



2001 National Curricular Guidelines contributions to political-pedagogic projects of Brazil's Medicine undergraduate courses

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ABSTRACT

Over the last few years, 2001 National Curricular Guidelines (DCN2001) acted as criteria for political-pedagogic projects of medicine undergraduate courses in Brazil. In that moment, the proposals was concerned about professionals training for the recently implanted health system. The study looks at medical education, while studying the case of political-pedagogic project of Universidade Estadual do Oeste do Paraná medicine undergraduate course in Francisco Beltrão campus (PPPMFB), and correlate with DCN2001. Objective is evidence the way PPPMFB emerged from new medical education proposals suggested by DCN2001. As results, study demonstrates DCN2001 proposals basis about workers professional profile, named “conceptual-philosophic” references; and about curricular organization, teaching and learning methodologies, named “methodological” references. After, study demonstrates tangency points between PPPMFB and DCN2001. Study concludes that PPPMFB text keeps intense resemblance with DCN2001 resolution.

KEYWORDS

Curricular reform. Medical Education. Medical training. National curricular guidelines. Political-pedagogic project.

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As contribuições das Diretrizes Curriculares Nacionais de 2001 aos projetos político-pedagógicos dos cursos de Medicina do Brasil

RESUMO

Ao longo dos últimos anos, as Diretrizes Curriculares Nacionais de 2001 (DCN2001) atuaram como critério para o remodelamento dos projetos político-pedagógicos (PPP) dos cursos de medicina espalhados pelo Brasil. Naquele momento, as propostas contidas naquele documento demonstraram a preocupação com a formação de profissionais de saúde voltados ao novo modelo de sistema de saúde recém implantado. O estudo volta-se à educação médica, ao estudar o caso do PPP do curso de Medicina da Universidade Estadual do Oeste do Paraná, no *campus* de Francisco Beltrão (PPPMFB) e correlacioná-lo com as DCN2001. O objetivo é evidenciar a forma como o PPPMFB foi constituído a partir dos elementos integrantes de uma nova educação médica sugeridos pelas DCN2001. Como resultados são apresentados, em primeiro lugar, as bases que sustentam as propostas das DCN2001 quanto ao perfil do profissional a ser formado, chamadas de referências “filosófico-conceituais”; e quanto à organização curricular e metodologias de ensino e aprendizagem, chamadas de referências “metodológicas”. Em seguida, são demonstrados os pontos de tangência entre o PPPMFB e as DCN2001. Conclui-se que o texto do PPPMFB mantém uma relação de intensa semelhança com a resolução das DCN2001.

PALAVRAS-CHAVE

Diretrizes nacionais curriculares. Educação médica. Formação médica. Projeto político-pedagógico. Reforma curricular.

Contribuciones de las Normas Curriculares Nacionales de 2001 a los proyectos políticos pedagógicos de los cursos de Medicina brasileños

RESUMEN

En los últimos años, las Pautas Curriculares Nacionales de 2001 (DCN2001) actuaron como criterios para los proyectos político-pedagógicos de medicina de pregrado en Brasil. En ese momento, las propuestas estaban preocupadas por la capacitación de profesionales para el sistema de salud recientemente implantado. El estudio analiza la educación médica, mientras se estudia el caso del proyecto político-pedagógico de la Universidad Estadual do Oeste do Paraná, un curso de medicina en el *campus* de Francisco Beltrão (PPPMFB), y se correlaciona con DCN2001. El objetivo es evidenciar la forma en que PPPMFB surgió de las nuevas propuestas de educación médica sugeridas por DCN2001. Como resultado, el estudio demuestra las propuestas de DCN2001 sobre el perfil profesional de los trabajadores, denominadas referencias "conceptual-filosóficas"; y sobre la organización curricular, las metodologías de enseñanza y aprendizaje, denominadas referencias "metodológicas". Después, el estudio demuestra puntos de tangencia entre PPPMFB y DCN2001. El estudio concluye que el texto PPPMFB guarda un gran parecido con la resolución DCN2001.

