the market, left, and still leaves, the public network with a continuous deficit in certain specialties. Intervening on this reality meant breaking with various education organizational logics, coming into conflict with groups, interests, and the know-how produced by them[2].

Although the MMP was born as a response to claims related to the inadequacies in the provision of professionals, it is undeniable that its structuring condensed several efforts and strategies of the Ministry of Health for primary care in response to its development below what is necessary. Thus, in addition to focusing on the number of professionals available to work in the Family Health Strategy in priority regions, the program focused on improving the physical structure and medical practice, investing heavily in the standing education of hired professionals and the reorganization of professional education. This reorganization needed to be sustained in an articulated manner between the Ministry of Health and the Ministry of Education, interfering, among others, in the criteria for opening undergraduate and residency programs[2].

In this sense, the focus on improving the medical education of the MMP became one of the most relevant government actions of the period since it displaced the centrality occupied by the hospital and medical specialties, bringing the focus to the public health network and generalist education. The education model proposed by the MMP sought to operate on the traditional paradigm that sustains medical knowledge and practice, advancing from the biological to the social model. It also emphasized the historical asymmetry of power between professor-student and doctor-patient. It wagered on a practice based on the collective dimension of the health-disease-care process inserted in the community. However, such changes triggered reactions of resistance to change in the medical corporation, better demonstrating the forces and interests involved in the problem of an insufficient number of doctors and inadequate training to work in the UHS.

For the institutionalist conception, institutions are organized based on instituted and instituting. The institutent is characterized by a dynamic that generates movement in institutions since the instituted has a stabilizing function, essential for social life. As reality is in permanent transformation, the instituted must be functional to social life, accompanying the new social states. These dialectical movements of institutions, which make up the dynamics of a society, are, a priori, neither good nor bad but necessary and complementary. However, when the forces of the instituted exacerbate their stabilizing function, they can become conservatism, expressing themselves through extreme resistance to change. Permeability and fluidity for changes are necessary for

improving social life to occur satisfactorily[3].

This study aimed to map and understand how the forces involved in implementing the new medical programs affected medical education and the subjects and groups involved. Understanding the field in which medical education is inserted is essential for directing educational policies and institutional articulations that strengthen an education policy aimed at acting in the UHS, especially concerning supporting the public dimension of health policy. Thus, this study sought to answer whether the MMP was configured as a device in the field of medical education. In other words, whether from its discursive and non-discursive elements, it interfered with the modes of subjectivation, reorganizing knowledge and the relationship between those involved. The study did not focus on an idealized and pre-defined horizon of education but on the events and movements that triggered the emergence of new possibilities for medical education from the MMP.

Material and methods

The method used in this research was based on the theoretical and methodological framework of cartographic research, a qualitative approach that allows monitoring the dimension of procedures inherent to the object of study and considers the effects of research on the subjects, groups, and institutions involved[4,5]. Two medical programs were selected as the field in different phases and regions of the country to include regional differences and those related to the stages of development of these undergraduate degrees. The programs were located in the South and Northeastern regions, one in the planning process and the other already in progress. They were based on the guidelines of the MMP and the National Curricular Guidelines of Undergraduate Programs in Medicine of 2014. After defining the field, the study was submitted and approved by the Research Ethics Committee of the Universidade Federal de Santa Catarina (UFSC), having accepted the guidelines for research with human beings contained in Resolution nº 466/2012 – certificate of Presentation of Ethical Assessment (CAAE) nº 62293316.6.0000.0121 – Opinion nº 1,960,198.

The study participants were the professors, students, and technicians who made up the groups responsible for conducting and supporting the programs. The data collection techniques used were documentary analysis, which included the political-pedagogical project; interviews with members of the conducting groups; and participant observation of the group meetings. The data triangulation, derived from the combination of techniques, contributed to analyzing the forces involved in the programs, from their most immediate and visible expressions to their unfolding and batting effects.

