RBEM Revista Brasileira de Educação Médica

ORIGINAL ARTICLE

DOI: https://doi.org/10.1590/1981-5271v47.1-20210433.ING

Initial training of physicians working in primary mental health care

Formação inicial do médico que atua na Atenção Primária em Saúde Mental

Mayara Nakiria Tavares da Rocha[1] may_nakiria@hotmail.com
David dos Santos Calheiros[2] davidcalheiros@hotmail.com
Rozangela Maria de Almeida Fernandes Wyszomirska[1,2] rozawys@gmail.com

ABSTRACT

Introduction: The trajectory of medical schools towards the transformation of the traditional training model to an innovative and advanced perspective of training, including in the field of mental health, has been observed since the implementation of the Family Health Strategy.

Objective: The present study sought to understand the initial medical training in mental health, from the perspective of the physician working in Primary Health Care (PHC).

Method: For this purpose, a qualitative, exploratory, descriptive approach was adopted, in which data were obtained through interviews with physicians working in the PHC of a municipality in the Northeast of Brazil, whose corpus was treated based on the application of the thematic content analysis. Data collection for the study took place between June 2020 and June 2021, when medical professionals working in the municipal Family Health Strategy (FHS) were invited to participate. It is, therefore, an intentional, non-probabilistic sample. Of the seven physicians working in the municipal health network at the FHS level, five were included in the study.

Results: The study results indicate that medical training in mental health is still related to a biomedical vision, in which the hospital scenario is valued as a space for practices and PHC is underutilized in the development of professional skills and abilities, producing gaps that affect performance in the context of mental health care in PHC. The speeches also show deficiencies in the training related to the appreciation of issues related to medicalization and the difficulty in granting autonomy in mental health care.

Conclusion: Medical training in mental health should approach the reality of the general practitioner's work, in order to prepare them for the demands they will face in their daily routine in PHC.

Keywords: Mental health; Primary attention; Medical training.

RESUMO

Introdução: *O caminhar das escolas médicas em direção à transformação do modelo formativo tradicional em uma perspectiva inovadora e avançada de formação, inclusive no âmbito da saúde mental, vem sendo observado desde a implantação da Estratégia Saúde da Família (ESF).*

Objetivo: *O presente estudo buscou compreender a formação médica inicial em saúde mental, sob a perspectiva do médico atuante na atenção primária à saúde (APS).*

Método: *Para tanto, adotou-se uma abordagem qualitativa, de caráter exploratório, descritivo, na qual, por meio de entrevistas com médicos atuantes na APS de um município do Nordeste do Brasil, produziram-se dados, cujo corpus foi tratado com base na aplicação da análise temática de conteúdo. A coleta de dados do estudo ocorreu entre junho de 2020 e junho de 2021, quando os profissionais médicos atuantes na ESF municipal foram convidados a participar. Trata-se, portanto, de uma amostra intencional, não probabilística. Dos sete médicos atuantes na rede municipal de saúde em nível da ESF, cinco foram incluídos no estudo.*

Resultado: *Os resultados do estudo apontam a formação médica em saúde mental ainda vinculada a uma visão biomédica, em que se valoriza o cenário hospitalar como espaço de práticas e se subutiliza a APS no desenvolvimento de competências e habilidades profissionais, produzindo lacunas que afetam a atuação médica no contexto do cuidado de saúde mental na APS. Os relatos evidenciam, ainda, deficiências na formação relacionadas à valorização de questões pertinentes à medicalização e à dificuldade em conceder autonomia no cuidado em saúde mental.*

Conclusão: *A formação médica em saúde mental deve aproximar-se da realidade de atuação do médico generalista, a fim de prepará-lo para as demandas que enfrentará em seu cotidiano na APS.*

Palavras-chave: *Saúde mental; Atenção primária; Formação médica.*

[1]Universidade Federal de Alagoas, Maceió, Alagoas, Brazil.
[2]Universidade Estadual de Ciências da Saúde de Alagoas, Maceió, Alagoas, Brazil.

Chief Editor: Rosiane Viana Zuza Diniz.
Associate editor: Gustavo Antonio Raimondi.

Received on 10/27/21; Accepted on 11/21/22.

