

Repercussions of the Biomedical Model on the Formation and Humanization of Health Care Practices- A Conceptual Historical Picture

AS REPERCUSSÕES DO MODELO BIOMÉDICO NA FORMAÇÃO E HUMANIZAÇÃO DAS PRÁTICAS DE ATENÇÃO À SAÚDE – UM RECORTE HISTÓRICO CONCEITUAL

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ABSTRACT

This brief essay is centered in the teaching-learning universe and aims at translating and legitimizing the meaning of humanization in the medical formation process as well as analyzing a number of historical determinants that influence the formation of health professionals, particularly medical schools and the humanizing practices of health care. Through a thorough analysis of classical referential theory and of publications that focus on changes in medical teaching, the study considers proposals from the Brazilian Association of Medical Education (ABEM), from Promed (Program of Medical Education), from the Policies of Permanent Education and Humanization of Care (HumanizaSUS) and the current curriculum guidelines for Medicine courses. It can be observed that the proposal of a formation contextualized and modernized according to the needs of individuals and with the incorporation of a concept of health beyond biological bases are fundamental factors for integrality and humanization. We can consider, lastly, that medical formation is not constructed only in university classrooms nor exclusively through disease. It is actively constructed by the professors, students, health care professionals and by the relations among the various sectors and individuals that create a healthy life.

Keywords: Humanization – Teaching-Learning – Medical Formation

RESUMO

Esse breve ensaio está pautado no universo ensino-aprendizagem, no traduzir e legitimar o sentido da humanização no processo da formação médica e tem por objetivo analisar alguns determinantes históricos que influenciaram a formação de profissionais da saúde, particularmente a escola médica e as práticas (des) humanizadas de atenção à saúde. Através de uma análise em profundidade de referencial teórico clássico e de publicações que enfocam as mudanças do ensino médico, o trabalho considerou proposições da ABEM, da Promed, de Políticas de Educação Permanente e Humanização da Atenção (HumanizaSUS) e as diretrizes curriculares vigentes para os cursos de Medicina. Observou-se que a proposta de uma formação contextualizada e atualizada de acordo com as necessidades das pessoas e com a incorporação de um conceito de saúde para além das bases biológicas e medicamentosas se apresentam como fatores fundamentais para o caminho da integralidade e da humanização. Podemos considerar, finalmente, que a formação médica não é construída apenas nas salas de aula universitárias nem exclusivamente nos espaços da doença. Ela é ativamente construída pelos docentes, discentes, profissionais que atuam nos sistema de saúde e pelas relações entre os vários setores e pessoas que compõe os espaços de vida.

Palavras- Chave: Humanização – Ensino-Aprendizagem – Formação Médica

INTRODUCTION

This study proposes a discussion of some determinants that have influenced, over the course of history, the formation of health professionals, particularly medical school and the humanizing care practices. It does not pretend to offer an in-depth analysis of the origin of the clinic or of the *modus operandi* of medical activity.

In antiquity, health care was not practiced exclusively by one individual. Along with its practice, normally exercised by important personalities, there was the culture of philosophy and, as a basic principle, well-being was considered a state of harmony between body, soul and environment¹. The careful observation of the sick was, over time, substituted by deductive rationality, thus elevating the status of Medicine, to the detriment of patient care, and emphasizing attention to the disease. This fact signaled a significant approach between scientific discoveries and clinical practice.

It is pertinent to cite, in order to better understand the process of “dehumanization” of health practices, the scientific advances that occurred in the 17th and 18th centuries², mainly in the fields of physics and chemistry, when the morbidity became more than just a multi-faceted episode allied to functional deviations and variable pathologies. During this period, anatomical-pathological-clinical medicine assumed the role of interpreting, understanding and proceeding to a rational analysis of the disease, transforming itself from a speculative, theoretical and imaginative activity to a truly positive science with solid bases^{3,4,5}. Centering on increasingly specific parts and on micro elements led to the development of Scientific Medicine⁶, which, according to Foucault⁷, gave rise to the clinical model.