The result analysis made explicit the forces of the instituted and the instituting movements present in the field, locating the forms in which the MMP has been affecting the scenario of medical education in the country. The analysis adopted the institutionalist perspective, which understands education as an 'institution', that is, as a historically constructed social practice, producer of truths, objects-knowledge, and modes of subjectivation[5,6].

We sought a theoretical anchor that would allow us to map the morality produced from changes in education through social bioethics. This framework provided an opportunity to understand how the issues surrounding the struggle for the right to health and education are present in the reflections formulated in these programs, helping to analyze the factors that interfere with the struggles for better and more dignified forms of life[7-11].

Results and discussion

The organization of the data collected in the research field and the researcher's impressions recorded in a field diary allowed us to

understand some of the movements that give body to the 'medical education' institution. The movements express the exacerbations of the instituted and those that derive from the resistance to them and are destabilizing conservatism are evidenced[12].

Analyzing medical training as a practice that produces reality and subjects implies considering the lack of association between education and intervention since education is a field of human experience that produces power relations. The reproduction of historically constituted social practices is supported by mechanisms invented, especially agency relations of force, called devices. To substantiate the result analysis, we approached these two conceptual operators – power and device – developed by Foucault to historicize the forms in which human beings are constituted as subjects[13,14].

Power and conservatism in medical education

The data analysis showed a set of institutions that stressed the field, contributing to maintaining traditional forms of organizing medical knowledge, managing it, and training professionals. These barriers kept the dynamics of power relations unchanged, generating obstacles to producing new practices and knowledge and, therefore, new subjectivities.

Some forces of the instituted are so naturalized in medical education and public health that their expressions are capillarized even within potentially instituting movements, such as the MMP. An example of this is the first and most comprehensive force observed in this study: the biomedical model. As an organizer of truths and practices in medical education, the biomedical model appears in the researched field diffusely but intensely, generating knock-on effects in other forces. It was constituted in the shadow of the Cartesian paradigm as the conceptual basis of modern scientific medicine, organizing itself around premises such as unicausality, biologicism, fragmentation, mechanismus, nosocentrism, recovery and rehabilitation, technicism, and specialization. Criticisms of biomedical interventions focus on their limitation in capturing the health needs of populations, as they do not consider non-biological variables that single out the health-disease-care process[15,16].

Many MMP guidelines sought to insert elements to overcome the limitations of the current training model. An example is the proposal to reverse the centrality of the hospital as a scenario of practices, highlighting other services in the network, especially those of Primary Health Care (PHC). This reversal is not yet unanimous among the study participants involved in building the analyzed programs because of how the biomedical model shapes society's understanding of what medicine is and how medical education should occur, constituting a regime of truths regarding the profession.

Medical education paradigms and models result from historically produced knowledge and experiences, condensers of interests, forces, and disputes. Certain pieces of knowledge underlie power relations without it being possible to dissociate them. The knowledge-power binomial is engendered to produce truths – modes of subjectivation that conform to the different realities and produce modulations in the different subjects. The naturalization of these historically-produced truths makes them unquestionable, and the forces that constitute them are hidden. Such a process allows the instituted to stabilize itself, considered as necessary and certain and, therefore, does not need to be questioned. Thus, reality is always produced under a certain axiological, evaluative order, which is a partial expression of the moralities of an epoch. Power is thus constituted from the 'social' production of truths, from some to all, and legitimizes a certain form of living, delegitimizing others. Differences are reduced to unity, homogenizing subjectivities to maintain stable a certain form of organizing power relations[14,17].

This is not about demonizing the biomedical model but repositioning the challenges for its relativization in medical education. According to some study participants, the MMP, which proposes strategies to overcome this excessive influence, is still predominantly crossed by it. According to some study participants, the MMP's commitment only to physicians to strengthen PHC would express the importance of biomedical logic, given the deficits of professionals from other areas in this health care segment.

> *[...] It was an old debate within primary care that, in certain places, the doctor does more harm than good [...] We resisted the conservative onslaught of the 90s and 2000s with measures such as standing education poles, collective health, teamwork, interdisciplinarity [...] then the government says that health is done only with doctors.* (Do-002).

