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Interdisciplinarity in the methodology of teaching in Health: A Literature Review.

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REVIEW ARTICLE

ABSTRACT

The objective of this article is to carry out a sweep of the current medical literature on the relationship between interdisciplinarity in the methodology of teaching in Health. keywords "Teaching, Health, Interdisciplinarity, Health Education". Articles with more than 20 years of publication or that did not fit within the scope of the research were excluded. In all, 10 articles that fit within the search patterns were selected. It is concluded that most publications promote the need for changes in Health Education in higher education and in learning, knowledge and management of the SUS, in order to promote the Significant Learning of graduates in their professional careers.

Keywords: Teaching, Health, Interdisciplinarity, Health education.

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INTRODUCTION

A few years ago, several debates about Health Education in higher education and the need to train professionals who are in line with the principles advocated by the Unified Health System (SUS), are present in educational institutions and in the governmental sphere of Health Thus, the Ministry of Health has invested efforts to integrate public policies to health services, also seeking to relate undergraduate practice with the assistance provided to the population. In addition, the professional working in the field of Public Health must extend his knowledge beyond the technical-scientific domain of the profession, to all aspects of interest and social relevance, whether through the health area itself or by integrating it with other sectors. governmental[1] .

Given this premise, academic institutions in the health area need to seek new strategies so that the professional training of graduates is adequate for compliance with the health system, guaranteeing the quality of care for the population. Therefore, the health professional must be able to create, plan, implement and evaluate policies and actions aimed at the general well-being of a given community, in addition to having skills that can transform technical practice into subsidies to provide reception and care for the various aspects of people's health needs[1].

Despite the transformation movements, the education of health professionals is still, for the most part, based on a fragmented model of knowledge, disregarding the needs for action in practice and representing a teaching-learning centered on the teacher's knowledge, on the disciplinary content and in the reproduction of contents by memorization. Considering that the graduation lasts only a few years, while the professional activity lasts for decades, and that the competences are transformed, it is of extreme importance to approach a methodology for a practice of liberating education that allows the health professional to be critical, reflective, and able to learn how to learn[2] .

Educating the citizen consists of a process of “teaching how to think correctly”, going beyond the transmission of contents and encouraging the student to exercise critical and transforming reflection, taking into account the different knowledge necessary for their formation and the applicability of this knowledge to reality in which

the students are inserted. In this context, active teaching-learning methodologies emerge that pose challenges to be overcome by students, enabling them to take the place of subjects in the construction of knowledge and participate in the analysis of the care process, placing the teacher as a facilitator and guide of this process[2].

This article aimed to carry out a sweep of the current medical literature on interdisciplinarity in the methodology of teaching in Health.

METHODOLOGY

This article carried out a search in Google Scholar, Scopus and Web of Science search engines and indexers for the selection of articles, through the keywords "Teaching, Health, Interdisciplinarity, Health Education". Articles with more than 20 years of publication or that did not fit within the scope of the research were excluded. In all, 10 articles that fit within the search patterns were selected.

REVIEW AND DISCUSSION

A health training project for the quality of care for people and the management of systems and services involves reversing biomedical imaginaries and understanding citizenship in health. It also involves understanding the integrality and humanization of care, the development of thought structures capable of participatory management and conditions of responsibility and skill with regard to permanent education16. Little understood, all these natures, Health Education and Teaching did not configure a core of knowledge and practices within Collective Health and the Sanitary Movement, although reiterated in all instances of social control in the voice of users who claimed/claim another quality of service, another standard of adherence to the principles of the Unified Health System and other values for the self-assessment of professionals and services and for the corporate assessment of the quality of health work. In the health movement, the prevailing view was that the labor market would condition the characteristics of the training apparatus, that is, the new employability and work regulation would lead to prioritizing the change in the graduation of health professions towards the Unified Health System. The Sanitary Movement abandoned the

fight for changes in the training process, hoping that one day determination would take account of changes in training institutions and teaching practices. In fact, the relationships between the labor market, professional practice, academic-administrative structure of the courses and educational practice are made up of countless connections, co-production and co-engendering. The concept of determination proved to be inadequate and co-production or co-engendering was the resource of the opponents, of the reactionaries to change, while the militants had to discover new conceptual natures, many of them present precisely in Education.[3]

