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Articles

Competencies for the production of comprehensive health care: analysis of the assessment processes in Medicine Internship at Fluminense Federal University

Competências para a produção do cuidado integral: análise dos processos avaliativos no internato de Medicina da Universidade Federal Fluminense

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Competencias para la producción de cuidados integrales: análisis de los procesos de evaluación en el internado de Medicina de la Universidad Federal Fluminense

(resumen: p. 17)

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The objective of this study is to analyze the prioritization and valorization of competences within the production of comprehensive care at Mandatory Internship at the Faculty of Medicine at Fluminense Federal University. The methologic included analysis of the documents that contained the competencies and its forms of assessment at the Mandatory Internship, and remote interviews with professors. The analysis of the content was categorized into thematic units according to the moment of the production of comprehensive care: in the encounter with patient and beyond others encounters needed after this first one. By the encounter, there was a prioritization of the integration of communication skills and semiotic techniques and clinical reasoning with ethical and humanistic attitudes, and in the second one the competencies related to teamwork, participation in collective spaces for discussion, care management, community approach, in addition of the knowledge production process itself, based on the idea of being a doctor.

Keywords: Comprehensive health care. Clinical competence. Internship and Residency.

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Introduction

Care is a polysemic concept because it has a social construction in the sense attributed to it. However, we have in it the essence of what it means to be human, its essential way of being, for without the care it receives from birth to death, it would not survive (and therefore would not exist). The human being is, therefore, a being of care[1-4].

Moreover, the same does not support himself or herself to the moment of zeal and attention, but to what it represents in his or her relationship with the other, in concern, accountability and affective involvement[2]. Upgrading this concept in the health field, we have care as an inherent social practice for all professionals, because it is the means and end of all their actions, as a guiding thread of the construction of health care[3].

Even if justified or promoted by a technical success (in the biomedical or pathological sense), only assuming a humanized conformation will we have the production of care in this patient-professional-service meeting[4]. Therefore, it is essential to focus on the use of soft technologies[5], recognizing the subjectivities there present in a dialogical dimension of one hearing and listening to the other, with their singularities, ways of living, desires, needs, expectations, knowledge, this being the very richness of the encounter, from which together they build caring strategies[1,3,4,6]. These, therefore, enable the conduct of therapeutic attitudes that dialogue with the project of happiness of each one and update their existential sense at each meeting[4].

In the scope of health education, in order for these paradigm changes to happen, the educational institutions need to improve their methodologies related to care[7] and have integrality as a teaching principle[3,8,9]. In this sense, it is emphasized the experience and observation of all actions and relationships built between students-professors-patients-services-university, along with the protagonism of the student in his or her formation process[3,8-10].

In addition, we have the interdisciplinarity (with a tendency to transdisciplinarity) essential to the production of integral care and the importance of teaching-service integration[3]. There is also the inseparable character of integrality with the other principles of equity and universality and the importance of social control from the mechanisms of social participation in the Brazilian National Health System (SUS)[11].

The term "integral care" could sound redundant, but this objective choice is to pay attention to the importance of the practice of integrality, enabling the production of care through the organization of the work processes of the teams, care management, integration of health networks, interdisciplinarity and intersectionality, and in the planning and implementation of public policies[12].

In addition to the analysis of curricular organizations, we need to pay attention to the constant tensions between the power lines that go through academic activities during medical training. Problematizing teaching and evaluation contents and methodologies not only as educational issues, but intrinsically political and ideological, reflecting on who or what group serve the approach or not of certain themes[9].

The concept of skills in the context of medical training

The Diretrizes Curriculares Nacionais [National Curriculum Guidelines] (DCN) brought to medical training the curricular model based on the concept of competences, but with a diversity of understandings on the subject. Starting from the idea of skills such as the ability to mobilize knowledge in act[13] and the infinite possibilities from the meetings for the production of comprehensive care[1-6], we have here the intersection between these two concepts in health education.

Perrenoud[13,14] takes care of the challenge of developing and at the same time evaluating skills, mainly due to the difficulty standardizing situations to be experienced, not being possible to reproduce or plan them entirely, as occurs in the production of comprehensive care.