The research showed that the biomedical model also impacts the attributes of PHC since clinical resolvability takes precedence over integrality, longitudinality, and community orientation, among others, in the organization of the new programs, which would generate obstacles to the transition from a selective care model to the expanded care model. Consequently, the devaluation of this orientation by the medical category is perpetuated, including in the new programs, since it would divert future doctors from the destination of specialists. Thus, the positioning of the medical corporation in defense of the biomedical model is one of the forms in which its members seek to maintain the power relations that permeate the profession.

> *[...] the biggest obstacle to the operation of the program is the paradigm shift with doctors [...] it is common for us to hear reports that: 'ah, the medical program does not work, it only trains doctors for health centers' [...] it is as if the students who graduate here cannot turn out to be specialists.* (Do-003).

The medical corporation is presented throughout the narratives as a group that defends the biomedical discourse because it is a regime of truths that defines the profession's 'identity', with specific training, performance, and technical capacity. Forging a differentiated identity is one factor that accentuates the status of the category in relation to other health professions.

The MMP attacked this professional identity when it proposed to move the main scenario of practices from the hospital to the health unit and put more professionals on the market:

> *We are elitists. Not only the doctor but the medical school itself since the medical school, in Brazil, was founded to serve the court [...] we are also working with forces that have been active in Brazil for centuries. [...] And the Mais Médicos Program was on that blade.* (Do-004).

Tesser and Luz[18] indicate that the repositioning of biomedicine must occur in the environment of its clinical practice, redirecting medical education to scenarios that prioritize the basic network. There would be power to transform medicine, provided a necessary inversion occurred. Instead of patients orbiting biomedical diseases and their apparatuses, put biomedicine at the service of these individuals, with multidisciplinary reference teams producing personalized care for users and communities. However, despite the intention of the new programs to strengthen multidisciplinary work, the social status of the medical professional continues to be reinforced daily, as reported by professor 003:

> *Because I'm not a doctor, I sometimes experience a certain amount of resistance... even from some colleagues (professors), doctors themselves, and even students. [...], but, anyway, it's part of it.*

The initiatives of the new programs to relativize biomedicine and even to contrast it with other medical rationalities have been relatively successful. According to the study

participants, this is due to the lack of professors with compatible education and alternatives to the prevailing model. The biomedical model would legitimize itself through its explanatory power of the various phenomena of the process-health-disease-care, which announces something like an epistemological crisis in collective health. Attempts to develop other biological models are seen as fragile and isolated, not accounting for the complexity of the health field.

> *We searched a while back... philosophical, epistemological, [...] of other biology [...], but there is no work using Maturana's biological understanding matrix to understand the Zica epidemic [...] I mean, our biggest shortcoming in critiquing it (the biomedical model) is not having something else to put in place. It is important to understand this as a phenomenon not only philosophical, and epistemological, but social.* (Do-002).

The changes proposed by the MMP were incorporated with caution regarding the inclusion of other rationalities and disciplines, as professor 002 indicates: "*[...] we have already had a mindfulness workshop, of humanized childbirth..., but they are still non-mandatory inserts, still from the optional component*".

Although complexity is increasingly accepted as something inherent to health-related phenomena, the conceptual basis of medicine is still relatively little problematized. There is no consensus on the need to overcome the reductionist analysis proposed by the biomedical approach. An example is the little attention other conceptual models receive in medical education. And to mess with this is to mess with the medical institution itself:

> *[...] we are not facing the students nor the doctors of the city. We are facing Medicine [...] the more robust, coherent, and decisive in its confrontation, the greater the reaction of Medicine against it. [...] It (Medicine) invades everything. It takes every step, every strength [...] this is very strong in students, right? [...] We had several clashes, confrontations of conceptions, and such. And I don't know if we can answer that.* (Do-002).