Evaluated by double blind review process.

INTRODUCTION

In the context of health system operations, issues related to human resources have always implied concerns, given that the reorientation of health models requires changes and evolutions in the work process and professional training[1].

From this perspective, medical training is presented as a contributing factor to the quality of health, being an aspect of constant attention from institutions such as the World Health Organization (WHO) and the Brazilian Association of Medical Education (ABEM, *Associação Brasileira de Educação Médica*), and Higher Education Institutions (HEIs), among others[2].

Historically, in Brazil, medical education has been guided by the North American influence, through the flexnerian model of education, characterized by the appreciation of the hospital environment, whose methodological stringency contributes to the production of a fragmented and decontextualized knowledge of reality of professional performance[3].

In this model of medical training, teaching is a technicist activity, concerned with diagnostic and therapeutic aid procedures and tools, valuing medical specialization[4].

However, a tendency to question this training process arose, guided by terms discussed worldwide, such as: the broader concept of health proposed by the WHO; the defense of Primary Health Care (PHC) and equal access to health for all citizens, proposed by the Alma-Ata Conference; and the concepts of the Ottawa Charter for Health Promotion, which criticized this biomedical model, valuing the perspective of quality of life in the field of health[3].

In Brazil, the Sanitary Reform and the creation of the Unified Health System (SUS, *Sistema Único de Saúde*) reaffirmed the limitations of traditional training, pointing to the need to develop a training model that would adapt to the demands of the health system and value the technical dimensions of work, without neglecting the political, social and ethical dimensions, from a perspective of a generalist, humanist and critical-reflective training[5].

In the 2000s, the National Curriculum Guidelines (DNC, *Diretrizes Curriculares Nacionais*) for the undergraduate medical course, corroborating the global trend in medical training, proposed a humanist training, with the expansion of student contact, even in the early years, with a health care network, highlighting the community and the centrality of teaching in PHC, directing the training towards the acquisition of skills consistent with the principles and needs of SUS consolidation[6].

Therefore, medical schools are moving towards the transformation of the traditional training model to an innovative and advanced training perspective, as seen in the study by Lampert et al.[7], in which the assessed medical schools show the search for the implementation of changes aiming to adapt to the DNC; more than half fit into the Advanced or Innovative typology regarding the desired transformations.

In mental health, trends also move towards the search for transformations. The Brazilian Psychiatric Reform (RPB, *Reforma Psiquiátrica Brasileira*) and the implementation of the Family Health Strategy (FHS) brought contributions to the reformulation of health care, encouraging community-based care, to the detriment of the traditional, medicalizing and hospital-centered model[8].

More recently, studies on mental health training in undergraduate school have appeared in the literature. For instance, Morcef and Acero[9], in a study of medical students' perception of the contact with and approach of patients with mental disorders and mental health teaching, emphasized the medical students' feelings of fear in relation to the first contact with a patient in mental suffering, especially the students in the beginning of the course. For the authors, it is necessary to expand the medical student's contact with mental health, aiming at better preparing the future doctor to care for a person with a mental disorder. In another study with university students, it was observed that students found it difficult to differentiate the role of psychologists and psychiatrists, in addition to the fact that psychiatry was defined as a career of low popularity, due to the associated stigmas and the psychiatrist's work environment, considered stressful and having a strong emotional load[10]. For other authors[11-14], it is extremely necessary that practical coping training in varied mental health scenarios, including integrative practices, be incorporated into medical curricula, in order to reduce the stigma on mental disorders.

Finally, Cavalcanti et al.[15] contribute by stating that a way of transforming mental health care consists in developing medical training practices in PHC, from the perspective of a training that incorporates principles such as effectiveness and integrality, expanding medical practice beyond the traditional psychiatry.

Therefore, the present study sought to record the perception of physicians working in PHC about their medical training process in mental health.

METHOD

This is a study with a qualitative approach, with an exploratory focus, given the need to understand the phenomenon that is built during the experience of the individuals and in their subjectivities, being part of the Term paper of the Professional Master's Degree in Family Health in the PROFSAUDE Network, Medical School, Universidade Federal de Alagoas.