A number of scholars^{4,5,7} claim that what occurred was the substitution of the question: “What is wrong with you?” for: “Where does it hurt?”, causing a change between meaning and importance in medical knowledge. In this sense, the clinic underwent a profound reorganization not only with respect to medical knowledge, but also of the possibility itself of a “discourse” about disease and “doing” in health, forming with the same precepts, the therapist-patient relation, characterizing a dominant paradigm⁸.

Chaves⁹ refers that the *strictu sensu* paradigm

concept, as Kuhn¹⁰ defined it, does not apply to medical education, but calls attention to the fact that the term has been referred to indicate the dominant teaching model in the Americas. It is worth pointing out the strong North American influence on the formation process of these professionals⁹.

The Flexner Report and its shaping force in the formation of health professionals

A new structure in medical teaching and other health-related areas originated with studies solicited by the American Medical Association. With the objective of giving medical teaching a solid scientific base, besides an interest in channeling funds from recently-established foundations (Carnegie and Rockefeller) to a few carefully selected institutions, one of the greatest studies involving American and Canadian medical teaching was undertaken¹¹.

In 1910, under the guidance of Abraham Flexner, the Flexner Report¹¹ was published. Its main goal was to reformulate medical teaching according to the recognized scientific ideas of the time, substituting mere training based on empirical observations of the clinical field by the objective and technical rigidity of scientific methodology. Based on natural science characteristics, the scientific movement that directed the research was the positivism characterized by biological studies at the end of the 19th and beginning of the 20th century.

Even considering the socio-political context of the time, in which a great number of medical schools were profit-making institutions with poor teaching standards^{4,11}, the guiding logic of research and analysis developed by Flexner were firmly supported by the reductionist biomedical paradigm that characterized the sciences. Medical schools that wanted to present the scientific profile needed to prove that its formation was guided by mechanicism, biologism, individualism, specialization, and state-of-the-art use of technology, among other characteristics. A diploma in medicine had to certify the complete domination of medical science and not the capacity to care for patients.

Some principles in this report include four years as the minimum for formation, a structured curriculum

with a solid formation in the basic sciences (anatomy, biochemistry, bacteriology, pharmacology, physiology, histology, embryology, microbiology and pathology), a centralization of hospital practices teaching, centers of medical formation affiliated to universities and the inclusion of research in the teaching area ¹¹.

The development of teaching in hospital settings was another requirement, since medical practice should develop in an atmosphere in which the same technology is available as that existing for diagnosis and treatment, thus transforming the hospital into the ideal place for applying clinical practice, which became hegemonic. These characteristics, along with a concentration on increasingly fewer parts of the body, caused and continue to cause modern Medicine to lose sight of individuals as a whole, hindering the understanding of the interdependence among all the aspects of which they are composed ^{5,12}.

It is observed, however, that in England, immediately following the Flexner Report, the Dawson Report (1917) pointed to the need for a health sector organized by levels of complexity, serving as an organizational model after the Second World War ^{14,15,16}. Regarding Latin America, there was a significant increase in professors and researchers formed in the USA, further favoring the hegemony of the Flexner model.

For teaching, the specializations proposed by the model favored determinant subjects and led to curricular fragmentation with the creation and consolidation of medical specialities, strengthening of the dissociation between medical practice and social concerns, since, as previously cited, medicine was classified as a biological and not a social science ^{14,15,17}.

In defense of Flexner principles, Chaves ¹⁵ calls attention to the fact that the precepts presented by the Flexner Report were fulfilled in part, since, besides a solid scientific base, there were important aspects on medical formation in a social and humanist environment. Even with a strong scientific foundation, Flexner did not omit alluding to these precepts. For the researcher, the ideal physician should be a sensitive and polite person – for whom science and humanity are necessary and inseparable units. This is the entire content of the educational legacy left by Flexner ¹¹, a

legacy that today remains partially fulfilled, since Medicine has reached a scientific level unimaginable in 1910, but the reconciliation between medical science and a humanist formation has not yet occurred.