It is essential to recognize the social determination of the health-disease process to understand the relationship between the biological and the social, the individual and the collective. However, its social dimension is only clearly presented in the analysis of collectivity. The perspective of clinical medicine and epidemiology fragments the analysis of collectivity[19]. Health it is not fully explained only by its biological and natural aspects since it has a strong human and social dimension. This is only one of the dimensions to be considered, and its logic does not apply to understanding the other dimensions. The perspective of the social production of health poses the challenge of building scientific bases for medicine that contemplate all the dimensions involved in the phenomena of life and illness. Medical education, beyond the biological, would then need to include contextualized approaches from historical, political, ethical, and cultural perspectives[20,21].

Another force identified in the program analyses concerns the totalizing forms of understanding reality, which circulate in society and have interfered with the direction of the teaching-learning process, indicating the political crisis that has plagued the country in recent years reverberates in medical education. The roots of this may lie in how education was conducted in Brazil. According to Gomes and Rego[1], the Lei de Diretrizes e Bases da Educação Nacional of 1996 placed the task of humanistic education for schooling prior to university education, but this was not done, leaving this gap for university education and for the training of workers already inserted in the services. However, one of the consequences of the revolution experienced by the university during illuminism would have been the organic change from its function of full education to an education of a technical-scientific nature with an instructive purpose. This has caused the formation that reiterates the place of thought

and moral analysis of oneself and reality to be separated from the educational objective and the university mission[22].

Such a gap produces reifying looks at social processes and little receptivity to any reflection that singularizes reality and problematizes the trivialization of life, as expressed by Do 002:

> *These days, a student stands up and says: – we have to agree, some lives are worth more than others. This is an ethic, the ethics of the zombie. The ethics of disposable lives*.

Education as a strategy that produces essential agencies to change health practices is only effective when the ethical-political perspective transversals it since it produces the meeting of instituting forces essential to creating new forms of doing things and new subjects[23].

The labor market appears in the narratives as a force that contributes to maintaining the medical category's status and bargaining power through agencies operated from within, including medical education, knowledge, practices, and institutions constituting structures and mechanisms that have enabled doctors to exercise this power[14,24]. Historically, the number of professionals available in the labor market is one of the forces that make it possible to maintain the power relationship that the medical corporation establishes with other health professions and institutions and with society. The profession's fees and social status fueled the medical corporation's most visceral reactions to the MMP, and it was no different among students. We perceived the fear that the new programs created based on the MMP would flood the market with doctors, generating difficulties for the first job.

> *[...] was the Mais Médicos model, of the expansion,good? It was, but I think it was too much. I think it had to be expanded by public institutions [...] so that the neediest student would have access to education [...] I am against this excessive opening of private programs [...] where will there be a market to absorb so many people?* (Di-001).

The labor market would also impact medical education by the remuneration paid to professors. In public institutions, this remuneration is below the average salary resulting from the clinical activity, generating the need for professors to overlap functions. The career of a university professor would thus be a less relevant link for the medical professional, attractive only for the prestige that it can add to the professional activity in the private clinic. In the narratives, this combination would be responsible for those professors who, despite wishing to be on the teaching staff, have a low commitment to the program:

> *The professor seeks in the university a visibility, a projection in the private market [...] And teaching is the worst of public bonds. That's where he earns less.* (Do-002).

The instituting forces: intercession as the affirmation of difference

According to Deleuze[25], intercessors put thought on another route, instigating one to invent. They affect thinking, connecting one with ideas that make it possible to create other forms of thinking and allow the invention of new realities. The instituting forces that act in the researched programs are possible intercessors for medical education. In this sense, the UHS is understood as an intercessor force, proposing a model of care that opposes some of the assumptions of the biomedical model. An example of this interference is the guidelines of the National Policy of Integral Care to Women's Health, which reconfigure the traditional roles of nurses, doctors, and mothers in labor/birth.

> *Humanized childbirth is one of the forms to question medical power in a very strong way [...] they already have students in these spaces who will be*

> *able, in the case of obstetrics, to transform that. But this is not yet institutional [...] We know it's fragile, you know?* (Do-004).

