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Teachers' role in strengthening teaching-service-community integration policies:

the context of Brazilian medical schools*

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This article analyzes the teachers' participation and integration in healthcare services based on the perception of institutional actors of medical schools in Brazil. This qualitative study used the Wheel Method for data collection, and content analysis as a data analysis technique. Forty-one undergraduate medical courses took part in the study, eighteen of which are private and twenty-three, public. The results show that teachers' participation and teaching-service integration are limited to the accomplishment of actions included in the courses' pedagogical projects, sometimes decontextualized from the reality of the services. It is concluded that, in order to strengthen teaching-service-community integration policies, it is necessary to invest in teacher education, raising the awareness of teaching professionals to an effective integration into the health system and recognition of their social role as agents of change.

Keywords: Teaching-service; Teacher education; Medical education.

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Introduction

Teaching-service-community integration is one of the elements that stimulates, in Brazil, the movement of changes in health professionals' education. It is understood as a collective work that integrates students, teachers, and health services teams, and aims at the construction of synchrony among the quality of the care that is provided for users, the excellence of professionals' education, and the development of services' workers[1].

Teaching-service integration is strengthened by new concepts and values such as social responsibility and interprofessionality, which can contribute to enhance professionals' capacity to reflect critically on the current context[2]. Therefore, it has great potential in the education of future professionals, workers, managers of the services, and teachers.

Historical aspects of the relations between education institutions and health services started to be highlighted in the 1970s and 1980s and have assumed different models, guidelines, and theoretical configurations, from the simple utilization of the health services as practice spaces to attempts of reorganizing education under the perspective of a new model of service[3,4].

The attempts to shorten the distance between education processes and the reality of people's life and health have assumed a strategic position since the creation of *Sistema Único de Saúde* (SUS - Brazilian National Health System) by the 1988 Federal Constitution and its regulation by Laws no. 8.080/1990 and no. 8.142/1990, which establish it is the State's duty to organize education in the area of health to face health needs[5-7].

In Brazil, the projects *Integração Docente Assistencial* (IDA - Teacher-Healthcare Integration) and *Uma Nova Iniciativa na Educação dos Profissionais de Saúde* (UNI - A New Initiative in Health Professionals' Education)[4,8,9] have fostered curricular innovations and activities in interdisciplinary teams. Furthermore, they have empowered a critical mass that has continued to mobilize and implement changes[10-12].

The historical accumulations of these policies were intensified with the development and publication of National Curricular Guidelines (DCN) in 2001[13], the implementation of Incentive Program to Curricular Changes in Medical Schools (Promed) in 2002[14], and the creation of Management Department for Work and Education in Health (SGTES) in the Ministry of Health, in 2003.

Then, important policies started to be instituted, such as multiprofessional residencies in professional health areas, National Policy for Permanent Health Education (PNEPS)[15], Program *Aprender-SUS*[16], Project of Experience and Internship in the SUS Reality (VERSUS)[17], National Program of Reorientation of Professional Health Education (Pró-Saúde)[18], Education through Work Program for the Health Area (PET-Saúde)[19], and the National Support Program to the Education of Specialist Doctors in Strategic Areas[20].

Recently, another important movement of change started with More Doctors Program (PMM)[21], which triggered, in 2014, the review of the National Curricular Guidelines for undergraduate medical courses, emphasizing the importance of education in primary care, in the teaching-service-community relationship, and in preceptors' education through National Preceptors Education Plan (PNFP)[22-24], in 2015.

Although important policies have been instituted aiming at teaching-service-community integration, organized and transparent commitments between education institutions and health services managers remain problematic.

As a strategy to overcome this situation, regulate the relationship between universities and SUS managers, and foster processes of sustainable changes, guidelines for the celebration of Education-Health Public Action Organizational Contracts (COAPES)[25] were instituted in 2015.

The maturity of the policies, reached from the analysis of their strengths and weaknesses, underlines the teacher's role as an actor capable of implementing innovations and changes in university education[26,27]. Complementarily, it points to the need of actions that can develop teachers so that they can face challenges related to the reorientation of professional education in the area of health.

Initiatives directed at teacher development have been promoted and/or supported by SGTES, such as the specialization in Activation of Change Processes in the Higher Education of Health Professionals[28], *Pró-Ensino na Saúde*[29] and the Program Foundation for Advancement of International Medical Education and Research (FAIMER – Brazil)[30]. All of them sustain the strengthening of the professional education reorientation process in the area of health and, consequently, teaching-service-community integration.