Aspects of the Consolidated Criteria for Reporting Qualitative Research – COREQ[16] were used to guide the production process and data analysis, as well as the creation of the research report.

Data Collection

The data collection for the study took place between June 2020 and June 2021, in a municipality in the state of Alagoas, Brazil. All those invited to participate in the study were medical professionals working in the Family Health Strategy (FHS) in a municipality in Northeast Brazil.

A non-probabilistic intentional sample was adopted. According to Gil[17], this type of sampling criterion does not consider mathematical or statistical language as a foundation; on the contrary, it depends solely on subjective criteria established by the researcher.

Among the eligibility criteria to participate in the study, the participant should be an active physician in FHS and provide care to patients in mental distress. Of the seven physicians working in the municipal health network at the FHS level, five, voluntarily and by consent, signed the Free and Informed Consent Form (FICF) and were included in the study. Two medical professionals were excluded from the study, one for refusing to participate (the reason for which was explained by lack of time and work overload) to participate, and another for being the main researcher of the study.

There were five study participants, four male and one female physicians, aged between 27 and 72 years, with time since graduation ranging from three months and 44 years. Only one participant completed the course in a private institution, whereas the others studied in a public institution; only one of the participants had a specialization in Family Health; the time since they started working in the PHC ranged from one month to twenty years.

A semi-structured interview script, prepared by the researchers, was used as an instrument for data collection. The instrument has two parts: the first deals with the participants' sociodemographic aspects (gender, age, graduation, post-graduation, place and time of training, time working in PHC and in mental health); the second part is responsible for gathering the open questions directed at the study objectives, in a total of eight triggering questions. This interview script was revised and its sensitivity was checked through a pre-test, which was applied to two physicians working in the FHS, but who were not part of the research sample. The defined application standards were followed, aiming to allow the investigation of the need for changes in its structure.

To carry out the interviews, the characteristics of the workload of the medical professionals were noted and respected, both in the FHS and in other employment relationships. There were some difficulties, which were attenuated in the end. Moreover, the situation of the Covid-19 pandemic required adaptations for data collection, so that four interviews were carried out in person and one through virtual means (through the Google Meet platform, which is a service communication tool developed by Google).

All interviews were conducted by the main author of the research, who at the time of the study was working as a physician. The other two researchers were responsible for supervising the main author in the research and worked as professors/researchers at a public university in Brazil.

The participants were contacted individually by telephone, email address and/or WhatsApp application. This information was obtained from the Municipal Health Department of the assessed municipality. There were no conflicts of interest between the study researchers and the participants, which could, for any reason, interfere with the performance of the research.

The interviews were scheduled according to the participants' availability and took place individually in medical care rooms, which were airy and bright. It should also be noted that the interview took place away from the presence of third parties, to avoid possible constraints and/or research biases. The interviews lasted from 25 to 40 minutes; the content was recorded using specific electronic equipment and the transcription was made in full by the researcher herself. The transcripts were not returned to the participants for comments and/or corrections.

Data analysis

The analysis was guided by the data, characterizing an inductive approach, whose identified topics are detached from the previous literature. For this purpose, the Thematic Analysis, by Braun et al.[18], was used, which is one of the classic procedures for analyzing textual materials. This type of analysis tends to value the material to be considered, allowing, above all, to contextualize it with the social and historical facts in which it was produced. Due to its theoretical freedom, thematic analysis presents as a flexible tool, capable of providing a broad and complex set of data[18].

After the completion of the interviews, the thematic analysis phases were carried out (Table 1). The coding of the topics was carried out manually, through floating reading of the data.

Once the previously mentioned procedures of thematic analysis were established, five topics emerged, being discussed in this article "The interaction between medical practice in mental health in primary care and training", with two

Table 1. Phases of thematic analysis

Phases		Process description
1	Getting familiarized with the data	Transcription of data (if necessary), reading and rereading the data, taking notes of initial ideas.
2	Generating initial codes	Systematically coding interesting data characteristics in the entire data set. Collection of relevant data for each code.
3	Searching for topics	Clustering codes into potential topics, bringing together all relevant data for each potential topic.
4	Reviewing topics	Verifying whether the topics work in relation to the coded excerpts (Level 1) and the entire data set (Level 2), generating a thematic "map" of the analysis.
5	Defining and naming topics	New analysis to refine the specificities of each topic, and the overall story told by the analysis; generation of definitions and clear names for each topic.
6	Producing the report	Last opportunity for analysis. Selection of vivid and compelling examples from the excerpts, final analysis of selected excerpts, relationship between analysis, study question and the literature, creation of an academic report of the analysis.