If the encounter between Collective Health and the training of health professionals did not demonstrate the power of change in the first moment of the construction of the Sanitary Movement, the same did not happen in another point of encounter with education. One of the particularities of the Brazilian health reform process was the meeting of health with popular movements to carry out health education. At this meeting, popular education would both participate in the reduction of infant/maternal morbidity and mortality and would make care cheaper by assuming protective behaviors against illness and death that could be avoided with popular measures, and would contribute to raising the social and health awareness of the population. On the other hand, this health education was allocated, designated and justified in the orientation to the people, not to the teaching of the new professional generations or to the debate of university pedagogy and permanent education. This was the nomination that lasted and made itself known in the areas of Health and Education.[4]

as “Health Education”, hence the use of the designation “Health Education” in public teaching and continuing education policies. It should be noted that popular health education has a study or thematic group both in the Brazilian Association of Postgraduate Studies in Collective Health (Abrasco) and in the National Association of Postgraduate Studies and Research in Education (Anped), none of which has the grouping Health Education and Teaching. Health Education, a domain with unique interdisciplinary connections with anthropology, art, culture and social assistance, Health Education feeds and could be fed by the existence of a sub-area of Education and Teaching of Health. Health in the scientific, academic and political spheres, both in the area of Collective Health and in Education.[5]

In the actual implementation of the Unified Health System or in the implementation of the change in the graduation of health professions, in spite of the invention of Collective Health (in the field of knowledge), Social Control (in the field of participation) and the National Curriculum Guidelines (in the field of training), we are witnessing a way of operating in which traditional ways and values have not lost their validity and capture the networks of thinking, learning and knowing, blocking the processes of creation of oneself, of surroundings and of "health in the city". " (the project "the right of all and the duty of the State" as the driving force behind teaching, work and assessment initiatives). Theoretical references, normative texts and structured curricula are not enough if they do not change the "impulses for action", if there is no rupture with the intellectus sanctus that structures the ordering of theories, norms and teaching strategies. An "happening" of training is not in its forms, but in its imaginary: in the forces that constitute it, not in its forms. Therefore, a transformed health education and teaching does not "happen" if a connection (soul, aura, atmosphere, discursive practice, bonding impulse, affection) between professors and students is not established.6

The downgrading of citizenship achievements in the health sector by that of education gives rise to fashionable "theories" in teaching-learning and all kinds of uncritical appropriation of pedagogical technologies. This is where the need for debate on university pedagogy comes in, in what happens as training in teaching17. It is this intersection that we are talking about, those who militate in the fields of Education and Health Teaching. Research in education puts on the scene of intellectual production, today, no longer a cognition of the fields of knowledge, an area taken much more by research in science than in education. Education detects the pedagogies of life, the city, the socius, subjectivity or environments undergoing transformation, invention and singularizations.7

What outlines and potentialities for Health Education and Teaching do the DCN have for the training of nurses, doctors and nutritionists (block 1); pharmacists and dentists (block 2); physiotherapists, speech therapists and occupational therapists (block 3)? Guidelines that were produced in affinity, blocks of time and discursiveness in the period between 07/11/2001 to 19/02/2002. This notion of "block of time and discursiveness" shows the similarity between these careers and the distinction with the

others. They conserve, for this very reason, constitutive forces resulting from the meeting of forces in affinity and distinction. For the DCN of these blocks, the orientation of the graduation in health should be to contemplate the current health system in the country, the comprehensive health care in a regionalized and hierarchical system of reference and counter-reference and teamwork. For nurses and nutritionists, an addition: meeting the social needs of health, with emphasis on the SUS. In the nursing profession, there is still a complement: ensuring comprehensive care and the quality and humanization of care. For the training of pharmacists, the bet "with emphasis on SUS".7

For these DCN, professionals must be able to learn continuously, both in their training and in their practice, they must learn to learn and have responsibility and commitment to their education and that of future generations of workers, providing conditions for the benefit mutual relationship between those in training and service professionals, including encouraging and developing academic/professional mobility, training and cooperation through national and international networks (the "must" in the DCN belongs to the language of the instrument, not to a real regime). Professional training aims, among others, at providing professionals with the knowledge required to exercise general competences and skills for Permanent Education, assuming that there is no "the" professional, but professionals under learning and health production with which operate or will operate.8