Also, it emphasizes the importance of formative assessments in the development of skills, in order to serve more regulation of learning and less a classification of students within their class or group. Thus, they should be based on integrated domain criteria and objectives to didactic and pedagogical innovations, which are often prevented or delayed by the maintenance of traditional evaluations[14].

Despite considering the possibility of the evaluator having a model or a grid of observable aspects, the author pays attention to the fact that the evaluation of competences will never be tied to a closed list of tasks to be fulfilled and points attributed to them. It is necessary a self-assessment of students in this process and include qualitative observation of gestures, reasoning, hesitations and attitudes about what is being evaluated[14].

We used the conception of school excellence brought by Perrenoud[15] as the basis for this study. The author considers his or her own competence as a "virtual excellence", that is, a latent capacity of each student that makes his or her performance possible. This, therefore, is only the "observable face" of his or her competences, not the competence itself[14].

Therefore, the production of comprehensive care would be the performance expected by the internal ones, and the ability to mobilize previous knowledge (both from the perspective of a "know ", "know-how-to-do" or" know-how-to-be", respectively, knowledge, skills and attitudes), the competencies prioritized and valued in their evaluative processes, as illustrated in Figure 1.

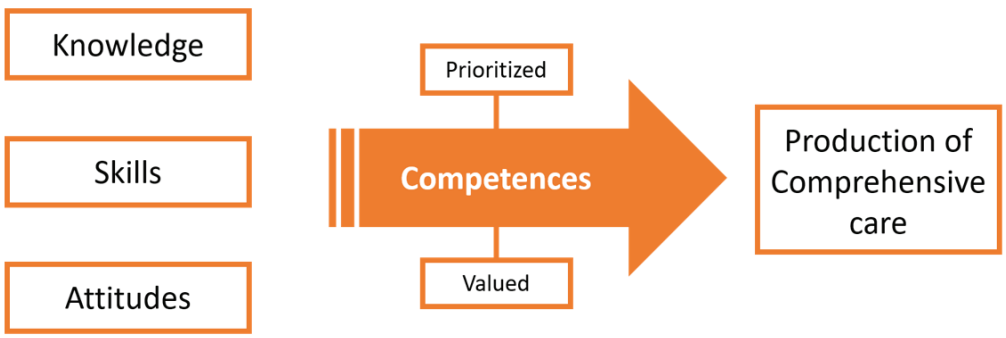

Figure 1. Evaluation of competences for integral care.
Source: Own elaboration.

The Mandatory Internship of the Faculty of Medicine of the Fluminense Federal University

The academic units involved in the course of Medicine of the Fluminense Federal University (UFF) held discussions about their syllabus since the 1970. The proposal of the new curriculum was implemented in 1994, the objective was a more ethical, humanistic and social commitment formation[15,16].

The curricular reform promoted important changes aimed at contact with the population and analysis of historical, social and ideological determinants of the health-disease process since the first period, in field activities[16]. The curriculum, illustrated in Figure 2, was structured by four programs: Theoretical-Demonstrative Program (TDP), Practical-Conceptual Program (PCP), Scientific Initiation Program (SIP) and the Internship Program (PI), developed in six stages, the first four being common to TDP and PCP, and the last two stages the PI. SIP occurs parallel to the others and will culminate in the work of completion of the course, integrated with the PI[17].

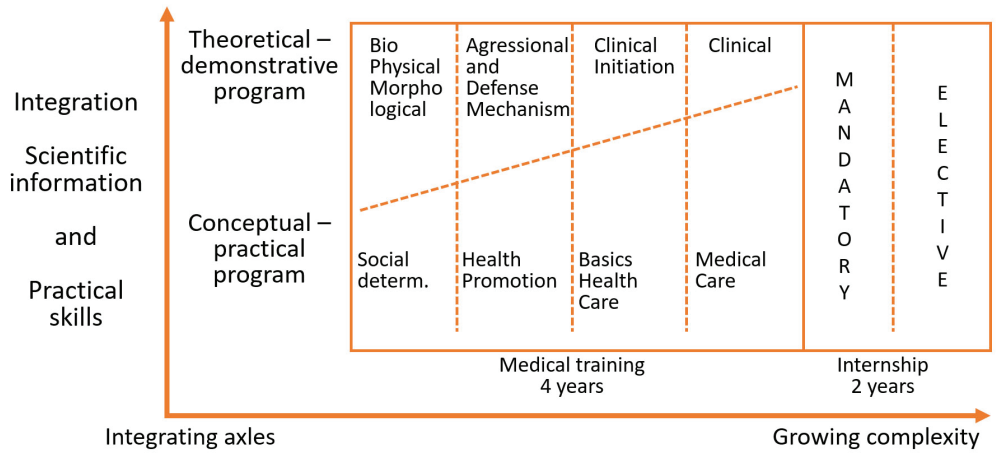

Figure 2. Curricular Model of the UFF Medical Course.
Source: Full curriculum of the UFF Medical Course (UFF,1992)