In view of the historicity of the policies that induce changes in teaching-service-community integration, and considering the relevance of developing specific competencies for the teacher to act in various practice scenarios, necessary to the teaching and learning process, this article aims to analyze teachers' participation and integration in healthcare services based on the perception of institutional actors of medical schools in Brazil.

Method

This article presents results of a self-assessment process carried out in 41 undergraduate medicine courses in Brazil in 2013, developed by Committee for the Assessment of Health Schools (CAES) of Brazilian Association of Medical Education (ABEM).

It is a descriptive-analytical study with a qualitative approach. For data collection, we used the self-assessment instrument for medical schools called *Método da Roda*[31], which recommends the participation of representatives of institutional actors, teachers, students, and administrative technicians, thus enabling researchers to obtain the perception of the individuals involved in the education process.

The instrument has five conceptual axes: Labor World, Pedagogical Project, Pedagogical Approach, Practice Scenarios, and Teacher Development. Each axis is organized in vectors based on which the questions present in the instrument are listed. Each question presents three alternatives related to a school typology: 1) traditional (T): Indicates a school oriented towards biomedical aspects; 2) innovative (I): Indicates a school in an innovation situation; (3) advanced (A): Presents a situation characteristic of the integrality model in compliance with the National Curricular Guidelines.

The group of institutional actors, in a meeting held with the objective of discussing and filling in the instrument, chose the option that predominantly represented the school at that moment, wrote an answer justifying the choice of the alternative, and another one describing the evidence for the chosen option.

In this article, we will present and analyze the results obtained in the justifications and evidence related to the Teacher Development axis and its vector Teachers' Participation in Healthcare Services, aiming to explore the reality of the teaching-service-community integration practices that occur at the school.

The answers were identified by medical school, using the acronym CAES followed by a number and the letters T (traditional), I (innovative) or A (advanced). For example: CAES1886 - A.

The answers were transcribed in a single text and submitted to Bardin's content analysis[32], following the stages of pre-analysis, exploration of the material, treatment of results, and interpretation.

The study complied with the recommendations of Resolution no. 466/2012 of the National Health Council, with guarantee of anonymity and the consent of the participant medical schools (CEP/UFSM /CONEP/MS n. 0150.0.243.000-07).

Results and discussion

Of the 41 researched medical schools, 18 are private higher education institutions (15 nonprofit and three for-profit institutions) and 23 are public higher education institutions (14 federal, eight state-run, and one municipal). As for typology, two were considered traditional (T), 19 innovative (I) and twenty advanced (A).

Four categories emerged from content analysis and are analyzed below: 1) Strengths of teacher participation in the health system; 2) Weaknesses of teacher participation in the health system; 3) Preceptors' integration into teaching; 4) Institutional teaching-service articulation.

Strengths of teacher participation in the health system

The institutional actors cited factors considered as strengths to teachers' integration into the health system, like: employment relationship in the health network; membership of municipal health councils or participation in local health planning; schools structured in teachers' healthcare practice; and schools with pedagogical projects based on active methodologies.

In some institutions, the teachers are also professionals of the health network, working as municipal managers. This interinstitutional relation can be considered a potential facilitator of teaching-service integration, as it favors the articulation and organization of teaching activities in different scenarios of the services[33]:

> The majority of the teachers involved with the course has an interinstitutional employment relationship (university-public health service). (CAES 8234-I)

> Teachers who act in this unit have already occupied the city's Health Department in some occasions. (CAES 28544 – A)

There are teachers who represent the university in the municipal and state health councils and participate in planning meetings. However, according to the researched group, this participation is restricted to the planning meetings, which discloses a possible discontinuity of this process. The participatory construction of the health system is recommended by the National Curricular Guidelines[22], aiming to provide an understanding of the role of citizens, managers, workers, and social control levels in the making of health policies:

> Teachers participate diligently in the planning meetings of the primary care units. (CAES 8206 – A)

> Participation of teachers from the School of Medicine representing the University in the Municipal and State Health Councils. (CAES 15263 – T)

Although the employment relationship and the position/function assumed in the public health network are seen as a positive point, they depend on the people who assume them and can be temporary factors to the desired integration. A long-lasting institutional investment is necessary to avoid the discontinuity of the integration process.