PALABRAS-CLAVE

Educación médica. Formación médica. Lineamientos curriculares nacionales. Proyecto político-pedagógico. Reforma curricular.

Introduction

Documents express the conflicts and contradictions of society. They contain a story, that is, they are the fruit of resolutions of a collective, in a given time and space, mediated by a stake of interests and forces, in which there are winners and losers. In large part, through them, it is possible to understand the ways of being, living and living with the collectives that sponsored them (LE GOFF, 1990). In this way, the critical reflection of the documents can only be possible from their sociological analysis.

The paper turns to medical education studying the case of the political-pedagogical project (PPP) of the Medicine course of the Universidade Estadual do Oeste do Paraná (UNIOESTE), in the campus of Francisco Beltrão (PPPMFB) and correlating it with the National Curricular Guidelines instituted by Resolution No. 4 of the National Education Council / College Education Chamber of the Ministry of Education (MEC), on November 7, 2001 (DCN2001).

In 2014, a new resolution was issued (DCN2014), but many medical courses will maintain the guidelines of the DCN2001 till the end of the deadline for adaptation to the DCN2014 proposals, on December 31, 2018. With the supposed adherence to the new guidelines, it is appropriate to review the contributions of the DCN2001 to the PPPs of medical courses.

The purpose of this article is to answer the following question: how was the PPPMFB constituted from the inherent elements of a new medical education suggested by the DCN2001?

As stated by Kramer (1997), it is not allowed to elaborate a PPP solely based on the aspirations of the collective that impacts it and that will be impacted by it. References and rules to be followed (KRAMER, 1997) are imposed. The latter are standardized in the form of other documents, laws that guide the way physicians are trained.

It is possible to claim that the PPPMFB is the result of an action of forces originating from two sources: a general, nationwide, comprehensive source that is shared with other medical schools, translated in DCN2001; and a particular source, local, circumscribed and that confers it singularity, related to the characteristics of the collective that elaborated it.

The article is constituted in the form of a case study. In order to unfold the social network from which DCN2001 and PPPMFB emerged, the content analysis proved to be an auxiliary tool in the segmentation and understanding of the texts content and allowed the interpretation of the object searched (BARDIN, 1977). From the clues left between the lines, one could find the material conditions that were the basis for the understanding of the documents, or if one prefers, from these clues, it was possible to find the social and power relations that allowed their validity.

The research sought to highlight the process of constitution of the two mentioned documents, with the identification of the social agents of the debate, as well as the historical context in which it occurred. The choice of other secondary documents supporting the argument followed recommendations contained within the main documents. Many of these sources and secondary references were nominally listed in the text of DCN 2001 and PPPMFB. From this list, the principles of content analysis were applied to the document selection.

Initially, as an inclusion criteria, all resolutions, opinions, decrees, ordinances, laws, articles and books suggested by the main documents were embraced as a theoretical support, a practice consistent with the "exhaustiveness" rule (BARDIN, 1977). Subsequently, the search for as many of these secondary documents as possible was carried out, which proved to be a difficult task. The first reason for that was because medical education, a theme with infinite facets, is supported by a myriad of documents and speeches. The second one, there is a diversity of secondary concepts and categories that make it heterogeneous, requiring a larger universe of documents to extract a representative sample of it. Many documents were not available for consultation because of the rarity and / or difficulty of access, which by no means made it impossible to draw up an extensive list of references.

During the detailed reading of the documents, notes were made on each article and section, trying to locate the central idea of each piece of text, as well as similarities and differences between them. Then each article underwent several treatment steps in which it received a set of codes with identifiers that expressed a meaning. This phase of the analysis work is called "coding" and "categorization" (BARDIN, 1997).

At first, the articles and items were classified according to broad areas of influence, such as: economic, political, ethical, cultural, philosophical, conceptual, pedagogical, technical, symbolic; and grouped according to this classification. The definition of areas of influence as initial categories occurred during the "pre-analysis" phase together with the first reading of the documents (BARDIN, 1997).

Even at this point, it was possible to perceive that a same article or item could belong to different areas of influence. This fact occurred because each of them could contain fragments of text that would be related to one or another area of influence at the same time. When there was competition, the article or item was incorporated into the set of each of the areas of influence identified as constituting it.