Source: Adapted from Braun et al.[18].

subcategories: Spaces for academic training and Contribution of academic training.

Ethical aspects

The research was approved by the Research Ethics Committee under opinion number CAAE: 331046720.5.0000.5013. In order to guarantee the participants' anonymity, fictitious names were assigned to them.

RESULTS AND DISCUSSION

During the development of the study, the physicians working in PHC who participated in the research were asked about their academic training process (training spaces and contribution of training), especially in the field of mental health.

Training spaces

The training spaces were presented as a component of the professional training process, being the place where the educational proposal and the perspective of action are designed, according to the following excerpts:

> *At the university, we had a discipline in the school, a mental health discipline, some practical classes at clinics in Maceió, Ulisses Pernambucana, a psychiatric hospital. There was a psychiatry discipline at the University. (JOSÉ)*

> *My experience when I graduated was like that, in an emergency room. I spent three years in the emergency room, internship experience at Ulisses Pernambucana. But it was not something I loved to do... More hospital-oriented. (FRANCISCO)*

Learning spaces were considered a crucial point in the educational process. In this perspective, Machado et al.[19] highlighted the scenarios of practices as places of unique experiences, where the student can develop experiences that are impossible to reproduce solely in the classroom context.

The aforementioned excerpts also point to the predominance of the psychiatric hospital as a space for the physicians' training and contact, as students, with mental health (MH). It should be noted that these excerpts are reports by professionals who graduated around forty years ago, thus representing a period of Flexnerian medicine, whose proposal for medical education was guided by a reductionist view, which valued hospital-centered care, conditioning the student to a restricted view of the patient, directed to anatomoclinical aspects[2].

In that period, the existence of the SUS was still not acknowledged, and the field of mental health showed, in an embryonic form, the concepts of the Brazilian Psychiatric Reform (RPB), which in the future would be the foundation for the National Mental Health Policy and the construction of the Psychosocial Care Network (RAPS, *Rede de Atenção Psicossocial*).

However, the reports of younger medical professionals, trained in the last five years, in a context of training different from the previous one, also emphasize the psychiatric hospital as the main training space, although other RAPS points of care, such as the Psychosocial Care Center (CAPS, *Centro de Atenção Psicossocial*), is presented as an alternative of learning experiences, as seen in the following reports:

> *In my medical school, we had a psychiatry outpatient clinic in undergraduate school; the internship also had two months of psychiatry and CAPS. We worked in the CAPS. As there was no access to Portugal Ramalho (psychiatric hospital), our field was just that (MARIA)*

> *During the psychiatry and mental health classes at Hospital Portugal Ramalho, there were many experiences with patients (JOÃO)*

> *In the undergraduate discipline itself, of the formal curriculum, we only experienced the Portugal Ramalho (psychiatric hospital) environment, right!!! Which is the reference hospital, and there we went through some fields, the PISAN, which is the outpatient clinic, the emergency room and the wards. But like that... Yeah... Theoretical classes were included, which had a deficiency from my viewpoint. They were very restricted to what the teacher wanted to communicate... The drug approach, the therapy in general "left something to be desired". (PEDRO)*

From this perspective, the question arises: are we still experiencing mental health training from decades ago?

Brazilian medical education, over the last twenty years, has undergone changes. The advent of the creation of the Unified Health System (SUS) and the mismatch between the configuration of the current medical practice and the health demands of the population culminated in curricular transformations[20].

The National Curriculum Guideline (DCN, *Diretriz Curricular Nacional*), in 2001, and especially in 2014, brought a proposal for innovation in medical training, as they supported the expansion of training spaces through the insertion of students into health services, as early as in the first years of medical school and when throughout the course[21].