Some schools have their teaching structured in the teacher's healthcare practice and use different learning scenarios. PET-Saúde is considered an evidence of success of the teaching-service-community articulation: "This school has its teaching structured in the teachers' healthcare practice. It is a practice that has been incorporated for more than three decades, and this school is a pioneer in teaching-service integration. PET-Saúde is a good example of this practice" (CAES 14756 – A).

It is important to highlight that the positive result of the initiatives of some programs like PET-Saúde is attributed to the work and motivation of the teachers involved[34], considered catalysts for actions that induce changes.

Teaching-service integration strategies like PET-Saúde, Pró-Saúde, and the Experience Internship in the SUS are powerful policies that induce changes. In addition, they signal advances concerning many aspects, such as: Teaching-service integration; the rupture of the fragmentation of health knowledge and practices; innovation in teaching methods; and stimulus to research and interprofessional education[10,34-37].

Despite the advance these strategies bring to teaching-service integration, it is necessary to bear in mind that, as governmental initiatives, they can have a temporary nature with no guarantee of continuity.

Schools with pedagogical projects based on active methodologies seem to favor the performance of teaching activities in the health services, as in this type of approach, students' admission to different practice scenarios usually happens since the beginning of the course[22,38-40].

In our study, the actors of these initiatives are still limited to the professional cycle, excluding the education that occurs in the basic cycle from the process. The fragment below reveals the permanence of knowledge fragmentation in cycles:

> As the employed teaching and learning methodology is active, this mobilizes teachers to use various learning scenarios to favor knowledge construction and evaluation, although it only applies to teachers from the professionalizing area, as teachers from the basic areas are not included in this process. (CAES 17831-I)

The advance promoted by transformations recommended by the National Curricular Guidelines in the teaching strategies of health courses has been incorporated initially by the curricula of the education institutions, due to the obligatoriness dictated by the superior levels, in courses that are being created, and can have continuity later on due to the dissemination of its benefits.

Weaknesses of teacher participation in the health system

Weaknesses in the integration between teachers and health services emerged in the study in two lines. In the first one, of an institutional nature, the services limit teacher participation to the planning of their actions. In the second one, of a personal nature, the teacher does not get involved with teaching activities in the services even when they are part of the higher education institutions' program.

Regarding the institutional line, the schools wrote:

> The planning of the health system does not allow the teacher's effective participation. (CAES 17353-I)

> Although the teachers participate in the health services, no effective influence is observed on their planning. (CAES 5979 – A)

It is clear that teachers face difficulties in participating in situations where health system's actions are discussed and planned, which minimizes the possibility of their effective participation in the organization of the services, mainly concerning educational actions.

The SUS services undoubtedly face organizational difficulties related to work management to the detriment of the inter- and intra-regional differences of a country with a complex and specific federation[41], which can limit teacher participation. Due to this, the local planning of the SUS must be shared and understood by the services' managers and professionals, and also by the assisted population[42], not to mention teachers and managers of higher education institutions.

When the teacher is prevented from participating in the planning of the services, they cease to play the social role of mobilizing agent of changes they should play in the community. The teacher's commitment to the community, beyond the provision of services, is related to the conviction that the attempts to transform teaching into a just and democratic practice cannot be disconnected from a similar request to the society as a whole. Therefore, such transformation attempts must be related to the population's needs[43,44].

Personal weaknesses also emerged in the study:

> Although it is an institutional policy, not all the teachers adhere to the participation in the health services. (CAES 26712-I)

> Teachers resist participating in the education promoted by the network. (CAES 25496-I)

In some higher education institutions, integration with the services is part of the planning of activities and is instituted as an institutional policy. In these institutions, weaknesses related to teacher participation in the services are associated with personal resistance and teachers' lack of interest.

Teachers do not have the possibility of acknowledging and analyzing factors that limit their action and of seeing themselves as agents who are potentially active and committed to changing situations[33,35]. Educators need to understand the socioeconomic and cultural reality that surrounds them, so that they can re-dimension their knowledge and their social and professional responsibilities[35].

To be able to act and intervene in the instituted policies, teachers must appropriate norms and knowledge and learn how to manage the variabilities that the daily routine presents in its historicity[45]. To face these weaknesses, both institutional and personal, higher education institutions must raise teachers' awareness through education programs, aiming at their action and engagement in teaching-service integration proposals.