It is important to emphasize that the advances resulting from this scientific approach cannot be disregarded, nor relegated to a secondary level. The discovery of new drugs, the eradication of diseases, the control of epidemics, new and modern painless surgical techniques, organ transplants, highly complex functional and esthetic prostheses, and finally therapeutic cloning are among the benefits that can be pointed to as a consequence of the influence of the precepts proposed and a result of the development of Scientific Medicine ⁴.

Another consequence to be considered about the model under discussion is the dogmatic question that involves medical knowledge: in the full exercise of power, in some situations, patients are excluded from deciding on their own health care, thus impeding their autonomy ^{18,19}. Many patients ⁸ do not understand the complexity of their organism, believe only in the words of the physician and in technology and drug treatment intervention, creating not a relation model, but a status, a dogma. This power is intrinsically linked to the system of common cultural beliefs ²⁷. There is, therefore, a cultural authority²⁰, which can be translated by the capacity of a socially-accepted conviction that the activity developed by the physician is essential and vital.

The current conditions medical practice with an increasingly more specialized, more technical formation, under questionable working conditions ⁸ have not contributed to a greater availability of the physician both in relation to contact with the patient and for a search for a wider formation with a deepening of ethical, social and human aspects capable of promoting humanized care.

Humanization: trajectory, means or end to professional formation?

Upon acquiring the status of science, Medicine, to a certain extent, relegated to a second level aspects considered subjective in the health/disease process (emotion, feelings, sensations, meanings, man himself

with his beliefs), in addition to aspects of the very context in which the individual lives. This fact led biomedical sciences to no longer characterize themselves by the dimension of care nor to be concerned about the phenomenon of the cure. This is perhaps the most serious deficiency of this approach and although cure is an essential aspect in all of Medicine, the phenomenon is considered outside the scientific orbit; the term cure is viewed with suspicion and the health concepts about social vision and cure are generally discussed by very few areas encompassing medical knowledge^{5,11,17,21}.

Thus, it can be concluded that the accelerated process of technological development in medicine, the uniqueness of the patients – emotions, beliefs and values – remained of secondary importance; their diseases became the object of scientifically recognized knowledge¹⁹. The action of the health professional, following this logic, became dehumanized.

The humanization of health professionals is currently part of formation and health care, but one must be careful not to underestimate the meaning and the word and understand what indeed is being sought where humanization is concerned^{19,23}.

Sgreccia²² points out that concerning this term, a number of concepts may be understood that are complementary among themselves. Therefore, we do not treat humanization only for the quality and importance of the interpersonal relation between the patient and health personnel faced with technological predominance or of the massification of health care services; it is also not understood only by introducing Human Sciences into the curricula of health courses. It deals with essence, with a deeper meaning of this tendency, that is, the recognition of the dignity in every human being, at any moment in life and under any social, psychic, economic, and cultural condition, from conception to death, including even his transcendent and collective character^{18,21,22}.

In this sense, the guidelines proposed by the National Humanization Policy of the Ministry of Health²³ emphasizes that humanization must not be interpreted as a proposal of vague actions that would be more closely associated to humanitarian attitudes of a philanthropic nature, voluntary and

charitable, a “favor” than to a civic attitude that reflects at the same time an obligation and a right of every individual.

This theme, in the health care setting, questions fundamental aspects of the offer and quality of services, the link between technological advances and care, with improved health care settings and working conditions for the professionals. Humanization, cannot be seen as but another “program” to be applied to different health services, but as a policy that operates transversally in all the National Health System network^{19,23}. Ceccim¹⁹, when discussing integrality and humanization in medical education, affirms that they do not involve only resolving organizational problems related to health services, but also refer to the professional profile, work organization and the effects of the formation of health professionals. According to Campos²⁴, humanization depends on personalized attention, considering the uniqueness of the individual and of the care required.

An important aspect for including humanization in the curriculum of medical schools must be the fact that the reform of current practices may be the result of a new form of teaching. The proposal of a contextualized and modern formation according to the needs of individuals and the incorporation of a concept of health beyond a biological model are fundamental factors for the evolution of integrality and humanization^{19,24}.