TDP aims to demonstrate content relevant to a theoretical discussion with integration among biological, psychic, physical, chemical, emotional development and interpretation of signs, symptoms and examinations. In the PCP there are practical activities in several scenarios of care production, at the community level and health care network of Niterói, with the observation, description and analysis of the reality of life and services and consequent lines of intervention[16].

PI aims to perform health actions at all levels of care, performing curricular internships in hospital and health care settings, mostly from the institution, divided into two phases: Compulsory Internship (CI) and Elective. This occurs in specialties or areas of Medicine at the discretion of the students, and the CI divided into the mandatory disciplines of Pediatrics, Tocoginecology, General Surgery, Medical Clinic, Primary Health Care (PHC) and Mental Health[16].

It is worth noting that, due to its proximity to graduation, this phase is commonly marked by the practice of extracurricular internships and preparation for medical residency exams. This fact promotes an overload of activities and studies that lead the interns to concentrate their learning on competences contained in the evaluation processes, reinforcing the important message they contain about what the institution values and/or considers priority in its professional performance[17].

Therefore, the objective of this study was to analyze the prioritization and valorization of competences for the production of integral care in the medical training process during the CI of the Medical School of Fluminense Federal University (UFF), having as object the evaluation processes of the interns. The choice of the term "evaluative processes" is due to encompass all forms of evaluation, including those that happen in the "between lines" of the approvals and daily failures of CI activities. This allows us to analyze the ethical, moral and professional conceptions and values of professors and the institution, as well as the very relationship of care present in these processes.

Methodology

This article is part of a qualitative research, of a descriptive nature, carried out during the academic master's degree in Public Health, which had as methodology of choice the case study.

In the first stage, the search and analysis of documents related to the curriculum of the UFF Medical School were carried out, having as inclusion criteria those that contained the competences and/or their forms of evaluation for the CI. This stage had as main objective to respond to the questions: What are the competences for the production of comprehensive care in the training process of the CI of UFF Medical School? What are the procedures for evaluating these competences established for the internship period?

In the second stage, in-depth interviews were conducted through recorded video calls between October 2021 and January 2022. We highlight that this study occurred still in the context of the Covid-19 pandemic, used as a potentiator for a deepening of approaches, questions and reflections from both professional and personal experiences on the subject studied.

The inclusion criteria of the participants initially were: effective professors who act in the practical activities of CI, prioritizing coordinating professors of each discipline and who act directly in the students' evaluation processes. In the initial findings, we noticed an important role and autonomy of medical servers in the evaluation processes of the interns, needing to include them in the criteria of participation of the study so that the objectives could be achieved. The contact list was provided by the internship coordination, followed by the indications of the teachers after clarifying the inclusion criteria and objectives of the study, characterizing the sampling process for convenience.

All interviews were conducted and transcribed by the same researcher, and both after the interviews and these transcripts were produced annotations on perceptions and reflections arising in these processes, constituting field journals added to the study *corpus*.

The last stage consisted of the content analysis of the material produced, which included the documents obtained in the first stage, the transcription of the interviews and the field diaries of the interviews and transcripts. As Bardin[18] suggests, initially there was a floating reading of the material, which dialogs with the references used in the study, led to the formulation of hypotheses and elaboration of indicators. From these, the units of record and context were delimited and extracted from the material, with the subsequent categorization of them into thematic units.

Because it involved the participation of human beings, there was prior appreciation and approval by the Research Ethics Committee (REC), with a Certificate of Presentation for Ethics Assessment (CPEA), number 46148921.3.0000.5243.