Preceptors' integration to teaching

Health professionals act as preceptors during teaching activities in primary care and in the internship:

> The services' professionals (doctors and nurses) participate in teaching as preceptors, mainly in primary care. (CAES 12451 – A)

> Services' professionals are preceptors in the internship. (CAES 8385 – A)

The data show that the preceptor's relation with teaching is, generally speaking, limited to technical and normative issues, aiming at the performance of the activities contained in the pedagogical projects. For this reason, it is necessary to promote moments of discussion so that each individual involved perceives his/her co-responsibility in the process of health professionals' education[46].

The preceptor acts in the work and education environment. Their function has characteristics that are fundamentally related to teaching, as they act in activities that qualify future professionals to perform practical activities. Thus, by providing pedagogical qualification to preceptors, the university reaffirms its commitment to the health of the Brazilian population and strengthens the ties that involve education, health and society[47,48].

Institutional teaching-service articulation

Teacher participation in healthcare services was referred by the institutional actors as an approach directed at the institutional sphere, that is, the focus ceased to be the teacher and was directed to the relations between education institutions and the services.

In some higher education institutions, the interaction with the health system is still rudimentary, given the lack of an institutional policy and the absence of the course's participation and representation in the health system levels:

> There is no dialog between the health system and the higher education institution, and the municipal and state planning fulfils it precariously, as it does not interact with the university. (CAES 25496-I)

> Even though the university is present in different practice scenarios of the public health system, there is little interaction between teaching and the healthcare services. (CAES 17353 – T)

Operationally speaking, the university must identify the needs of the services and practice scenarios, establishing pacts of collective accountability and participation between teacher and student[1]. In this relationship, it is fundamental that the products and practices of the health services can be part of the education provided in the institution, breaking with the hegemonic logic in which the service reproduces the academic way of doing things[49].

As for the articulations existing between higher education institutions and the services, the courses reveal that the main element that strengthens this interaction is the institutions' participation in meetings and in the planning of the services:

> The university, by means of the medicine course, is deeply involved in the planning and evaluation of the local health system, and is integrated into the local SUS. (CAES 12451 – A)

> The university participates in team meetings at family health units and in the meetings of the permanent education sector at reference hospitals. (CAES 8206 – A)

It is necessary to reduce the distance between educational institutions and the world of labor, which can strengthen teaching-service integration with the understanding of the work process and of social reality, and promote a pedagogical innovation in teaching[50]. In this sense, COAPES as a contractualization process has become an important political action to strengthen the integration between teaching, the services and the community[25].

The university is rethinking the interaction of the medicine course with the health services, attempting to amplify practice scenarios and improve the interaction with the community. Teaching-service integration experiences reduce the distance between universities and health institutions in the reorganization of education and healthcare, and also in relation to permanent education: "The higher education institution is striving to improve the current healthcare scenario and to offer better practice scenarios to students" (CAES 23315 – A).

The overcoming of possible obstacles involves willingness to establish a dialog and amplification of actions, both by academia and the services. Successful strategies involve raising the manager's awareness, celebrating formal partnerships between academia and the service, and promoting the participation of academia representatives (teachers, students, managers) in social control entities, like the Local Health Council[51]. However, there are challenges that still need to be faced, mainly when it comes to sharing objectives and strengthening relations based on dialog[52].

When the university approaches the health system, it contributes to change the paradigm of isolation and distinction between the activities called teaching and service. The shared management mechanisms of the teaching and learning process increase the degree of mutual interference between the university and the health services[49].

Based on the analyzed categories and considering the historical panorama exposed in the introduction of this article, Figure 1 brings, as the central axis, the research object Teacher Participation in Healthcare, from which four categories emerge: 1 and 2, connected with the teacher's role; 3, related to preceptors; and 4, relations between education institution and health system.

The next circle contains the actions and policies that induce education with the respective years in which they were created, showing their force in the movement of relations among teaching, service, and community.

The last level of the Figure is a track that surrounds it without interruptions, bringing to light the reflection on the importance of educational practices to teachers as a profession and as social commitment.