The expansion of learning spaces, including new practice scenarios in the context of the changes in medical education, allows a humanistic curriculum approach, under the exegesis of integrality[22].

Medical training, when guided by the student's acquaintance with the health service routine and the users' daily lives, tends to provide a more solid education, allowing the strengthening of bonds[19].

In the field of mental health, Touso et al.[14] state that it is necessary to include the student in care scenarios since their first steps in academia, aiming to develop the perspective of comprehensive care/assistance, stimulated by early contact with the person in mental distress.

However, the reports show that the expansion of training spaces, in the field of mental health, is still a limited process even for those professionals with more recent medical training, from the perspective and scope of the DCNs, with the persistence of hospital centrality and the restricted use of other care services, with the intention of diversifying training spaces.

The present study corroborates the findings of Chehuen Neto et al.[22], in which the perception of medical students and physicians participating in the study pointed to a merely occasional involvement with PHC, which for the authors constitutes evidence that the curricular reform has not yet been fully implemented, persisting in some schools the valuing of the hospital space as a training field.

For Cardoso et al.[23], the persistence of the hospital centrality contributes to the inadequacy of the trained medical profile, hindering the acquisition of skills and the professional identity formation, favoring distortions in health care and the maintenance of power relations between physicians and users.

In the study by Stella et al.[24] with medical schools, it was observed that no institution adopted the traditional model, having only the hospital as a training space. Around 25% of the evaluated schools were classified as innovative, that is, a structured course in the hospital environment, but with some interaction with PHC during internship. In this scenario, the difficulty of articulation with municipal services is identified as a limiting factor. The other schools, around 75%, have an advanced curriculum, which proposes and recognizes the importance of diversifying training scenarios, establishing partnerships with municipalities.

In their study, the aforementioned authors also point out that the use of other scenarios has been restricted to some disciplines such as Collective Health and Preventive Medicine, and add that there are mismatches between the intentionality of curricular innovation of medical schools and the experienced and evidenced reality, since although they are classified as innovative or advanced, using active teaching methodologies, they maintain actions without integration between theory and practice throughout the teaching-learning process.

As for the perspective of PHC as a training space in mental health, it is noteworthy that only one participant among all of them, especially among those trained in the last five years, refers to PHC as a field of practice and care in mental health, even if occasionally and undirected, as shown below:

> *[...] in primary care, it ended up that we had family medicine in the community [curricular discipline]; sometimes we cared for psychiatric patients, but, well, not focused on that, there was nothing special focused on that. But from the second semester until the end of my training, we went through many stages in primary care (MARIA).*

PHC is recognized as the main scenario for professional training in the field of health and mental health care, given its capacity to promote access to and the effectiveness of care for most mental disorders[24].

However, the participants' reports depict PHC in a secondary role when it comes to training in MH, disregarding the possibilities that this level of attention can propose.

DOI: https://doi.org/10.1590/1981-5271v47.1-20210433.ING

From this perspective, one does not take into account the fact that many medical school graduates will have their first professional experiences in the scope of PHC working in the Family Health Strategy[25].

For Costa et al.[20], the insertion of students in the PHC scenario throughout undergraduate school puts them in contact with the health reorganization model in the country, allowing the development of aspects such as doctor-patient relationship, diagnostic communication skills and therapeutic approaches in line with social, regional, economic and cultural variants.

Drawing on the experience gained from a MH internship integrated with Family and Community Medicine (FMC, *Medicina de Família e Comunidade*), Cavalcanti et al.[15] defend in their study that PHC is the best scenario to train future general practitioners in MH, given the possibility to fill out the existing therapeutic gap in this health field, by training professionals able to provide care from a biopsychosocial perspective and valuing the potential of PHC in this care. The authors also point out the PHC, CAPS, Family Health Centers (NASF, *Núcleos de Saúde da Família*) and Street Clinics (CR, *Consultórios na Rua*) as priority scenarios for medical training in the field of mental health, bearing in mind that what is intended is the training beyond the perspective of psychiatry, with the recognition of mental disorders, expanding the perception of human suffering free from the need for a diagnosis.