Another intercessor movement was the dialogue established between the programs and the health services of the UHS in the process of outlining the education. The profile of the professors in one of the programs was defined along with the managers of the public network, articulating education to the health requirements of the territory. This integration destabilized the disciplinary reasoning of medicine in program management, replacing it with the knowledge born from the analysis of concrete reality.

> *There is a significant innovation in terms of university management in breaking with the definition of professor profiles by disciplinary groups [...] the second round of profile definition was done with UHS managers. Then we open the door of UHS.* (Do-002).

> *[...] the fact that we have been inserted in the community since the first day makes all the difference because it is a construction [...] We train doctors from that region, we know what the problems are in that place. [...] In addition, it has a much broader view of medicine [...] Even if I don't want to be a primary care doctor, I know how it works.* (Di-001).

The integration between education, service, and community is essential to understand health from an ethical-political perspective as a person's right and the community's interest. According to Berlinguer, such understanding is the basis for forming a sanitary consciousness[7,8]. The physician can reconcile social transformations with his/her health performance and thus influence health management. However, according to the author, this will only happen if you understand the relationship between medicine and society, at the risk that your activity loses its desired social function. The ethical implications of the actions of those who will become health workers, moral agents with health responsibility inserted in a dispute of political interests, individual and collective desires, values, and beliefs of the most varied orders emerge as questions[26].

Guattari[27] proposed the ethical-aesthetic-political paradigm to oppose it to the scientific paradigm from practices that produced new modes of subjectivation. The ethical aesthetic-political paradigm, applied to education, emphasizes experimentation and questioning of reality. Addressing the ethical dimension implies constructing a listening experience that provides contact and openness to other forms of being and living. The aesthetic dimension approaches life as an open work based on the creative flow and thinking that interrogates reality and proposes transforming it. The political dimension focuses on the ability to assert our choices and opinions and interfere in reality and forms of organizing the world[28].

Another instituting force that emerged from the data analysis was the interference of Family and Community Medicine (FCM) in integrating it into the political-pedagogical strategies of articulation from undergraduate to graduate studies. The increase in the space given to this specialty, either in graduate school or by the increase of family doctors in education or even in program management, was considered a generator of reactivity jute to the medical corporation:

> [FCM] *is a dispute, a plan for graduate school. And we put it on the plane of graduation. We opened a medical residency along with the program in the first year. It is* [a political-pedagogical strategy] *much discussed in Brazil. All people found it an interesting strategy*. (Do-002).

Integrating FCM into undergraduate and graduate studies can become a powerful strategy to highlight the generalist dimension of clinical practice, even in specialized practice, strengthening a more comprehensive approach to care. However, this is still a challenge for undergraduate studies despite the orientation of continuity of medical education through

graduate and standing education, preventing undergraduate studies from functioning as a self-limited stage[29]. The establishment of concrete strategies for articulating from undergraduate to subsequent stages should be accompanied by devices that allow dialogue between specialties to overcome the difference in status between medical residencies of a generalist nature and those that address clinical specialties.

Another destabilizing force of those established in medical education is the action of groups from movements for changing this type of education. These groups generally have the passage through the student movement while an undergraduate program in common, when they begin their interest and engagement with the movement. These actors brought a discourse in tune with the proposal of social medicine and FCM to the programs. They built a common theoretical and methodological framework, which provided an opportunity for a truly collective political project. Professors and students involved in this movement attribute to it the support of the programs' most innovative and counter-hegemonic proposals.

The experience of working in a movement for changing education would have been fundamental for the proposition of strategies to fight conservatism. It would have provided an opportunity to create a network of partners with a previously tuned worldview and society project. Finally, it would have provided accumulations regarding the reflection of what would today be a good medical education and what medicine we need in the country.

> *This group of professors who begin considering a program project comes from the School of DENEM – the National Executive Directorate of Medical Students [...] They are several militants who graduated from this school. So I think it's the common past. And the cradle of the discussion of medical education as an agenda of the health movement.* (Do-004).