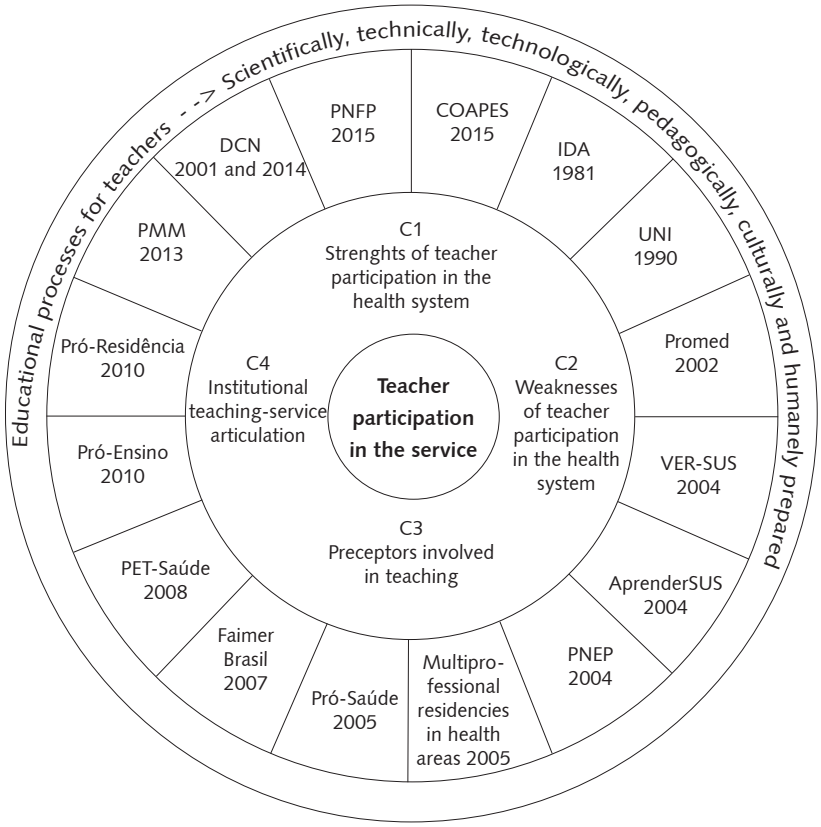

Figure 1. Illustrative scheme representing, in four levels, the research object and its unfolding in data and theoretical framework.

Teaching-service integration is fundamental to the education of future professionals and also to the permanent education process of services' professionals and teachers[48]. The integration process requires constant communication, commitment, and participation availability of all the actors involved[12].

In the spaces of dialog between work and education, health services professionals, teachers, students, and users gradually establish their social roles.

Despite all the possibilities in teaching-service integration spaces, the existence of a relative distance between the individuals involved is disturbing[1]. Due to this, reflecting on practice strengthens the relations between educational and healthcare institutions based on the understanding of the work process and of social reality[50].

Reflecting critically on the activities developed in practice scenarios during the undergraduate course is fundamental to develop in the graduates a political and human professional identity, which tends to persist in their professional action[50,51].

The teacher articulates the teaching-service-community interaction and should be capable of promoting, together with students, critical reflections that can generate an emancipatory education[44].

Thus, teachers' action in the university needs to undergo transformations and, to achieve this, health teachers must have a critical, humanized, and committed education. As a professional who provides a service for society, the university teacher needs to act in a reflective, critical, and competent way, clarifying their meaning and contribution to the students' educational process[50,51].

The National Curricular Guidelines[22] for medical courses establish, in art. 34, that the Health Teachers' Education and Development Program must have a permanent character within the course. It is necessary to emphasize and plan programs that value teachers' work, so that teachers can commit themselves to transform the medical school.

In addition, a permanent teacher education program must integrate teaching-service-community and go beyond a mere technical education that reproduces pedagogical protocols for the use of teaching methodologies, as it is neither one course nor one isolated experience that will transform the teacher into a teaching professional.

This transformation occurs in the teacher's interaction with the other actors (students, teachers, coordinators, administrative personnel, and services' professionals) and with various education opportunities[53].

Another important aspect to teachers' work and education in the area of health is viewing social practice as the core of the educational programs, as it is the knowledge the individual accumulates in his/her history[54].

Final remarks

The institutional actors observed advances in teacher participation and involvement in the healthcare services. Curricular transformations to comply with the National Curricular Guidelines were also identified. These transformations put teachers and students in contact with practice scenarios and enhanced their involvement in teaching-service-community. Programs that recommend teaching-service integration, such as PET-Saúde, were considered strengths in this relation, showing the potential of the policies that induce changes.

However, the outlined panorama demonstrated that the teaching-service-community integration still has weaknesses and can be considered incipient because many actions are decontextualized from their political and social importance in the future professionals' educational process.

The integration between teaching and service remains attached to compliance with institutional rules for the performance of actions contained in the curriculum, and teachers' and students' contact with the health network is restricted to the teaching activities.