Once again, it must be emphasized that technoscience is not being condemned while the humanities are being exalted, but rather an attempt is being made to understand the complexity of the relation between both, and to abandon fragmentation for totality¹⁸. Reflecting on the proposal for humanization therefore, argues for the joining of the binomial human factor and the relationship with new technologies beneficial to humanity.

According to the Ministry of Health²⁵, the human factor gives rise to new strategies when faced with technologies and organizational precepts, above all, in the care process. To disregard this reality creates incompatibilities and/or resistance during organizational and behavioral negotiation. We could,

therefore, return medical practice to a social practice in a universe that, according to Souza ²⁶ demands the interpretation of meaning. This argument demonstrates that health does not consist of an educational subject or an area unconnected to social reality ²⁷.

According to Minayo (1998, p.13) ²⁷ the health field "requires a dialectic approach that understands in order to transform and whose theory, challenged by practice to a permanent rethinking". The health-disease process expresses therefore, a relation that, far beyond the individual and social body, is confronted with the turbulence of the human being as a total being. The clinical, philosophical and sociological elements experienced culturally are important in any health action, whether treatment, prevention or planning. The actions must be attentive to the values, attitudes and beliefs of the individuals and groups to which they are directed.

The possibility of valuing meaning, recognizing the construction of knowledge, suggests a rethinking of professional identity in the implementation of the concepts, practices and health care experienced in the teaching-learning process. Cassirer ²⁸ advises us that the content originating in this practice must be learned and interpreted according to the context in which it is produced, proceeding to a familiarization with the thinking that originated it and that will certainly be reproduced in professional life. It is necessary to consider that communication between the professional and his environment is marked by expressions, thoughts and values that the professors experience in the face of the reality of health care, often shaping thinking and assuming preconceptions when presented with the actions and attitudes of some types of professional activities when treating the user and in the definition of professional identity ⁵.

The concern with developing attitudes in the context of formation establishes a distinct relation between professor-student and transfers itself to the field of practices, in which the attitudes of professors, preceptors and supervisors with students in their first experiences treating individuals, take on great importance. There is a

reflexivity in humanized treatment that goes from teaching and learning to the student-patient. ^{29,30}.

Following this line of reasoning, Aach ³¹ emphasizes the need for understanding the conditions that surround learning, in which the vicissitudes inherent to medical formation are reconsidered and interpreted, especially in recognizing the experiences of the professors and students themselves. This initiative is confirmed by Laplantine ³² (1991), Carapineiro ³³ (1993), Helman ³⁴ (1994), Pitta ³⁵ (1994), Adam & Herzlich ³⁶ (1994), Svenson ³⁷ (1996), Caprara & Franco ³⁸ (1999), Deslandes ³⁹ (2004), intertwining the democratization of the relations that involve health care, a better dialogue and improved communication between the health professional and users of the service, as well as recognizing the expectations of the professionals themselves, as subjects in the therapeutic and learning process. Thus, in agreement with Deslandes ³⁹, we would be glimpsing a new field of possibilities: both with increased health care quality and a new relation based on recognition and dialogue. Cembramelli ⁴⁰ visualized a new era, anchored on the principle of language and communicative action.

Thinking of humanization as an object of investigating medical formation, seems to us pertinent to understanding the practices experienced in this field. Proposals for change in formation ^{41,42,43,44,45,46}, **besides considering the aspects already presented, have given emphasis to the broadening of teaching scenarios, removing the center of the process from hospitals ^{47,48,49,50}, as occurred one hundred years ago, which seems opportune to us, mainly in the search for more effective, resolute, and better quality health actions that provide the individual with autonomy. Caprara & Franco ³⁸ suggest that the formation of health professionals, when restricted to the hospital-centered and biomedical model, limits the understanding of experiences and suffering as components of their professional work experience.**

There is a movement in the field of education and health that calls for significant changes in the formation of the medical professional. Curriculum directives, the effective work of ABEM, Promed, Permanent Education Policies, Policies of Humanization in Health Care (HumanizaSUS), and the National Network Movement (Rede Unida) have been important approaches that should transform the manner

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