The professor's reports regarding their participation in the student movement for changing medical education reveal key points to understanding the role of these actors in the programs. Such points would be the exercise of political participation in collectives, the theoretical study on medical education based on medicine, the critical discussion on how medicine can respond to the real health needs of the country, and the analysis of the relationship between medicine, the market, and health. The experiences in the movement for changes in education forged in these subjects a disposition and knowledge that would later prove crucial for the proposition of programs with new forms of education.

Final remarks

The narratives showed conservative forces that cross and modulate medical education. Among them stands out the biomedical model, which continues to reproduce a regime of truths, guiding the predominant form of thinking about the health-disease-care process, not only in professional practice but throughout the entire social fabric. The break with this form of conceiving and conducting medical practice and, by extension, health practices proved to be a great challenge for educational institutions. We also observed that the ongoing political crisis in the country has contributed to the hardening of ways of thinking and the possibilities of dialogue and mediation, disfavoring initiatives that seek to promote an integral education based on humanistic, social, and scientific foundations. In summary, it can be said that medical education is not presented for analysis in isolation: it expresses the effects of a broader process. It has been crossed by the forces that usually impact the civilizational process.

The agencies carried out between professors and the health network and the previous experiences of these professors with the

movement for change in medical education stood out among the instituting movements observed in the field of research. One factor contributing to a cohesive program project was the significant number of professors who shared the same premises in building the document. With the expansion of the teaching staff, it was essential to promote strategies to strengthen the dialogue to ensure a common basis for directing the work.

The UHS, inserted in this scenario, has been fighting for the construction of an education policy articulated to the real needs of the system and its users. There is a tendency for efforts to change medical education to be configured as a circular exercise: they always return to the importance of the method, the choice of contents, the expansion of the practice scenario, and the technical-methodological qualification of education practice. Although none of these strategies can be dismissed, they are still insufficient for education to produce the necessary displacement in professors and students who go through the programs. The exercise of critical-reflective thinking, capable of producing subjectivities that question the medical institution, is fostered in collective experiences and constitutes what we call the ethical-aesthetic-political challenge for educational policies in health: a policy that considers the ethical challenge of providing health care dignified and accessible to all citizens; the aesthetic challenge of providing opportunities for teams and users to produce knowledge from practice, creating their own solutions to daily difficulties; and the political challenge of democratization of organizations and health practices.

The MMP proposal generated destabilizing effects in the new programs, calling for a different form of conceiving and developing medical education and highlighting the health needs it must respond to. In isolation, no official guideline guarantees effective changes in medical education since there are always ways to accommodate new guidelines to traditional forms of doing things. However, what was noticed is that the proposals leveraged by the MMP opened the possibility for subjects and groups already engaged in the movement for change in education to join other strategic elements to the official guidelines. Initiatives were forged to expand critical thinking for the new scenarios of practices, curricular arrangements, and active methodologies, understanding medicine as a socio-historical production. The understanding derived from this is that the health-disease process is a complex phenomenon woven at the intersection of the biological, the forms of social operation, and its modes of subjectification, which cross everything and everyone. This refers to one of the first reports collected in the research field, which gave expression to the findings of this cartography:

> *There is a phrase from a politician from Piauí, who is also a doctor. He said that medicine is the most humane of the sciences. And then we, for starters, must learn humanities.*

One understands the need to extend this conclusion beyond medicine to all the other health sciences, that, because they touch on the various dimensions of human life, one must immerse into all their multiplicity.

Collaborators

Matias MC (0000-0002-3707-3946)* helped design the project in data collection and analysis, writing the text, and final approval for the version to be published. Verdi M (0000-0001-7090-9541)* helped design the project, reviewed the text, and finalized approval for the version to be published. Finkler M (0000-0001-5764-9183)* co-advised the research project and helped in the result discussion, critical review of the text, and final approval of the version to be published. ■

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