Teachers do not participate effectively in the planning of activities in the services and, generally speaking, services' professionals do not collaborate with the planning of teaching actions. This causes mismatches in the performance of the actions. This dichotomy can lead to the performance of actions disarticulated from the services' real needs.

It is necessary to invest in educational processes capable of raising teachers' awareness to actions beyond their function of teaching specific knowledge from the medical area, thus enabling the recognition of their social role as articulators of teaching-service-community integration and potential agents of change.

Authors' contributions

Fabiana Aparecida da Silva participated actively in the discussion of the results, in the review, and in the approval of the text's final version. Nilce Maria da Silva Campos Costa, Jadete Barbosa Lampert and Rosana Alves participated in data collection, in the discussion of the results, and in the review and approval of the text's final version.

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References

1. Albuquerque VS, Gomes AP, Rezende CHA, Sampaio MX, Dias OV, Lugarinho RM. A integração ensino-serviço no contexto dos processos de mudança na formação superior dos profissionais da saúde. Rev Bras Educ Med. 2008; 32(3):356-62.

2. Bollela VR, Germani ACCG, Amaral E. Educação baseada na comunidade para as profissões da saúde: a experiência brasileira. In: Bollela VR, Germani ACCG, Campos HH, Amaral E, organizadores. Educação baseada na comunidade para as profissões da saúde: aprendendo com a experiência brasileira. Ribeirão Preto: FUNPEC; 2014. p. 3-8.

3. Teófilo TJS. Políticas de indução à mudança na educação dos trabalhadores da saúde: matrizes discursivas do campo. Saude Redes. 2015; 1(3):73-86.

4. Almeida MJ. Educação médica e saúde: a mudança é possível. 2a ed. Rio de Janeiro: ABEM; 2011.

5. Presidência da República (BR). Constituição (1988). Constituição da República Federativa do Brasil. Brasília, (DF): Senado Federal; 1988.

6. Presidência da República (BR). Lei nº 8.080, de 19 de Setembro de 1990. Dispõe sobre as condições para a promoção, proteção e recuperação da saúde, a organização e o funcionamento dos serviços correspondentes e dá outras providências. Diário Oficial da União. 19 Set 1990.

7. Presidência da República (BR). Lei nº 8.142, de 28 de Dezembro de 1990. Dispõe sobre a participação da comunidade na gestão do Sistema Único de Saúde (SUS) e sobre as transferências intergovernamentais de recursos financeiros na área da saúde e dá outras providências. Diário Oficial da União. 28 Dez 1990.

8. Kisil M, Chaves M. Programa UNI: uma nova iniciativa na educação dos profissionais de saúde. Battle Creek: Fundação W.K. Kellogg; 1994.

9. Ministério da Educação e Cultura (BR). Secretaria do Ensino Superior. Programa de Integração Docente-Assistencial - IDA. Brasília: MEC, SESU, CCS; 1981. (Cadernos da Ciência da Saúde).

10. Lima PAB, Rozendo CA. Desafios e possibilidades no exercício da preceptoria do Pró-PET-Saúde. Interface (Botucatu). 2015; 19(1):779-91.

11. Sena RR, Leite JCA, Silva KL, Costa FM. Projeto Uni: cenário de aprender, pensar e construir a interdisciplinaridade na prática pedagógica da enfermagem. Interface (Botucatu). 2003; 7(13):79-90.

12. Ellery AEL, Bosi MLM, Loiola FA. Integração ensino, pesquisa e serviços em saúde: antecedentes, estratégias e iniciativas. Saude Soc. 2013; 22(1):187-96.

13. Ministério da Educação (BR). Conselho Nacional de Educação. Câmara de Educação Superior. Resolução CNE/CES nº 4, de 7 de Novembro de 2001. Institui diretrizes curriculares nacionais do curso de graduação em medicina. Brasília: MEC; 2001.

14. Ministério da Saúde (BR). Promed-Programa de Incentivo às Mudanças Curriculares para as Escolas Médicas. Brasília: Ministério da Saúde; 2002.

15. Ministério da Saúde (BR). Portaria ministerial nº 198, de 13 de Fevereiro de 2004. Instituir a Política Nacional de Educação Permanente em Saúde como estratégia do Sistema Único de Saúde para a formação e o desenvolvimento de trabalhadores para o setor. Brasília: Ministério da Saúde; 2004.