Understanding the forging of this instrument requires knowledge of the movement for guidelines for nursing education (1st and 2nd National Seminars on Nursing Education Guidelines - Senaden), of the interinstitutional movement for the evaluation of medical education (National Interinstitutional Commission for the Evaluation of Medical Education - Cinaem, phases 1, 2 and 3), the movement for the definition of principles and guidelines concerning workers within the scope of the SUS (Intersectoral Human Resources Commission – Cirh, of the CNS) and the movement for change in the education of health professionals (Rede IDA and UNI Projects already aggregated by Rede Unida and its project of evaluation and systematization of experience in multiple health careers). The DCN sealed a stage of the struggle, turning into national political-pedagogical guidance, within the Education sector, the lessons learned from movements for change in the education of health professionals. What was lacking was to see any similarity in the health sector, which happened at the turn of the

project in the federal government when, in 2003, intellectuals from the health movement, builders of the theoretical field of Collective Health predominated in the management posts of the Ministry of Health and intellectual militants from the health education and teaching were able to propose and constitute a domain in public health policies designated as Education in Health. The period 1997-2001 intensively brought together a health education movement and the period 1999-2002 accumulated a focal experience in one state of the federation , Rio Grande do Sul, when the state public health education policy was formulated (collective health education and health education, in these places of use, are synonyms and result from the same interpretations already set out in this text). The impetus for action, the intellectus sanctus, present among the occupants of the management position brought together a past of education, evaluation and pedagogical production in health. Education gained a name in health policy, detached itself from work management and called into question the designation Human Resources because human “resources” (the human factor in the assembly lines of monopoly capital) are not intended for a permanent resingularization, if for recycling, training and qualification. The new language was presented, not under the validity of a new domain of knowledge within the health sector, but under the current domain of Human Resources in Health. It is in this game of forces that the conceptual operator Permanent Education in Health emerges: concept that underlies an invention of the Unified Health System to mark the encounter between health and education, an inextricable link between teaching (formal education, in-service education, continuing education), work (sectoral management, professional practices, service) and citizenship (social control , participatory practices, otherness with popular movements, links with civil society)9 . It is important to say that Permanent Health Education is proposed as a public and participatory policy under the circumstances of the Unified Health System, and it is not possible to understand it outside these two inscriptions. In 2003, the National Health Council approved, as a public policy for the sector, the Training and Development Policy for the SUS: Pathways to Permanent Education in Health (CNS Resolution No. 335, of November 25, 2003). This document was the landmark for the definition of a field of knowledge and practices to which Brazilian society was summoned in the development of health education and development of health management, in view of the unfolding of Brazilian citizenship in this area. What outlines

and potentialities for Health Education and Teaching does the Training and Development Policy for the SUS have: Paths to Permanent Education? The concept of permanent health education present there was that of managing education as part of the daily routine of the Health System. Everyday life taken as a “wheel” or “collective”, the point from which one starts, sets in motion (not “the directional arrow” for vertical ascension of certificates and diplomas, but “the wheel” for ciranda movements). With this, it provokes thinking about Permanent Education in Health as a training process that triggers movements of estrangement, discomfort, “questioning” and implication, power for a collective to differ from itself and to adopt new practices. The guidelines of Permanent Education in Health as a policy were the locoregional intersectoral and interinstitutional articulation for the development of work and health education, thus its main device were the “wheels”, locoregional instances of teaching-service-management-control interaction for the formulation, implementation and evaluation of permanent health education or Permanent Health Education Centers. Merhy on health work: live work in action.8

For this Collective Health thinker, the exercise of health is largely dependent on live work in the act, where workers can put all the knowledge they have at their disposal as technological options “for the production of effective [ways of proceeding] at the service of the user and your problem". The author points out that health workers cannot refuse to offer everything they have to defend life (let's say: listen, care, treat), this includes knowledge, knowledge and work in action (let's say: a exposing oneself and committing oneself), hence the possibility of building a mutual complicity between users and workers, “in the real improvement of the quality of life”. If the Education sector, via DCN, indicates the path of Permanent Education, the health sector assumes permanent education as its path. A logic of complementarity and intersectoriality, without subordination, without contradictions: the meeting of Education with Health in each sector, in each area of knowledge and, also, formulations, actions and evaluations in interface or intersection. Languages: Education in health, Education in health, Education in health sciences and Permanent education in health. A language for the intersection: Education and health teaching.9