Contribution of training

As for the contributions of academic training in medical practice in mental health in PHC, the participants are categorical in giving predominantly negative connotations, as they recognize the training gaps that affect their performances from the perspective of working in mental health in PHC, as shown in the following excerpts:

> *The medical school training in psychiatry is very insufficient, it does not provide the adequate support that we need. (JOSÉ)*

> *No, it didn't prepare me for this. Today I see mental health as something very much based on medication, when in fact medication would just be an aid... We study a lot of drugs, how they will relieve those symptoms, and forget the psychosocial part, which for me today is the most important. (JOÃO)*

> *Look, I don't think so, honestly, because even though we go through some internships that include mental health, for me the autonomy of being a doctor as soon as we graduate is already very difficult, for you to acquire this autonomy of making decisions, establishing conducts and everything. In mental health, I think it's even more so, because you have to be a medical, scientific and emotional help for the patient as well. We are often not ready, especially emotionally... (MARIA)*

> *I think our training in psychiatric emergencies has many gaps, because we end up seeing patients and treating them scientifically, technically, but emotionally we don't have the basis to deal with some situations. (MARIA)*

> *It was very deficient, as I said. The discipline itself. The internship. I believe that we do not have an active attitude towards mental health, right? I'm talking about my university, what I experienced. And since we are faced with the reality of assistance as a professional, I believe I was not fully prepared. Very fragile indeed, very anxious, very worried about this approach. (PEDRO)*

> *[...] it deals a lot with the specialization. I think it's a remnant of the hegemonic biomedical model, which encourages us to work focused on that specialist's role. I believe that what we experienced, especially in medical school, was focused exclusively on a specialty performance, and not on the broader, generalist sense, which can significantly contribute to Primary Care and public health. But like that, we didn't have a generalist training, no. It was more focused on the specialty. (PEDRO)*

The aforementioned reports point to deficiencies in training in the field of mental health related to the appreciation of questions related to the "use of medication" and the difficulty in granting autonomy in mental health care, through learning affective skills (emotional and psychological) and that imply the performance of the PHC professional.

Corroborating these reports, Campos et al.[26] state that the difficulties inherent to the practice of mental health care in PHC arise from the maintenance of the medicalizing biomedical model, associated with a fragile training, driven by the fragmentation of care into specialties, with reduced territory and community practices.

Similarly, the study by Pereira et al.[8], carried out with PHC physicians in the city of Sobral, state of Ceará, identified the feeling of being unprepared, expressed by these professionals, in meeting mental health demands and emphasized flaws inherent to academic training, as highlighted by the authors:

> *[...] the mental health topics were insufficient, eminently hospital-centered, curative and outside the context of community care. In some cases, training took place in a very negative way, reinforcing prejudices and taboos in relation to psychiatric care, creating barriers that hindered the interest and availability of these physicians to care for patients with mental disorders (p. 8)[8].*

Pereira et al.[8] mention the training gaps related to the unpreparedness of physicians regarding the development and use of non-pharmacological resources, such as listening and the

construction of therapeutic plans, seen as limiting regarding professional performance, disclosing the need for change in the care paradigm due to the patients' emotional demands.

To transform this perspective is a challenge, considering the marginalization and isolation given to the mental health topic in the context of medical schools[27].

Although authors such as Cardoso et al.[23] highlight the scarcity of Brazilian studies, in recent years, aimed at learning cultural skills focused on psychosocial suffering in the undergraduate period, especially in the context of internship, other studies such as the one Touso et al.[14] show the possibility of transforming care, by proposing the expansion of training scenarios in the context of mental health, encouraging contact of students, as early as in the first years of medical school, with psychosocial care, and providing a discussion of skills aimed at a humanistic approach and the integral assistance of the human being.

Thus, the need to pay more attention to medical training in the field of mental health and the way this process is conducted is emphasized, since, according to the 2014 DNC, MH is a mandatory area to be included in the development of medical graduation. From this perspective, the training needs to result in general practitioners who are effective in their approach to patients, whatever the level of care, especially in PHC and urgency/emergency medicine. They must be professionals not only endowed with general skills, but also capable of promoting a humanistic approach, guided by the integrality of care[21].

CONCLUSION

The present study aimed to understand the process of medical training in mental health. It was verified that the training still values the hospital setting and biomedical interventions, underutilizing PHC spaces in the teaching of young doctors in training.