16. Ministério da Saúde (BR). Secretaria de Gestão do Trabalho e da Educação na Saúde. Departamento de Gestão da Educação na Saúde. AprenderSUS: o SUS e os cursos de graduação da área da saúde. Brasília: Ministério da Saúde; 2004. (Série B. Textos Básicos de Saúde).

17. Ministério da Saúde (BR). Secretaria de Gestão do Trabalho e da Educação na Saúde. Departamento de Gestão da Educação na Saúde. VER-SUS Brasil: cadernos de textos. Brasília: Ministério da Saúde; 2004.

18. Ministério da Saúde (BR). Pró-Saúde-Programa Nacional de Reorientação da Formação Profissional em Saúde. Brasília: Ministério da Saúde; 2005.

19. Ministério da Saúde (BR), Ministério da Educação (BR). Portaria Interministerial nº 1.802, de 26 de Agosto de 2008. Institui o Programa de Educação pelo Trabalho para a Saúde-PET-Saúde. Brasília: Ministério da Saúde; 2008.

20. Ministério da Saúde (BR), Ministério da Educação (BR). Portaria Interministerial nº 1.001, de 22 de Outubro de 2009. Institui o Programa Nacional de Apoio à Formação de Médicos Especialistas em Áreas Estratégicas (PRÓ-RESIDÊNCIA). Brasília: Ministério da Saúde; 2009.

21. Presidência da República (BR). Lei nº 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. Brasília; 2013.

22. Ministério da Educação (BR). Conselho Nacional de Educação. Câmara de Educação Superior. Resolução CES/CNE nº 3, de 20 de Junho de 2014. Institui diretrizes curriculares nacionais do curso de graduação em medicina e dá outras providências. Brasília: Ministério da Educação; 2014.

23. Cyrino EG, Pinto HA, Oliveira FP, Figueiredo AM. O Programa Mais Médicos e a formação no e para o SUS: por que a mudança? Esc Anna Nery Rev Enferm. 2015; 19(1):9-10.

24. Ministério da Saúde (BR), Ministério da Educação (BR). Portaria Interministerial nº 1.618, de 30 de Setembro de 2015. Institui o Plano Nacional de Formação de Preceptores para os Programas de Residência na modalidade Medicina Geral de Família e Comunidade. Brasília: Ministério da Saúde; 2015.

25. Ministério da Saúde (BR), Ministério da Educação (BR). Portaria Interministerial nº 1.124, de 4 de Agosto de 2015. Institui as diretrizes para a celebração dos Contratos Organizativos de Ação Pública Ensino-Serviço (COAPES). Brasília: Ministério da Saúde; 2015.

26. Cyrino EG, Pinto HA, Oliveira FP, Figueiredo AM, Parreira CMSF. Há pesquisa de ensino na saúde no Brasil? ABCS Health Sci. 2015; 40(3):146-55.

27. Perim GL, Abdalla IG, Aguilar-Da-Silva RH, Lampert JB, Stella RCR, Costa NMSC. Desenvolvimento docente e a formação de médicos. Rev Bras Educ Med. 2009; 33(1):70-82.

28. Lima VV, Feuerwerker LCM, Padilha RQ, Gomes R, Hortale VA. Ativadores de processos de mudança: uma proposta orientada à transformação das práticas educacionais e da formação de profissionais de saúde. Cienc Saude Colet. 2015; 20(1):279-88.

29. Ministério da Educação (BR). Coordenação de Aperfeiçoamento de Pessoal de Nível Superior (CAPES). Diretoria de Programas e Bolsas no país – DPB. Coordenação Geral de Programas Estratégicos – CGPE. Coordenação de Indução e Inovação – CII. Pró-Ensino na Saúde: Edital nº 024/2010. Brasília: MEC; 2010.

30. Bollela VR, Carvalho Junior PM, Araújo MNT, Ribeiro MGF, Campos HH, Amaral E. Instituto regional de educação para as profissões da saúde: o currículo FAIMER Brasil. Cad ABEM. 2016:12-6.

31. Lampert JB, Costa NMSC, Alves R. Ensino na saúde: modelo de avaliação CAES/ABEM na construção de mudanças: método da roda. Goiânia: UFG; 2016.

32. Bardin L. Análise de conteúdo. 6a ed. São Paulo: Edições 70; 2011.

33. Lampert JB, Aguilar da Silva RH, Perim GL, Abdala IG, Stella RCR, Costa NMSC. Projeto de avaliação tendências de mudanças no curso de graduação nas escolas médicas brasileiras. Rev Bras Educ Med. 2009; 33(1):5-18.