Results and discussion

The first finding of the research was an expected lack of competence indication in the documents found, since the implementation of the curriculum occurred before the DCN, and therefore, this logic in the elaboration and organization of the Brazilian medical curricula. This fact increased the importance of the interview stage to obtain this information.

30 invitations were made to participate of representatives of the six compulsory disciplines, obtaining 24 answers, two refusals and ten interviews conducted. The mean time of the interviews was 52 minutes, ranging from 25 to 90 minutes.

The group of participants consisted of 7 women and 3 men, all with a minimum degree of Medical Residency plus a Master's degree, as well as a Doctorate or Post-Doctoral degree. The graduation in Medicine of all participants took place in public universities in the Southeast region of Brazil, with 7 of the 10 participants in the UFF Medical School and, among them, both graduated before and after the curricular reform.

There was also representativeness regarding the total teaching time (between 1 year and 9 months and 42 years), if exercised either strictly or mostly in the UFF or in other faculties as in the CI and/or other stages of graduation, regarding the direct or indirect participation in the evaluation processes of the internal, pedagogical functions (care, supervision and coordination) and institutional links (professors, servers, or both links with the service, including position of leadership).

The thematic units were categorized according to the moment when these skills are mobilized during the production of care, classified as: "At the encounter", which include skills evaluated at the time of the student-patient meeting(s), and "At the encounters beyond the encounter related to the competencies evaluated in other non-strict encounters to that with patients, essential for integral care to be produced.

At the encounter

These competences were organized according to a hypothetical chronological order in which they are mobilized throughout the encounter.

Starting with the skills related to verbal and non-verbal communication, we have the attitudes from the initial approach of the patient in the first contact, such as, for example, what happens, in an outpatient context, with the visit of the health professional to meet in the waiting room, and the way it is done (if and how he or she identifies himself or herself or how he or she addresses him). Another prioritized aspect was the body posture of the students, as evidenced in the excerpts:

> Sitting right without "lying" in the chair, without "being" with gum in hand, without messing with the cell phone [...] talk directed to the patient. (Interview A)

> Whether they look at the person or keep writing while the person speaks. (Interview E)

In addition to these, and also as a component of non-verbal communication, competences related to the student's cleanliness integrated to a rigorous evaluation of the correct use of Personal Protection Equipment (PPE). These, also associated with an indissociabilityof the production of self-care with individual and collective care[19].

Communication related skills were also related to the idea of empathy of students with patients:

> [...] the way you position yourself, you show empathy for the patient, for the problem he or she is living, you hear the complaint, right, I think that... This is important... The way you speak, you being kind in the way of dealing. (Interview F)

This speaks is attentive to the fact that only gentle attitudes will not be sufficient for the production of care, but associated with a qualified listening and genuine interest in the desires, expectations, feelings and experiences of disease of each one, they may serve as a basis for caring therapeutic attitudes[3,4,9]. For this purpose, the internal needs to be present, delivered, attentive and open to the encounters[4] and, in this context, there is a prioritization of the relationship of respect and care in the professor-student relationship in order to maintain an environment of trust and openness to meetings, concomitant to the own learning of care production within its evaluative processes.

As for verbal communication skills, although they do not use this term, there is great appreciation of cultural competence, exemplified in the excerpts:

> Whether they use words that are easy to understand or if they are using "medical terms". (Interview E)

> You could not translate these problems into the language of this mother. (Interviewee of the Pediatrics Internship)

Associated with this competence, there was the use of the term "complete anamnesis" as execution of all components of medical history to understand clinical history when considering them essential for the exercise of the profession. We need to analyze whether this prioritization of the execution of a "complete anamnesis" in the period of the Internship can contribute or limit the production of comprehensive care at this stage. This is because, on the one hand, it can restrict the encounter to the execution of pre-established protocols, limiting the perception of subjectivities, fluidity in dialogue (with several interruptions to the direction of reports) and the presence of the patient's agendas in these encounters[20], on the other hand, we highlight the integration of the evaluation of skills for the execution of specific anamneses of specialties to those involving the permeability of the technician to the non-technical[4], highlighted in the section:

> Forget a little about the medical record. [...] make an anamnesis directed to gynecology, more than that for the health of the woman, the organism as a whole. For example, I tell the emotional, psychological part can also interfere with these things. What is the consequence of endometriosis in the intestine, for urine, for pain, for life, to be seeking doctor. [...] This is experience, that is observation, it is not in the book. (Interviewee of the Tocoginecology Internship)