The next step was to analyze each particular area of influence, this time considering the fragment of text that allowed classifying the article or item in the specific area of influence. By highlighting this fragment, it was possible to elaborate a new classification system, regrouping them again, now by more specific identifier codes. The new classification was originated from the advancement of content analysis and the expansion of knowledge about the themes.

From this stage on, it was possible to perceive an advanced categorization of the documents content from the saturation of the appearance of new identifier codes. After several revisions of the grouping and classification processes, the categories contained at DCN 2001 and PPP-FB were set.

In the first section of this article, we will demonstrate the factors that drove the creation of the DCN2001 articulated with the need of health system reducing cost. In the second section, the crucial characteristics for the formation of the new doctors, indicated by the DCN2001, will be listed. In the third section, the points of tangency between the DCN2001 and the PPPMFB will be indicated.

DCN2001: a New Formation for a New Health System

The trajectory of medical education in Brazil is linked to three main groups: medical practice, public health policies and college education policies. Based on the observation of these groups, it can be concluded that the main guidance of DCN2001 proposals was tied to two needs: to expand the care coverage of the population, ie to increase and improve the population's access to health; and to reduce the costs related to medical practice (BRIANI, 2003; EDLER; FONSECA, 2006; CAVALHEIRO; MARQUES; MOTA, 2008; TEIXEIRA; EDLER, 2012).

These two needs appear to be closer to public health issues than to training ones. However, to promote change in health systems, it is necessary for current and future workers to internalize the proposals of change. At this point lies the articulation between medical practice, public health policies and superior education policies. What it is wanted to change is practice, and for that we need to change policies. But what has been going on with the medical practice that needed to be changed?

Since the end of the XIX century, a great movement of "technologization" has occurred in medicine. This movement made it expensive and dependent on inputs and equipment, both difficult to access. The "specialization" of medicine, with the fragmentation of the medical work, was also succeeded by a logic determined by the tissues and organs of the human body; and "curativism", by a practice focused on the individual with the disease (SANTOS; WESTPHAL, 1999; LAMPERT, 2001). Consequently, such material conditions could only promote a medical education whose learning space was centralized in the hospital and, in the same way, could only promote the valorization of the specialty. From that, students were led to seek the complementation of their formation within the logic of the knowledge fragmentation, perpetuating the rising cost of medical practice.

Adding to this fact is a great public health reform movement that had been taking place since the 1930s, with the progressive expansion of the health care coverage of the population, which culminated in the creation of the Sistema Único de Saúde (SUS), an unified health system, in 1990, whose coverage today is the entire population

The combination of a specialized, hospital-centered, "technologized" medical practice and the need to subsidize the entire population of the country is economically explosive. Therefore, it is understood that there was a great economic-political motive that would culminate in the DCN2001: the need to reduce the costs of the health sector.

It is clear that one cannot arbitrarily reduce the explanation of the DCN2001 emergence to the pure economic aspect. However, in order to legitimize the DCN2001 proposals of change, there was the appropriation of speeches that covered the text with an appearance of innovative proposal, but, in the end, contributed to the role of justifying the need to reduce health costs. In other words, the references that were used in the DCN2001, in a way, brought concepts that interested the new health system project. Likewise, it cannot be said that the discourses that justified the DCN2001, in themselves, had the exclusive interest of reducing costs, but one can recognize that the choice of certain discourses, besides containing concepts for the advancement of medical education, fulfilled the role to validate proposals for change in order to contain health spending.

One idea that the DCN2001 intended to pass throughout the text is the rupture with the past of medical education, as quoted in Opinion No. 1,133 / 2001, of the Superior Education Chamber of the National Education Council of the MEC, of August 7, 2001, which deals with the National Curricular Guidelines for Undergraduate Nursing, Medicine and Nutrition Courses and gives them theoretical support.