It is also noteworthy that the training scenario in mental health, which is outlined through the participants' reports, depicts a training that is partially incompatible with the real work needs and demands of these professionals in PHC, because, whereas it teaches them to recognize mental disorders and carry out medication interventions, it neglects other possibilities for action and the development of cultural and emotional skills necessary to care for human suffering.

Therefore, there is a mismatch between the DCN training proposals and the reality experienced by professionals during the undergraduate period, due to the restriction of training spaces and the valuing of the specialty, to the detriment of the generalist performance.

Therefore, it can be said that medical training in mental health needs to get closer to the reality of the general practitioner's work, aiming to prepare them for the demands they will face in their daily routine in PHC.

It should also be noted that this study does not fill all the necessary gaps to understand the proposed topic, and its limitations comprise the non-evaluation of the pedagogical curricular projects of the universities attended by the participants, as well as by the limitation of the data collection procedure, but only through interviews. It is therefore suggested to expand the discussion through other collection methods, such as focus groups, encompassing the participation of other categories – such as medical educators and students – aiming to understand medical training from other perspectives.

As for the interpretation of the results, the need for caution is emphasized to avoid generalizations, considering the limitations of the sample and the local context where the study was developed.

AUTHORS' CONTRIBUTION

Mayara Nakiria Tavares da Rocha, as the main author and Master's degree student, was responsible for leading the study, especially the bibliographic review, data collection, article writing, data curation, and discussion of the results. David dos Santos Calheiros, in turn, was in support, from the project design, structuring of the methodology, discussion of results and review of the manuscript and approval of the final version of the manuscript. Rozangela Maria de Almeida Fernandes Wyszomirska, as the advisor, supervised all the work, coordinating research orientation meetings, monitoring data collection, monitoring compliance with the methodology, evaluation and discussion of results, manuscript review and approval of the final version of the manuscript.

CONFLICTS OF INTEREST

The authors declare no conflicts of interest.

SOURCES OF FUNDING

The authors declare no sources of funding.

REFERENCES

1. Barbosa SP. Aspectos que compõem o perfil dos profissionais médicos da Estratégia Saúde da Família: o caso de um município polo de Minas Gerais. Rev Bras Educ Méd. 2019;43(1-1):395-403.
2. Meireles MAC, Fernandes CCP, Silva LS. Novas Diretrizes Curriculares Nacionais e a formação médica: expectativas dos discentes do primeiro ano do curso de Medicina de uma instituição de ensino superior. Rev Bras Educ Med. 2019;43(2):67-78.
3. Machado CDB, Wuo A, Heinzle M. Educação médica no Brasil: uma análise histórica sobre a formação acadêmica e pedagógica. Rev Bras Educ Med. 2018;2(4):66-73.
4. Ceccim RB, Feuerwerker LCM. Mudança na graduação das profissões de saúde sob o eixo da integralidade. Cad Saude Publica. 2004;20(5):1400-10.