The institutional process of the DCN involved a call notice, 4 years of debates by profession, in the already named networks of education for health professionals, public

hearings and approval by the plenary of the National Council of Education and homologation by the Ministry of Education. The institutional process of the Basic Operational Standard for SUS Workers involved the decision of the 10th National Health Conference for the demonstration of effectiveness and normative unification for work management in all spheres of the health system (hence, “Basic Operational Standard”), had its first document formulated in 1998 after a CNS workshop on Human Resources for the SUS, finalizing its formulation in the 3rd version, approved in 2000, at the 11th National Health Conference. Only in 2003, celebrated by the 12th National Health Conference , it gained the status of recommendation to all segments of the SUS of a national policy for the management of health work, its 4th version (CNS Resolution No. 330, of November 4, 2003, approved by the Minister of Health as a National Policy for Management of Work and Education in Health, within the scope of the SUS).9

Noteworthy is that this document, from the original, keeps identity to work management and, in fact, its shortest section is the one related to training and development. Its dense accumulation is related to work, not education. Not by chance, society, via the National Health Council, not only approved the education policy in the minutes, it deliberated on a Resolution, referring to the NOB/RH-SUS. The Ministry of Health, only 3 months later, issued an Ordinance that gave shelter to the Policy. The national health education management policy, as legitimacy, recorded the following documentation: approval at the 133rd Ordinary Meeting of the National Health Council (09/04/2003); approval by the National Council of State Representatives – Conares and Plenary of the Board of Directors of the National Council of Municipal Health Secretaries – Conasems (09/17/2003); agreement at an Extraordinary Meeting of the Tripartite Inter-Management Commission – CIT (09/18/2003); Resolution nº 335, of the National Health Council (11/27/2003); Ordinance No. 198, of the Minister's Office / Ministry of Health (02/13/2004). As a sectorial coverage of health, the “Pathways to Permanent Education in Health” recorded the following strategies, proposing their outline9,10,11 . – Pole of Permanent Education in Health - locoregional, intersectoral and interinstitutional articulation corresponding to the Permanent Commissions of Teaching-Service Integration in Health, foreseen by Law 8.080/90 (Art.14); – VER-SUS – Experiences and Internships in the Reality of the SUS for undergraduate students; – AprendiSUS – SUS and Undergraduate Courses in the Health Area: training in activating

processes of change in teaching for higher education teachers in 14 undergraduate courses, formation of the National Forum for Education of Health Professions (Fnepas), research national on integrality teaching practices in undergraduate health courses (EnsinaSUS), support projects agreed with locoregional and intersectoral instances of permanent health education and regional workshops for systematization of accumulations and structuring of developments in training and research; – Training of health policy makers (coordinators of central policies and programs or support to decentralized networks); – Monitoring and evaluation of health training and development initiatives within the scope of the SUS; – Review of the policy of specializations in medical services and residencies, construction of Integrated Residencies in Health (RIS), single or multi-professional, with the creation of an Institutional Program of Scholarships for Education through Work, internalization of programs and construction of training paths specialized in services; – SES Educadoras – State Secretariats of Health Educators: formulation and follow-up of the state attributes of the SUS towards education and development in health; – Network of Collaborating Municipalities for Permanent Education in Health; – Health qualification and training project for professionals with basic and technical education (professionalization); – Popular Health Education: line of support and mobilization to enhance health education with social movements and the school network (which generated the National Articulation of Movements and Practices in Popular Health Education – Aneps and the Intersectoral Chamber of Health Education in Basic School); – Professional Civil Service Program and priority to the Brazilian Amazon region with interiorization programs, regional interprofessional internships and internships with popular movements (links with VER-SUS, RIS, AprendiSUS, SES Educadoras); – Education in teaching hospitals (construction of pedagogical responsibilities towards the health network, reception of interns and residents, educational development of preceptors).10

An interesting note about the knowledge domains of Health Work and Health Education are their reverse stages. Work predominates in the NOB/RH-SUS (74% of its recommendations), while in the preparatory base document for the 3rd National Conference on Work Management and Health Education (the first two Conferences were designated as the National Conference on Human Resources in Health), elaborated in 2005, predominated Education (65% of its recommendations). The annotation is that

of the emergence of the knowledge domain of health education. On the other hand, there is an urgent need to attribute value to study, research and policy formulation on Work, under penalty of this field becoming confused with education for work, with the prejudices suggested a little earlier in this text. 10

FINAL CONSIDERATIONS

It is concluded that most publications promote the need for changes in Health Education in higher education and in learning, knowledge and management of the SUS, in order to promote the Significant Learning of graduates in their professional careers.

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