Within the perspective of ensuring the flexibility, diversity and quality of the training offered to students, the guidelines should encourage the abandonment of the old and closed conceptions of curricula (prisons), often acting as mere instruments of knowledge transmission and information, and ensure a solid basic training, preparing the future graduated to face the challenges of the rapid changes in society, the labor market and conditions of the professional practice (BRAZIL, 2001b).

It is clear that DCN2001 sought to respond to society. With the re-democratization, definitely effected with the Federal Constitution of 1988; with the creation of SUS, in 1990; with the creation of the Family Health Program in 1994; superior education could not maintain previous conceptions and practices. Proposals that had as motto the discourses of easing and emancipation of the curricular grades arose. The word "prisons", in parentheses in the text of the opinion, gives the tone of liberation that the editors wanted to express with the DCN2001.

Another idea announced by DCN2001 was that of democratic experience. In the Opinion No. 583/2001 of April 4, 2001, which provides directions for curricular guidelines to undergraduate courses, the Ministry of Education affirmed that it received more than 1,200 proposals to change medical education (BRASIL, 2001a). In the list of references of opinion no. 1,133 / 2001, documents from non-governmental entities related to medical education, such as the Brazilian Association of Medical Education and the UNIDA Network (BRAZIL, 2001b), are cited. Both situations confirm the idea of participation and representativeness.

Associated with DCN2001, several strategic measures were adopted, such as to bring physician to the interior of the country (interiorization) programs for medical labor and programs to encourage curricular changes. Also in 2001, through a partnership between the Ministry of Education and the Ministry of Health, the Project for Incentive to Curricular Changes in Medicine Courses (PROMED) was an initiative to train professionals who could more easily adjust to Family Health teams and serve instrument of change in medical practice (BRASIL, 2001d). In 2005, the PROMED would be updated and replaced by the National Program of Reorientation of Professional Training in Health (PRO-SAÚDE). Initially, the program would expand its activities to other courses in the Family Health Strategy, Nursing and Dentistry (BRASIL, 2007). The Health Work Education Program (PET-SAÚDE) had as objectives to contribute to the implementation of the DCN2001 in undergraduate courses in the health area, to induce the staying of the professionals in the places of operation of the program and to prepare the students for the work in health, according to the needs of the population (BRAZIL, 2010).

All these measures converge towards the same goal. By proposing programs to encourage curricular changes and interiorization of the medical workforce, the State recognizes the need to reduce the sector costs and wishes to promote a new model of public health that is less assistance oriented and more focused on prevention and health promotion, by reducing the need for hospital interventions and the demand for specialists.

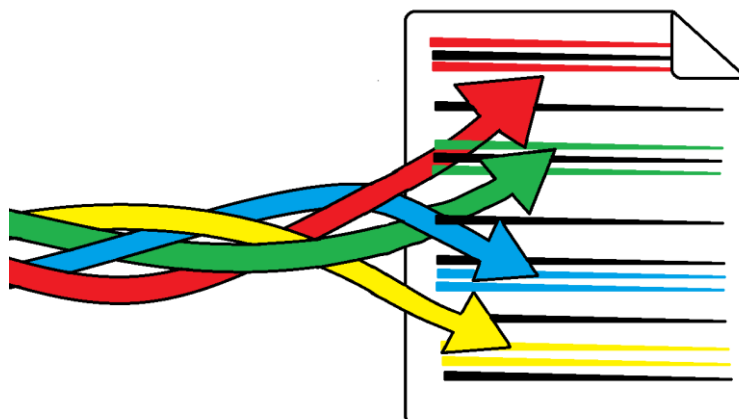
Features of the New Health Professional

The proposals of the DCN2001 for a new medical training can be divided in two large groups. The first is the one articulated to a new profile of the egress - "philosophical-conceptual" references; the second one, a new way of proceeding with training - "methodological" references.

Proposals to change the egress profile can be evidenced in structuring axes (KUSSAKAWA; ANTONIO, 2017). Each axis corresponds to a central idea and a number of secondary ideas that support it. The central ideas are present in each piece of text, to a greater or lesser extent. Another characteristic of the axes is the strong adhesion and competition of ideas. They intertwine and share concepts, that is, concepts that are present on one axis may be present in another, concomitantly.