34. Camara AMCS, Grosseman S, Pinho DLM. Educação interprofissional no Programa PET-Saúde: a percepção de tutores. Interface (Botucatu). 2015; 19(1):817-29.

35. Leal JAL, Melo CMM, Veloso RBP, Juliano IA. Novos espaços de reorientação para formação em saúde: vivências de estudantes. Interface (Botucatu). 2015; 19(53):361-71.

36. Costa MV, Borges FA. O Pró-PET-Saúde frente aos desafios do processo de formação profissional em saúde. Interface (Botucatu). 2015; 19(1):753-63.

37. Batista SHSS, Jansen B, Assis EQ, Senna MIB, Cury GC. Formação em saúde: reflexões a partir dos programas Pró-Saúde e PET-Saúde. Interface (Botucatu). 2015; 19(1):743-52.

38. Morán, J. Mudando a educação com metodologias ativas. In: Souza CA, Morales OET, organizadores. Convergências midiáticas, educação e cidadania: aproximações jovens. Ponta Grossa: UEPG/PROEX; 2015. v. 2, p. 15-33. (Coleção Mídias Contemporâneas).

39. Cyrino EG, Toralles-Pereira ML. Trabalhando com estratégias de ensino aprendizado por descoberta na área da saúde: a problematização e a aprendizagem baseada em problemas. Cad Saude Publica. 2004; 20(3):780-8.

40. Marin MJS, Oliveira MAC, Otani MAP, Cardoso CP, Moravcik MYAD, Conterno LO, et al. A integração ensino-serviço na formação de enfermeiros e médicos: a experiência da FAMEMA. Cienc Saude Colet. 2014; 19(3):967-74.

41. Paim J, Travassos C, Almeida C, Bahia L, Macinko J. O sistema de saúde brasileiro: história, avanços e desafios. Lancet. 2011; 377(9779):1778-97. (Série Saúde no Brasil).

42. Vieira FS. Avanços e desafios do planejamento no Sistema Único de Saúde. Cienc Saude Colet. 2009; 14(1):1565-77.

43. Woollard RF. Caring for a common future: medical schools' social accountability. Med Educ. 2006; 40(4):301-13.

44. Contreras J. A autonomia de professores. 2a ed. São Paulo: Cortez; 2012.

45. Guizardi FL, Pinheiro R. Participação política e cotidiano da gestão em saúde: um ensaio sobre a potencialidade formativa das relações institucionais. Physis. 2012; 22(2):423-40.

46. Gonçalves CNS, Corrêa AB, Simon G, Prado ML, Rodrigues J, Reibnitz KS. Integração ensino-serviço na voz de profissionais de saúde. Rev Enferm UFPE. 2014; 8(6):1678-86.

47. Botti SHO, Rego S. Preceptor, supervisor, tutor e mentor: quais são seus papéis? Rev Bras Educ Med. 2008; 32(3):363-73.

48. Rocha HC, Ribeiro VB. Curso de formação pedagógica para preceptores do internato médico. Rev Bras Educ Med. 2012; 36(3):43-50.

49. Azevedo BMS, Ferigato S, Souza TP, Carvalho SR. A formação médica em debate: perspectivas a partir do encontro entre instituição de ensino e rede pública de saúde. Interface (Botucatu). 2013; 17(44):187-99.

50. Reibnitz KS, Daussy MFS, Silva CAJ, Reibnitz MT, Kloh D. Rede docente assistencial UFSC/SMS de Florianópolis: reflexos da implantação dos projetos Pró-Saúde I e II. Rev Bras Educ Med. 2012; 36(1/2):68-75.

51. Panúncio-Pinto MP, Rodrigues MLV, Fiorati RC. Novos cenários de ensino: a comunidade e o território como espaços privilegiados de formação de profissionais da saúde. Medicina (Ribeirão Preto). 2015; 48(3):257-64.

52. Brehmer LCF, Ramos FRS. Experiências de integração ensino-serviço no processo de formação profissional em saúde: revisão integrativa. Rev Eletronica Enferm. 2014; 16(1):228-37.

53. Masetto MT, Gaeto C. Docência com profissionalidade no ensino superior. Braz Geogr J. 2013; 4(1):299-310.

54. Triviños AS. A dialética materialista e a prática social. Movimento. 2006; 12(2):121-

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