Following the moment of the physical examination, extremely valued by the professors in the interviews, there is a prioritization of its execution in all the consultations regardless of the scenario in which they operate. Greater emphasis was given to attitudes of respect and empathy, both related to the comfort of patients, especially to the touch of intimate regions or involving decency (such as gynecological examination or rectal touch), as to verbal and non-verbal communication at this time:

> [...] If he even asked the patient to urinate [...] urinate before taking physical examination, inform how to put on the bathrobe, guide lie on the stretcher, guide positioning, go explaining what he was doing in the physical examination all the time. "I will examine the breast... [...] "I will examine the abdomen... [...] "I will examine vulva, vagina, i will put speculum" [...]. (Interviewee of the Tocoginecology Internship)

In addition, another convergence in the reports was a prominent prioritization of the technical quality of physical examination integrated into ethical attitudes throughout the meeting. This refers to an indissociability of technical, ethical and humanistic know-how-to-do for the production of integral care, as exemplified in the excerpt:

> Then we will evaluate from the patient entering the room, how this student received, how he or she behaved, the ethical question, the posture of this student. [...] he took physical examination, he measured the pressure, he washed his hands before evaluating, he made an adequate anthropometry, he examined the patient on the right side. [...] until he opens the door to [...] go away. (Interview H)

The skills related to ethics were present in almost all interviews in different ways. When asked to explain how or what they evaluated, the participants used terms such as "respect", "posture" and "ethical posture", except for one of the interviewees who conceptualized it as a student's search for doing the best possible, either in the individual or collective context, and he or she stressed the importance of the patient's perspective in relation to their values, beliefs and desires in the production of care.

Next, we have the skills related to clinical reasoning, evidenced as the basis for therapeutic conducts and actions produced at each meeting. Frequent examples in the interviews focused on the assertive request of complementary examinations, either for screening or diagnostic investigation.

> The reasoning he did upon that. Whether he knew how to ask for exams or not. [...] The way he conducted clinical reasoning [...] if he asked for the exams, whether he asked correctly or not. The request for preventive, mammography, especially these surveys was well or not directed. (Interviewee of the Tocoginecology Internship)

With a constant development of new (hard) technologies, the capture processes occur not only with professionals, but about the desires and expectations of patients and family members who will generate attempts to persuade prescriptions and requests for unnecessary examinations and thus, produce "disguised" iatrogenesis of cares[6]. In this context, we highlight the importance of the use of soft technologies integrated into the field of soft-hard and hard technologies[5], as a form of quaternary prevention in the production of integral care, as highlighted:

> This conduct, in fact, will sometimes not result in a prescription [...] So when I'm talking about conduct, it's not what antibiotic, [...] What exam I will take. [...] It's "ah, it's an innocent heart murmur" so my conduct will be guidance to the mother. He has no commemoration that he thinks is a pathological heart murmur, [...] The conduct I will evaluate from the student is whether he was able to reassure, to pass this news to this mother, to reassure this mother. (Interviewee of the Pediatrics Internship)

Also, the importance of the reflection in act on the positive or negative impacts of care produced in the life of each individual in an integrated way to that on health costs generated by excessive medicalization were highlighted:

> I have to have a goal in that there I ask. [...] Exam has a cost, you can't ask for all exams for everyone and for nothing, right? [...] it is to help reason a diagnosis or it is to help define a treatment, so that is one of the questions: What I ask for and why I ask. (Interview F)

This same logic is integrated with the great appreciation of conducts that are not restricted to the medical profession, such as guidelines and actions of health promotion and prevention:

> But what is this proper conduct? I guided exclusive breastfeeding, I guided the vaccination update, I guided a proper diet for mother, I guided the question of exercise, the issue of sleep hygiene, so when we talk a conduct, it is the global one, it is not a medicine appointment. It is a conduct to improve the quality of life of that patient. (Interviewee of the Pediatrics Internship)

In addition, another convergence was in valuing the identification of the family, cultural, community, spiritual and social context. However, it is worth highlighting in some speeches the prioritization not only of "knowing" these contexts, desires and expectations, but how much their understanding dialogs with the actions produced in these meetings and updates the existential sense and happiness project of each one[4]. For this, they need a capacity to mobilize knowledge in other meetings with other actors of this care production, which influence and are influenced by it, and these skills will be discussed in the next section.