This feature has two consequences. The first is the impression that the text is cohesive, harmonious, and articulate. The other is the difficulty of individualizing each axis in order to study it as if, when pulling the thread of one of them, the others came entangled to the first one (Figure 1). One of the research task was to untangle the axes, to make them individualized, to make it possible to observe only the ideas related to that particular axis.

Figure 1. The DCN2001 structuring axes.



Source: Authors (2018)

The axial axis, that is, the one to which all others are intertwined in some way, is the axis of "health promotion." For a long time, it was believed that the concept of health was limited to the absence of disease. This concept reduced health to a purely biological aspect, of nature, excluding any social contamination. From the second half of the XX century, the concept was expanded, incorporating also social determinations, ie, issues such as hygiene and sanitation, income, levels of physical activity, schooling, etc. Health has come to be seen as a resource, among others, for achieving a quality life.

When observed as the absence of disease, health would be situated only in the individual level, in the definition between the healthy and the pathological. When the concept incorporates social determinations, it gains a greater scope. Decision-making on what to do to improve the health of individuals should consider issues that involve the whole community. This is the concept of "collective health." In the same way, if health is no longer a counterpoint to the disease and it gains the status of a resource to be administered by each of the individuals, it is necessary to speak in a medicine that maintains it, that does not let it escape. This concept is "preventive medicine".

What kind of physician would be competent to act in this scenario? The answer is the physician who works in the community, and over the community. This takes the name of "family physician" and the program one meets is "family health". And what profile does this physician need to have? "Generalist", because one must understand the individual as a whole, as a member of a community whose characteristics impact all the individuals that belong to it, therefore, from an "integral" perspective of the individual and the community.

The second axis is the "economic-political". The main central idea is to bring to the surface, directly, the competences articulated with the reduction of health sector costs. The primary expectation is to provoke the physician to see oneself as a worker of health production; engage in promotion, prevention, rehabilitation and rehabilitation activities; to produce individual and collective well-being, distributed to society, through the mediation of

acquired rights, and consumed by society, whose needs must be met. Secondly, in the productive process, one must be a manager and administrator, capable of producing health in an efficient, safe and quality way; work and lead teams; consider costs and benefits; prioritize the most urgent demands; continuous learning with the difficulties faced and with the results obtained; and create solutions to problems with available resources. It should also consider as specific competences: cost and effectiveness, standards of quality and safety, prioritization of problems, appropriate use of the workforce and inter professionalism. In addition to these objective competences, other subjective ones are added, such as: commitment, responsibility, empathy, creativity, autonomy, development of divergent thinking and communication capacity. In short, it is clear that the pretension is to highlight the role of the medical "professional" in the capitalist structure.

The third axis is the "ethical-cultural" one. The main central idea is the concept of "equity", that is, the opportunity of equal access to health for all individuals. It contains ethical and humanistic principles. To achieve "fairness" and ethical conduct per excellence, the physician should promote a "horizontal communication", that is, one should consider the other as a participant in the decision about the process of promoting one health. The verticality of the physician's action on the patient will give rise to a reflection that will consider the centrality of the patient in the choices of the paths to go to achieve health.

The last axis is the "symbolic-technological". It is hidden between the lines of the text and is the most difficult to locate and interpret. It refers to certain commands embedded in the texts, based mainly on two central ideas. The first is that the physician must follow treatment algorithms and produce information that will feed into databases, on the grounds of improving the way the health of that area is conducted. The second is that the physician should contribute to the increase of health indexes. This axis is controversial and everything related to it is a matter of preserving or restricting the autonomy of the physician. From one point of view, it may seem an evolution in the democratization of data and the quality of access to health; from another point of view, may seem like control over the physician and an attack to innovation.

After the discussion about the egress profile, what did the DCN2001 propose for the training process? The "methodological" references of the new medical training are based, basically, by two substitutions. The first is the substitution from a model of technician curricular organization by a model of curricular organization based on competences. The second is a traditional teaching methodology through active teaching and learning methodologies.