5. Silva LA, Muhl C, Moliani MM. Ensino médico e humanização: análise a partir dos currículos de cursos de Medicina. Psicol Argum. 2015;33(80):298-309.
6. Rodrigues LHG, Duque TB, Silva RM. Fatores associados à escolha da especialidade de medicina de família e comunidade. Rev Bras Educ Med. 2020;44(3):e078.
7. Lampert JB, Costa NMSC, Perim GL, Abdalla IG, Silva RHA, Stella RCR. Tendências de mudanças em um grupo de escolas médicas brasileiras. Rev Bras Educ Med. 2009;33(1 supl 1):19-34.
8. Pereira AA, Andrade DCL. Estratégia educacional em saúde mental para médicos da atenção básica. Rev Bras Educ Med. 2018;42(1):4-12.
9. Morcerf CCP, Acero PHC. Saúde mental nas escolas médicas: trabalhando com percepções de acadêmicos de Medicina. Pluralidades em Saúde Mental. 2021;10(1):1-5.
10. Firmin MW, Wantz RA, Geib EF, Ray BN. Undergraduate students' perceptions of practicing psychiatrists. J Psychiatr Pract. 2012;18(6):460-6.
11. Benedetto MAC, Gallian DMC. Narrativas de estudantes de Medicina e Enfermagem: currículo oculto e desumanização em saúde. Interface (Botucatu). 2018;22(67):1197-207.
12. Feijó LP, Motta SG, Saldanha RP, Kubrusly, M, Augusto KL. Diminuição do estigma sobre transtorno mental após internato em psiquiatria do curso de Medicina de duas instituições em Fortaleza (CE). Rev Bras Educ Med. 2019;43(4):141-50.
13. Santos VH, Ferreira JH, Alves GCA, Naves NM, Oliveira SL, Raimondi, GA et al. Currículo oculto, educação médica e profissionalismo: uma revisão integrativa. Interface (Botucatu). 2020; 24: 1-17.
14. Touso MFS, Figueiredo GLA. A educação médica nos cenários de práticas em anos iniciais da formação: sentidos tecidos pelo photovoice. Interface (Botucatu). 2020; 24:e190327.
15. Cavalcanti MT, Gomes MK, Azevedo LMS. Internato de saúde mental para alunos de Medicina: qual o melhor cenário de formação? Interface (Botucatu). 2020;24:e190159.
16. Souza VR, Marziale MH, Silva GT, Nascimento PL. Tradução e validação para a língua portuguesa e avaliação do guia COREQ. Acta Paul Enferm. 2021;34:eAPE02631.
17. Gil AC. Como elaborar projetos de pesquisa. 4a ed. São Paulo: Atlas; 2002.
18. Braun V, Clarke V. Using thematic analysis in psychology. Qual Res Psychol. 2006;3(2):77-101.
19. Machado C, Oliveira JM, Malvezzi E. Repercussões das Diretrizes Curriculares Nacionais de 2014 nos projetos pedagógicos das novas escolas médicas. Interface (Botucatu). 2021; 25:e200358 [cited 2021 feb 10]. Available from: https://www.scielo.br/pdf/icse/v25/1807-5762-icse-25-e200358.pdf.
20. Costa JRB, Romano VF, Costa RR, Gomes AP, Alves LA, Batista RS. A transformação curricular e a escolha da especialidade médica. Rev Bras Educ. Med. 2014;38(1):47-58.
21. Brasil. Resolução CNE/CES nº 3, de 20 de junho de 2014. Institui Diretrizes Curriculares Nacionais do curso de graduação em Medicina e dá outras providências. Brasília: MEC; 2014 [cited 2021 aug 10]. Available from: http://portal.mec.gov.br/index.php?option=com_docman&view=download&alias=15874-rces003-14&category_slug=junho-2014-pdf&Itemid=30192.
22. Chehuen Neto JA, Sirimarco MT, Cândido TC, Ulhoa CM, Reis BP, Lima VM. Formação médica generalista: percepção do profissional e do estudante. HU Revista. 2014;40(1-2):15-25.
23. Cardoso FM, Campos GWS. Aprendendo a clínica do sofrimento social: narrativas do internato na atenção primária à saúde. Ciênc Saúde Colet. 2020;25(4):1251-60.
24. Stella RCR, Abdalla IG, Lampert JB, Perim GL, Silva RHA, Costa NMSC. Cenários de prática e a formação médica na assistência em saúde. Rev Bras Educ Med. 2009;33(1 supl 1):63-9.
25. World Health Organization. Mental Health Gap Action Programme. Genebra: WHO; 2019 [cited 2021 apr 15]. Available from: http://www.who.int/mental_health/mhgap/en.
26. Campos DB, Bezerra IC, Jorge MSB. Produção do cuidado em saúde mental: práticas territoriais na rede psicossocial. Trab Educ Saúde. 2020;18(1):e0023167 [cited 2021 mar 8]. Available from: http://www.scielo.br/scielo.php?script=sci_arttext&pid=S1981-77462020000100502&lng=en&nrm=iso.
27. Hamamoto Filho PT, Santos Filho CA, Abbade JF, Peraçoli, JC. Produção científica sobre educação médica no Brasil: estudo a partir das publicações da Revista Brasileira de Educação Médica. Rev Bras Educ Med. 2013;37(4):477-82.