At the encounters beyond the encounter

These competences were evidenced in situations starting or beyond the encounter with each patient and considered essential to produce comprehensive care and were based on the idea and signs of "being a doctor", as shown in Figure 3.

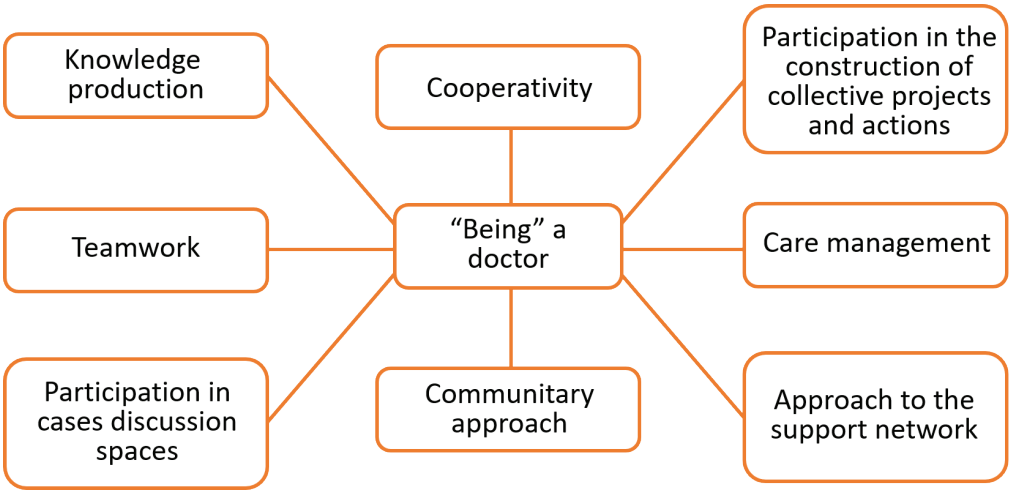

Figure 3. Prioritized and valued competences at the encounters beyond the encounter.
Source: Own elaboration.

The first to be highlighted is how the internal ones relate to their colleagues, staff, servers and residents of the services they are inserted in. We highlight that this appreciation was evidenced in the context of high competitiveness among students in the courses of Medicine, and highlighted as relations of respect and cooperativity that are used even in criteria for the attribution of the final grades of the interns.

Also, among the objectives of this cooperation is the stimulus to participate actively in the production of care to patients, exemplified in the search for resolution of patients' pending in infirmary and Primary Health Care (PHC) contexts. Therefore, it is necessary that the interns be inserted in the work processes of the teams, and thus, highlighted in these contexts great appreciation of the recognition of the power of multidisciplinary teamwork, understanding the role of each professional and the limitations of the medical profession in the production of care.

Thus, the evaluation of relationships with other professionals integrated to the comments of patients on the care performed by them was reported, as suggested in part of the evaluation in 360° or with multiple sources[21].

> Because we need to understand that he understood and managed to integrate into the PHC team. So, for example, when I see an intern playing with the CHA [Community Health Agent], [...] with the nurse, when I see a patient get out of the appointment and say "Wow, I loved your appointment, you will be a great doctor" I know it was good, you understand? (Participant of CI, from Primary Health Care Internship)

It is worth noting that satisfaction about health care has the potential for indirect evaluation of the establishment of a bond and relationship of trust. However, depending on the processes of capture that have managed this meeting, not considering the patient's protagonism about his or her life or his or her desires and beliefs, they can adopt doctrinal and/or pathologizing "disguised" conduct of care[6].

Moreover, it is emphasized by the professor of the CI of PHC as a potentiality of this scenario the proximity to the community and the context of life of patients. Thus, there is an appreciation of skills related to the dialogue and articulation with support networks, equipment of the territory and local leaders that influence the production of care both in the individual and collective scope:

> Because otherwise you pass a treatment, then the pastor says it is one thing... This lady [...] earn 300 reais per month, [...] she is 50 years old, she does not get any retirement, right? [...] And then she said "Oh, but here in the spiritist Center they were donating the food staples but then my daughter said she would not go back in my house if I took contaminated food because we are believers." So, [...] She has the right to think differently. So how do I do for her to negotiate, with the pastor? [...] Either the church takes this, or how he could bless this food [...] so it's another language, right? (Participant of CI, from PHC Internship)

This speech highlights that the skills mobilized in these encounters require a creative capacity of those who produce this care, and dialogue with the idea that care is the real support of creativity, freedom and intelligence of the human being, where we identify "his or her principles, values and attitudes that make life a good living and actions a right act."[2] (p. 9).