One way of explaining the shift from the technician perspective of curriculum to competency-based curriculum can be met in the form of work organization, in its broadest sense. Starting in the 1950s and gaining strength in the 1970s, as a response to one of the many crises of the capitalist system, when the products began to run aground, due to

overproduction and low consumption, "toyotism" emerged as a solution allowing greater flexibility in the production line (RAMOS, 2002).

First, production would not have to remain stable and at full capacity, but should shape the demands of the market. Second, the worker would not only fulfill the specialized portion of the work one was taught, but would have to learn all the functions of the production chain. This would make it "flexible" to the various activities within the production process and more, it could even fulfill more than one function at the same time. Such a measure would reduce production costs by reducing the need for hiring. This practice would also stimulate the presence of temporary workers in the production line (GOUNET, 1992).

For a new worker with a "flexible" profile and who responded to the new characteristics of the market, it was necessary a training in which it is learned several skills to work in the same productive chain. Therefore, the curriculum thought and organized for this worker would consider the skills to be learned to meet the market characteristics. This model is called the competency curriculum organization (RAMOS, 2002).

In this perspective, the DCN2001 proposed that the physician become "flexible" by means of acquisition of several competences not previously required. From that appears terms for competences such as management, administration, educational, communicative, etc, in text guidelines.

There are some potential problems associated with this way of organizing the curriculum. It is known that the world is based on novelty and it can quickly be seen that today's skills will not account for complete medical training tomorrow. Medical science is produced and revisited in a fast-track way. How can one account for all this knowledge? Skills will be out of date and there will be a need to update them. Another criticism lies in the excess of skills that the physician needs to acquire. Is it possible to act on so many functions simultaneously?

Articulated with the reflection on the competences lightness and perishing are the active learning methodologies. What they want is for the individual to be able to learn from their own experiences. By them is determined an axis constituted of action (concrete situation to which the student is exposed); reflection (search for the solution of the problem) and action (application of the solution to the real situation).

The message that is intended to pass with the substitution of the traditional methodology for the active methodologies is one of change of sovereignty. In traditional methodology, there is the sovereignty of theory. First, knowledge is acquired; then it is applied. In active methodology, there is the sovereignty of practice. First, there is exposure to the situation or problem; then follows the quest for theory to then expose itself again to the problem.

In summary, the use of active methodologies is an attempt to make the physician an individual capable of "learning to learn", to reduce the difficulty imposed by the novelty of concrete situations and to reduce the difficulty of dealing with the information overload that one is exposed.

THE PPPMFB, THE DCN2001 AND THE PHYSICIAN TRAINING

The creation of the UNIOESTE Medicine course at Francisco Beltrão presented a strong appeal in the years 2009 and 2010, when the local community was organized around this cause. According to the PPPMFB, three reasons for the existence of the course in Francisco Beltrão can be highlighted. The first was the difficulty of hiring doctors for the Regional Hospital of the Southwest, inaugurated in 2010. The second justification was the discrepancy between the economic importance of the region and the human development index (HDI) of it, below other regions of the State of Paraná (UNIOESTE, 2010). Other justifications cited were the number of places for public superior education in the Southwest region of Paraná, considered below other regions, and the comparison with the benefits that the implantation of the Medicine course of UNIOESTE, in the city of Cascavel, brought to that city.

Francisco Beltrão's medical course emerges as an expansion of vacancies at the campus of UNIOESTE de Cascavel, and PPPMFB appears as a copy of the PPP of the medical course of Cascavel. There was no previous debate on the constitution of the PPPMFB, a situation that is foreseen by institutional rules of the UNIOESTE itself. Article 8 of Resolution No. 092/2016 of the Education, Research and Extension Council - CEPE, of June 30, 2016, provides the characteristics to be respected by the PPP from courses whose vacancies are expansion of other campuses courses: Art. 8º The request for expansion of vacancies begins with the protocol of the PPP to the Center Council, with subsequent appreciation and approval of the Campus Council affection "(UNIOESTE, 2016, page 3). It is understood that to begin the process of vacancies expansion it is necessary to file a PPP to the Center Council that will be appreciated and approved by the Campus Council of the subordinate course.