Another important convergence occurred in the valorization of skills for care management. In internship in the PHC, we have the characteristic of the longitudinally of care, and in them are prioritized competences related to the coordination of care and monitoring of the needs of patients in their territory. Such skills need a capacity for dialogue and articulation with the different levels of health care, management and intersectoral, in order to ensure access and integration between them for the production of care of patients who live in their territory of activity.

These competencies were also present in hospital contexts by the ward advice system, which occur from the request of evaluation of professionals from other specialties about hospitalized patients. Thus, there is an exchange of knowledge and opinions about the clinical condition and discussion of conduct to be adopted by the professional or team.

In the participation of the interns in these discussions, competences related to the history (clinical, personal, family, social, cultural) of the accompanying patients were highlighted, including their desires, expectations and values, and the ability to include them in these discussions, especially in therapeutic behaviors. Thus, communication skills and attitudes that demonstrate interest, security and accountability about these behaviors are evaluated (especially when the difference of opinion between different professionals, teams and patients), providing opportunities for the development of skills related to other sectors and specialties present in the discussions.

Similarly, these competencies are evaluated in participation in discussions and clinical sessions of the services that are inserted, mandatory activities of some specialties, including as a criterion in the final grade. They also evaluate the ability to organize ideas, responsibility and interest in bringing the relevant information of the history of each patient to the discussion, clinical reasoning, construction of diagnostic hypotheses and proposition of therapeutic projects, as discussed in the previous section but here with a logic of collective care production.

The clinical reasoning and the proposed conducts were evidenced as inseparable from the skills related to the construction and production of knowledge of each student. In a transversal way, we have in CI a great prioritization and appreciation of the constant search for updating the knowledge acquired about it are experiencing in practice, through the frequent search and critical and reflective analysis of studies and scientific articles from reliable sources (including search methodology and analysis of this reliability). It should be noted that they are associated both as a demonstration of interest and responsibility with patients and with their own training process, from the idea of a characterization of their professional identity, that is, what they consider as a "being" doctor.

Still on these signs of the "Medical Being", it is highlighted the importance of its participation in spaces of discussion and construction of projects and collective actions from its perspective and professional experience associated with the social prestige of the profession as an opinion makers, as highlighted in this excerpt:

> You start to meet people at ICU [Intensive Care Units] dying for preventable causes, and you say: 'Man, what time will I stop with that, right?' So we have to get involved yes, [...]you have to go to board meeting, you have to engage with the leaders. (Interview E)

We also have the skills related to the organization and development of prevention, promotion, protection and rehabilitation of health at the individual and collective level. For this, these skills need to be guided by what points us to the participant E: "It is, in fact, you approach a reality and try to help that place to have a better quality of life possible," updating the concept of integral care from the individual to the collective.

Another aspect "beyond" of care production of patients is related to the production of selfcare. Although not explicitly highlighted in the interviews, which may represent, within the limits of this study, a non-prioritization within the evaluation processes, it was evidenced in all interviews concerns by the mental health issues of the students and its interference in the medical training process.

However, we highlight an internal organization in the CI of Pediatrics that has an organization process that includes all students to have a reference professor not only for pedagogical issues, such as learning difficulties, personal, health or bureaucratic issues. There is also an "internal flow", according to the needs of the student who involves the group of professors and coordination, which can be characterized as a sign, as conceptualized by Yazdani[22], in the institutional organization of valorization of the production of care to the student in his or her training process.

Final considerations

From the findings and reflections of this study, it is evidenced the importance of the recognition of the one who produces the care both as a being that affects and is affected by it, and according to the successive affections that are exposed and exposed builds your idea of the medical "being", that is, his or her professional identity.

All knowledge (including "know-how-to-do" and "know-how-to-be") to be developed in the medical training process will be at least components to be mobilized in the production of care by these future professionals. Thus, assessing the skills for the production of comprehensive care will depend more on the centrality of health technologies used in the meetings and the permeability of the technician to the non-technical than on a specific format or set of specific competences of a context or specialty.

In this sense, another question arose from the results of this study was: if to produce care, and thus evaluate their skills, we need the permeability of the technician to the non-technician in each internal-patient meeting, the evaluation processes based on expected performances, protocol or standardized were extremely limited for this purpose. These, however, have a potential to evaluate knowledge, skills and/or attitudes that may be mobilized in real situations of integral care production.

It is worth mentioning the important participation of medical servers in the evaluation processes of the internal ones in the various scenarios in which they are inserted. However, no direct participation of other professional categories was evidenced in the students' evaluation processes.

In addition, it is necessary to highlight that the prioritization of experiences in real situations are essential in the organization of the internship, which for this purpose require their insertion in the work processes of the services. These questions lead us to reflection on the obstacles still faced in the integration of teaching-service and interdisciplinarity in medical training, which is still attached to a discussion about the integration of disciplines of the formal curriculum.

In addition, we have in the experience of the relationships of student-teacher-service-institution care, the learning of these skills and the internalization of desirable values and behaviors. Thus, we emphasize these processes from institutional organization, insertion in evaluative processes to the relations between the actors involved in everyday university practice.

We also highlight the indissociability of skills related to caring for oneself with those for the production of care in the individual and collective scope. Just as the production of the integral care of our patients is essential to know and value the individual and collective processes of the students and the context in which they live, be it community, family, life cycles, as well as their expectations, ideas and desires, in order to recognize their influences on the care produced by them. These skills, in turn, require creative ability and intelligence, as well as ethical attitudes.

Finally, the Internship is a significant phase in the construction of the student's professional identity, having the potential to be aligned their happiness projects to their professional choices (such as specialties, services or levels of attention that aim to act). Therefore, it is important that the evaluation processes are elaborated in order to serve more to identify their potentialities for professional performance and less to the processes of capture of a hegemonic model that often hinders the production of care. Thus, the evaluative processes, especially those with a formative character, of technical and scientific competences integrated with ethical and humanistic attitudes, were central to the evaluation of competences for the production of integral care in the period of the Internship.

Authors' contribution

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

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Conflict of interest

The authors have no conflict of interest to declare.

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O objetivo deste estudo foi analisar a priorização e valorização de competências para a produção do cuidado integral no internato obrigatório (IO) da faculdade de Medicina da Universidade Federal Fluminense. O percurso metodológico contou com análise documental das competências para o IO e suas formas de avaliação, seguido de entrevistas remotas com docentes. A análise de conteúdo categorizou unidades temáticas de acordo com o momento da produção do cuidado integral no encontro com o paciente e nos demais encontros ocorridos para além deste. Foram evidenciadas priorização e valorização da integração de habilidades de comunicação e de técnicas semióticas; e raciocínio clínico com atitudes éticas e humanísticas e de competências relacionadas ao trabalho em equipe; participação em espaços coletivos de discussão; gestão do cuidado; abordagem comunitária; e processo de produção do conhecimento baseado nos signos do "ser médico(a)".

Palavras-chave: Cuidados integrais de saúde. Competência clínica. Internato de Medicina.

El objetivo de este estudio es analizar la priorización y valorización de las competencias para la producción de cuidados integrales en el Internado Obligatorio de la Facultad de Medicina de la Universidad Federal Fluminense. La metodologia incluye análisis documental y entrevistas con profesores. El análisis de contenido fue categorizado en unidades temáticas según el momento de producción de la atención integral: en el encuentro y en los encuentros necessários a partir de este encuentro com el paciente. Em el encuentro, se priorizó la integración de habilidades comunicativas y técnicas semióticas y de razonamiento clínico con actitudes éticas y humanísticas, y en los demás encuentros, las habilidades relacionadas con el trabajo en equipo, participación en espacios colectivos de discusión, gestión del cuidado, enfoque comunitario, además del propio proceso de producción de conocimiento, todos basado en la idea de lo que significa ser médico.

Palabras-clave: Atención integral de salud. Competencia clínica. Internado de Medicina.