Regarding the content of the PPPMFB, the articles and paragraphs of the text that deal with the egress profile, curriculum organization and teaching and learning methodologies are consistent with the proposals articulated around the "philosophical-conceptual" references and the "methodological references" "Of DCN2001.

Regarding the "philosophical-conceptual" references, the PPPMFB mentions that the UNIOESTE medical course seeks to train professionals able to act in: "sanitary practices of prevention and control of diseases, intervening on population groups and / or individuals in meeting their needs "(UNIONSTEP, 2013, p.12). There are some items that are copies of specific skills and abilities described in the DCN2001 itself, especially regarding the

"economic-political", "ethical-cultural" and "symbolic-technological" axes (UNIOESTE, 2013, p. 12-16).

Regarding the "methodological" references, the PPPMFB demonstrates the concern in orienting the curricular contents by competences and lists those that it considered essential.

The curriculum is focused on **basic skills**, based on the ability **to learn and continuity of learning, on the organization of knowledge and skills, the ability to relate theory to practice and preparation for work and citizenship**. Curricular contents should be understood as basic means to build **cognitive and social skills**, through organized blocks of knowledge (UNIOESTE, 2013, page 12, emphasis added).

In item III - Didactic-pedagogical organization, in the Historical sub-section of the PPPMFB, there is a paragraph that deals with the active methodologies of teaching and learning and points out the execution paths of the traditional teaching transference to the active methodologies: a gradual substitution, with classes in small groups of students and with the need for more tutors (UNIOESTE, 2013).

It was noted that the proposals contained in the PPPMFB are broadly supported by the DCN2001. From this observation, a question remains. As reference points for the writing of the PPPs of Medicine courses, whose speech was intended to allow flexibility and innovation, did DCN2001 fulfill their role?

Conclusions

The fact that the PPPMFB translates into a copy of much of the DCN2001 allows some criticism. A PPP is not a mere document that combines teaching plans, schedules, or describes the physical and functional organization of any school. The importance of it goes beyond a bureaucratic liability. It is the document that shows the identity of the school. It shapes and regulates the actions of agents within it; it interferes in the pedagogical work inside and outside the classroom, in the routine of students and teachers; it defines content, work relationships, times and evaluations. In other words, it can be said that it is the "soul" of the school, something that gives it direction and meaning.

Since it is so important, it needs to be valued. It needs to become a space for broad and permanent debate, where everyone should be invited, in the search for decisions transparency and legitimacy, guaranteeing control over the agreements reached and establishing an open channel of communication and contemplation of issues.

The pre-requisites accountable by the reviewer authorities, at the opening or revalidation of the courses, required a textual and practical alignment between the DCN2001 and the PPP, which allows the statement that the discourse of innovative potential of the DCN2001 is a fallacy. Little or no breach would be granted to IES to innovate in their PPPs due to the need to comply with legal requirements.

Institutional rules and relationships that limit the debate, the physiology, the fear of innovation, and the lack of creativity are also factors that go in the opposite direction to what is sought by DCN2001.

Referências

BARDIN, Laurence. **Análise de Conteúdo**. Lisboa: Edições 70, 1977.

BRASIL. Ministério da Educação/Conselho Nacional de Educação/Câmara de Educação Superior. **Parecer n° 583/2001**. Orientação para as diretrizes curriculares dos cursos de graduação. Brasília, 04 abr. 2001a.

BRASIL. **Diretrizes Curriculares Nacionais dos Cursos de Graduação em Enfermagem, Medicina e Nutrição**. Conselho Nacional de Educação. Câmara de Educação Superior. Ministério da Educação. Parecer CNE/CES n° 1.133/2001, de 07 de agosto de 2001b.

BRASIL. **Diretrizes Curriculares Nacionais do Curso de Medicina**. Conselho Nacional de Educação. Câmara de Educação Superior. Resolução n° 4, de 07 de novembro de 2001c.

BRASIL. Ministério da Saúde/Ministério da Educação. **Projeto de incentivo a mudanças curriculares em cursos de medicina - PROMED**. Brasília, 2001d. [online]. Disponível em: <<http://portal.mec.gov.br/sesu/arquivos/pdf/inc.pdf>>. Acesso em: 02 jul. 2017.

BRASIL. Ministério da Saúde/Ministério da Educação. **Programa Nacional de Reorientação da Formação Profissional em Saúde - PRO-SAÚDE**. Brasília, 2007. [online]. Disponível em: <<http://portal.mec.gov.br/sesu/arquivos/pdf/inc.pdf>>. Acesso em: 02 jul. 2017.

BRASIL. Portaria Interministerial n° 421, de 03 de março de 2010. Institui o Programa de Educação pelo Trabalho para a Saúde (PET Saúde) e dá outras providências. **Diário Oficial da União**. Brasília, 05 mar. 2010. Seção 1, n. 43, p. 52.

BRIANI, Maria Cristina. **História e construção social do currículo na educação médica: a trajetória do curso de medicina da faculdade de ciências médicas da Unicamp**. Dissertação (Mestrado em Educação) - Faculdade de Educação, Universidade Estadual de Campinas, Campinas, 2003.

CAVALHEIRO, José da Rocha; MARQUES, Maria Cristina Costa; MOTA, André. A construção da saúde pública no Brasil no século XX. In: ROCHA, A. A.; CESAR, C. L. G. (Org.). **Saúde Pública: bases conceituais**. São Paulo: Atheneu, 2008. p. 1-14.

EDLER, Flávio Coelho; FONSECA, Maria Rachel Froés. Saber erudito e saber popular na medicina colonial. **Cadernos da ABEM**, Rio de Janeiro, v. 2, p. 8-9, 2006a.

GOUNET, Thomas. **Fordismo e toyotismo na civilização do automóvel**. São Paulo: Boitempo, 1992.

KRAMER, Sonia. Propostas pedagógicas ou curriculares: subsídios para uma leitura crítica. **Educação & Sociedade**, Campinas, ano XVIII, n. 60, dez., p. 15-35, 1997.

KUSSAKAWA, Diogo Hiroshi Beçon; ANTONIO, Clesio. Acilino. Os eixos estruturantes das Diretrizes Curriculares Nacionais dos cursos de medicina no Brasil. **Revista Docência do Ensino Superior**, Belo Horizonte, v. 7, n. 1, p. 165-184, jan./jul. 2017.

LAMPERT, Jadete Barbosa. Currículo de graduação e o contexto da formação do médico. **Revista Brasileira de Educação Médica**, Rio de Janeiro, v. 25, n. 1, p. 7-19, 2001.

LE GOFF, Jacques. **História e memória**. Tradução: Bernardo Leitão [et al.]. 4ª ed. Campinas: Editora da UNICAMP, 1996 (Coleção Repertórios).

RAMOS, Marise Nogueira. A educação profissional pela pedagogia das competências e a superfície dos documentos oficiais. **Educação & Sociedade**, Campinas, v. 23, n. 80, p. 401-422, set. 2002.

SANTOS, Jair Lício Ferreira; WESTPHAL, Marcia Faria. Práticas emergentes de um novo paradigma de saúde: o papel da universidade. **Estudos Avançados**, São Paulo, v. 13, n. 5, p. 71-88, 1999.

TEIXEIRA, Luiz Antonio; EDLER, Flávio Ceolho. **História e cultura da medicina no Brasil**. São Paulo: Aori, 2012.

UNIOESTE. Parecer n° 075/2010. **Carta consulta para o curso de Medicina**. Francisco Beltrão, Conselho de *Campus* de Francisco Beltrão - CCFB, 29 set. 2010.

UNIOESTE. **Projeto político-pedagógico do curso de Medicina da Universidade do Oeste do Paraná - Campus Francisco Beltrão**. Francisco Beltrão: Unioeste, 2013.

UNIOESTE. Resolução n° 092/2016, de 30 de junho de 2016. **Aprova o regulamento para criação de cursos de graduação e expansão de vagas na Unioeste**. Cascavel, Conselho de Ensino, Pesquisa e Extensão, 30 de junho de 2016b.